



Miami Valley Hospital

Other Policies Pertaining to Residents and Fellows

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Plan for the Provision of Patient Care

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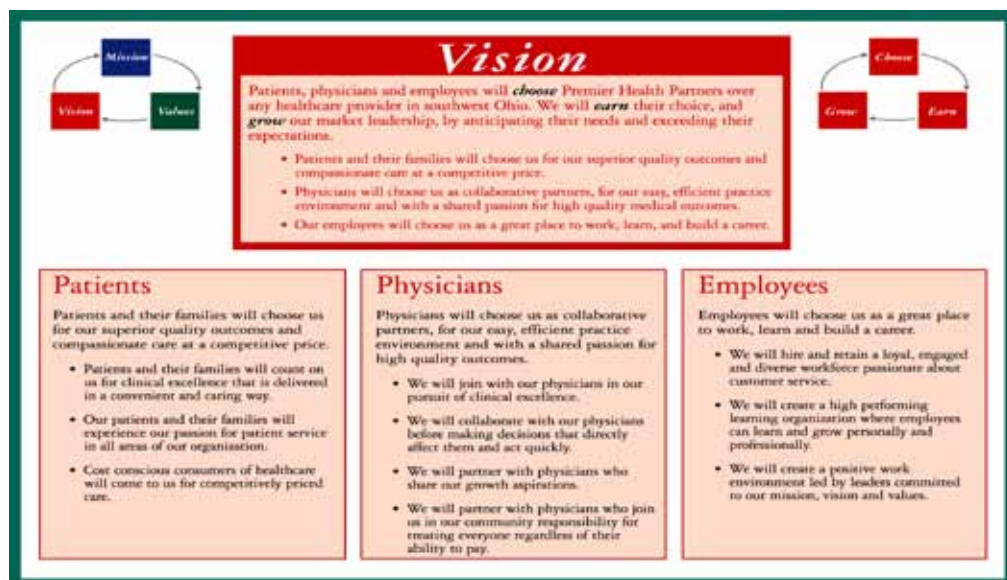
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Approved by:

Mission



Vision





Description of Setting

Miami Valley Hospital (MVH) is a non-profit, 865-bed acute care, tertiary referral hospital with specialties in Level I trauma services, cardiology services, cardiac and thoracic surgery, orthopedic services, dialysis and transplantation services, hematology/oncology services, blood and marrow transplant services, perinatal services, Level III neonatal services, air ambulance service, mobile intensive care unit, medical-surgical services, bariatric services, burn injury services, pain, women's health, outpatient chemical dependency services, rehabilitation services, and psychiatric services. Miami Valley Hospital also includes Miami Valley Hospital South which provides the following services: Emergency Department, inpatient care, Surgical Services, Preadmission Testing, Hyperbaric Oxygen Center, Physical Therapy, Hand Therapy and Sports Medicine, Outpatient Testing and Diagnostic Services, ATA, Cancer Center with gynecologic oncology health and infusion, perinatal services and Level II nursery. Miami Valley Hospital also includes the Jamestown campus with a free standing Emergency Department with outpatient diagnostic and therapy services.

Miami Valley Hospital has a long-standing history of student development in all health care fields. Clinical and administrative educational opportunities are provided by MVH in affiliation with area colleges and universities. Affiliations include, but are not limited to: Wright State University, Miami University, Sinclair Community College, Kettering College of Medical Arts, Cedarville University, University of Cincinnati, Ohio Northern University, and The Ohio State University.

Clinical and administrative educational opportunities are provided in conjunction with, but not limited to, the medical staff, the nursing staff, and numerous other patient care and patient support departments (e.g., MVH has an accredited dietetic internship program and an accredited program of clinical pastoral education). Educational experiences are provided for students based on a sense of commitment to the community, patient care, education and research, and as part of ongoing recruitment efforts.

The Planning Process

Patient services at MVH are based on its mission and are provided through an organized and systematic process. Planning for patient services is driven by input from many sources including, but not limited to, patient satisfaction tools and feedback, community needs and expectations, the internal organization, industry and business, performance improvement teams and quality improvement measures, market research, focus groups, third-party payers, and employee and physician surveys. The Heart Vascular and Ortho Tower, NICU Renovation, Lift Team, Bariatric Care, Diabetes Program, Trauma Unit, and MVHS expansion projects are examples of services developed in response to the monitoring of local and national trends and patient satisfaction surveys.

The Plan for the Provision of Patient Care Services outlines the organizational components integral to the provision of safe, effective and efficient patient care. The plan is integrated with the hospital's strategic priorities and the budgeting process. It is reviewed by executive leadership and revised when indicated. It considers the following:

1. Planning for services
2. Directing services
3. Implementing and coordinating services
4. Improving/redesigning services
5. Adding or deleting services
6. Providing services to populations with diverse needs
7. Communication/integration necessary between departments and services throughout Premier Health to achieve optimal outcomes in a timely manner.

A planned approach to integrating patient care services allows each department to better understand the interrelationship between services and patient care needs and expectations necessary to move patients through the system in a timely and cost-efficient manner. The Plan for the Provision of Patient Care Services at MVH assures the following:

1. Provision of a comparable level of care to patients throughout the organization;
2. Meeting acuity and staffing needs;
3. Ongoing efforts to improve processes in the design and delivery of patient care from admission through the continuum of care;
4. Commitment to recruiting and retaining qualified staff; and
5. Integrated communications throughout the organization.

Organizational Structure: See Chart Appendix.

Governance

The MVH Board of Trustees is responsible for the quality of care provided by the organization. The board is responsible for adhering to the mission and is accountable for the functioning of activities related to credentialing, community benefits, human resources, diversity and quality/safety. The Premier Health Board and is responsible for the financial supervision and resource allocation.

The President and Chief Executive Officer

The President and Chief Executive Officer is accountable for the development, implementation, and evaluation of short-range and long-range objectives, plans, and policies that impact the nature and scope of MVH in order to assure continued viability, growth, and success.

Chief Nursing Officer

The Chief Nursing Officer (CNO) is licensed as a registered nurse in the state of Ohio and is a Vice President of Hospital Operations functioning as a member of the administrative team. Responsibilities include planning, organizing, staffing, influencing and coordinating clinical services, utilization of evidenced based nursing practice, monitoring and evaluating nursing care, supporting nursing education, professional development, research, promoting collaboration between various hospital departments, financial planning and resource allocation. The CNO functions as an integrator and facilitator of institutional, interdepartmental, and interdisciplinary communications. The CNO participates in the formulation, interpretation, and implementation of departmental and institutional strategic plans. The CNO is ultimately responsible and accountable for the assessment, development, implementation, and evaluation of nursing practice and standards throughout the organization. She/he represents nursing on the MVH Board of Trustees, the Joint Conference Committee of the MVH Board of Trustees, the Medical Staff Executive Committee, the Premier Systems Leadership Council Quality Council, and the Sentinel Event Response Team.

The CNO is responsible for developing, implementing, and evaluating a hospital-wide plan for providing nursing care. This plan can be found in the Nursing Administrative Manual. The primary focus of nursing throughout the organization is the delivery of responsible, evidence-based and outcome-oriented nursing care based on standards that reflect quality derived from the literature, performance improvement and research. Processes are in place to assure communication between the CNO and nurses throughout the organization. These include rounding in patient care areas, publicizing email and phone number, Nursing Leadership Group meetings, Open Meetings with the CNO, and attendance at the Professional Practice Council meetings.

Chief Medical Officer

The Chief Medical Officer (CMO) is responsible for key interfacing between the medical staff and the interdisciplinary teams directly interfacing with the CNO and delegates. The primary focus of CMO throughout the organization is the delivery of responsible, outcome-oriented medical care based on evidence based standards that reflect quality derived from performance improvement and research.

The Medical Staff

The 1,110 member MVH Medical Staff is a self-governing body and subject to the authority of the MVH Board of Trustees. The Medical Staff Bylaws, Rules, and Regulations govern members. The medical staff is accountable to the governing body to oversee all medical aspects of patient care. The medical staff reviews the credentials and information related to the clinical competence of medical staff members and makes recommendations to the governing body for membership and/or delineation of privileges. It is the responsibility of the medical staff to recommend action to the President and Chief Executive Officer on matters of a clinical-administrative nature and to make recommendations related to strategic planning to the governing body.

Leadership

The role of the leadership at MVH is to define a strategic direction that is consistent with the organization's mission. The leadership clearly communicates the organization's mission and strategies and provides the framework to accomplish the priorities of the organization. Leadership is responsible to empower staff to assume accountability and responsibility for work processes. The leadership at MVH is charged with 24-hour accountability for the processes integral to the care of the patient.

The evaluation of staffing needs is the responsibility of leadership and is developed based on the intensity, scope, and frequency of care to be provided. Guidelines outline the number and mix of staff members in each unit, area, or department required to provide patient care. (The Acuity Plus/WinPFS inpatient, and mental health are examples of acuity and staff modeling systems used in the organization.)

Staffing Collaborative

As part of our shared governance structure, a staffing collaborative (a shared governance subgroup), consisting of nurses from direct care positions, along with various members of nursing leadership, exists to provide safe, high quality care in an environment that promotes shared leadership in staffing plan decisions. This collaboration promotes employee satisfaction while promoting quality patient care by providing more consistency in caregivers for our patients

With Staff input, Leadership is responsible for:

1. Coordinating and integrating services to provide a uniform level of care
2. Developing policies and procedures that guide and support services
3. Identifying equipment and resources needed to provide services
4. Determining qualifications and skill mix needed to provide patient care
5. Continually improving services offered to promote safe & effective patient care
6. Ensuring staff are competent to provide care
7. Developing educational programs to provide on-going skill enhancement
8. Prioritization of services and utilization resources and
9. Developing and implementing new programs based on market trends, patient needs and research.

The Strategic Plan

The strategic planning process is interdisciplinary and involves the medical and patient care staff. The strategic goals of MVH are to:

1. Improve the quality of patient care and customer service to achieve the highest level in the region.
2. Attract and retain employees with superior skills and teamwork behaviors.
3. Expand the margin of leadership in hospital services in the Greater Miami Valley Region.
4. Maintain at least a 3 percent overall operating margin to support the MVH mission.

Relationship of Planning to Budget

The planning and budgeting process is continuous. Miami Valley Hospital's planning methodology incorporates relevant information and data specific to each of its service departments for integration into the planning for the organization as a whole. Sources of information and data include, but are not limited to, performance improvement and research activities, diagnostic monitoring of benchmarking projects, (e.g. pain management, infection control, integrative care management), meeting minutes, staffing plans, policies and procedures, patient satisfaction studies, financial reports, the scope of service descriptions, standards of care, Safety Committee recommendations, Employee Health reports and Professional Practice meetings.

On a regular basis the Strategic Plan, operational priorities, the Plan for the Provision of Patient Care, and scopes of services are reviewed and revised as appropriate. These documents are utilized at the department level to develop plans to address the hospital's priorities for the coming year.

The Finance Department reviews past financial performance and forecasts performance for the next five years. The five-year forecast becomes the basis for the budget targets annually.

During the budgeting process, departments are asked to review their scopes of service, department specific plans, and other data to identify significant changes that may not be reflected by the historical financial data. Examples of department input may include starting a consultant contract or changes in preventative maintenance contracts that would not be captured through the historical data process.

Departments submit changes to the Finance Department to assist in preparing the five-year financial forecast and operating budget targets. Departments are charged with achieving their targets and/or providing justification for variances. Individual department/unit goals are also derived from the operational priorities.

Integration and Communication among Departments

The patient care services provided by each of these identified service groups are described in the scope of services and include:

1. Service goals;
2. The type(s) and age(s) of patients served;
3. The scope and complexity of the patients' care needs;
4. The extent to which the levels of care meets the patients' needs;
5. The appropriateness, clinical necessity, and timeliness of support services;
6. Standards or guidelines for practice; and
7. Methods that are used to assess and meet patients' care needs.

Scopes of service are used in program planning, staff orientation, and as a communication tool between departments (see attachments). Services are integrated through performance improvement and research efforts, collaborative practice groups, and integrative care management. Management Forum meetings, mailings, and the hospital's Operations Manual facilitate communication.

Care of the Patient

Patients at MVH can expect:

- To be treated with compassion, respect, and dignity without regard to race, color, sex, age, religion, national origin, handicapped status, or economic means;
- A health status assessment relevant to the patient's diagnosis, care setting, and desire for treatment;
- An individualized, interdisciplinary plan of care that is monitored and evaluated;
- Procedures, treatments, interventions, and care delivered according to established policies, procedures, care guidelines, and protocols that reflect practice standards and research;
- Health education and discharge assessment and planning;
- An environment that promotes healing and psychosocial well-being;
- Care in a timely and efficient manner;
- Care to be delivered through an interdisciplinary approach which promotes continuity and seamless delivery of care across the continuum;

- A process of care delivery that is continually reviewed to effectively utilize resources, enhance communication and address technological advancements;
- and
- A health care team that is provided with the continuing education necessary to master new technological advancements and to maintain competency in their fields.

Assessment

Assessment is a function of all professionals who plan and implement care. Each patient's physical, psychosocial, spiritual, and cultural status is assessed. The scope and intensity of assessment is based on the patient's diagnosis, the care setting, the patient's desire for treatment, identified needs, and the patient's response to care (see unit/department assessment statements in Operations Manual).

Collaboration

Collaboration among disciplines is essential to patient care planning at MVH. Interdisciplinary and collaborative approaches to care, treatment, and rehabilitation are enhanced by our Electronic Care Planning and Patient Education tools and benchmarking guidelines, resource documents, point-of-care communications, hand-off reports, patient rounding, the Patient History and Initial Assessment in the Electronic Medical Record (EMR), Interdisciplinary Report in EMR, interdisciplinary team conferences, and collaborative practice/joint practice committees.

Consultations and Referrals for Patient Services

A full range of medical and professional services is available to meet the needs of our customers. Consults for physician assessments and services are ordered by the patient's attending physician, Advanced Practice Registered Nurse or by the patient's Emergency and Trauma Center physician, and may be recommended in collaboration with the interdisciplinary team. If questions arise regarding the appropriateness of obtaining medical consultations, these issues are referred to the department's medical director or hospital administrator. Departments such as the Intensive Care Unit and the Emergency and Trauma Center have specific policies regarding consultative medical services. Rules and regulations of the medical staff specify timeframes for service consultations.

Consultations by Advanced Practice Registered Nurses (APRN's) are available to meet patient needs as appropriate. Medical and professional staff may request an APRN consult.

The hospital supports an open referral policy for additional professional services to meet the needs of our customers such as Social Services, Integrative Care Coordinators, Pastoral Care, Nutrition Services, Diabetes Education, and Pharmacy.

Standards of Care

Professional practice at MVH is defined in accordance with state licensure laws, regulation and standards for hospitals, the Code of Federal Regulations and quality indicators and standards of nursing practice as defined in the 3rd edition of the *ANA Nursing Administration: Scope & Standards of Practice* (2009), and the ANA Code of Ethics for Nursing, and specialty specific standards of practice. Care standards are patient-focused and outline the basic elements necessary for the safe and effective provision of care.

Providing patient services and the delivery of patient care requires specialized knowledge, judgment and skill derived from the principles of biological, physical, behavioral, psychological, and medical sciences. Patient services are planned, coordinated, provided, delegated, and supervised by professional health care providers who recognize the unique physical, cultural, emotional, and spiritual needs of each person. MVH is guided by a tradition of professional, clinical, and technological excellence, with a dedication to providing quality patient care with compassion and respect for the individual and family.

Patient, Family and Staff Education

Physicians, nurses, hospital staff, patients, families and the community have access to information services, including print and non-print resources in the Craig Memorial Library.

Education Resource Center

Patient/family education at MVH is an organization-wide effort. An interdisciplinary medical staff education committee coordinates activities and resources for the provision of patient and family education. The patient education channel and MVH website, the Internet, and external databases are examples of resources made available to patients, families and the community through organizational planning efforts.

The Craig Memorial Library

The library serves as a central hub for physicians, nurses, hospital employees, students, patients and families to support patient care, education, research and management. The Craig Memorial Library has an additional site, the Health Information Center, in the Heart Vascular and Ortho Tower Lobby.

The Continuum of Care

Strategic planning at Miami Valley Hospital provides for coordination and integration of care across the continuum. Patients with like health problems and needs can expect to receive a uniform level of care throughout the MVH organization. Planning facilitates mechanisms that address the continuum of care and the coordination of services. The Continuum of Care is addressed through a multitude of interdisciplinary processes, including but not limited to, Integrative Care Management weekly rounds, Benchmarking Guidelines, Clinical Nurse Specialist/Care Management activities, Interdisciplinary Team Meetings, the History and Initial Assessment in the Electronic Medical Record (EMR), Interdisciplinary Report in the EMR, and Triforce Council feedback sessions and collaborative practice groups.

Core Quality Measures in the EMR provide an outcome-oriented framework to promote positive patient outcomes including coordination of care for high-risk, high-volume patient populations.

Patient Rights and Organizational Ethics

MVH supports the philosophy that patients should understand and participate in their health care decisions. MVH believes that patients can better participate if they are aware of their rights and responsibilities. Each patient receives a copy of the Patient Bill of Rights on admission and has the opportunity to watch an educational video on patient rights on the hospital's patient education channel. This information also educates the patient on how to seek the assistance of a patient representative and how to file a complaint. In addition, the Patient Bill of Rights is posted throughout the hospital, including the outpatient areas. Assuring that patient rights are met is the responsibility of all hospital employees and members of the medical staff.

MVH provides the patient, the patient's authorized representative, care givers, or members of the medical staff the right to participate in the consideration of ethical issues that arise in the care of the patient. Health care is provided within an ethical framework established by the specific professions, the hospital, and the law. The views of the patient are respected at all times.

Should an ethical dilemma arise concerning patient care, the patient or the patient's representative may seek assistance through the Department of Consumer Relations. When the patient and/or family seek assistance through the nurse or ancillary staff, the staff member should follow the chain of command for resolution. Patient care providers have 24-hour, 7-days-per-week access to Integrative Care Coordinators, Social Workers, Pastoral Care Services, Legal, and/or nursing and hospital administrators for assistance in resolving ethical issues.

The staff rights mechanism provides that patient care remains uninterrupted should staff members need to resolve ethical dilemmas related to patient care.

A Clinical Consultation Team can be convened if the issue cannot be resolved through the hospital's chain of command. Furthermore, MVH has an Ethics Committee that meets regularly and as needed to resolve ethical dilemmas.

Miami Valley Hospital recognizes:

1. The right of the patient to reasonable access to care;
2. The right of each patient/family to make health care decisions in collaboration with the physician;
3. The right of the patient to personal privacy and confidentiality of information; and
4. The right of the patient to designate a decision maker in the event of being incapable of understanding a proposed treatment or procedure or the inability to communicate his/her wishes regarding care.

Miami Valley Hospital:

1. Assists the patient with the Advanced Directives process.
2. Assesses and develops plans of care that address the patient's psychosocial, spiritual, and cultural needs.
3. Helps resolve patient complaints.
4. Assists the patient or the patient's designated representative to seek resolution of ethical issues arising in his/her care; and
5. Follows policies for reaching decisions about withholding resuscitative services from patients and foregoing, withholding or withdrawing of life-sustaining treatment. These policies were developed by medical staff and nursing staff in accordance with prevailing law, with the approval of the Medical Staff Executive Committee. The rights of the patient and/or family members are always respected.

Support Services for the Care of the Patient:

Surveillance, Prevention, and Control of Infection

The surveillance, prevention, and control of infection are a function of the entire organization. The organization plans and supports this function through the ongoing efforts of an interdisciplinary Infection Control Committee. Standard and transmission-based precautions are incorporated in the care of all patients. The organization supports the prevention of infection in its employees by offering numerous services, such as, but not limited to, Hepatitis vaccines, TB screening, and flu shots through Employee Health. Special ventilation and/or air filtration is provided for specific patient populations to prevent airborne nosocomial infections in-patients and/or employees (e.g., negative air pressure rooms for TB and HEPA filtration with positive pressure).

The Performance Improvement Plan

MVH monitors, measures, assesses, and improves performance of important functions on an ongoing basis. Projects are allotted resources, both human and material, as appropriate to their priority within the organization. Projects sanctioned by the organizational Quality Council are based on strategic priorities. Projects sanctioned by the Organizational PI Committee are given operational priority. Priorities for performance improvement activities at MVH are projects that impact patient outcomes, resource utilization, and customer satisfaction (see MVH PI Plan).

Management of Human Resources

Employees hired by MVH meet pre-employment qualifications and specific job preparation requirements. All employees, volunteers, students, and contract employees receive a formal, individualized orientation program consistent with the scope of responsibilities defined by their job description and/or the patient population to whom they will provide service. Systems are in place to meet the mandatory annual education needs of employees (e.g., fire and safety, infection control, HIPPA, CPR).

The Department of Human Resources initiates hospital orientation for all employees. Department specific orientation, education and development of employees is defined and accomplished by each department.

Center of Nursing Excellence

The Center of Nursing Excellence, in addition to coordinating nursing orientation and education, also assists with the coordination of interdisciplinary educational programs and ongoing development of staff for patient care units.

The planning for the development of the educational programs is based on the following: the organization's mission, the case mix of patients served,(including complexity and degree of care required), the technology utilized, the learning needs identified by staff surveys, trends in literature, law and healthcare, and needs identified by performance appraisal.

Performance Review

The performance review serves as part of the competency process at MVH by providing assessment and providing opportunities for professional development. Performance appraisals provide a formal means of communicating with employees, addressing how well they are meeting or exceeding job expectations, and are used as a guide for possible promotion and further development. The annual appraisal is based on specific job descriptions and includes professional development.

All new employees receive a performance appraisal upon completion of the first 90 days of employment. The purpose of this appraisal is to evaluate whether the employee is meeting expectations of the job. It also allows the employee to evaluate the orientation process. Following the successful completion of the 90-day probationary period, employees are evaluated annually. Performance appraisals and accompanying documents are secured in each employee's personnel record (education records, annual competency assessments, licensure verification, certification, etc).

Retention and Recruitment Strategies

MVH is committed to recruiting and retaining qualified staff. Some examples of recruitment and retention strategies include:

- Clinical Ladder (Advancement in Clinical Excellence (ACE)
- Tuition reimbursement
- Continuing education reimbursement
- Certification Reimbursement
- Local, state, and national workshop reimbursement
- Travel reimbursement
- Productivity bonuses
- Employee recognition activities
- Clinical and administrative educational opportunities
- Employee Referral Program
- Equity increases
- Internship and externship programs
- Minority Nurse Manager Fellowship Program
- Work/study programs
- Onsite continuing education programs with credit hours

The Environment of Care

The environment of care at MVH ensures the safe and effective environment for patient care. The safety of the environment is one in which identified risks are managed by staff training and by the use of safety devices, or are eliminated by reworking the environment.

An interdisciplinary Environmental Safety Committee is established to monitor the environment of care and trend issues for safety, security, hazardous materials and waste, emergency preparedness, life safety, medical equipment, and utilities. The MVH Safety Officer develops and operates an information, collection, and evaluation system to continuously measure, assess, and improve the status of the environment of care. The status of the environment of care and performance standards are communicated to all levels of the organization through the distribution of committee minutes to the management of the organization and is further served by each department's safety representative.

Management of Information

All clinical staff is responsible for the accurate and timely documentation of clinical information. Information is managed to assure confidentiality of patient information as required by state and federal law. Policies and procedures protect patient confidentiality, by limiting access to protected health information (PHI).

Inpatient, emergency department, ambulatory surgery, labor and delivery and post-procedure recovery medical records (electronic or hard copy) are housed in the Health Information Management (HIM) Department. All other medical records are located in the area where the treatment takes place, e.g., ambulatory clinics, ambulatory testing and ambulatory treatment areas. Divergent medical records are accessed through the use of EPIC encounter Master Patient Index for those records housed in the HIM Department by retrieving the patient's unique medical record number. For those records housed off-site, the Solcom MPI is utilized to access the patient's unique medical record number and date of service. The Solcom MPI also incorporates all of the information found in the EPIC encounter Master Patient Index for all-inclusive index. These two access methodologies facilitate the quick retrieval of all medical records throughout the Miami Valley Hospital patient care system.

Leaders of the organization and those who need to interpret data are educated in the principles of information management through the Quality Management Department. Aggregate data support managerial decisions, operations, improvement activities and patient care activities. Planning for information systems is based on the projected needs of the organization.

Miami Valley Hospital Medical Staff Rules and Regulations

I. Admitting Policy and Procedure

A. Admission Requirements

1. The Admitting Office will be notified of any admissions by the physician/practitioner or the physician/practitioner's agent. A provisional diagnosis shall be given at the time of admission.
2. Only members of the medical and resident staff are authorized to admit inpatients at Miami Valley Hospital. The procedure for determining medical staff membership is detailed in the Hospital Operations Manual. (MSEC: 10/11/06)
3. Physicians/Practitioners admitting patients shall be responsible for giving to those having a legitimate need to know such information as may be necessary to assure the protection of others.
4. All admitted patients shall be evaluated by a physician/practitioner within twenty four (24) hours of admission.
5. There shall be adequate written documentation by a physician/practitioner on each patient's medical record the first twenty four (24) hours of admission to substantiate the admission or the admitting diagnosis.

B. General Dental Admissions

1. All patients admitted for dental procedures shall have the name of the patient's responsible physician recorded on the medical record before or at the time of admission.

C. Oral and Maxillofacial Surgery Admissions

1. All ASA I and II patients admitted for oral and maxillofacial surgery procedures shall have the name of the patient's responsible oral/maxillofacial surgeon recorded on the medical record before or at the time of admission. ASA III and IV patients shall have the patient's responsible oral/maxillofacial surgeon and physician recorded on the medical record by the time of admission.

D. Podiatry Admissions

Initiation of admission, as well as discharge, may be through a podiatrist with clinical privileges in Category I - V. Consultations concerning any condition of the patient will be made by the podiatrist when deemed appropriate. (MSEC: 3/9/05)

E. Supervision of Residents

1. Resident staff are supervised according to policies mandated by the Department of Medical Education pursuant to Article XI, Section 6 of the Medical Staff Bylaws, which has liaison responsibilities between the hospital and all medical residency programs.

II. Emergency and Trauma Center

1. Referral of a patient to the Emergency Center by a physician/practitioner or physician/practitioner's office personnel shall always be by prior notification to the Emergency and Trauma Center; oral or written orders shall be given by the referring physician/practitioner. Referral of a patient to the Emergency and Trauma Center may be by direct consultation with the Emergency Center physician, requesting regular consultation, giving the Emergency Center physician sufficient background information and requesting care to be rendered where appropriate.
2. Emergency and Trauma Center personnel may obtain consultation as mutually agreed upon between the attending physician/practitioner and the emergency and trauma center physician/practitioner.
3. A physician/practitioner may not sign out to the Emergency Center. A physician/practitioner shall sign out to a properly notified alternate who is then responsible for private patients being seen in the Emergency Center.
4. Physician/Practitioner office staff referrals to the Emergency and Trauma Center should not generally take place except in cases involving life threatening emergencies or severe pain. Prior notification to the emergency and trauma center should be made.
5. Failure to arrange for after hours' coverage and failure to be available for patient care on an emergency basis will require disciplinary action through medical staff/administrative channels. (4/02)

6. On-call physicians who have been contacted by the hospital to provide an onsite emergency screening or stabilization that cannot otherwise be provided by emergency staff should arrive at the hospital within ninety (90) minutes after being contacted. Failure to do so may require disciplinary action through medical staff/administrative channels. (Approved: MSEC 10-12-05)
7. The medical director of the emergency and trauma center or designate, shall retain authority to examine all patients who present to the emergency and trauma center, in order to timely monitor the condition of the patient and maintain an appropriate level of patient care.

III. Alternates

Every member of the medical staff must name a member of the medical staff who may be called to attend the member's patients in an emergency. The member must certify that the alternate has the same or substantially similar clinical privileges as the member, and is generally qualified to provide medical care and treatment to or obtain appropriate consultations for all patients referred to the designated alternate by the medical staff member. If a member of the medical staff is not a resident within the city or immediate vicinity the member must name a qualified member of the medical staff who is a resident of the city or immediate vicinity.

Determination of availability standards shall be left to the discretion of individual departments and sections; however, as a general guideline, alternate coverage should be available and able to respond to any necessary situation within thirty minutes. (revised 6/01)

IV. Discharge Policy and Procedure

A. Discharge Orders

Patients will be discharged only upon written orders of the attending physician/practitioner or a member of the resident staff when the discharge is so authorized by the attending physician/practitioner.

B. Noncompliance by Nonprivate Patients

Nonprivate patients refusing the treatment prescribed by the resident staff shall not be dismissed from the hospital until the matter has been referred to and approved by the attending staff or the chair of the respective department or section in the absence of the attending staff member.

The attending physician/practitioner shall be immediately notified by the resident regarding noncompliance by a nonprivate patient under resident care, including patient refusal in patient ongoing care; patient refusal to follow up management and treatment recommendations upon discharge; and patient leaving the hospital against medical advice.

V. Physicians'/Practitioners' Orders and Stop Orders

A. Physicians'/Practitioners' Standing Orders

1. Department/section and/or individual physician/practitioner standing orders shall be reviewed by multidisciplinary staff representing the lab, pharmacy, nursing, medical information services, nutrition and others as appropriate with recommendations made where improvement/corrections are felt to be indicated. Such recommended orders shall always be approved by a member of the medical staff whose clinical practice lends expertise to the order set(s) being developed/revised. Once this process has been completed, the order set is presented to the appropriate department or section chair or chairs if applicable. The department/section chair shall have the following options with regard to any such order set:
 - a. Determine that the order set is such that Medical Staff Executive Committee approval is required;
 - b. Determine that the order set requires approval by his/her department and/or section, or
 - c. Determine that no additional over cite/approval is needed and approve the order set. (MSEC: 10/11/06)

B. Physicians'/Practitioners' Verbal/Telephone Orders

1. All orders from appropriately licensed physicians, dentists and podiatrists for diagnostic procedures, treatment, or medication shall be in writing. Verbal order use should be minimized. When used, a verbal order shall be considered to be in writing if indicated to the nurse in charge and authenticated by the responsible member of the medical staff or house staff. (MSEC: 5/12/04)
2. Verbal/telephone orders must be written on the physician order sheet and must be timed and dated. They must include the name of the ordering physician, dentist, podiatrist or other credentialed provider authorized to give such orders and the name of the person writing or taking the order. For example v.o. Dr Z Jones/S. Black, RN. (Medical students may not give or accept verbal/telephone orders.)
3. Verbal/telephone orders may be received from a physician, dentist, podiatrist and other credentialed provider authorized to give such orders or the employee of the prescriber, who is under the immediate and personal supervision of the prescriber. For example, Dr. Z Jones/ Susan Apple MAS. /S.Black RN. Note: the last name of the employee of the provider must be included.

4. Only the following personnel are authorized to accept and implement verbal/telephone orders within the scope of their practice, education and licensure:
- Registered Nurse
 - Licensed Physical Therapist
 - Licensed Practical Nurse
 - Licensed Occupational Therapist
 - Registered Dietician
 - Licensed Speech Pathologist
 - Respiratory Therapist
 - Licensed Clinical Psychologist
 - Registered Pharmacist
 - Medical Imaging Technologist
 - Cardiac Laboratory Technologists
 - Radiation Therapy Technologists
 - Physician Assistant
 - Social Worker
5. Verbal/telephone orders should be authenticated with signature, date and time by the ordering or covering physician, dentist, podiatrist or other credentialed provider authorized to give such orders at the time of the next patient visit or within 48 hours of giving the verbal order. (approved: 6/19/07)
6. Verbal/telephone DNR status orders must be received by 2 nurses and documented on the appropriate DNR order form. Both nurses shall sign the orders. A responsible medical staff member must countersign such verbal orders at the next visit.
7. The individual receiving the orders will write all orders and then read them back in their entirety, including the name of the patient to verify accuracy. For example: "two zero milligrams" not "twenty milligrams" and "one tablet three times a day" not "1 tab tid".
8. Verbal/telephone orders or medications will include the name of the patient, drug name, dosage form, exact strength or concentration, dose, frequency and route, quantity and duration, indication for use, name of prescriber and name of person receiving the order.
9. Physicians, dentists, podiatrists and other credentialed providers authorized to give such orders should write orders(s) rather than verbally stating them when in the unit/department. Exceptions may be made during a procedure, crisis or code 99.
10. Orders that are faxed (see Facsimile Transmission Policy in the Operations Manual) are not subject to this policy.(MSEC: 3/03)

C. Signature Stamps

Signature stamps are not to be used in the medical record. Exceptions may be made on an individual basis based on hardship. (i.e. physical handicap) A member desiring such exception must petition the hospital's Chief Operating Officer for approval. Upon approval by the hospital's Chief Operating Officer, the stamp, which clearly represents the signature of the physician, may be used on the medical record. An explanatory statement must be submitted to the Executive Office. The statement must indicate that the stamp represents the member's name and that only the member has and will use the stamp. A copy of the explanatory statement and a sample of the signature stamp will be sent to Medical Information Services.(MSEC 10/08)

D. Compliant Orders

An order cannot be accepted, even if complete/compliant, if it is written by a medical staff member for him/herself or for a family member. A family member is defined as:

- Husband or wife
- Natural or adoptive parent, child, and sibling
- Stepparent, stepchild, stepbrother and stepsister
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law
- Grandparent and grandchild
- Spouse of grandparent and grandchild

**Divorce or death do not terminate the defined relationships above.

In an elective situation, the member has a duty to disclose to the hospital the family relationship. In this case, the patient must sign an ABN (Advance Beneficiary Notice) which notifies the patient that the patient will be responsible for the hospital bill because Medicare and/or any third party payers cannot be billed. (MSEC: 4/11/07)

VI. Medical Record Rules

A. Responsibilities of Attending Practitioner

1. The attending physician/practitioner is responsible for preparation of a complete and accurate medical record having to do with consultations, surgery, etc. performed by others with medical staff privileges.
2. The attending physician/practitioner is responsible for completion of the medical records of his/her private inpatients and outpatients irrespective of the resident's involvement. The attending physician/practitioner is responsible for the content and authentication of the medical record.
- 3 All entries into the medical record must be dated and timed. (approved:3/07)
4. All face sheets of radiologic procedures of outpatients receiving IV sedation or general anesthesia must have the reason for the sedation (i.e. anxiety, claustrophobia, etc.) documented on the face sheet and be signed by the anesthesiologist. All face sheets of outpatient interventional procedures must be completed and signed by the physician performing the test. (MSEC: 7/9/97)
5. If an attending physician/practitioner is unable to complete a medical record, then the Chair of the attending physician/practitioner's department or section shall be authorized to sign the record as the attending physician/practitioner. In the event that a medical resident was involved in the case, the resident's program director shall be authorized to complete the record as the attending physician/practitioner. (4/08)

B. Contents

The record may include present complaint, personal history, psychosocial needs appropriate to the age of the patient, family history, history of present illness, including an assessment of the patient's emotional, behavioral and social status, physical examination, special reports (such as consultations clinical laboratory, x-ray, physical medicine and others), provisional diagnosis, medical or surgical treatment, pathological findings, progress notes, final diagnosis, condition on discharge, stated in terms that permit a specific measurable comparison with the condition on admission, medication reconciliation on admission, inhouse transfer, when changes to current medications are required and at discharge. (1/22/08)

History

NOTE: Only asterisked (*) items are required-all other items are recommended. Heart and Lungs are required on inpatient only.

- Chief complaint*
- History, present illness
- Current medications*(can be found on the "Medication Reconciliation" form)
- Allergies* (can be found on the "Medication Reconciliation" form)
- Review of systems
- Relevant past history*
- Relevant social history
- Relevant family history
- Occupational history

Physical

Must include Impression/Plan of Care and Heart and Lungs (on Inpatient only) in addition to one of the following based on patient diagnosis & plan of care:

- Vital Signs
- Skin & General Assessment
- Head & neck
- EENT-ears, eyes, nose, throat
- Heart *
- Lungs *
- Abdomen
- Genitalia / Rectal
- Pelvic
- Extremities (pulses)
- Neurological assessment
- Impression / Plan of care*

1. History and Physical Examination

- a. A medical record is initiated for every individual assessed and/or treated at Miami Valley Hospital. An original or reproduction of a history and physical completed within 30 days of the admission or procedure by a LIP or affiliate with privileges at MVH to perform Histories and Physicals is required to be completed and on the chart within 24 hours of a medical admission and on the chart prior to any procedure requiring a history and physical.

The history and physical must be updated if performed prior to the day of admission or outpatient procedure. Such update shall be documented within 24 hours of the admission or prior to performing any inpatient or outpatient procedure. The update must be documented whether or not there is a change in the patient's condition. The update may be written on the H&P or contained in the admission note or pre-procedure documentation.

If the history and physical was performed on the day of admission/outpatient surgical procedure or within 24 hours of the medical admission, the update does not need to be completed and may remain blank.

If the patient is discharged and readmitted, the history and physical from the previous admission may be used under the following conditions:

1. The history and physical is no older than 30 days and
 2. The patient is being admitted for the same condition and
 3. Any changes to the history, the physical exam, the chief complaint, the current illness, the current medications, the allergies, the plan or the impression are documented on the medical record as a readmission note or an interval note. If no changes occurred, a note must be documented regarding "no changes." (MSEC: 3/05)
- b. A history and physical shall contain a statement of the course of action planned for the patient with periodic review as appropriate.
- c. Any history and physical examination performed by a physician/practitioner other than a member of the Miami Valley Hospital medical staff or properly privileged affiliate may be countersigned by the admitting physician/practitioner if the authorized/privileged LIP reviews the H&P; conducts a second assessment to confirm the information, updates any findings as necessary which would include a summary of the patient's condition and course of care during the interim period, notes the patient's current physical/ psychosocial status and signs and dates the information as an attestation to it being current. (approved: April 2007)
- d. In an emergency, when there is no time to record the complete history and physical examination, a note indicating the physician's plan of action for the patient must be recorded in the chart prior to or at the completion of any procedure/surgery. A complete history and physical must still be completed within 24 hours of the admission or after the procedure was performed.
- e. Resident record keeping responsibilities are delineated in the "Resident Manual" upon the recommendation of the respective department and approval by the Medical Education Department and the Medical Staff Executive Committee.
- f. A history and physical is required for the following types of patients:
1. The obstetrical record shall include a Hollister form (Health History Summary, Initial Pregnancy Profile, and current Prenatal Flow Record) or equivalent office prenatal documentation. The prenatal record may be transferred to the hospital before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings within 24 hours of admission. It is preferable that the complete original Hollister form be sent to Medical Information Services following delivery. Hollister forms for obstetrical staff patients are found on the Perinatal Health Center clinic records. For patients greater than or equal to 35 weeks of gestation, if the Hollister or equivalent documentation is unavailable at the time of admission, documentation must reflect that the physician has reviewed and agrees with the nursing assessment, including documentation of any other pertinent findings or prenatal problems.

For patients less than 35 weeks gestation, the record shall include a Hollister form or equivalent documentation and an admission note. If the Hollister is unavailable, a complete history and physical must be documented. For all outpatient obstetrical procedures, the Short Stay Form or Physician Office History & Physical the Outpatient Short Stay Form or Outpatient Treatment Summary must be completed and on the chart prior to the surgical procedure.

A written or dictated narrative summary of the labor and delivery process and a written delivery note is required on patients who deliver with five minute Apgar scores which are less than seven. (MSEC: 3/05)
 2. For Outpatient Surgeries/Cardiac Catheterizations and Same Day Surgeries, patients must have a history and physical on the record prior to the performance of the procedure. Acceptable histories and physicals include: (1) a dictated or written history and physical; or (2) a Short Stay Form or (3) A physician office history and physical.
 3. Inpatients
 - a. Dictated or written history and physical is required to be completed on all inpatients within 24 hours of admission or prior to procedure/operation.

The history must include chief complaint and current medications and should include history of present illness, allergies, relevant past history, relevant social history, occupational history and review of systems.

The physical examination performed during the initial assessment must include impression/plan of care and at least one of the following items based upon patient diagnosis and plan of care:

- Heart
- Lungs
- Head and Neck
- EENT—ear, eyes, nose throat
- Abdomen
- Genitalia/rectal
- Pelvic
- Extremities
- Neurological assessment

- b. A Short Stay Form / History & Physical Treatment Summary is completed. The Short Stay Form is acceptable for all inpatients, outpatients and observation patients - per physician discretion.
- c. A physician office history and physical with all components defined under 3. A of this article is acceptable. (MSEC 3/05)
4. Medical and Osteopathic Physicians—All medical and osteopathic physicians (i.e. M.D. and D.O.) may perform a history and physical on their patients or any patient referred to them for that purpose.
5. Podiatry the history and physical examination may be completed by a podiatric physician for ASA I and II patients.
6. Dental and Oral/Maxillofacial—Each Outpatient Surgery patient must have a dental assessment appropriate to the chief complaint performed by the dentist and a medical history and physical (Short Stay Form or physician office) performed by an oral surgeon or a physician. Patients in other outpatient settings must have a dental assessment appropriate to the chief complaint with a medical history performed by a dentist. The oral / maxillofacial surgeon may perform a medical history and physical on ASA I and II patients. In all other cases, a physician shall be responsible for the medical history and physical examination and shall be available to treat any medical problems that may arise during hospitalization. Oral / maxillofacial surgeon shall be responsible for the areas for which they are credentialed, operative report, progress notes and completion of the face sheet of the medical record.
7. Ophthalmology—Each patient having an ophthalmologic procedure performed in the operating room must have a medical history and physical (Short Stay Form or physician office) performed by a physician. An ophthalmologic assessment must be included in the medical history and physical, or if not included there, an ophthalmologic assessment must be provided by the ophthalmologist. Each patient having a laser procedure must have an ophthalmologic assessment provided by the ophthalmologist.
8. Ambulatory Treatment Areas—The various types of patients require the following:
 - A. Radiologic Procedures with Sedation - pre-procedure assessment and procedure note required.
 - B. MRIs with Sedation - No history and physical required. A nursing assessment is required.
 - C. Pain Blocks with Sedation - No history & physical required. A nursing assessment required. Physician responsible for the patient during the procedure will review the nursing assessment & complete the second page, lower portion with pertinent information along with signatures.
 - D. Pain Blocks without sedation – No history and physical required. An initial assessment/evaluation will be completed for patients on their first visit and a follow-up form will be completed by the nurse on each subsequent visit. The responsible physician will review and sign both forms.
 - E. Plasmapheresis – Short Stay Form or physician office history and physical required.
 - F. Transfusions and IV Medications - no history and physical required.
9. Radiation Oncology—Patients receiving a general anesthesia require a history and physical prior to the procedure being performed.
10. Endoscopy—Each patient must have one of the following: a dictated or written history and physical, a Short Stay Form, a physician office history and physical or an endoscopic pre-admission and assessment and short stay form.
11. Trauma Service—Each trauma patient must have a trauma history and physical completed.
12. Observation
 - A. Each patient (including those on the Psychiatric Observation Unit) require history and physical.
 - B. Labor and delivery patients require an Obstetrical History & Physical Evaluation and Treatment Plan.
13. Minor Procedures—Patients receiving a local anesthesia only do not require a history and physical. (MSEC: 3-05)

2. Discharge Summary

- a. A dictated discharge summary shall be required on all discharges except routine maternity and newborn patients and patients with less than a forty-eight (48) hour hospital stay. A final progress note shall be written in lieu of the discharge summary in these instances. This final progress note must include any instructions given to the patient and/or family. With specific reference to maternity patients, a dictated discharge summary shall be required for: (1) any length of stay greater than two days (more than 48 hours); any patient who undergoes a surgical procedure, regardless of the length of stay; (3) any patient who delivers a stillborn infant; and (4) any patient who delivers an infant with a five minute Apgar score less than seven.

With specific reference to newborns, a dictated discharge summary shall be required for all infants admitted to the NICU and for all newborn deaths unless the infant is not admitted to a nursery and receives only "comfort measures." (MSEC: 11/8/00)

- b. The discharge summary contains the reason for hospitalization, significant findings, procedures performed, treatment rendered, condition at discharge and instructions given to the patient and/or family.
- c. When members of the resident staff are involved in patient care, sufficient evidence is documented in the medical record to substantiate the active participation in, and supervision of, the patient's care by the supervising attending physician/practitioner responsible for the patient.
- d. Complete dictated discharge summaries on all nonprivate patients are the responsibility of the resident staff or the attending physician/practitioner assigned to the case and ultimately the supervising attending physician/practitioner assigned to the service.

3. Progress Notes

For inpatients, pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. When possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders, as well as results of tests and treatment. In every case, except as exempted in this paragraph, the patient shall be seen and a progress note written at least daily by the responsible physician/practitioner and/or the consulting physician/practitioner. Any exception to the requirement for daily progress notes by a specialty service may be obtained only if approved by the Medical Staff Executive Committee after its determination that such exception is within a prevailing practice standard. (MSEC: 3/10/99)

For Obstetrical Patients - For laboring patients, a progress note is to be made at least every 24 hours and when there is a significant change in the patient's status. (MSEC: 11/05)

Outpatient Status (observation, post-procedure recovery, outpatient surgery)

- (1) Face Sheet, to include final diagnosis and physician signature
- (2) Complete history and physical, including medical necessity, and dictated within 24 hours of admission or prior to surgery/procedure
- (3) Physician Orders, including order for dated admission and discharge order
- (4) Progress Notes the physician must see the patient at least once during the short term stay with documentation in the progress notes
- (5) Evidence of informed consent, where applicable
- (6) Operative procedure report, when indicated, dictated/written immediately after surgery.(revised 6/01)

Post Procedure Recovery Post Procedure Recovery status is utilized for post procedure outpatients who are transferred to an inpatient nursing unit for extended recovery prior to discharge. This status would include post cardiac catheterization, myelogram, or other outpatient procedures when the patient needs extended recovery but does not meet admission criteria. The same physician documentation requirements in place for outpatient surgery patients would also apply to post procedure recovery patients.

4. Symbols and Abbreviations

Only those symbols and abbreviations approved by the Quality of Documentation Committee may be used in the medical record. Unless otherwise indicated and approved by the, Quality of Documentation Committee, the most current revision of Mosby's Survival Guide to Medical Abbreviations and Acronyms will prevail. A copy of this guide is available for review in the Medical Staff Office. Requests for use of additional abbreviations not listed in Mosby's Survival Guide to Medical Abbreviations and Acronyms must be approved by the Quality of Documentation Committee. Abbreviations and terminology on the computer generated coding summary sheets are those of the computer coding system of the hospital vendor, are consistent and uniform for all patients, and are based on the universal ICD-9 Classification System. These are acceptable as the final diagnosis. If an abbreviation is written by a member of the medical staff and is an approved abbreviation, Medical Information Services personnel are permitted to fully write out the abbreviated word on the face sheet. There must be an explanatory legend of approved symbols and abbreviations.(4/03)

C. Delinquent Medical Record Procedure

Medical records remaining delinquent as defined in the delinquent medical record procedure shall result in automatic suspension of medical staff admitting privileges until the delinquent medical record(s) are completed. On the third such suspension, or for a continuous suspension of six (6) weeks in any calendar year, medical staff membership and all clinical privileges shall be automatically terminated after due notification to the physician/practitioner by telephone, followed by written notice of termination sent by registered letter. The record of discharged patients shall be completed within a period of time that will in no event exceed thirty (30) days following discharge. (The delinquent medical record procedure is available from the Medical Information Services administrator.)

If a physician/practitioner, terminated as outlined above, completes all outstanding records, both incomplete and delinquent, within thirty (30) days of the date of the termination notice, full membership and clinical privileges will be restored following receipt of a reprocessing fee. The reprocessing fee shall be the same fee incurred for initial appointment to the medical staff. A member reinstated in this manner, shall not be required to submit another application for membership nor will the reinstatement be processed as an initial application.

A physician/practitioner requesting reinstatement of membership and clinical privileges greater than thirty (30) days after being terminated for delinquent medical records shall be required to submit a completed application which will be processed as an initial application. (MSEC: 10/02)

D. Ownership and Availability

1. The medical record, including x ray films, is the property of the hospital and is maintained for the patient, the medical staff and the hospital. It is the responsibility of the hospital to safeguard the information in the record against loss, defacement, tampering or use by unauthorized persons. (See Medical Information Services administrator for policies for maintenance of confidentiality of patient health information.)
2. The medical record may not be removed from the hospital except in response to a court order. Unauthorized removal of charts from the hospital is grounds for suspension of the physician/practitioner for a period to be determined in accordance with the Medical Staff Bylaws. X ray films may be removed from the hospital when released by authorized persons.
3. In the case of readmission, all of a patient's previous records shall be available for the use of the attending physician/practitioner whether the patient is attended by the same physician/practitioner or another.

E. Confidentiality of Medical Record

The information in the medical record is confidential and shall be accessed only upon a legitimate need to know. No physician/practitioner, or anyone employed by or affiliated with such physician/practitioner shall access the medical record, either in hard copy or through computer access, without having a legitimate need to know such information. Violations of this paragraph shall be referred to the Chief of Staff for appropriate action, including future restriction of access to such records, and/or summary suspension or corrective action. (MSEC: 1/13/99)

F. Inaudible Dictation Policy

When a transcriptionist receives a dictation that is inaudible and cannot be transcribed, the transcriptionist is to contact the auditor of the department and report the inaudible dictation. The transcriptionist is to transcribe what can be heard from the inaudible dictation. After the transcriptionist has completed the report, the auditor will audit the report by listening to the dictation. An inaudible dictation is defined as a dictation with ten blanks or more. The cause of the inaudible dictation will be addressed with the medical staff member at that time. After the third offense, the medical staff member will be reported to the appropriate department chair. (MSEC: 10/8/03)

G. Accessing and Reviewing Medical Records by Medical Staff Members and Practitioners for Treatment Purposes

Miami Valley Hospital collects and maintains personal health information about Miami Valley Hospital patients. The federal HIPAA regulations on patient privacy and confidentiality place limits on how health care providers may use and disclose this information. In many cases, prior authorizations from the patient must be obtained. The purpose of this policy is to allow practitioners providing treatment to hospital patients better access to records for treatment purposes.

1. SCOPE: This policy applies to all members of the medical staff of Miami Valley Hospital, as well as any practitioner who has a treatment relationship with a Miami Valley Hospital patient.
2. DEFINITIONS: As used in this policy and in the federal HIPAA privacy regulations at 45 C.F.R. Parts 160 and 164, "treatment" means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another. As used in

this policy, “practitioner” means any licensed physician, nurse, nurse practitioner, allied health professional, and other health care providers such as hospitals, nursing homes, outpatient testing facilities, and/or physician offices, in which the “practitioner” is in an active treatment relationship with a current or past patient of Miami Valley Hospital, and needs access to the patient’s Miami Valley Hospital medical records for current treatment purposes.

3. PROCEDURE: The procedure for access to records shall be as set forth in Miami Valley Hospital and/or Premier Health Partner’s Administrative and/or Information Privacy/Security Policies regarding access and release of records.

4. POLICY

- a) Any practitioner with a treatment relationship with a Miami Valley Hospital patient may access and review medical records of Miami Valley Hospital for treatment purposes regardless of whether the patient is a hospital patient, a patient in the practitioner’s private office, or a patient in a medical facility in which the practitioner has privileges to practice, and the practitioner is providing treatment to the patient at that facility.
- b) Any practitioner with a treatment relationship may access and review medical records of Miami Valley Hospital to obtain reimbursement or payment for services provided by the practitioner to patients who the practitioner treats in Miami Valley Hospital, in the practitioner’s private office, and/or in a medical facility in which the practitioner has privileges to practice.
- c) Medical records of Miami Valley Hospital may not be used by the practitioner or released by the practitioner for research purposes, even if the patient is the practitioner’s patient. Prior to any use or disclosure of Miami Valley Hospital medical records for research purposes, such use or disclosure must be approved by the Hospital’s Institutional Review Board.
- d) Medical records of Miami Valley Hospital may not be accessed or reviewed for any purpose not specifically stated in this policy unless the practitioner and Miami Valley Hospital have received a signed patient authorization form which authorizes the practitioner and Miami Valley Hospital to disclose that patient’s medical record to the practitioner or unless Miami Valley Hospital has provided such records to the practitioner for a specific purpose related to the health care operations of Miami Valley Hospital.
- e) Practitioners accessing medical records of Miami Valley Hospital shall be solely responsible for any re-release of such information, and all Practitioners accessing medical records shall be allowed to re-release such records only in accordance with applicable law, including, but not limited to, federal HIPAA privacy laws and regulations. The Miami Valley Hospital has the sole discretion to terminate a Practitioner’s access to any records of Miami Valley Hospital if, in the sole opinion of the Hospital, the Practitioner re-releases information in violation of any law. Furthermore, such re-release in violation of the law may subject a member of the Miami Valley Hospital Medical staff to corrective action in accordance with the Medical Staff Bylaws.
- f) Federal law allows patients to request restrictions on how their medical records may be used and disclosed. It is the practitioner’s responsibility to adhere to any restrictions that have been placed on a patient’s medical records.
- g) Federal law requires that all uses of patient information, including for treatment, be limited to that which is reasonably necessary to accomplish the purpose for which information is being used.

Failure to follow this policy by members of the Medical Staff of Miami Valley Hospital may result in restrictions, including and up to denial of access to records until compliance with this policy is assured. Furthermore, any breach of this policy by members of the Miami Valley Hospital Medical Staff could result in corrective action, up to, and including, the suspension and/or termination of Medical Staff privileges. For practitioners not on the Medical Staff of Miami Valley Hospital, failure to follow this policy may result in restrictions, including and up to denial of access to records until compliance with this policy is assured. (MSEC: 10/11/06)

VII. Standards of Conduct

Criticism or personal attacks against physician/practitioners, dentists, hospital personnel or the hospital itself shall not appear in the medical record. Any violation of this rule shall be referred to the current Chief of Staff or Chief of Staff Elect for interpretation, judgment and action. If warranted, they may recommend suspension, termination or nonreappointment of the offender’s hospital privileges.

VIII. Standards of Clinical Care

A. Surgical Patients and Procedures

- 1. Appropriate informed consent must be obtained and documented in the medical record.
- 2. In surgical cases, the history and physical examination must be recorded on the chart or dictated prior to surgery. The preoperative diagnosis should be recorded prior to surgery.
- 3. In elective surgery cases, it is the surgeon’s responsibility to assure that the history and physical examination or admission note in the patient’s progress sheet plus results of pre-surgical testing must be on the chart before the patient can be anesthetized. The admission note should include any significant findings from the history and physical and any other information pertinent to the anesthesiologist’s pre-surgical evaluation. (MSEC 4/02)

In an emergent situation when there is no time to record the complete history and physical examination, a note indicating the physician's plan of action for the patient must be recorded in the chart prior to or at the completion of any procedure/surgery. (MSEC: 9/10/97)

4. When surgery or anesthesia is performed, another physician/practitioner is immediately available on campus to provide care in the event of a medical emergency.
5. Each operation or other high risk procedure performed in the hospital shall be described in detail by dictating a report and immediately documenting pertinent patient information in the hospital record. At a minimum, the report shall include the name of the surgeon and assistants, procedure(s) performed and description of each procedure, findings, estimated blood loss, specimens removed, disposition of each specimen, and postoperative diagnosis. A separate report must be dictated for each operation performed. (MSEC: 3/05)

B. Pathological Examination

All pertinent materials and tissues removed in surgery shall become the property of the hospital and shall be examined by the hospital pathologist whose report shall form a part of the patient's clinical record. The same applies to any pertinent tissue and/or cytological material and pertinent body fluid removed or obtained other than in surgery. Upon request of the attending surgeon, tissue specimens will be prepared by the hospital pathologist to send to any recognized pathologist for opinion.

C. Pap Smear

All female patients eighteen (18) years of age or older admitted to the Miami Valley Hospital must have a cervical cytological examination performed and recorded on the patient's chart unless this has been done in the one year period prior to admission, or unless contraindicated or refused by the patient, or unless contrary orders are given by the attending physician/practitioner with notation of the reason made on the medical record. (MSEC: 3/10/99)

D. Rh Type and Coombs Testing

1. Determination of Rh type and a CBC will be routinely performed on all patients admitted to the labor room in labor, unless otherwise ordered by the physician/practitioner. A routine cord blood will be drawn and a direct Coombs test performed, unless otherwise ordered by the physician/practitioner. If the mother's blood is Rh negative, Du negative and she has no actively produced anti D by indirect Coombs testing and the infant is Rh positive (or abortus where this cannot be determined), the blood transfusion service will notify the physician/practitioner that the mother may be a candidate for immunoprophylaxis.
2. Indirect Coombs testing shall be performed on all pregnant women admitted to the hospital on the obstetrical service.

E. Multidisciplinary Treatment Plans

1. Written policies shall be in place that address the requirements of multidisciplinary treatment plans for psychiatric and substance abuse patients.
2. The written policies shall be developed with input from members of the Department of Neuropsychiatry and the director of the hospital's chemical dependency program. The Department of Neuropsychiatry shall approve the policies or changes in policies for multidisciplinary treatment plans.

IX. Requirements and Guidelines for Consultation

A. Definition

1. A request for consultation should be stated as such in either the physician progress notes or on the physician order sheet and signed by the requesting practitioner.
2. A consultation must state that appropriate portions of the medical record were reviewed and the patient interviewed and examined. The findings must be recorded and the date and signature affixed on the medical record.
3. It is strongly recommended that clinical consultations be obtained on a practitioner-to-practitioner basis. Clinical consultations shall be the responsibility of the attending physician and not the responsibility of the Division of Nursing.
4. Consultation with another member of the medical staff may be advisable in the following cases:
 - when the diagnosis is obscure after ordinary diagnostic procedures have been completed
 - when there is doubt as to the choice of therapeutic measures to be used
 - for high risk patients undergoing major operative procedures
 - in situations where specific skills of other physicians may be needed;

- or when otherwise required by medical staff or hospital policies. (MSEC: 10/11/06)

B. Psychiatric

Any patient admitted to psychiatric service by a doctor other than a psychiatrist, must have a psychiatric consultation secured within forty eight (48) hours of the admission, preferably within twenty four (24) hours.

X. Special Rules and Procedures

A. APGAR Ratings

The attending physician/practitioner is responsible for insuring that the APGAR rating is recorded on all newborns. The responsibility for determining the APGAR rating resides with the nurse and the attending physician/practitioner with both being recorded if different.

B. Criteria for Autopsies

1. Ohio law (Ohio Revised Code Section 313.12) requires that all deaths falling into these categories must be reported to the Montgomery County Coroner's Office, whose representative will in each case make a decision as to whether an autopsy will be performed.
 - a. All deaths resulting from criminal or other violent means; i.e. known or suspected accidents, homicides, and suicides.
 - b. Sudden, unexpected and unexplained death in persons apparently in good health.
 - c. Death in any suspicious or unusual manner.
2. Although there is no statutory requirement that deaths falling into these categories be reported to the Montgomery County Coroner's Office, the office urges that they be reported. Miami Valley Hospital will continue to cooperate by reporting these deaths.
 - a. Deaths occurring during or following any dental or medical surgical diagnostic or therapeutic procedure.
 - b. Persons dead on arrival at Miami Valley Hospital.
 - c. Deaths occurring in Miami Valley Hospital within 24 hours after admission.
 - d. Deaths involving allegations of medical malpractice.

C. Autopsy Consents

The content of Section 2108.50 of the Ohio Revised Code relative to autopsy or post mortem examination is as follows:

1. An autopsy or post mortem examination may be performed upon the body of a deceased person by a licensed physician/practitioner or surgeon, if consent has been given in the order named by one of the following persons of sound mind and eighteen (18) years of age or older, in a written instrument executed by him/her or on his/her behalf at his/her express direction:
 - a. The deceased person during his/her lifetime.
 - b. The decedent's spouse.
 - c. If there is no surviving spouse, if the address of the surviving spouse is unknown or outside the United States, if the surviving spouse is physically or mentally unable or incapable of giving consent, or if the deceased person was separated and living apart from such surviving spouse, then a person having the first named degree of relationship in the following list in which a relative of the deceased survives and is physically and mentally able and capable of giving consent may execute consent:
 1. Children.
 2. Parents.
 3. Brothers or Sisters.
 - d. If there are no surviving persons of any degree or relationship listed in division (c) of this section, any other relative or person who assumes custody of the body for burial.
 - e. A person authorized by written instrument executed by the deceased person to make arrangements for burial.
2. Consent may be revoked only by the person executing the consent and in the same manner as required for execution of consent under this section.

As used in this section, "written instrument" includes a telegram, FAX or cablegram. Telephone consent is not acceptable.

3. When a necropsy is performed, provisional anatomic diagnoses should be recorded in the medical record within two (2) working days, and the complete protocol should be made part of the record within thirty (30) days. (MSEC: 4/02)

D. Compulsory Laboratory Procedures and Reference Laboratory Testing

1. Laboratory procedures performed while patients are admitted to the hospital will be performed by the laboratory authorized by the hospital. Pre-admission Testing (PAT) laboratory results will be accepted only from an appropriately accredited laboratory.
2. Appropriate laboratory procedures should be ordered based upon the clinical setting.
3. Hemoglobin and Hematocrit are required pre-transfusion and are documented in the record.
4. All tests available in the hospital authorized laboratory will be done there. Only those tests not available will be sent to an appropriately accredited reference laboratory.

E. Rules and Procedures for Primary Sterilization

Primary sterilization is defined as an operative procedure of which the primary objective is to render an individual incapable of reproduction. Patients at Miami Valley Hospital may be sterilized.

1. For patients of majority age:
At the request of the patient with a signed consent. When possible, the signed consent of the spouse is desirable, but not required. No consultation is required.
2. For mentally incompetent patients and/or minors:
 - a. In cases involving physical or mental pathology when pregnancy would be detrimental to life or health, a sterilization procedure may be performed with the consent of the patient (if practical) and (1) the court appointed guardian and parent(s) when both exist; or (2) the court appointed guardian or parent(s) when only one exists.
 - b. A written consultation from two physicians, one practicing in the specialty dealing with the physical or mental pathology is required.

F. Investigational Drug Policy

1. The medical staff should do all in its power to foster research and clinical evaluation of investigational drugs consistent with adequate safeguard of the patients.
2. The medical staff regulates the use of investigational drugs by requiring all members of the medical staff who may be interested in participating in a program of drug evaluation to submit to the Institutional Review Board a resume of qualifications and experience in the use of investigational drugs. Privileges in drug investigation shall be granted where advisable through review and approval of a specific research protocol. The list of approved protocols will be provided to the Medical Staff Executive Committee and the Department of Pharmacy. In situations in which a physician/practitioner wishes to use a specific investigational drug for an individual patient outside an approved protocol, he/she must obtain approval from the Food and Drug Administration. The Clinical Research Center can assist in that approval. Emergency use is defined as the use of an investigational drug or biological product with a human subject in a life-threatening situation in which no standard acceptable treatment is available and in which there is not sufficient time to obtain IRB approval [21 CFR 56.102(d)]. The emergency use provision in the FDA regulations [21 CFR 56.104(c)] is an exemption from prior review and approval by the IRB. The exemption, which may not be used unless all of the conditions described in 21 CFR 56.102(d) exist, allows for one emergency use of a test article without prospective IRB review. Such use must be reported to the IRB within 5 working days [21 CFR 56.104(c)] Emergency use means the use of a test article on a human subject in a life-threatening situation in which no standard acceptable treatment is available, and in which there is not sufficient time to obtain IRB approval. Even for an emergency use, the investigator is required to obtain informed consent of the subject or the subject's legally authorized representative unless both the investigator and a physician who is not otherwise participating in the clinical investigation certify in writing all of the following [21 CFR 50.23(a)]:
 - (1) The subject is confronted by a life-threatening situation necessitating the use of the test article.
 - (2) Informed consent cannot be obtained because of an inability to communicate with, or obtain legally effective consent from, the subject.
 - (3) Time is not sufficient to obtain consent from the subject's legal representative.
 - (4) No alternative method of approved or generally recognized therapy is available that provides an equal or greater likelihood of saving the subject's life. The individual granting emergency permission should advise the Director of Pharmacy Services of such permission.
3. The physician, in proposing to undertake such investigation, is required to submit to the Institutional Review Board, a protocol of investigation including indications, dosage, side effects and precautions, along with the availability of the investigational drug and its source. The investigator may appoint several physician/practitioner co-investigators that may participate in the program. The names of the additional physicians shall also be submitted.
4. A bulletin will be provided the nurse or nurses administering the investigational drug, listing briefly its intended use, types of patients and disease, and expected complications or reactions to the investigational drug. This is to be prepared by the investigator and submitted to the Pharmacy and Therapeutics Committee and Institutional Review Board for review. Any nursing

personnel who feel inadequate due to lack of ability or information may refuse to give such medication after consultation with their supervisor.

5. All investigational drugs shall be kept in Pharmacy Services and dispensed by authorized personnel. Exceptions to this policy will be approved by the Director of Pharmacy Services and Director of Clinical Research Center.
6. Pharmacy Services shall maintain a dispensing record for each investigational drug.
7. The investigational drug will be properly labeled, stored and dispensed, only upon written order of the investigator or investigators. No other signatures will be honored.
8. Procedures for handling the study, including double blind or other techniques, shall be worked out between the investigator and the Director or Assistant Director of Pharmacy Services and/or Clinical Research Center.
9. The physician's medication order shall indicate the drug requested is an investigational drug. The requisition shall be signed by the authorized physician/practitioner only.
10. The term "investigational drug" shall be typed or stamped in red on all investigational drugs dispensed from the pharmacy.
11. When patients are participating in an investigational drug study prior to hospital admission, the admitting physician should notify the Director of Pharmacy Services and the Director of Clinical Research. They jointly shall make the determination if the hospital is "involved" in the research according to FDA regulations. The investigational agent should be handled in the manner prescribed for patients using own medications. (4/06)

G. Termination of Pregnancy/Obstetrical Consult Committee.

Abortions (or inductions of labor without intent to resuscitate if necessary), shall be considered obstetrical and gynecological procedures which shall be supervised by the Department of Obstetrics and Gynecology, which will establish criteria for approval by the Medical Staff Executive Committee.

1. No abortions (or inductions of labor without intent to resuscitate if necessary) shall be performed except for cases involving fetal anomaly or to preserve the life or health of the mother, and as allowed by law.
2. Terminations of pregnancy may be performed in the event the attending physician determines the existence of an emergency in which there is an imminent danger to the life of the mother. In such cases, a medical consult confirming the existence of the emergency is desirable, but is not required if the nature of the emergency makes it impractical to obtain. In non-emergent cases, a termination of pregnancy may be offered to the patient for the following: Confirmed cases of a fetal anomaly incompatible with life: anencephaly, trisomy 13, trisomy 18, pre-term rupture of membranes at twenty (20) weeks or less, renal agenesis, imminent miscarriage with pre-viable fetus, or infantile polycystic kidneys (subject to change as recommended by the Obstetrical Consult Committee and as approved by the Department of Obstetrics and Gynecology from time to time.) A semi-annual review will be completed by the Department Chair and the Obstetrical Consult Committee. This information will be presented to the Ethics Committee annually. (Approved: MSEC 5/12/04)
3. In any other case involving risk to maternal health or life, or a fetal anomaly, any physician desiring to perform an abortion (or induction of labor without intent to resuscitate if necessary) shall first refer the case to the Obstetrical Consult Committee for review and approval. The OB Consult Committee shall consist of two physician members as follows:
 - A neonatologist or pediatrician in good standing on the active medical staff, appointed by the Chief of Staff;
 - The Chair of the Department of OB/GYN or designee from the department; and, the following persons appointed by the President of the hospital:
 - A representative from the General Counsel's Office;
 - An obstetrical nursing representative;
 - An administrative representative and/or Consumer Relations representative;
 - A Pastoral Care representative;
 - A Social Service representative and/or Department of Health Psychology representative;
 - A Medical Ethicist (if available and deemed by the committee to be necessary or desirable) on a non-voting, consultative basis;
 - Chair of the Ethics Committee. (Revised: MSEC 10/04)

Every member of the OB Consult Committee shall name a designee or alternate to serve in the event of their unavailability.

The Chair of the committee shall rotate between the OB/GYN physician and the other physician on an annual basis. At least five (5) members of the committee are necessary for a quorum to exist.

The OB Consult Committee shall function under the general authority of the Department of OB/GYN, and its decision shall be reviewed by the Quality Improvement Committee, and be reported to the Ethics Committee.

The physician desiring to terminate a pregnancy under this Section 3. shall request a hearing by the OB Consult Committee through either the Chair of the OB/GYN department, the Chair of the Ethics Committee or the Senior Vice President of Operations,

who shall notify the members of the committee and schedule a meeting within 72 hours of receipt of the request for hearing. (However, if it appears that the case involves a clear risk to the life of the mother, or a fetal anomaly clearly incompatible with life, a pre-hearing conference call of a quorum of committee members may be held, at which the members may, by a majority vote, authorize the termination of pregnancy without conducting a formal hearing.)

At the hearing (if one is held) the attending physician shall be present and shall submit such evidence as the committee deems necessary, including any relevant medical consults, to adequately explain the circumstances of the case. If appropriate, the patient and, if applicable, her partner and/or close family member, may attend the meeting to provide additional evidence. Upon the conclusion of the hearing, the committee shall consider the evidence, and render a decision based on the evidence and the following relevant considerations:

- Gestational age of the fetus and the anomaly or maternal health issue involved;
- Economic circumstances;
- Religious and cultural preferences of parents;
- Quality of life (of all parties involved);
- Alternative resources and/or options available in the community;
- Accepted or appropriate medical standards; and Legal, contractual and institutional policy issues.

The committee shall render its decision within twenty-four (24) hours of the hearing and shall communicate its decision verbally and in writing to the attending physician. A simply majority vote of the committee members at a meeting at which a quorum is present is sufficient to reach a decision. If the decision is to authorize the termination of pregnancy, the attending physician may schedule the procedure immediately upon receipt of verbal notice of the decision. If the decision is not to authorize the termination, the attending physician will be immediately advised by telephone by the Chair of the committee and, if desired, a representative from the committee will meet with the attending physician and, if appropriate, the patient to discuss the reasons for denying the procedure. It shall be stressed to the patient that the decision of the committee is not reflective of the patient's wishes or preference, but simply a reflection of institutional policy.

4. If the decision is to authorize the termination of pregnancy, prior to performing the termination, the attending physician shall be responsible for documenting in the patient's chart in the History and Physical or Progress Notes, that the committee has reviewed and approved the procedure. (MSEC: 11/8/00)
5. All physicians performing terminations of pregnancy must have privileges granted by the Department of Obstetrics and Gynecology. Physicians performing terminations should refer to and comply with Ohio law concerning parental notification for minors and the provision of educational materials concerning abortion alternatives.
6. Physicians who do not maintain acceptable diagnostic ability and skills, or whose complications become unacceptable to the department, shall be subject to review and possible revision of their privileges in accordance with the Medical Staff Bylaws. (MSEC: 11/08/06)

H. Criteria for Granting Privileges in the Use of Radioactive Materials

All radioactive sealed sources (i.e. cesium, Iridium, iodine, etc.) used at Miami Valley Hospital shall be dispensed by the Department of Radiation Oncology. These sources may be used only by practitioners appropriately named as authorized users on the Miami Valley Hospital State Radioactive Materials license.(MSEC: 7/02)

I. Special Treatment Procedures

The medical record shall document the justification for the use of the following special treatment procedures:

1. Restraint, Seclusion, or Use of Protective Devices

Miami Valley Hospital "Guidelines for the Use of Seclusion and Restraint Devices for Behavior Purposes" and Miami Valley Hospital "Guidelines for the Use of Protective Devices" as updated and approved by the Medical Staff Executive Committee, shall be followed. These guidelines are filed in the Administrative Manual and are available on all nursing units.

2. Electroconvulsive and other forms of convulsive therapy:

An anesthesia evaluation of the patient is to be performed and documented before the administration of electroconvulsive therapy and following the procedure. An anesthesia evaluation is to be documented prior to any subsequent electroconvulsive treatment.

J. Guidelines for Levels of Progressive Patient Care

1. Intensive Care Level (ICU, CICU, NICU)

The intensive care units will provide a level of care for treatment of critically or seriously ill patients who have a disease process requiring intensive and highly specialized medical and nursing services and for treatment of conditions associated with a high incidence of lethal and possibly preventable complications.

Admission and discharge of patients will be based only on their need for this level of nursing care.

Every specialty unit has developed detailed guidelines pertinent to their specialty. These are filed and available through the specialty unit.

Patients in terminal phase of an incurable disease are generally not candidates for this level of care.

2. Advanced Care Level

The advanced care level unit will provide a level of care for the treatment of seriously ill patients who require a great amount of highly specialized medical and nursing care.

Admission and discharge of patients will be based on their need for this level of nursing care.

Types of patients who are candidates for this level of care include:

- a. Patients who have recently undergone extensive major surgical procedures and require a concentrated level of highly skilled nursing observation and care.
- b. Patients whose physiological conditions are unstable and who require a concentrated level of nursing observation and care.
- c. Patients with traumatic injuries who require frequent professional observation and care.
- d. Patients requiring ventilator management but not during acute phase. (MSEC 4/02)

3. Acute Care Level

The acute care level units will provide specialized medical and nursing care for the treatment of acutely ill patients of all types. Nursing care is based on assessing the needs and problems of the patient. Admissions and discharges of patients will be based only on their need for this level of nursing care.

- a. All patients with various illnesses, injuries, and diseases of a serious short term nature.
- b. All immediate postoperative patients not requiring the level of care provided.
- c. Patients in the terminal phases of illness.
- d. Complications of pregnancy and normal pregnancy at term.
- e. Newborn infants.

K. Eating/Drinking/Cosmetic Application at Bedside

In recognition of Center for Disease Control Guidelines and in an attempt to decrease the possibility of transmitting infectious diseases, members of the medical staff shall not eat/drink or apply cosmetics at the bedside.

L. Identification

Members of the medical staff shall be able to produce identification in the hospital which will identify them to hospital staff and patients. (MSEC: 4/02)

M. Guidelines for the Disclosure of an Unanticipated Outcome

1. Purpose - The following guidelines are intended to:

- a. Respect the dignity of patients and their families, physicians and healthcare givers
- b. Formulate the preparation and delivery of communication of unanticipated patient outcomes that result in harm.
- c. Conduct activities with honesty, integrity, respect, fairness and good faith
- d. Guarantee integrity and enhance the relationship between patient/family and physicians and healthcare givers

2. Definitions

- a. Unanticipated outcome-A result that differs significantly from the anticipated result of a treatment or procedure that results in potential harm, discomfort or inconvenience to the patient. When a patient is informed in advance about risk potential, the fact that it has come to fruition no longer renders the outcome unanticipated.
- b. Harm-Physical or emotional injury or damage.
- c. Disclosure-The communication of information regarding the results of a diagnostic test, medical treatment or surgical intervention.

3. Unanticipated Outcomes That Require Disclosure to the Patient - Unanticipated outcomes that involve patient adverse outcomes (as defined above) will be communicated to the patient and/or family members in accordance to the procedures described below. This disclosure should occur as soon as possible, and should be directed by the attending physician who has responsibility for the overall care of the patient.

Unanticipated outcomes of care that relate to a sentinel event considered reviewable by the JCAHO are to be disclosed to the patient and/or guardian/legal representative. The following are reviewable sentinel events as defined by the "Sentinel Event/Near Miss" policy:

- a. The event has resulted in an unanticipated death or permanent major loss of function, not related to the natural course of the patient's illness or underlying condition.
- b. Or the event is one of the following (even if the outcome was not death or major permanent loss of function):
 - 1. Suicide of a patient in a setting where the patient receives around-the-clock care (e.g., hospital, residential treatment center, crises stabilization center)
 - 2. Infant abduction or discharge to the wrong family
 - 3. Rape of a patient
 - 4. Hemolytic transfusion reaction involving administration of blood or blood products
 - 5. Surgery on wrong patient or body part
 - 6. Full term infant death

4. Guidelines

- a) Immediately inform the attending physician, Risk Manager and the department chain of command. The attending physician or Risk Manager may consult with the appropriate Department Chair for assistance.
- b) Staff will complete an occurrence report.
- c) The physician or his/her designee will be responsible for disclosing information regarding an unanticipated outcome to the patient and when appropriate, family members.
- d) Communication should be with the patient and as permitted, with the patient's family.
- e) The physician may utilize the resources of Risk Management and/or Consumer Relations to assist with coordinating the communication process.
- f) A conference with the patient/family may be used when the physician does not want to address the issue alone or when there are multiple physicians involved in caring for the patient.
- g) The patient's physician or designee, acting as spokesperson, must be knowledgeable of the case and have authority to address follow-up plans.
- h) Verify all pertinent facts and discoveries. Information should be presented in a timely manner recognizing that in most cases, the entire truth is learned gradually, and so information should be presented in a cautious and careful manner. To avoid the appearance of contradictory information, a prudent approach is to put the explanation in a context that allows for further elaboration, as details become available.
- i) The well being of the patient and family is continually considered with emotional support readily available if needed.
- j) The information provided to the patient and authorized immediate family members/decision makers shall be true and should contain as many of these elements as possible:
- k) Describe the incident that happened.
- l) Describe who was involved (by job function, not by name).
- m) Describe the reasonable potential short term and long term consequences.
- n) Describe what has been done to reduce or manage the consequences to the patient.
- o) Discuss signs and symptoms that may indicate complication.
- p) Discuss appropriate actions the patient or decision-maker shall take if complications occur.

q) Describe what plans have been made to prevent the same type of incident from reoccurring.

5. Communication do's and don'ts:

A. Do

1. Share only the facts of the unanticipated outcome, not what is believed to be the cause
2. Express regret/sympathy that the unanticipated outcome occurred
3. Address the recommendations for treatment and/or the next steps
4. Explain the implications for the patient's prognosis

B. Don't

1. Blame a person, process or imply/state a causation
2. Communicate in an "off-the-record fashion"
3. Make excuses, be misleading, defensive or mysterious
4. Inform the patient/family of litigation opportunities
5. Admit any liability
6. Reveal any corrective action, peer review findings, or that occurrence report completed.

6. Documentation in the patient's medical record shall include the time, date, sequence of events, consequences to the patient of what happened, outcomes, actions taken relative to patient treatment and the information given to the patient and family. In some situations, more harm (physical or psychological) can be done than prevented with the disclosure of unanticipated outcome information. When the decision to withhold information is made, the reason should be documented.(MSEC: 10/8/03)

XI. HIV/HBV/HCV (Human Immuno-deficiency Virus/Hepatitis B Virus with E-antigen Positive Status/Hepatitis C Virus) and Communicable Disease/Infection Policy

A. Physician/Practitioner with Communicable Disease/Infection

All medical staff members with a communicable disease/infection have an obligation to avoid the spread of the disease/infection to patients and employees.

B. Physician/Practitioner with HIV, HBV, or HVC

Any medical staff member who has reason to suspect that he or she may be infected with HIV, HBV or HVC shall obtain appropriate testing to reveal his/her HIV status, HBV and HCV status before performing or participating in an exposure-prone invasive procedure.¹

Any medical staff member who knows that he or she is infected with HIV, HBV or HVC infection is obligated to timely report this to the Chief of Staff and all other governing or licensing bodies as may be required by law or otherwise mandated. The medical staff member shall not perform or participate in any exposure-prone invasive procedure until the situation has been accessed by a review panel designated by the Ohio Department of Health and the Ohio Department of Health's recommendations have been reviewed and approved by the Chief of Staff as further provided for in this policy.

Upon receipt of the Ohio Department of Health's recommendations and/or in conjunction with the Ohio Department of Health, the Chief of Staff will:

1. Evaluate and counsel the medical staff member to determine the member's responsibilities and involvement with exposure-prone invasive procedures at the hospital.
2. At his/her discretion, convene a meeting with a Review Panel (the medical staff member, a representative from the hospital's General Counsel's office, and an Infectious Disease Specialist) to review the situation. The panel will also explore the need for initiation of Lookback Procedures dependent upon the medical staff member's responsibilities within the hospital.

It shall be the responsibility of the Medical Staff member to monitor his/her health and advise the Chief of Staff accordingly.

¹ Exposure-prone invasive procedure (per Ohio Administrative Code) means an invasive procedure in which there is risk of percutaneous injury to the medical staff member by virtue of any of the following: (1) Digital palpation of a needle tip or other sharp instrument in a body cavity; (2) The simultaneous presence of the medical staff member's fingers and a needle or other sharp instrument or object in a poorly visualized or highly confined anatomic site; or (3) Any other invasive procedure in which there is a significant risk of contact between the blood or body fluids of the medical staff member and the blood or body fluids of the patient. If percutaneous injury occurs to a medical staff member during an exposure-prone invasive procedure, the medical staff member's blood is likely to contact the patient's body cavity, subcutaneous tissues, or mucous membranes.

XII. TREATMENT OF HIV PATIENTS AND HIV INFORMED CONSENT POLICIES

A. Physician/Practitioner Refusal to treat AIDS OR HIV Positive Patients

Physicians should adhere to the Policy Statement of the AMA Ethics Committee* which is supported by the hospital and the medical staff of MVH:

- 1) Physician/practitioner should not refuse treatment based solely on the HIV status of a patient or
- 2) On the basis of the potential HIV infection risk to the physician physician/practitioner should treat the HIV infected patient or assist the patient with access to medical treatment through referrals to qualified physicians and/or other providers.

*NOTE: AMA Ethics Committee "A physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient has been infected with the AIDS virus. When an epidemic prevails, a physician must continue his labors without regard to the risk to his own health."

B. HIV Informed Consent Policy

In consideration of the patient confidentiality and psychosocial implications involved with HIV testing, routine HIV testing/ "screening" for evidence of HIV infection is not recommended, but may be indicated under certain circumstances. An HIV test shall only be performed only if informed consent has been given by the person to be tested or his/her legal guardian. Consent may be given orally or in writing after the person or guardian has been given the following information:

- 1) An explanation of the test and testing procedures, including the test's purposes and limitations and the meaning of its results;
- 2) An explanation that the test is voluntary, that consent to be tested may be withdrawn, if the test is performed on an outpatient basis, at any time before the person tested leaves the premises where blood is taken for the test, or if the test is performed on an inpatient basis, within one hour after the blood is taken for the test, and that the person or guardian may elect to have an anonymous test or be referred to a site where an anonymous test is available (except in the case when the test is ordered by a court in connection with a criminal investigation);
- 3) An explanation of the nature of AIDS and AIDS related conditions and the relationship between the HIV related test and those diseases;
- 4) An explanation about behaviors known to pose risks for transmission of HIV infection;
- 5) A list of resources for further counseling or support;
- 6) Notification of the results of the HIV test;
- 7) Post-notification counseling by the physician or by a specially trained individual as arranged by the physician.

EXCEPTIONS The aforementioned do not apply in the following circumstances:

- 1) When the test is performed in a medical emergency by a nurse or physician and the test results are medically necessary to avoid or minimize an immediate danger to the health or safety of the person to be tested or another person, except that counseling shall be given to the person as soon as possible after the emergency is over;
- 2) When the test is performed for the purpose of research if the researcher does not know and cannot determine the identity of the person tested;
- 3) When the test is performed by a person who procures, processes, distributes, or uses a human body part from a deceased person donated for a purpose specified in Chapter 2108. of the Revised Code, if the test is medically necessary to ensure that the body part is acceptable for its intended purpose;
- 4) When the test is performed on a person incarcerated in a correctional institution under the control of the department of rehabilitation and correction if the head of the institution has determined, based on good cause, that a test is necessary;
- 5) When the test is performed by or on the order of the physician who, in the exercise of his/her professional judgment, determines the test to be necessary for providing diagnosis and treatment to the person to be tested, if the person or his parent or guardian has given consent to the physician for medical treatment;
- 6) When the test is performed on a person after the hospital's Infection Control Committee has determined that a health care provider, emergency medical services worker, or peace officer, while rendering health or emergency care to that person, has sustained a significant exposure to the body fluids of that person, and that person has refused to give consent for testing. Contact General Counsel's Office prior to performing test in this situation.

XIII. BLOOD/BODY FLUIDS EXPOSURE POLICY

A. Medical Staff Members Exposed to Blood/Body Fluids

Private attending physicians who suspect they have sustained an exposure incident and desire to know the status of the source patient may notify the Infection Control Coordinator (ICC) by telephone and complete a Request for Information form which the ICP will pick up and retain. In the event that a member of the medical staff reports an exposure incident, the ICP will:

- 1) Obtain the consent for testing from the patient or family per guidelines defined in the HIV Testing and Notification section of this policy.
- 2) Order the HIV antibody, HBs-Ag, and HC lab tests on the appropriate requisition and submit it to the laboratory.
- 3) Upon receiving the test results, complete the Response to Internal Request for Information and inform the physician and the source patient (if requested) of the results.
- 4) The follow up care for the exposed physician is performed by their employer. If the exposure is to a known HIV positive patient, the physician may report to the Emergency Center and be evaluated for post-exposure prophylaxis.

Records pertaining to such exposure incidents will be maintained by the Physician's Employer. (MSEC - 7/9/03)

XIV. NON-SMOKING POLICY

A. In order to provide a healthier, cleaner, and safer environment for our patients and visitors, Miami Valley Hospital is a smoke-free environment. Smoking is not permitted anywhere on Miami Valley Hospital grounds, property and parking areas. The medical staff has approved an order set for management of nicotine withdrawal. (1/22/08)

B. Guidelines for noncompliance

1. Patients will be reminded of the Smoking Policy by the nursing staff. The nursing staff will actively seek patient compliance through education and support.
2. The attending physician will be notified during rounds to speak with the patient regarding compliance.
3. Nursing staff will document in the medical record when a patient chooses to smoke in noncompliance of the policy.
4. Smoking materials may be removed from a patient after the nurse has discussed the situation with the patient, the physician/practitioner and the patient continues to be noncompliant and poses a safety risk to himself and others. (Approved: 4/12/00)

XV. Affiliates of the Medical Staff

A. Criteria and Privileges

1. Each affiliate must be employed or engaged by a member or members of the medical staff who assume full responsibility for the affiliate.

This physician (or physicians) must be named at the time of granting privileges to each affiliate. Any designated alternate (vacation, residency, illness) must also agree to assume such responsibility.
2. When state, county, or city licensure has been established, each affiliate must have such licensure as it applies to the area of activity.
3. If formal courses have been established, each affiliate must document satisfactory completion. Experience may be substituted for a formal course in rare instances, but must be documented and acceptable to the department, Credentials Committee and Executive Committee.
4. Each department must develop its own criteria which apply to all affiliates, but privileges must be granted on an individual basis to each affiliate. These must be well defined, but may differ from affiliate to affiliate.
5. All privileges for affiliates shall be withdrawn upon cessation of employment or engagement, or death of the physician, or action of the department, Credentials Committee or Executive Committee.
6. Temporary privileges may be granted in accordance with Article VII. Section 2(a) of the Medical Staff Bylaws. (MSEC 4/02)
7. The affiliate shall sign his/her name and affiliate designation (i.e. Affiliate, MSA I, or MSA II or MSA III). (MSEC 4/07)
8. When the primary physician is unavailable, his/her alternate shall become the responsible physician.
9. Affiliates shall wear name tags in the hospital in order to identify them to hospital personnel and patients. The tags shall include their names, under which will be their classification (i.e. Mary Jones, Medical Staff Affiliate II). Name tags are provided through the hospital's Security Department and are issued after verification of privileges and after presentation of photo identification. (MSEC: 7/14/04)

10. Definition of Primary Physician and Responsible Physician:
- a. Primary Physician and/or physicians are the sponsors of the individual medical staff affiliate.
 - b. The Responsible Physician is the specific physician assuming responsibility at any given time.

B. Classifications

1. Where applicable, affiliates may be classified into groups for convenience in granting privileges.
- Category I Those who have had formal training and education as physician assistants, advanced practice nurses or nurse anesthetists.
- Category II Those who have had formal training or education in other areas and special experiences or qualifications to work as an assistant to a physician. These may take action at the direction of the responsible medical staff member.
- Category III Those who perform a specific service and work only under the direct supervision of the responsible medical staff member. This would include private operating room personnel, technicians, perfusionists, hearing screeners, etc. (MSEC: 4/07)
2. As national specialty groups develop criteria for identifying and using affiliates, the above rules and regulations on affiliates of the medical staff shall be reviewed and revised. (MSEC: 7/14/04)

- C.** Criteria and privileges of affiliates, as established by each department/section, are on file with the Medical Staff Coordinator.

XVI. Criteria and Privileges of Departments/Sections

The criteria and delineation of privileges of each department/section of the medical staff as formulated and approved by the departments/sections, Credentials Committee, Medical Staff Executive Committee, and the Board of Trustees are on file in the Executive Office.

XVII. Amendments

These rules and regulations of the medical staff shall be adopted, revised, amended and become effective upon recommendation of the Executive Committee of the Medical Staff and approval of the Governing Body. The Bylaws Committee of the medical staff shall be responsible for reviewing these rules and regulations no less than on an annual basis and make recommendations to the Executive Committee of the medical staff as to whether any amendments are appropriate.

Approved: Medical Staff Executive Committee

3/8/95

MVH Board of Trustees

3/28/95

Revised: 1/2/98, 1/26/99, 6/22/99, 3/28/00, 4/12/00, 1/23/01, 9/25/01; 6/25/02; 1/28/03; 6/24/03; 9/23/03; 1/20/04; 6/22/04; 1/25/05; 3/22/05; 6/20/06; 1/30/07; 6/19/07, 1/22/08; 6/08; 10/08

Bylaws of the Medical Staff of the Miami Valley Hospital

PREAMBLE

WHEREAS, the Miami Valley Hospital is a nonprofit corporation organized under the laws of the State of Ohio; and

WHEREAS, its purpose is to serve as a general hospital providing patient care, education and research, and

WHEREAS, the governing body has organized the medical staff of the hospital and has outlined the general duties and responsibilities of the medical staff pursuant to Article VIII of the hospital's Code of Regulations, which medical staff organization shall be subject to the supervision and authority of the governing body;

THEREFORE, the medical staff and the governing body hereby adopt these Bylaws, which shall govern the organization and government of the medical staff, in conformity with and pursuant to the hospital's Code of Regulations. The Medical Staff Bylaws, Rules and Regulations, and policies of the governing body shall not conflict.(1/22/08)

DEFINITIONS

(1)The term "hospital" shall mean Miami Valley Hospital.

(2) The term "medical staff" means all physicians holding unlimited, unrestricted medical licenses and duly licensed dentists and podiatrists and psychologists without restriction on their license who are privileged to attend patients in the hospital. Any physician, dentist, podiatrist, or psychologist who has a restriction on his or her license to practice shall be eligible to be a member of the "medical staff" only upon recommendation of the Executive Committee and approval of the governing body. Such recommendation and approval shall take into account the specific restriction and the reason for such restriction.

(3) The term "governing body" means the Board of Trustees of the hospital.

(4) The term "Executive Committee" means the Executive Committee of the medical staff unless specific reference is made to the Executive Committee of the governing body.

(5)The term "president" means the individual appointed by the governing body to act on its behalf in the overall management of the hospital. With the exception of Articles XVI and XVII which define the mechanisms for amending and adopting these Bylaws, unless specifically indicated otherwise, the President shall have the authority to act on behalf of the governing body during the interim between meetings of the governing body on any matters which the President, being fully informed, deems non-controversial. All actions taken by the President hereunder shall be reported to the governing body at its next meeting, and shall be subject to ratification thereby.(Approved 6/22/99)

(6) The term "clinical administrative director" means the physician or dentist appointed by, or contracting with, the President, with approval of the medical staff, to serve in a capacity as having both administrative and clinical responsibilities over a particular area or department. Clinical responsibilities include those involving professional competence as a practitioner such as to require clinical judgment with respect to patient care and include supervision of professional activities under his/her direction.

(7)Unless the context indicates otherwise, the term "practitioner" means an appropriately licensed physician, dentist, oral and maxillofacial surgeon, podiatrist, or psychologist, and, when not contrary to law or accepted standards of care, such person authorized and designated by such practitioner to act on his or her behalf.

(8) The term "adverse to the practitioner" is defined by Article IX, Section 1(b) of these Bylaws.

(9)The term "clean" with regard to a medical staff application is defined as an application that meets the applicable criteria for expedited appointment as defined in Article VI. Section 2(d) of these Bylaws. (Approved: 5/7/02)

(10) "Affiliate" means an individual other than a licensed Physician (allopathic, osteopathic or podiatric), Dentist, or Psychologist who functions in a medical support role who exercises independent judgment within the area of his or her professional competence and is qualified to render direct or indirect medical, surgical, dental, podiatric, or psychological care under the supervision of or in collaboration with a practitioner who has been accorded privileges for such care in the hospital. These affiliates may include, but are not limited to, physician's assistants, certified registered nurse anesthetists, advanced nurse practitioners, or other individuals whose scope of practice has been recognized by the hospital. (approved 12/3/03)

(11) "Good Standing" means that an appointee, at the time the issue is raised, is not in arrears in dues payments; and has not received a suspension or restriction of his or her appointment or privileges in the previous twelve (12) months; provided, however, that if an Appointee has been suspended in the previous twelve (12) months for failure to comply with the hospital's policies or regulations regarding medical records and has subsequently taken appropriate corrective action, such suspension shall not adversely affect the appointee's Good Standing status.(approved 12/3/03)

ARTICLE I. NAME

The name of this organization shall be the "MEDICAL STAFF OF MIAMI VALLEY HOSPITAL."

ARTICLE II. PURPOSES

The purposes of this organization are:

- (1) To provide that all patients admitted to or treated in any of the facilities, departments or services of the hospital shall receive the same level of appropriate professional care regardless of the department of the admitting practitioner.
- (2) To provide a high level of professional performance by all members of the medical staff through appropriate delineation of the clinical privileges that each practitioner may exercise in the hospital and through an ongoing review and evaluation of each practitioner's performance in the hospital.
- (3) To provide an appropriate educational setting that will maintain scientific standards and lead to continuous advancement in professional knowledge and skill for the medical staff, staff affiliates, nurses and allied health personnel.
- (4) To cooperate with affiliated medical schools, other educational institutions and other hospitals in undergraduate, graduate and postgraduate medical education.
- (5) To create a framework within which members of the medical staff can initiate and maintain rules for self government of the medical staff with a reasonable degree of freedom and confidence as authorized by the governing body.
- (6) To provide a means whereby issues concerning the medical staff of the hospital may be discussed by the medical staff with the governing body and the President.

ARTICLE III. MEDICAL STAFF MEMBERSHIP

Section 1. Requirement.

- (a) Membership on the medical staff of Miami Valley Hospital is a privilege which may be extended only to physicians, podiatrists, psychologists, and dentists licensed to practice in the State of Ohio who can document their background, experience, training, demonstrated competence, their adherence to the ethics of their profession, their good reputation, their health, and their ability to work with others with sufficient adequacy to assure the medical staff and the governing body that any patient treated by them in the hospital will be given care in accordance with accepted standards within their profession. Such practitioners must continuously meet qualifications, standards and requirements set forth in these Bylaws.
- (b) All staff with clinical privileges shall be required to maintain professional liability insurance in not less than the minimum amount as determined by resolution of the governing body after recommendation from the Medical Staff Executive Committee, or other evidence of financial responsibility as the governing body may establish.

The insurance may be either of the occurrence type or the claims made type. If claims made insurance is selected, the practitioner must acquire "tail" or "prior acts" coverage in the event the practitioner changes insurance carriers. In addition, the insurance must be issued by an insurance carrier approved by the Department of Insurance for the State of Ohio, to write insurance in the State of Ohio or shall be determined by the Board of Trustees, in its discretion, upon recommendation by the President after consultation with the Medical Staff Executive Committee, to be substantially equivalent thereto. Failure to comply with this requirement shall constitute a voluntary relinquishment of membership and clinical privileges as noted in Article III. Section 1 (e). (Revised 5/2/06)

- (c) As the hospital administration and medical staff are committed to continuous quality improvement, every member of the medical staff shall actively participate in quality assurance, utilization management activities, and peer review as required by the Chief of Staff.
- (d) Sex, race, age, creed, national origin, sexual orientation and/or a handicap unrelated to the ability to fulfill patient care and required medical staff obligations are not used in making decisions regarding the granting or denying of medical staff membership or clinical privileges. (12/3/03)
- (e) No applicant who is currently excluded from any health care program funded in whole or in part by the federal government, including Medicare, Medicaid, or Champus, is eligible or qualified for membership on the medical staff. No report to the National Practitioner Data Bank shall be required for any applicant whose application is determined to not meet medical staff qualifications in this regard. (Revised 5/2/00)
- (f) All medical and/or allied health staff shall be required to be able to read and understand the English language, to communicate effectively and intelligibly in the English language (written and verbal), and be able to prepare medical record entries and other required documentation in a legible and professional manner. (Approved: 12/3/03)

Section 2. Medical Staff Year

For the purposes of these Bylaws, the medical staff year commences on the first day of June and ends on the thirty first day of May of each even numbered year.

Section 3. Privileges.

The medical staff shall confer on the appointee only such clinical privileges as have been granted by the governing body in accordance with these Bylaws, except as otherwise approved by the Governing Body. (1/07)

Section 4. Application.

Every application for staff appointment and clinical privileges shall be signed by the applicant and shall contain the applicant's specific acknowledgment of applicant's obligation as a member of the medical staff to provide for the continuous care and supervision of the applicant's patients, to abide by the medical staff Bylaws, rules and regulations, and the Code of Regulations of Miami Valley Hospital, to accept committee assignments where appropriate, to authorize release of information by present or past malpractice insurance carriers, to authorize the release of information deemed necessary for the completion of the application, and to release from liability anyone who in good faith provides, receives, reviews or acts on information concerning such application. Such application shall be accompanied by a payment of such fee as may, from time to time, be approved by the governing body. (Revised 5/2/06)

All applicants for medical staff or affiliate privileges shall undergo a criminal background check. The background check shall be limited to a criminal background check and shall commence from day following graduation from medical/professional school. A professional agency may be engaged by the hospital to perform the criminal background check. (Approved: 5/03)

ARTICLE IV CATEGORIES OF THE MEDICAL STAFF

Section 1. The Medical Staff.

(a) CATEGORIES. The medical staff shall be divided into active, courtesy, academic attending, and emeritus categories. Each medical staff member shall be assigned to a department and a section if such department is divided into sections.

(b) ELIGIBILITY. With the exception of active duty military as authorized or required by applicable law, only physicians, dentists, psychologists and podiatrists duly licensed in Ohio shall be eligible for medical staff membership. (Revised 5/06)

Section 2. Provisional Appointments.

(a) GENERAL. All initial appointments to any category of the Medical Staff shall and all reappointments of former members of the Medical Staff after an absence of at least one year shall be provisional for one calendar year during which time the appointee shall not be eligible to hold office or to vote. With respect to applicants who are granted temporary privileges during the pendency of their application for Medical Staff appointment and/or privileges, the provisional period shall not run during the period of temporary privileges, but shall begin at such time as their application is approved. During the provisional period, the provisional appointee shall undergo a one year period of focused peer process evaluation (FPPE) which is accomplished through review of hospital-based utilizing review processes detailed in Article XI of these Bylaws. On a quarterly basis, profiles delineating the member's activity along with local and national comparative statistics (when available) shall be reviewed by the provisionally appointed member's respective department chair. At the termination of the provisional period and upon the recommendation of the department/section, the Credentials Committee and the Executive Committee and with approval by the governing body, the appointee will be granted the privilege of full membership in the staff category in which approval was granted. (Approved 12/08)

During the provisional period, a practitioner must meet all qualifications, must fulfill all of the obligations of his or her Medical Staff category, can exercise all of the prerogatives, and can utilize all of the privileges granted to him or her. (Approved 12/3/03)

(b) FAILURE TO ADVANCE. Reappointment to provisional membership after one calendar year of provisional appointment may not be made. The failure to advance an appointee from provisional to regular or conditional status shall be deemed a termination of staff appointment. A provisional appointee whose membership is so terminated shall have the rights accorded by these Bylaws to a member of the medical staff who has failed to be reappointed. Members placed on conditional appointment shall not be eligible to hold office or to vote during the one year conditional period.

(c) OBSERVATION AND WAIVER. A provisional staff member shall be assigned to a department and a section, when appropriate, where performance shall be observed by the chair of the department/section or a designated representative to determine the eligibility of such provisional member for regular staff membership and for exercising the clinical privileges provisionally granted to the member. Provisional appointments may be waived by approval of the Executive Committee and governing body when it is deemed appropriate.

(d) CHANGE IN CATEGORY. A change in staff category shall not be considered an initial appointment or a reappointment of a former member within the meaning of this section.

Should the termination of the provisional period coincide with the member's reappointment, the review following the provisional period and reappointment review may be combined.(5/06)

Section 3. Conditional Appointments

An applicant applying for membership/clinical privileges or requesting reinstatement of clinical privileges following a period greater than one year in which he/she was not in clinical practice, may be granted a conditional appointment so that he/she may participate in a re-entry proctoring program if the pertinent section or department has an established re-entry protocol.(12/08)

Section 4. Active Staff.

(a) CRITERIA. The active medical staff shall consist of physicians, dentists, psychologists and podiatrists who:

1. Routinely admit or render service to patients in the hospital as determined and monitored by appropriate departments/sections;
2. Meet department and/or section rules on qualifications for active staff appointment in the department and/or section requested; and
3. Assume all the obligations and responsibilities of membership of the active staff.

(b) AVAILABILITY Determination of availability standards shall be left to the discretion of individual departments and sections; however, as a general guideline, Active Staff members, or alternate coverage, should be available and able to respond to any necessary situation within thirty minutes.

(c) RIGHTS AND PRIVILEGES. Members of the active staff shall be eligible to:

1. Vote at medical staff and department/section meetings;
2. Serve on medical staff committees;
3. Serve on department/section committees.

(d) REQUIREMENTS. Members of the active staff shall be required to:

1. Participate in teaching and educational programs;
2. Serve on medical staff committees if appointed, and;
3. Participate in the medical and dental management and care of patients, regardless of ability to pay, as assigned by the appropriate department and/or section. (5/06)

(e) ELIGIBILITY TO HOLD OFFICE.

1. Members on the active staff who meet the following criteria shall be eligible to hold medical staff department or section offices:
 - a. Be able to represent the department in a knowledgeable manner and be able to present the opinion of the respective department in any discussion.
 - b. Meet the requirements of Article X, Section 3 for selection of the Chief of Staff Elect and Article XI, Section 2. for the selection of department and section officers.

Section 5. Courtesy Staff.

(a) CRITERIA. The courtesy staff shall consist of physicians, dentists, psychologists and podiatrists otherwise qualified for staff membership and who:

1. Do not meet the requirements for active staff under Section 3; or
2. Expect to use the hospital facilities to a limited degree; and
3. Meet department and/or section rules on qualifications for courtesy staff appointment in the department and/or section requested.

(b) RESTRICTION. Courtesy Staff members shall not be:

1. Eligible to vote in medical staff, department, section and committee meetings;
2. Eligible to hold any medical staff department or section office;
3. Required to serve on any medical staff committee;

4. Required to attend any medical staff meeting except that a department or section may impose reasonable attendance requirements at department or section meetings, but such requirements shall be no more restrictive than that for active staff members.

Section 6. Academic Attending Staff.

(a) CRITERIA. Members of the academic attending staff shall consist of physicians, psychologists, dentists, and podiatrists who otherwise meet medical staff requirements, but whose primary purpose of staff membership is teaching and education.

(b) ELIGIBILITY. Academic attending staff members are eligible to:

1. Admit patients subject to department or section limitations which have been approved by the governing body;
2. Provide consultation services;
3. Serve as nonvoting members of committees;
4. Attend medical staff, department, or section meetings without vote.

Section 6. Emeritus Staff.

(a) CRITERIA. The emeritus staff shall consist of physicians, dentists and podiatrists who have served as members of the active staff and have been advanced to the emeritus staff by the Executive Committee upon the member's retirement from active practice, because of impaired health, or any other valid reason as determined by the Executive Committee.

(b) RESTRICTION. Emeritus staff members shall retain full rights of membership, shall not be required to attend meetings, but are not eligible to:

1. Vote;
2. Hold office;
3. Serve on medical staff committees;
4. Retain clinical privileges except that limited clinical privileges may be awarded upon request and acted upon as required in Article VII.

(c) **LICENSE.** Emeritus staff members are exempt from maintaining a current state medical license except when clinical privileges are requested.

ARTICLE V. AFFILIATES OF THE MEDICAL STAFF

Section 1. Services

Services of certain allied health professionals may be made available for patient care. Such services shall be performed by the medical staff affiliates, who will perform such services within the limits of their skills and the scope of their lawful practice. A medical staff affiliate shall participate directly in the care of patients and exercise judgment within their area of responsibility under the supervision and direction of a member of the medical staff who has ultimate responsibility for patient care. All affiliates shall be sponsored by a member of the medical staff. (1/22/08)

Section 2. Appointments.

Affiliate Category I (Physicians Assistants, Advanced Practice Nurses, Nurse Anesthetists) applications for appointment/reappointment and privileges shall be processed through the same channels as those for medical staff membership. Affiliate Category II and III applications shall be processed through the same channels as those for medical staff membership. Subsequent reviews of persons with Affiliate Category II and III privileges shall be performed at the same frequency as individuals employed by the hospital. Such applications shall be accompanied by a payment of such fee as may, from time to time, be approved by the governing body. (Approved: 1/22/08)

Section 3. Responsibility.

Affiliates of the medical staff shall be individually assigned to an appropriate clinical department or section and shall carry out their professional activities subject to established departmental and sectional policies and procedures.

It is the responsibility of the appropriate clinical department or section to define the criteria for appointment of the specified category of allied health professionals. Such criteria must be approved by the Credentials Committee, the Executive Committee, and the governing body.

Section 4. Nonreappointment of Affiliates

Notwithstanding anything herein contained to the contrary, allied health professionals as may be granted affiliate status hereby shall not be considered for any purpose to be appointees to the medical staff, do not possess any of the rights or prerogatives that come with such medical staff appointment, and are not entitled to the due process hearings afforded to medical staff members pursuant to Article IX of these Bylaws. Notwithstanding the foregoing, however, should an adverse action be proposed against an Affiliate of the medical staff, the Affiliate or sponsoring member of such Affiliate may petition the Credentials Committee for a hearing at which the affiliate and sponsoring member may respond to such proposed adverse action. Attendance at the hearing by the Affiliate and sponsoring member is mandatory. Following such hearing, should the Credentials Committee continue to recommend any adverse action against the Affiliate, the Affiliate and/or the Affiliate's sponsor may request a hearing by the Medical Staff Executive Committee. The Medical Staff Executive Committee shall consider the request for a hearing, and may choose to grant or not grant such hearing, in its sole and absolute discretion. The decision of the Medical Staff Executive Committee (or, in the event the Medical Staff Executive Committee chooses not to grant a hearing) shall be forwarded to the Joint Conference Committee of the Governing Body. In the event that the President does not agree with the decision of the Medical Staff Executive Committee, the matter will be deferred to the Joint Conference Committee for review and final recommendation to the governing body. (1/22/08)

ARTICLE VI. PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT.

Section 1. Application for Appointment.

(a) APPLICATION FORMS. All applications for appointment to the medical staff or affiliates shall be in writing signed by the applicant, notarized, and submitted on a form prescribed by the Credentials Committee. The application shall contain detailed information concerning the applicant's professional qualifications and shall include a letter of recommendation from a member of the Miami Valley Hospital medical staff and/or a record of personal interview conducted by a member of the appropriate department or section. One of the recommendations for appointment must be from a peer (i.e. practitioner in the same professional discipline as the applicant who has personal knowledge of the applicant.)(1/22/08)

(b) BURDEN OF PROOF. The applicant shall have the burden of producing adequate information for a proper evaluation of his/her identity, competence, character, physical and mental health status, ethics and other qualifications necessary for resolving any doubts about such qualifications. (Approved: 5/4/04)

(c) SUBMISSION AND VERIFICATION. Upon completion, the application shall be submitted to the President who shall transmit the application and all supporting materials through the chair of the department or section in which clinical privileges are being sought after verifying any references, license, and all other pertinent material submitted by the applicant.

(d) INFORMATION REQUIRED. The application for appointment or reappointment shall include information as to any current pending challenges or whether any of the following have ever been or are in the process of being voluntarily or involuntarily denied, revoked, suspended, reduced, not renewed, or voluntarily relinquished limited or terminated:

1. Staff membership status or clinical privileges at any hospital or health care institution;
2. Specialty board certification/eligibility;
3. Residency or internship in any training program;
4. License to practice any profession in any jurisdiction;
5. DEA License.

If any such actions ever occurred or are pending, the particulars thereof shall be included.

(e) CLAIMS HISTORY. The applicant shall provide information regarding malpractice claims history and experience during the past ten (10) years, including a consent to the release of information by present and past malpractice insurance carrier(s).(1/22/08)

(f) ACKNOWLEDGMENT. By applying for appointment or reappointment to the medical staff, each applicant:

1. Signifies a willingness to appear for interviews in regard to the application;
2. Authorizes hospital representatives to consult with others who have been associated with the applicant and/or who may have information bearing on the applicant's competence and qualifications; and specifically agrees to submit any reasonable evidence of current health status that may be requested by the Medical Staff Executive Committee (including a physical or mental health examination.)
3. Consents to hospital representatives inspecting all records and documents that may be material to an evaluation of the applicant's:
 - a. Professional qualifications and competence to carry out the clinical privileges requested;
 - b. Physical and mental health status; and
 - c. Professional ethical qualifications.
4. Releases from any liability all hospital representatives for their acts performed in good faith in connection with evaluating the applicant and his/her credentials.

5. Releases from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to hospital representatives in good faith concerning the applicant's competence, professional ethics, character, physical and mental health, emotional stability, and other qualifications for staff appointment and clinical privileges.
6. The application form shall include a statement that the applicant has received and read the Code of Regulations of the hospital, the Bylaws, and the rules and regulations of the medical staff, and that the applicant agrees to be bound by the terms thereof. Additionally, the application form shall include a statement that the applicant agrees to comply with the hospital's corporate compliance plan, state and federal law, and abide by terms of the Notice of Privacy Practices prepared and distributed to patients as required by the federal patient privacy regulations (i.e. HIPAA). (Approved: 12/3/03)

(g) COMPLETED APPLICATION.

An application shall be deemed complete when the application has been fully filled out, all requested documentation has been supplied and verified; and any additional or supplemental information requested by the Credentials Committee or department chair has been provided, to the satisfaction of the Credentials Committee or department chair as the case may be.

Applications which have not been deemed complete as defined above within 120 days of the date of receipt of the application shall be considered to have been voluntarily withdrawn. An applicant whose application has been voluntarily withdrawn as defined in this section shall not be eligible to submit another application for a period of 6 months at which time payment of another application fee shall be required. Requests for an extension of the 120 day time period may be granted due to extenuating circumstance which must be detailed in writing to the Chief of Staff. The decision to approve an extension of the application time frame will be made at the sole discretion of the Chief of Staff/designee. Failure to approve the request for an extension does not give rise to any due process rights as detailed in Article IX of these Bylaws. (1/22/08)

Section 2. Appointment Process.

(a) DEPARTMENT/SECTION. Within thirty days, or as soon thereafter as possible, after receipt of the completed application by the chair of the clinical department/section in which privileges are being sought, the chair shall make a recommendation for either acceptance, modification or rejection of the application. In the instance that the chair recommends acceptance of the applicant for the clinical privileges and membership being sought, the chair shall forward the application and supporting documents directly to the Credentials Committee. Specific written recommendations for delineating the practitioner's clinical privileges shall be included and the application form shall be signed by the appropriate chair. Should the chair recommend modification or rejection of the application, the application will be presented before the department/section for review and recommendation. The action of the department/section shall be recorded in its departmental meeting minutes or in the minutes of the appropriate section and on the application form which shall be signed by the chair of the department/section. The reasons for any adverse recommendation shall be stated and supported by reference to the completed application and other documentation considered by the department/section. (Approved: 11/28/95)

(b) CREDENTIALS COMMITTEE. Within thirty days, or as soon thereafter as possible, after receipt of the application, the Credentials Committee shall make a written report of its recommendation to the Executive Committee. This recommendation shall be based upon a thorough examination of all information contained in the references given by the applicant as well as from other sources available to the committee including the appraisal by the clinical department/section in which the privileges are sought, and shall verify that the applicant meets and has established all the necessary credentials for medical staff membership in regard to character, professional qualifications and competence, physical and mental health status, and ethical standing. The Credentials Committee will recommend to the Executive Committee that the application be accepted, rejected, or returned to the appropriate department or section for further consideration of the application. Recommendation to reject or return an application shall include written reasons for such action.

(c) EXECUTIVE COMMITTEE. At its next regular meeting after the receipt of the application and report of the recommendation of the chair and/or clinical department/section and the Credentials Committee, the Executive Committee shall determine whether to recommend to the governing body that:

1. The practitioner be appointed to the medical staff in a provisional category;
2. The practitioner be rejected for medical staff membership; or
3. The application be returned to the Credentials Committee or the appropriate department/section for further consideration.

Recommendations to provisionally appoint a practitioner shall be reported by the chair at the next regular meeting of the appropriate department/section. Recommendations to reject or return the application shall include written reasons for such action. Recommendations to appoint must specifically delineate the clinical privileges to be granted. (Approved: 5/1/01)

(d) PRESIDENT. In the absence of any adverse recommendations and following receipt of favorable recommendations from the department/section chair, Credentials Committee, and Medical Staff Executive Committee, a three member committee of the governing body may act on behalf of the governing body in expediting appointing the applicant to the medical staff and in granting clinical privileges. The three member committee of the governing body shall be composed of the President, Chief of Staff and Senior Vice President for Medical Affairs. Two of the three members shall represent a quorum at any meeting of the committee.

An applicant is ineligible for expedited appointment if at the time of appointment any of the following has occurred:

- An incomplete application has been submitted by the applicant;

- The Medical Staff Executive Committee makes a final recommendation that it adverse or has limitations;

An applicant is usually ineligible for expedited appointment if at the time of appointment any of the following has occurred:

- There is a current challenge or a previously successful challenge to licensure or registration;
- The applicant has received an involuntary termination of medical staff membership at another organization;
- The applicant has received an involuntary limitation, reduction, denial, or loss of clinical privileges; or
- There has been a final judgment adverse to the applicant in a professional liability action. (Revised: 1/22/08)

(e) RETURN TO CREDENTIALS COMMITTEE. When the recommendation is to return the application to the Credentials Committee for further consideration, it must be returned to the Executive Committee within thirty days.

(f) RETURN TO EXECUTIVE COMMITTEE. At its next regularly scheduled meeting the Executive Committee shall act upon the appointment, delineating the specified clinical privileges or reasons for rejection of staff membership or clinical privileges. Reasons for an adverse recommendation shall be included in the minutes of the Executive Committee.

(g) ADVERSE RECOMMENDATION. When the recommendation is adverse to the practitioner, the procedures set forth in Article IX of these Bylaws shall be followed.

(h) GOVERNING BODY. At its next regular meeting, in addition to other recommendations relative to clinical privileges requiring its action, the governing body shall receive a report delineating those applicants who were appointed to the medical staff on its behalf by the three member committee of the governing body. In the event that the governing body does not concur with the recommendation of the Credentials Committee, Medical Staff Executive Committee and governing body committee, the matter will be referred to the Medical Staff Executive Committee for further evaluation. Should the recommendations of the Medical Staff Executive Committee and governing body continue to disagree, the matter will be referred to the Joint Conference Committee in accordance with item (j) of this section. An applicant whose application has been referred to Medical Staff Executive Committee shall not lose his/her medical staff membership and clinical privileges unless it is determined that a summary suspension is warranted as outlined in Article VIII, Section 2 of these Bylaws. If the decision of the governing body is adverse to the practitioner, the procedure set forth in Article IX of these Bylaws shall be followed. (approved 12/5/00)

(i) FINAL ACTION. After receipt of an adverse recommendation from the Executive Committee following completion or waiver of the appellate review provided in Article IX of these Bylaws, the governing board shall act on the matter at its first regular meeting.

(j) JOINT CONFERENCE COMMITTEE. Whenever the governing body's decision is contrary to the recommendation of the Executive Committee, the governing body shall refer the matter to the Joint Conference Committee for further review. Within fifteen days, the Joint Conference Committee shall make recommendation to the governing body.

(k) GOVERNING BODY. At its next regular meeting after receipt of the Joint Conference Committee's recommendation, the governing body shall make the final decision.

(l) NOTICE OF DECISION. Notice of the governing body's decision shall be sent through the President to the Executive Committee and, by certified mail to the practitioner.

(m) REAPPLICATION PROHIBITION. A practitioner may not reapply for appointment or an increase in clinical privileges for at least eighteen (18) months following final decision of the governing body when the final decision is adverse to the practitioner.

Section 3. Reappointment Process.

(a) CHANGE OF STATUS. Any individual practitioner may at any time initiate a request for a change in category or a change of privileges when the final decision of the governing body on their current appointment or privileges was not adverse to the practitioner. Such request shall be treated as an initial appointment.

(b) TIME RESTRICTION. A practitioner may not initiate a request for a reappointment, or a change in category for at least eighteen (18) months following final governing body action when the practitioner's current appointment or privileges were considered adverse to the practitioner at the time they were awarded.

(c) DEPARTMENT/SECTION. Members of the medical staff are reappointed on a rotational basis, during all even numbered years. A copy of the rotation schedule is on file in the Medical Staff Office. Prior to the date the department is scheduled to present its members to the governing body, the clinical department/section shall review all pertinent information available on each practitioner scheduled for periodic appraisal for the purpose of determining its recommendations for reappointment to the medical staff and for the granting of clinical privileges for the ensuing period and shall transmit its recommendations in writing to the

Credentials Committee. Where nonreappointment, conditional reappointment, or restriction in clinical privileges or change in category is recommended, the reason for such recommendation shall be stated in writing. In the event that a department/section will not meet prior to the date reappointment recommendations must be submitted to the Credentials Committee, the chair of the department/section shall be authorized to act on behalf of the department/section in making the afore referenced recommendations for reappointment of members. At the next regular meeting of the department/section, the recommendations for reappointment shall be submitted for ratification. (approved: 12/3/02)

(d) CRITERIA. Each recommendation concerning the reappointment of a medical staff member and the clinical privileges or category to be granted upon reappointment shall be based upon such factors as the member's professional competence and clinical judgment in the treatment of patients, continuing medical education which must be related to the privileges being renewed, current licensure, ethics and conduct, attendance at medical staff meetings and participation in medical staff affairs, compliance with the hospital policies and the medical staff Bylaws, Rules and Regulations, cooperation with hospital personnel, use of the hospital's facilities for his/her patients, relationship with other practitioners, and general attitude toward patients, the hospital and the public, and his/her physical and mental health status. (Approved: 12/3/02)

With reference to determination of a member's physical and/or health status, the Executive Committee may require the applicant for reappointment to submit reasonable evidence of current health status, including a physical or mental health examination.

(e) AVAILABLE RECOMMENDATIONS. The clinical department/section may recommend full reappointment, nonreappointment, conditional reappointment, or reappointment with restriction of privileges, of a member depending upon the department's evaluation of the member's compliance with the factors outlined in (d) above.

(f) CREDENTIALS COMMITTEE. Prior to the meeting at which the department/section is scheduled to present its members for reappointment to the governing body, the Credentials Committee shall review all pertinent information available on each practitioner scheduled for periodic appraisal as submitted to it by the various clinical departments/sections for the purpose of making its recommendation for reappointments to the medical staff and for the granting of clinical privileges for the ensuing period. The Credentials Committee shall transmit its recommendations in writing to the Executive Committee. Where nonreappointment, conditional reappointment, reappointment with restriction, or change in clinical privileges or in category is recommended, the reason for such recommendation shall be stated in writing.

(g) EXECUTIVE COMMITTEE/GOVERNING BODY. Prior to the meeting at which the department/section is scheduled to present its report to the governing body, the Executive Committee shall make to the governing body, through the President, its written recommendations for reappointment to the medical staff and for the granting of clinical privileges of each practitioner then scheduled for periodic appraisal. If an application for reappointment will not be fully processed by the expiration date of the member's appointment because the meeting schedule of the governing body has either been modified or cancelled, a three member committee of the governing body may act on behalf of the governing body in appointing those practitioners scheduled for periodic appraisal in the manner set forth in Section 2 (d) and (h) of this article for initial applicants. (approved: 12/5/00)

Whenever the governing body's decision is contrary to the recommendation of the Executive Committee, the governing body shall refer the matter to the Joint Conference Committee for further review. Within fifteen days, the Joint Conference Committee shall make recommendation to the governing body. Where nonreappointment, conditional reappointment, reappointment with restriction, or an adverse change in clinical privileges or in category is recommended, the reasons for such recommendation shall be stated in writing. At its next regular meeting after receipt of the Joint Conference Committee's recommendation, the governing body shall make the final decision.

(h) CONDITIONAL REAPPOINTMENT. The Credentials Committee shall review quarterly the progress of any practitioner conditionally reappointed, or appointed with restriction, to the medical staff, except for conditional reappointment for failure to attend department and section meetings which will be monitored by their respective medical staff department or section. Failure to demonstrate improvement in the area of deficiency may result in recommendation for disciplinary action. A practitioner shall not be reappointed conditionally in the same area of deficiency for consecutive terms.

(i) ADVERSE RECOMMENDATION. In the event a recommendation by the Executive Committee or the governing body is adverse to the practitioner, the procedures set forth in Article IX of these Bylaws shall be followed.

(j) REINSTATEMENT

A member whose voluntary resignation has been processed based solely upon his/her failure to submit a completed reappointment application prior to the due date, may request reinstatement of his/her staff appointment and clinical privileges if the following conditions are met:

1. The appropriate department/section chair has determined that reappointment materials are complete;
2. The complete reappointment application has been received within thirty days of the member's notification from the President of their non-reappointment

A member whose reappointment has lapsed for a period greater than thirty days as noted in item 2 above would be required to complete a new application for medical staff membership which will be processed as an initial application. Determination as to whether the member would serve another provisional year would be determined based upon Article IV, Section 2 (a) of these Bylaws.

(k) PRIVILEGE DECISION NOTIFICATION. With reference to appointment and reappointment decisions which are not adverse to the practitioner, notification of the practitioner of his/her appointment/reappointment shall be sent via the hospital's courier service or via regular mail within thirty (30) days of the appointment/reappointment decision. (Approved: 1/22/08)

Section 4. Clinical and/or Administrative Agreements.

Physicians, podiatrists, and dentists, employed by, or contracting with, the hospital, whose duties are clinical/administrative in nature and include clinical responsibilities or functions with the medical staff involving their professional capability as physicians, podiatrists, or dentists, must be members of the medical staff, achieving this status by the same procedure provided for other medical staff members. Their privileges should be delineated consistent with their education, training, competence and character as well as in terms of their employment or contract.

Effect of Exclusive Contract Effective May 1, 2001, a practitioner shall not be eligible to apply or reapply for medical staff membership or clinical privileges in any hospital-based department (emergency, radiology, radiation oncology, pathology, neonatal intensive care unit, anesthesia or other similarly situated department) if, at the time, the hospital has exclusively contracted with a physician or group of physicians to provide the physician services for which such privileges are sought in that department, unless such practitioner provides evidence that he/she is employed by (or contracts with) the physician or group of physicians holding the exclusive contract. The failure or refusal of the hospital to consider any application under such circumstances shall be considered non-adverse to the practitioner under Article IX, Section 1(c) of these Bylaws and shall not give rise to any appeal rights under that Article. Any exception to this provision must be for good cause and approved by the President and Chief of Staff. (approved 12/4/01)

Section 5. Leave of Absence.

(a) REQUESTS. A practitioner may request a voluntary leave of absence from the medical staff by submitting written notice to the Executive Committee and the President stating the approximate period to time of the leave, which may not exceed twelve (12) months. Acceptance of such request shall be in the sole discretion of the President, upon the recommendation of the Executive Committee.

Should the practitioner be on a leave of absence at the time of reappointment, membership and clinical privileges will be deemed as lapsed, however membership and clinical privileges can be reinstated using the reappointment process rather than processing the application as an initial appointment. A practitioner whose membership and clinical privileges have been reinstated in this manner shall not be required to serve another provisional year and shall maintain their original appointment date. (5/06)

(b) REINSTATEMENT. At least thirty (30) days prior to the termination of a leave, or at any earlier time, the practitioner may request reinstatement of privileges and prerogatives by submitting a written notice to that effect to the President for transmittal to the Executive Committee. The practitioner shall be required to submit a written summary of relevant activities during the leave prior to the reinstatement of the practitioner's appointment and privileges. (Approved 5/27/97)

(c) RESIGNATION. Failure, without good cause, to request a reinstatement or to provide a requested summary of activities as above provided shall be deemed a voluntary resignation from the staff and shall result in automatic termination of staff membership privileges and prerogatives. A practitioner whose membership is so terminated shall be entitled to the procedural rights provided in these Bylaws for the sole purpose of determining the issue of good cause. A request for staff membership subsequently received from a practitioner so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

(d) MILITARY OBLIGATION. In the case of United States military obligations, this section may be waived.

(e) Resumption of Clinical Practice Following an Extended Illness. If a practitioner is away from clinical practice for a period greater than six weeks for a medical reason, (excluding maternity leave), or any other reason which could impact clinical skills, the practitioner, prior to resumption of clinical practice at the hospital, shall submit written notification to the appropriate department or section chair. The written notification shall include a brief summary describing the reason for the leave and the anticipated date when practice will be resumed. At the discretion of the department or section chair, the practitioner may be required to submit evidence of current health status, which could include a written statement from the treating physician, or submission to a physical or mental health examination. (Approved: 6/22/99)

(f) OTHER ACTION. Nothing in this section shall preclude action under Article VIII or any other Article herein.

ARTICLE VII. CLINICAL PRIVILEGES

Section 1. Delineation of Clinical Privileges.

(a) GENERAL. A staff appointment shall confer on the appointee only such clinical privileges as are specified in the notice of appointment. Clinical privileges in one or more departments/sections are applied for as a part of the initial application. Specific criteria for clinical privileges in each department/section shall be on file in the Medical Staff Office. (1/22/08)

(b) BURDEN OF PROOF. The clinical department/section in which the privileges are being sought shall evaluate the request based upon the applicant's education, training, experience, demonstrated competence, references and other relevant information. The applicant shall have the burden of establishing his/her qualifications and competency in the clinical privileges requested.

(c) RENEWAL AND CHANGES. Renewal of clinical privileges and change of such privileges may be based, as deemed appropriate, upon the direct observation of care provided, review of the records of patients treated in this or other hospitals and shall, at a minimum, be based on a review of the record of the medical staff which document the evaluation of members participating in the delivery of medical care. Applications for additional clinical privileges must be in writing and should state the type of privileges desired as well as the applicant's relevant training and experience. Such applications shall be processed as an initial appointment.

(d) REDETERMINATION. At any time a department/section may initiate a redetermination of clinical privileges of any practitioner in the department/section.

(e) DENTISTS AND PODIATRISTS. Privileges granted to dentists and podiatrists shall be based on their training, experience and demonstrated competence and judgment. The scope and extent of the surgical procedures that each dentist or podiatrist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. All dental or podiatric patients shall receive the same basic medical appraisal as patients admitted to other clinical services. All dentists and podiatrists shall arrange for a physician member of the medical staff to be responsible for any medical problem that may be present at the time of admission or that may arise during hospitalization.

(f) AFFILIATES. Affiliates of the medical staff shall have privileges conferred in the same manner as members of the medical staff.

Section 2. Temporary Privileges.

(a) TEMPORARY PRIVILEGES. Temporary privileges shall not generally be granted, but temporary privileges shall be limited only to those given to fulfill an important patient care need or when an application has been determined to be a complete, clean application and has been evaluated and recommended for approval by the appropriate department or section chair. The applicant desiring temporary privileges to fulfill an important patient care need shall be required to delineate on the application form the specific patient care need which justifies the granting of the temporary appointment. Upon receipt of an application, including proof of professional liability insurance as is required by these bylaws, and the referenced documentation of patient care need, for medical staff membership from an appropriately licensed and qualified practitioner, the President, or a designee in the event of the President's absence, may, upon the basis of information available and with the advice and consent of the relevant section/department chair, or if deemed necessary or desirable by the President, the majority vote of the Medical Staff Executive Committee, and the Chief of Staff, grant temporary admitting and clinical privileges to the applicant. Special conditions and/or restrictions may be imposed by the section/department chair concerned on any practitioner granted such privileges. Such privileges shall not exceed 120 days (subject to earlier termination for good cause). (Approved: 12/7/04)

(b) SINGLE CASE PRIVILEGES. Single case clinical privileges may be granted by the President for the care of a specific patient to a qualified practitioner who is not an applicant for membership upon the same conditions set forth in paragraph (a) of this section, provided that there shall first be obtained such practitioner's signed acknowledgment that a copy of the Medical Staff Bylaws, Rules and Regulations has been received and that agreement to be bound by the terms and conditions thereof in all matters relating to the request for single case clinical privileges. Such privileges shall be restricted to the admission and/or treatment of not more than one patient in any one calendar year by any practitioner. Such practitioner shall be required to apply for membership on the Medical Staff before being allowed to attend additional patients.

(c) LOCUM TENENS. The President may permit a practitioner serving as a locum tenens for a member of the Medical Staff to attend patients without applying for membership on the Medical Staff for a period not to exceed 90 days, upon the same conditions, limitations and restrictions set forth in paragraph (a) of this section.

(d) EMERGENCY PRIVILEGES. In a case presenting an imminent threat of danger to the life of a patient, any physician, podiatrist or dentist, duly licensed and qualified to practice, shall, to the degree allowed by his/her license and regardless of department/section or staff status or lack of it, be permitted and assisted to do everything possible to save the life of such patient, using every facility of the hospital necessary and including the calling for any consultation necessary or desirable. When the life of the patient is no longer in imminent danger, such practitioner must then request the privileges necessary to continue to treat the patient pursuant to paragraph (b) of this section, and in the event privileges are denied or the physician does not request such privileges, the patient shall be assigned to an appropriate member of the Medical Staff.

(e) Disaster During Times of Community Disaster. During a disaster in which the hospital's emergency preparedness plan has been activated and the hospital is unable to handle immediate patient care needs, the Chief Executive Officer, upon the recommendation of the Chief of Staff or their designee(s) may grant disaster privileges to a licensed independent practitioner (LIP). Disaster privileges may be granted if the LIP presents a valid government-issued photo identification issued by a state or federal agency (i.e. driver's license or passport) and Disaster privileges may be granted if one of the following items is presented:

- A current hospital ID card
- A current license to practice medicine or Primary source verification of current license to practice medicine and a valid picture ID issued by a state, federal or regulatory agency
- Identification which indicates that the individual is a member of a Disaster Medical Assistance Team (DMAT) or MRC, ESAR-VHP or other recognized state or federal organization or group
- Identification from a state, federal, municipal or regulatory agency which identifies the individual has been granted authority to render patient care in emergency circumstances
- Verification by a current hospital or medical staff member with personal knowledge regarding the practitioner's identity.
- Verification by a current hospital and ability to act as a LIP during a disaster and
- The LIP signs a statement which verifies that he/she has current professional liability coverage which meets or exceeds the hospital's minimum requirement.

In granting the disaster privileges, the name of an alternate member of the medical staff who can be called to assist if necessary is identified as is a statement relative to the specific privileges granted to the LIP. The applicable medical staff department or section chair shall be responsible for managing the activities of the LIP and shall be identified in the written statement granting the disaster privileges. A badge which identifies the LIP as having disaster privileges shall be issued out of the Security Department and will be worn by the LIP while performing clinical services at the hospital. The disaster privileges granted shall automatically be terminated when the hospital's emergency preparedness plan is deactivated. Any patients currently being seen by the LIP shall be reassigned to an appropriate member of the medical staff.

As soon as the immediate situation is under control, the Medical Staff Office will obtain verification of the LIP's credentials as detailed for persons granted temporary privileges for an important patient care need as outlined in item (a) of this section. Unless extended by the governing body due to extenuating circumstances, primary source verification of the LIP's licensure must be completed within 72 hours of the LIP's arrival at the hospital. Based upon information obtained regarding the professional practice of the volunteer LIP, a decision is made related to continuing the disaster privileges initially granted within 72 hours. (1/22/08)

(f) **MODIFICATION OR TERMINATION.** Any privileges granted under this section may be modified or terminated at any time by the President on recommendation of the chair of the department/section concerned or by the Chief of Staff, without rights provided in Article IX herein by the physician whose temporary privileges have been modified or terminated. Where it is determined by the chair of the department/section, or in the chair's absence, the Chief of Staff, that the life or health of any such patient would be endangered by continued treatment by the practitioner, the person making such determination shall assign a member of the medical staff to assume responsibility for the care of any such patient(s) until the patient's discharge.

Section 3. Retrieval for Organ Donation

A physician need not have medical staff membership or clinical privileges in order to retrieve organs from a deceased donor for the purpose of organ transplantation pursuant to a contract with Life Connection or other procurement agency with the hospital provided that such physician is adequately qualified and trained to do the retrieval procedure, possesses a license to practice medicine and has adequate professional liability coverage in accordance with the terms and conditions set forth in such contract. (Approved: 5/4/04)

ARTICLE VIII. CORRECTIVE ACTION

Section 1. Procedure.

(a) REQUESTS. Corrective action against any practitioner may be requested by the governing body, the President, the Chief of Staff, or the chair of the practitioner's clinical department/section whenever a practitioner's activities or professional conduct is considered to be lower than the standards or aims of the medical staff or to be disruptive to the operations of Miami Valley Hospital. All requests for corrective action shall be in writing, shall be made directly to the Chief of Staff, and shall be supported by references to the specific activities or conduct which constitute the grounds for the request.

(b) DEPARTMENT/SECTION. Whenever the recommended corrective action includes the reduction or termination of clinical privileges, the Chief of Staff shall forward such requests to the chair of the department/section wherein the practitioner has such privileges. Upon receipt of such requests, the chair of the department/section shall immediately appoint a review committee of no less than three (3) physicians, podiatrists, or dentists, to investigate the matter at the request of the Chief of Staff.

(c) REVIEW COMMITTEE. The review committee shall immediately notify the practitioner of the charges against him/her. Within thirty (30) days after the chair's receipt of such a request for corrective action, the review committee shall make a report of this investigation to the Executive Committee. The practitioner against whom corrective action has been requested shall be notified of his/her opportunity for an interview with the review committee prior to the making of such a report, which the practitioner must request in writing. At such interview, the practitioner shall be informed of the general nature of the charges and be permitted an opportunity at such meeting to make a statement on his/her own behalf. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. A memorandum record of such interview shall be made by the committee conducting the review.

(d) EXECUTIVE COMMITTEE. Within thirty (30) days following the receipt of the report from the review committee, the Executive Committee shall take action upon the request. If the recommended corrective action is adverse to the practitioner as defined in Article IX, the affected practitioner shall be entitled to the procedural rights provided in Article IX of these Bylaws.

(e) CORRECTIVE ACTION. The action of the Executive Committee on the request for corrective action may be to do any or a combination of the following:

1. Reject or modify the request for corrective action;
2. Issue a warning, a letter of admonition or a letter of reprimand;
3. Impose terms of probation or a requirement for consultation;
4. Recommend reduction or revocation of clinical privileges;
5. Recommend that the practitioner's staff membership be terminated.

(f) ADVERSE RECOMMENDATION. Any recommendation by the Executive Committee adverse to the practitioner shall entitle the affected practitioner to the procedural rights provided in Article IX of these Bylaws.

(g) NOTIFICATION REQUIREMENT. The chair of the Executive Committee shall promptly notify the President and the affected practitioner in writing of all requests for corrective action received by the Executive Committee and shall continue to keep both fully informed of all actions taken in connection therewith.

In the event that a request for corrective action or a summary suspension involves a Wright State University fully affiliated faculty member, notification of the request for corrective action and/or the summary suspension shall also be made to the Wright State University School of Medicine Department Chair of the affected faculty member. In the event that the affected fully affiliated faculty member is a Wright State University Department Chair, notification shall be made to the Dean of the Wright State University School of Medicine. (Approved: 5/05)

Section 2. Summary Suspension.

(a) GENERAL. Whenever a practitioner willfully disregards these Bylaws or other hospital policies or whenever the practitioner's conduct requires that immediate action be taken to protect the life of any patient(s) or to reduce the likelihood of immediate injury or damage to the health or safety of any patient, employee or other person present in the hospital:

1. The Chief of Staff, upon consultation with the President; or
2. The President, upon consultation with the Chief of Staff; or
3. The Executive Committee of the medical staff; or
4. The Executive Committee of the governing body, upon consultation with the Chief of Staff,

shall have the authority to summarily suspend the medical staff membership status or all or any portion of the clinical privileges of such practitioner. Where warranted and if so designated, such suspension shall be deemed an interim precautionary step in the professional review activity preliminary to action that will be taken with respect to the suspended practitioner, but is not a formal disciplinary action in and of itself. It shall not imply any final finding of responsibility for the situation that gave rise to the suspension. (Approved 6/22/99)

(b) FELONY CHARGES. If any court or any grand jury should find cause to believe that a practitioner has committed a criminal felony of such a nature that the practitioner's moral or ethical character or medical competence is suspect, the practitioner may be summarily suspended in accordance with Section 2(a) of this Article. Such suspension may remain in effect until final resolution of the matter or until a final decision of the governing body not adverse to the practitioner. The affected practitioner shall be afforded all rights conferred under Article IX.

(c) NOTIFICATION AND EFFECTIVE DATE. Such summary suspension shall become effective immediately upon imposition and is deemed an adverse recommendation pursuant to Article IX, Section 1 (b) (3). The President shall promptly give written notice of the suspension to the practitioner.

(d) TERM OF SUSPENSION. Pending a final decision under Article IX, the terms of the suspension shall remain in effect.

(e) MEDICAL COVERAGE. Immediately upon imposition of a summary suspension, the Chief of Staff or the responsible department/section chair shall have the authority to provide the alternative medical coverage or consultation for the patients of the practitioner still in the hospital at the time of such suspension. The wishes of the patient shall be considered in the selection of the alternative practitioner.

Section 3. Voluntary Relinquishment/Termination.

In the event any of the following occurs, the affected practitioner shall be deemed to have voluntarily relinquished his/her medical staff membership and clinical privileges. Upon correction or resolution of the matter, the affected practitioner shall be eligible for automatic reinstatement of membership and privileges if the lapse in privileges has not exceeded thirty (30) days. Failure to correct the matter within 30 days shall require completion and submission of a new application for membership and clinical privileges which will be processed as an initial application. Determination as to whether the member would serve another provisional year would be based upon Article IV, Section 2 of these Bylaws. (12/06)

(a) INCOMPLETE MEDICAL RECORDS. Three failures in one calendar year, or one suspension lasting for a continuous six week period, to complete medical records in accordance with the rules and regulations shall constitute voluntary termination of membership and clinical privileges. (1/22/08)

(b) LICENSE TO PRACTICE. Notification from the Ohio State Board of Medical Examiners or other appropriate state board of the revocation, suspension, or relinquishment of a practitioner's license shall constitute a voluntary termination of the practitioner's staff appointment and hospital privileges. Termination when a restriction is placed on a license is subject to review by the Executive Committee and approval by the governing body.

(c) NARCOTICS NUMBER. A practitioner whose DEA number is revoked, relinquished, suspended, or restricted shall immediately and automatically be divested of the right to prescribe medication except as permitted by such number.

(d) DUTY TO NOTIFY. A practitioner is under a continuing obligation to notify the Chief of Staff upon revocation, suspension, relinquishment, or restriction of his/her license or DEA number. Failure to do so is ground for denial of staff appointment and/or clinical privileges.

(e) PROFESSIONAL LIABILITY COVERAGE. Failure to maintain professional liability insurance coverage pursuant to Article III, Section 1(b) shall constitute a voluntary relinquishment of membership and clinical privileges.

(f) VOLUNTARY RELINQUISHMENT/TERMINATION. Each medical staff member, upon notice of any proposed or actual exclusion from any federally funded health care program, shall disclose immediately to the Chief of Staff, by telephone and in writing, any notice to the member or his or her representative of proposed or actual exclusion and/or pending investigation of the member from any health care program funded in whole or in part by the federal government, including Medicare, Medicaid and Champus. With regard to any pending or proposed exclusion from any federally funded health care program, the member's continued medical staff membership and clinical privileges is subject to review and approval by the governing body. A voluntary termination of membership and clinical privileges shall be processed for any member who has actually been excluded from any such federally funded health care program as herein defined. Failure of the member to notify the Chief of Staff of any proposed or pending exclusion is ground for denial of staff membership and/or clinical privileges. No report to the National Practitioner Data Bank shall be required for any member whose appointment and/or clinical privileges have been so terminated. This section shall not apply to voluntary termination by a member from participation in any government-funded program.(5/2/00)

Section 4. Expungement of Information

(For purposes of these Bylaws, any "expunged" information shall not be destroyed, but shall remain in the practitioner's medical staff file, but shall be regarded as not having occurred except in the event of future similar conduct of the practitioner involved.) A practitioner seeking to expunge adverse information in his medical staff file shall send a written request to the Chief of Staff. Such request shall set forth the specific information sought to be expunged, the reasons justifying the expungement, and shall include verification by the practitioner that the conduct which was the subject of the adverse information has not been repeated by the practitioner.

Upon receipt of a written request for expungement, the Chief of Staff shall refer the matter to a committee comprised of the Chief of Staff-Elect, the Department Chair and the President or his designee. Within ninety (90) days of receipt of the request for expungement, the committee shall review the request and make a written recommendation to the Chief of Staff, taking into consideration such factors as: the severity of the offense involved, extenuating circumstances (if any), the length of time which has transpired, whether the matter was an isolated occurrence, and any other factors deemed relevant and material by the committee. Any action which also resulted in the filing of a public record shall not be subject to expungement here under. Should the Chief of Staff disagree with the recommendation, he and the committee shall meet to attempt to resolve any matters in dispute and reach agreement if possible. If this does not resolve the matter, it shall be referred to the Medical Staff Executive Committee for resolution. In any event, the decision of the Chief of Staff (if in accord with the Committee) or the Medical Staff Executive Committee (if it acts to resolve a disagreement between the Chief of Staff and the Committee) shall be final. A denial of a request to expunge the records shall not create a right to any appellate relief under these bylaws. A practitioner shall be eligible to request an expungement under these Bylaws only one time. (5/2/00)

ARTICLE IX HEARING AND APPELLATE REVIEW PROCEDURE

Section 1. Right to Hearing and Appellate Review.

(a) GENERAL. When any practitioner receives notice of a recommendation of the Executive Committee that, if ratified by the decision of the governing body, will adversely affect the practitioner's appointment to or status as a member of the medical staff or the ability to exercise clinical privileges, the practitioner shall be entitled to a hearing before an ad hoc committee of the medical staff. If the recommendation of the Executive Committee following such hearing is still adverse to the practitioner, the practitioner shall then be entitled to an appellate review by the governing body before the governing body makes a final decision on the matter.

(b) ADVERSE TO THE PRACTITIONER. For purposes of these Bylaws, the following recommendations or actions shall be deemed adverse to the practitioner and shall entitle the practitioner affected thereby to the rights conferred under this Article:

1. Denial of initial staff appointment;
2. Denial of staff reappointment;
3. Summary suspension of staff membership or clinical privileges;
4. Termination of staff membership or clinical privileges;
5. Denial of requested advancement in staff category;
6. Reduction in staff category (except for failure to meet attendance requirements);
7. Limitation of admitting privileges except with respect to temporary privileges as provided in Article VII, Section 2;
8. Denial of requested department and service affiliation;
9. Denial or reduction of requested clinical privileges;
10. Requirement of consultation;

11. Failure to advance from provisional membership;
12. Conditional reappointment except when such condition is imposed due to failure to comply with meeting attendance requirements.

(c) NOT ADVERSE TO THE PRACTITIONER. The following actions shall not be considered adverse to the practitioner and shall not give rise to any appeal rights under this Article:

1. Issuance of a warning, a letter of admonition, a letter of reprimand;
2. Denial, termination or reduction of temporary privileges;
3. Denial of teaching status;
4. Terms of a provisional year;
5. Voluntary relinquishment or termination under Article VIII, Section 3;
6. Any suspension of clinical privileges of 14 days or less;
7. Terms of probation; and
8. Nonrestrictive consultation requirements.
9. Non-appointment or nonreappointment based upon being a non participant in an exclusive arrangement with the hospital as detailed in Article VI, Section 4. (approved 12/4/01)
10. Denial of a request for a leave of absence, or for an extension of a leave;
11. Determination that an application is incomplete;
12. Determination that an application will not be processed due to a misstatement or omission (After exhaustion of all good faith efforts at clarifying the misstatement and/or omission)
13. Voluntary relinquishment of staff appointment or privileges
14. Denial of a clinical privilege because of a failure to meet an established minimal threshold criteria for that privilege
15. Ineligibility for privileges that are granted only via an exclusive contract arrangement.
16. Failure to obtain board certification as required by the applicable department or section. (1/22/08)
17. Failure to be granted a Conditional Appointment or failure to proceed from Conditional Appointment to Provisional Appointment as detailed in Article IV. Section 3
18. Denial of membership

(d) GOVERNING BODY ADVERSE RECOMMENDATION. When any practitioner receives notice by the governing body that will adversely affect the practitioner's appointment to or status as a member of the medical staff or his/her exercise of clinical privileges, and such decision is not based on a prior adverse recommendation by the Executive Committee of the medical staff with respect to which the practitioner was entitled to a hearing and appellate review, the practitioner shall be entitled to a hearing by the Joint Conference Committee. If such hearing results in a recommendation adverse to the practitioner, the practitioner is entitled to an appellate review in accordance with this Article before the governing body makes a final decision on the matter.

(e) RIGHTS OF PRACTITIONER. All hearings and appellate reviews shall be in accordance with the procedural due process set forth in this Article to assure that the affected practitioner is accorded all entitled rights hereunder.

(f) REMEDIES. The appellate review procedure herein shall constitute the only remedy of any practitioner with respect to any adverse action taken against him/her.

Section 2. Request for Hearing.

(a) GENERAL. The President shall be responsible for communicating prompt written notice of an adverse recommendation or decision to any affected practitioner who is entitled to a hearing by certified mail, return receipt requested. Within ten (10) days after receipt of such notice the affected practitioner may request a hearing by written demand to the governing body delivered through the President either by certified mail, return receipt requested or in person. The failure of a practitioner to request a hearing within the time and in the manner herein provided shall be deemed a waiver of the right to such hearing and to any appellate review which might otherwise have been entitled on the matter.

(b) WAIVER. Waiver in connection with:

1. an adverse action by the governing body shall constitute acceptance of that action which shall thereupon become effective as the final decision of the governing body.
2. an adverse recommendation by the Executive Committee shall constitute acceptance of that recommendation, which shall thereupon become and remain effective pending the final decision of the governing body. The governing body shall consider the Executive Committee's recommendation at its next regular meeting following the waiver. In its deliberations, the governing body

may review all the information and material considered by the Executive Committee. The governing body's action on the matter shall constitute the final decision of the governing body. The President shall promptly notify the affected practitioner of this status by certified mail, return receipt requested, and shall advise the Chief of Staff of such action

Section 3. Notice of Hearing.

(a) GENERAL. Within ten (10) days after receipt of a request for a hearing from a practitioner entitled to the same, or as soon thereafter as practical, the Executive Committee or the governing body, whichever is appropriate shall schedule and arrange for such a hearing and shall, through the President, notify the practitioner of the time, place and date so scheduled by certified mail, return receipt requested. The hearing date shall be not less than 30 days nor more than 60 days from the date of receipt of the request for hearing; provided, however, that a hearing for a practitioner who is under a summary or suspension or termination shall be held as soon as arrangements may reasonably be made, but no later than 60 days from the date of receipt of such practitioner's request for a hearing.

(b) CONTENT OF NOTICE. The notice of hearing shall state in concise language the acts or omissions with which the practitioner is charged, a list of specific or representative charts being questioned and/or the other reasons or subject matter that was considered in making the adverse recommendation or decision.

Section 4. Composition of Ad Hoc Hearing Committee.

When a hearing relates to an adverse recommendation of the Executive Committee, such hearing shall be conducted by a hearing committee of not less than three members of the medical staff appointed by the Chief of Staff, and one of the members so appointed shall be designated by the Chief of Staff as chair. No staff member who has actively participated in the consideration of the adverse recommendation, serves on the Executive Committee, or is a member of the governing body shall be appointed a member of this hearing committee.

Section 5. Conduct of Hearing.

(a) PROXY. There shall be at least three members of the hearing committee present when the hearing takes place, and no member may vote by proxy.

(b) RECORD. An accurate record of the hearing must be kept. The mechanism shall be established by the hearing committee and may be accomplished by use of a court reporter, electronic recording unit, detailed transcription or by the taking of adequate minutes.

(c) PRESENCE OF PRACTITIONER. The personal presence of the practitioner for whom the hearing has been scheduled shall be required. A practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived any rights in the same manner as provided in Section 2 of this Article and to have accepted the adverse recommendation or decision involved, and that decision shall thereupon become and remain in effect as provided in Section 2.

(d) POSTPONEMENT. Notwithstanding Section 3(a), postponement of hearings beyond the time set forth in these Bylaws shall be permitted, but only with the approval of the chair of the hearing committee. Granting of such postponements shall only be for good cause shown and in the sole discretion of the hearing committee chair.

(e) REPRESENTATION. The affected practitioner shall be entitled to be accompanied by and represented at the hearing by a member of the medical staff in good standing or by a member of the affected practitioner's local professional society.

(f) Proceedings. The chair of the hearing committee shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence and to maintain decorum.

Section 6. Procedure and Evidence.

(a) GENERAL. The hearings provided for in these Bylaws are for the purpose of resolving, on an intra professional basis, matters bearing on professional competency and conduct. Accordingly, the affected practitioner shall be permitted to be represented by not more than one attorney at any hearing under this Article; and provided however that the affected practitioner provide written notice of the intent to be so represented at least ten (10) days prior to the scheduled date of such hearing. In any case where an attorney represents the affected practitioner at any hearing under this Article, such attorney's role shall be limited solely to that of an advisor or counselor for the affected practitioner and in no event shall such attorney be permitted to engage in direct or cross examination of any witness (including the affected practitioner), make any opening or closing statement or argument, or make any written or oral objection to any aspect of the proceedings. In any case where the affected practitioner is represented by an attorney, the party conducting the hearing shall, if desired, likewise be represented by legal counsel, subject to the same restrictions set forth hereinabove. Nothing contained herein shall be deemed to deprive any party to any hearing under Article IX of the right to legal counsel in connection with prior preparation for such hearing.

(b) RECEIVING EVIDENCE. The hearing need not be conducted strictly according to the rules of evidence relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible in civil or criminal actions. The practitioner for whom the hearing is being held shall, prior to or during the hearing be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become a part of the hearing record. The chair may, but shall not be required to, order that the oral evidence be taken on oath or affirmation administered by any person designated by the chair and entitled to notarize documents in this state.

(c) MEDICAL STAFF REPRESENTATIVE. The chair of the Executive Committee, when its action has prompted the hearing, shall appoint one of its members or some other medical staff member to represent it at the hearing, to present the facts in support of its adverse recommendation and to examine witnesses. The chair of the governing body, when its action has prompted the

hearing, shall appoint one of its members to represent it at the hearing, to present the facts in support of its adverse decision and to examine witnesses. This member shall not be a member of the Joint Conference Committee.

(d) BURDEN OF PROOF. It shall be the obligation of such medical staff representative to present appropriate evidence in support of the adverse recommendation or decision, but the affected practitioner shall thereafter have the burden of proving, by clear and convincing evidence, that the adverse recommendation or action which occasioned the hearing lacks substantial factual basis or that such basis or the conclusions drawn therefrom are either arbitrary, unreasonable, or capricious.

(e) RIGHTS OF PARTIES. During a hearing, each of the parties shall have the following rights to:

1. Make opening statement;
2. Testify;
3. Call and examine witnesses;
4. Introduce exhibits;
5. Question any witness on any matter relevant to the issues;
6. Rebut any evidence.
7. Give closing summation

(f) TESTIMONY OF PRACTITIONER. If the practitioner does not testify on his or her own behalf, the practitioner may be called and examined as if under cross examination.

(g) RECESS. The hearing committee may, without special notice, recess the hearing, for not more than 90 days later, and reconvene the hearing for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation.

(h) DELIBERATIONS. Upon conclusion of the presentation of oral or written evidence, the hearing shall be adjourned. The hearing committee may thereupon at any time convenient to itself, conduct its deliberations outside the presence of the practitioner for whom the hearing was convened.

(i) WRITTEN REPORT. Within thirty (30) days after final adjournment of the hearing, the hearing committee shall make a written report and recommendation and shall forward the same together with the hearing records and all other documentation to the Executive Committee or to the governing body, whichever appointed it. All findings and recommendations shall be supported by reference to the hearing record and other documentation considered by it.

(j) EXECUTIVE COMMITTEE. At its next regular meeting after receipt of the report of its hearing committee, (provided that the report is received within ten days of the regular meeting, if not, at its next regular meeting thereafter) the Executive Committee shall consider the report and make its recommendation to the governing body and provide a copy of the report to the affected practitioner. The President shall forward the Executive Committee's recommendation, together with all such supporting documents including the report of the hearing committee to the governing body.

(k) GOVERNING BODY. At its next regular meeting after receipt of the report of its hearing committee, (provided that the report is received within ten days of the regular meeting, if not at its next regular meeting thereafter) the governing body shall consider the report and act upon the matter; provided that if the recommendation contained in the report is adverse to the practitioner, the governing body shall not take any action until after the practitioner has exercised or has been deemed to have waived any right to an appellate review as provided in this Article. The decision of the governing body, if not adverse to the practitioner, shall be final and notice of such decision shall be promptly sent through the President to the Executive Committee and to the practitioner by certified mail, return receipt requested.

Section 7. Request for Appellate Review

(a) GENERAL. Within ten days after receipt of notice of an adverse recommendation or decision made after a hearing as provided for in Section 6 of this Article, the practitioner may by written notice to the governing body delivered to the President in person or by certified mail, return receipt requested, request an appellate review by the governing body. Such notice may request that an appellate review be held only on the record on which the adverse recommendation or decision is based, as supported by the practitioner's written statement provided for below, or may also request that oral argument be permitted as part of the appellate review.

(b) ACCESS TO RECORD. The affected practitioner shall have access to the report and record of the hearing committee and all other material, favorable and unfavorable, that was considered in making the adverse recommendation.

(c) WRITTEN STATEMENT BY PRACTITIONER. The affected practitioner may submit a written statement in his/her own behalf in which those factual and procedural matters with which he/she disagrees and his/her reasons for such disagreement shall be specified. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in this preparation. Such written statement shall be submitted to the appellate review committee through the President in person or by certified mail, return receipt requested, at least fifteen (15) days prior to the scheduled date for the appellate review.

(d) WRITTEN STATEMENT IN SUPPORT. A written statement may be submitted by the Executive Committee of the medical staff or by the chair of the hearing committee that conducted the hearing, and if submitted, the President shall provide a copy thereof to the practitioner prior to the date of such appellate review by certified mail, return receipt requested.

(e) WAIVER. If appellate review is waived, such waiver shall have the same force and effect as that provided in Section 2 of this Article.

(f) SCHEDULING. Within ten (10) days after receipt of a request for appellate review, the governing body shall schedule a date for such review, including a time and place for oral argument if such has been requested and shall, through the President, by written notice sent by certified mail, return receipt requested, notify the affected practitioner. The day of the appellate review shall not be less than thirty (30) days nor more than sixty (60) days from the date of receipt of the request for appellate review except that when the practitioner requesting review is under a summary suspension or termination, such review shall be scheduled as soon as the arrangements for it may reasonably be made, but not more than sixty (60) days from the receipt of request.

Section 8. Conduct of Appellate Review.

(a) GENERAL. The proceedings shall be in the nature of an appellate review based upon the record of the ad hoc hearing before the hearing committee, that committee's report, and all subsequent results and actions thereon. The appellate review body shall also consider the written statements submitted throughout the review process and the oral arguments made, if any.

(b) COMPOSITION OF COMMITTEE. The appellate review shall be conducted by an appellate review committee of not less than three (3) members of the governing body appointed by the chair of the governing body, after initial effort to obtain at least five members has been made. One of its members shall be designated by the chair of the governing body as chair of the appellate review committee. (revised 12/3/96)

(c) POWERS OF COMMITTEE. The appellate review committee shall have all powers granted to the ad hoc hearing committee, and such additional powers as are reasonably necessary to the discharge of its responsibilities.

(d) PRESENCE OF MEMBERS. A majority of the appellate review committee must be present throughout the review and deliberations. If a member of the review body is absent from a substantial part of the proceedings, the member shall not be permitted to participate in the deliberations or the decision.

(e) RECESS. Notwithstanding Section 7 (f) of this Article, the appellate review body may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or for consultation.

(f) SCOPE. The appellate review committee shall review the record created in the proceedings and shall consider the written statements submitted pursuant to the foregoing paragraphs of this Section and any oral arguments for the sole purpose of determining whether the adverse recommendation against the affected practitioner was justified and was not arbitrary or capricious.

(g) ORAL ARGUMENT. If oral argument is requested as part of the review procedure, the affected practitioner shall be present at such appellate review, shall be permitted to speak against the adverse recommendation and shall answer questions by any member of the appellate review committee. The Executive Committee or the governing body, whichever is appropriate, may designate a member who shall be permitted to speak in favor of the adverse recommendation and who shall answer questions by any member of the appellate review committee.

(h) NEW MATTER. New or additional matters not raised during the original hearing or in the hearing committee report, nor otherwise reflected in the record, shall only be introduced at the appellate review under unusual circumstances. The committee appointed to conduct the appellate review shall in its sole discretion determine whether such new matters shall be accepted.

(i) ACTION. The committee shall, within fifteen (15) days after completion of the appellate review, either make a written report recommending that the governing body affirm, modify or reverse the recommendation of the Executive Committee, or refer the matter back to the Executive Committee. Such referral may include a request that the Executive Committee arrange for a further hearing to resolve disputed issues. Such further hearings shall be conducted in a timely manner pursuant to Article IX, Section 6. Within five (5) days after receipt of the subsequent recommendation, the appellate review committee shall make its recommendation to the governing body as provided for in these Bylaws.

(j) CONCLUSION. The appellate review shall not be deemed to be concluded until all the procedural steps provided in this section have been completed or waived.

Section 9. Final Decision by Governing Body.

(a) GENERAL. At its next regular meeting after the conclusion of the appellate review, the governing body shall make its final decision in the matter and shall send notice thereof to the Executive Committee and through the President, to the affected practitioner, by certified mail, return receipt requested. If this decision is in accordance with the Executive Committee's last recommendation in the matter, it shall be immediately effective and final and shall not be subject to further hearing or appellate review.

(b) JOINT CONFERENCE COMMITTEE. If this decision is contrary to the Executive Committee's last such recommendation, the governing body shall refer the matter to the Joint Conference Committee for further review and recommendation. At its next meeting after receipt of the Joint Conference Committee's recommendation, the governing body shall make its final decision with like affect and notice as first provided in this Section.

(c) FINALITY. Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled to more than one hearing and one appellate review of any matter which shall have been the subject of an action by the Executive Committee of the medical staff or by the governing body or by a duly constituted committee of the governing body.

(d) REPORT TO NATIONAL PRACTITIONER DATA BANK. In the event the governing body makes a final decision which results in an action which is adverse to the practitioner and requires the filing of a report with the National Practitioner Data Bank (pursuant to the Health Care Quality Improvement Act of 1986) and such adverse action is based on issues or concerns related to clinical competence, the governing body shall also make a report of such filing to the Greater Dayton Area Hospital Association for centralized reporting to area hospitals. (Approved 5/30/95)

ARTICLE X. OFFICERS

Section 1. Officers of the Medical staff.

The officers of the medical staff shall be a Chief of Staff, a Chief of Staff Elect, and department/section chairs and vice chairs.

Section 2. Qualifications of Officers.

(a) INITIAL QUALIFICATIONS. Officers must be:

1. Members of the active medical staff;
2. Qualified to hold office in accordance with Article IV, Section 3;
3. In good standing at the time of nomination and selection;
4. In good standing during their term of office;
5. For the offices of Chief of Staff, Chief of Staff Elect and department chair, the member may not simultaneously be the Chief of Staff, Chief of Staff Elect, or department chair at another hospital nor may the member be the chair of a department of a medical school.
6. Competent in their field of practice; which shall mean the member is certified by an appropriate specialty board, or possesses comparable competence which has been established through the privilege delineation process.
7. Qualified on the basis of experience and ability to direct the clinical administrative aspects of the hospital and medical staff activities.

(b) GROUNDS FOR REMOVAL OF OFFICERS. Permissible basis for removal of any officer, including the Chief of Staff and Chief of Staff-Elect, shall include, but not be limited to:

1. Failure to maintain those qualifications listed in item a of this section
2. Failure to perform the duties of the position held in a timely and appropriate manner
3. Failure to continuously satisfy the qualifications for the position
4. Imposition of corrective action
5. Physical or mental infirmity that renders the officer incapable of fulfilling the duties of his/her office.
6. Conviction of a felony. (Approved: 5/1/01)

Section 3. Selection of the Chief of Staff Elect.

The selection of the Chief of Staff Elect of the medical staff shall be made in the following manner:

(a) MEDICAL STAFF NOMINATING COMMITTEE. The nominating committee of the medical staff shall be appointed by the Chief of Staff and shall be composed of five (5) members selected from the Executive Committee. The nominating committee shall notify each department of the medical staff of the meeting date for the selection of the candidate.

(b) PETITION. Opportunity shall be given for nomination of candidates by petition. Any petition must be submitted to the nominating committee by March 1 of the year of the selection. A petition signed by ten percent (10%) of the active staff members shall be required to place a candidate before the nominating committee.

(c) CONSENT. Prior to the submission of his name, each candidate shall give his written consent to be considered for the position.

(d) CHIEF OF STAFF ELECT. The nominating committee shall select one candidate for the position of Chief of Staff Elect in accordance with the standards for the selection of officers. The nominating committee shall select the candidate from those names submitted. Three votes shall be necessary to nominate a candidate for Chief of Staff Elect. Voting by proxy shall not be permitted.

(e) SELECTION. The name of the candidate selected by the nominating committee shall be submitted as soon as possible after March 1 to the Executive Committee and, if elected, forwarded to the governing body for final approval.

(f) FAILURE TO ELECT. If there is no approval by the Executive Committee, the nominating committee shall be asked to provide another candidate. A majority vote of those members of the Executive Committee present at a duly convened meeting is necessary for approval. Voting by proxy shall not be permitted.

Section 4. Term of Office.

(a) GENERAL. The Chief of Staff Elect shall be chosen for a two year term, followed immediately by a two year term as Chief of Staff. Such selection shall be held prior to the Annual Meeting of the medical staff.

(b) INSTALLATION. The Chief of Staff and the Chief of Staff Elect shall be installed in office at the Annual Meeting of the medical staff. The term of office of the Chief of Staff and the Chief of Staff Elect shall commence on June 1, the beginning of the medical staff year.

Section 5. Vacancies in, or Removal from, office.

(a) CHIEF OF STAFF. In the event of a premature vacancy in or the removal from the office of Chief of Staff, the Chief of Staff Elect shall automatically assume the position and serve for the remainder of the current term and shall then serve the next term. His term shall be at least two years and shall not exceed four years.

(b) CHIEF OF STAFF ELECT. In the event of vacancy in or removal from the office of Chief of Staff Elect, the Chief of Staff, with the approval of the Executive Committee, shall appoint a member of the active medical staff qualified to hold office to serve temporarily in this capacity. As soon as practical thereafter and prior to the expiration of the term of the Chief of Staff, the method of selection of the Chief of Staff Elect according to Section 3 of this Article, shall apply and a new successor to the Chief of Staff Elect shall be selected. This individual shall serve out the term of Chief of Staff Elect and automatically thereafter assume the position of Chief of Staff.

(c) PROCEDURE FOR REMOVAL FROM OFFICE. Removal of the Chief of Staff or Chief of Staff Elect from office during the term of office may be initiated by the submission of a petition signed by any twenty five (25) voting members of the medical staff which mandates a special meeting of the medical staff to address the petition for removal. The special meeting shall be held in accordance with provisions contained in Article XIII of these Bylaws. A two thirds majority vote of those present of the voting medical staff who vote, shall be required for removal, however, no such removal shall be effective unless and until it has been ratified by the governing body.

Section 6. Duties of Officers.

(a) CHIEF OF STAFF. The Chief of Staff shall serve as the Chief Administrative Officer of the medical staff to:

1. Act in coordination and cooperation with the President in all matters of mutual concern within the hospital, including investigation and prompt reporting of any breach of ethics, unprofessional conduct or mismanagement of patient care on the part of any member of the staff;
2. Call, preside at, and be responsible for the agenda of all annual or special meetings of the medical staff, except as otherwise provided by these Bylaws;
3. Serve as the chair of the Executive Committee;
4. Serve as ex officio member of all medical staff committees without vote;
5. Be responsible for the enforcement of medical staff Bylaws, rules and regulations, for implementation of sanctions where these are indicated, and for the medical staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;
6. Appoint committee members to all standing, special and multi disciplinary medical staff committees, except the Executive Committee;
7. Represent the views, policies, needs and grievances of the medical staff to the governing body and to the President;
8. Receive and interpret the policies of the governing body to the medical staff and report to the governing body on all activities of the

medical staff pertaining to the welfare of patients;

9. Be the spokesman for the medical staff in its external, professional and public relations activities;

10. Assume all additional duties as may, from time to time, be assigned by the governing body or these Bylaws.

(b) CHIEF OF STAFF ELECT. The Chief of Staff Elect shall:

1. Assume all duties of and have the authority of the Chief of Staff in his absence;

2. Assume the position of Chief of Staff in the event of the resignation, demise, incapacitation, or other disqualification of the person serving in that capacity;

3. Be a member of the Joint Conference Committee, and an ex officio member of all medical staff committees without vote;

4. Serve as chair of the Quality Performance Improvement Committee;

5. Have such additional duties or positions as may be designated by the Chief of Staff.

(c) SECRETARY. The minutes of the Executive Committee and of any medical staff meeting shall be kept by a secretary acceptable to the Executive Committee. The secretary need not be a member of the medical staff.

Section 7. Vice President of Medical Affairs

The Vice President of Medical Affairs (SVPMA) is a physician with clinical training and eligible for membership on the medical staff in his/her specialty. Board certification in that individual's clinical authority is preferred. The SVPMA reports to the President and Chief Executive Officer of Miami Valley Hospital, and to the medical staff through the Chief of Staff to:

1. Integrate medical staff support functions, serving as a liaison to the medical staff for performance improvement, utilization, credentialing and privileging, bylaws and medical education issues;

2. Provide support services to the elected leadership of the medical staff, and chairs of medical staff committees;

3. Attend key meetings of the Executive Committee, medical and administrative, plus a variety of department meetings on a regular basis;

4. Provide medical staff support to include scheduling and logistics for department meetings, continuing medical education and select committee meetings;

5. Assist with research and report preparation for medical staff leadership;

6. Integrate medical staff perspectives into administrative planning;

7. Develop and maintain effective communication between administration and the medical staff;

8. Develop and maintain relationships with external regulatory agencies and maintain obligations to the Joint Commission on Accreditation of Health Care Organizations;

9. Provide support for external educational affiliations and medical education and may serve in a clinical teaching role depending on his/her specialty.

ARTICLE XI. DEPARTMENTS OF THE MEDICAL STAFF

Section 1. Organization of Departments.

The medical staff shall be organized into departments. Each department shall have a chair who shall be responsible for the overall supervision of the clinical work within the department. The following is a list of the departments of the medical staff:

(a) Medicine

(b) Surgery

(c) Obstetrics and Gynecology

(d) Pediatrics

(e) Neuropsychiatry

(f) Emergency Medicine

(g) Family Practice

(h) Pathology

(i) Medical Imaging

(j) Anesthesiology

(k) Orthopaedic Surgery

(l) Medical Education

Section 2. Qualifications and Selection of Department Officers.

(a) GENERAL. Each chair and vice chair of a department shall be a member of the active staff qualified by training, experience, demonstrated ability for the position, and shall meet the requirements contained in Article IV, Section 3. Department chairs will acknowledge that more of their adult professional work is conducted at Miami Valley Hospital than at any other hospital.

(b) SELECTION. Each officer, except those of the Department of Medical Education, whose appointments are governed by Section 6 of this Article, shall be selected for a two year term, subject to the approval of the Executive Committee and the governing body. The following procedure shall be used in selecting a chair and a vice chair:

1. Prior to April 1 concurrent with the election of Chief of Staff Elect by the Executive Committee, members of the voting medical staff in each department shall nominate a chair of the department and a vice chair. Candidates shall be recommended by the departmental nominating committee to the membership. Each candidate shall give consent prior to submitting the candidate's name for consideration.
2. The term of office of the officers of the department shall commence on June 1, the beginning of the medical staff year, and shall run concurrently with the term of the Chief of Staff Elect. With the exception of the chair of the Dept. of Medical Education, department chairs may serve only two consecutive terms. Members shall be eligible for re election as chair after vacating the position for one term excluding the Department of Medical Education. A member selected to fulfill a premature vacancy in office shall be eligible to serve as department chair for two full consecutive terms in addition to the time served to fulfill the vacancy in office. (5/06)
3. Unless otherwise modified by the individual department or section and approved by the Medical Staff Executive Committee, Officers will be selected by majority vote of those voting members present at a duly convened meeting. (12/08)
4. Unless otherwise modified by the individual department or section and approved by the Medical Staff Executive Committee, Voting by proxy shall not be permitted. (12/08)

(c) REMOVAL FROM OFFICE. Removal of any officer during the term of office may be initiated by a two thirds majority vote of all active staff members of the department, but no such removal shall be effective unless and until it has been ratified by the Executive Committee and by the governing body.

(d) TEMPORARY APPOINTMENT. In the event of a premature vacancy of the office of chair of a department or if the Executive Committee or governing body fails to approve a nominee, the Chief of Staff, with the approval of the Executive Committee, shall appoint a member of the active medical staff of such department qualified to hold office to serve temporarily in this capacity. As soon as practical thereafter, a new chair of the department shall be nominated and approved in the manner set forth in paragraph (b) of this Section.

Section 3. Functions of the Department Chair.

The chair of a medical staff department is responsible to the Executive Committee and the Chief of Staff for the following:

- (a) All professional activities within the department, and particularly for the quality of patient care rendered by members of the department;
- (b) Effective conduct of quality review and evaluation functions delegated to the department;
- (c) Enforcement of Medical Staff Bylaws and of the rules and regulations within the department;
- (d) Implementation within the department of action taken by the Executive Committee of the medical staff and the governing body;
- (e) Transmission to the Executive Committee through the Credentials Committee of the department's recommendations concerning the staff classification, the reappointment and delineation of clinical privileges for all practitioners in that department;
- (f) The teaching education and research programs in the department (in conjunction with the Director of Medical Education, where applicable);
- (g) Investigation and prompt written reporting to the Chief of Staff of any breach of ethics, unprofessional conduct or mismanagement of patient care on the part of any member of the department;
- (h) Conducting and presiding over scheduled meetings of the department; enumerated herein as deemed appropriate;
- (i) Delegate to section chairs any functions enumerated herein as deemed appropriate;
- (j) Perform such other duties commensurate with the office as may from time to time reasonably be requested of the chair by the President, the Chief of Staff, the Executive Committee, or the governing body.
- (k) The integration of the department into the primary functions of the hospital;
- (l) The development, coordination and integration of interdepartmental and intradepartmental services.
- (m) The recommendation and determination of the number, qualifications and competence, including orientation and continuing education, of all departmental personnel who are not licensed independent practitioners, and who provide patient care services;

- (n) Recommendation for space and other resources needed by the department.
- (o) The continuous assessment and improvement of the quality of care, treatment and services.
- (p) The maintenance of quality control programs, as appropriate
- (q) The orientation and continuing education of all persons in the department/section. (1/22/08)

Section 4. Functions of Departments.

(a) GENERAL. Each clinical department shall:

1. Establish its own criteria, consistent with the policies of the medical staff and of the governing body, for the granting of staff appointment, clinical privileges and holding of office in the department when required by these Bylaws.

With respect to new applicants applying for membership and clinical privileges after May 23, 1995, such criteria shall be conditioned, in part, upon such applicant's maintaining eligibility for certification by a national Board of Examiners designated as appropriate by the department, and diligently pursuing and achieving certification by such Board within such time as deemed appropriate by the department, but in no event to exceed six (6) years after the applicant has completed residency training. Nothing contained herein shall require that any applicant, once appropriately certified by such Board, shall be required, as a condition of the Bylaws, to obtain recertification in order to maintain medical staff membership and clinical privileges. (Approved 5/30/95) An initial applicant to the medical staff who achieved board certification as required by the appropriate department but did not obtain recertification may not apply for membership and clinical privileges until board certification is obtained. (5/06)

2. Submit the recommendations required under Article VI and VII regarding the specific privileges each staff member may exercise and affiliate may provide;
3. Meet at least monthly, or less frequently if approved by the Executive Committee, to conduct peer review activities in accordance with Section 8 of this Article. (approved 12/4/01)
4. Establish or recommend such rules as are necessary to promote the proper standards of medical care rendered to private and nonprivate patients in that department. Rules affecting the members of another department shall be referred through the Chief of Staff to that department. The Chief of Staff shall be responsible for the continuity of this action. Rules affecting hospital policy or procedures shall require the approval of the President;
5. Foster an atmosphere of professional decorum within the department appropriate to the healing arts.
6. As determined necessary or appropriate by the Department chair, assess and recommend to the President and/or Chief of Staff, as the case may be, off site sources for needed department/service or the hospital. (Approved: 5/30/95)

(b) VOTE. A member of the medical staff may be on the active staff of more than one clinical department, but with only one vote at medical staff meetings.

(c) DELEGATION AUTHORITY. Each department may delegate to any section of that department any function contained herein.

(d) LIMITATION OF ADMISSIONS. Each department, with the approval of the Executive Committee, shall have the privilege of limiting the number of admissions by any membership category except Active. Such limitations must be reasonable and consistent with governing body policy and with these Bylaws.

Section 5. Special Provisions.

(a) FAMILY PRACTICE. The department of family practice shall have a family practice inpatient service and a family practice outpatient service. Members of the department of family practice may have privileges in the clinical services of other departments and shall be subject to the rules of such departments.

(b) EMERGENCY MEDICINE. The emergency medicine department shall provide medical services in accordance with the hospital's basic plan for the delivery of such services, including the delineation of clinical privileges by the medical staff for all physicians who render emergency services. The director shall be appointed by the President with approval of the Executive Committee. The director shall be administratively responsible to the President or his/her designee, and clinically responsible to the Chief of Staff. Members of this department shall not have privileges to admit patients to the hospital. The department chair may serve only two consecutive terms. Members shall be eligible for reelection as chair after vacating the position for one term.

Section 6. Medical Education.

(a) GENERAL. The department of medical education shall have the responsibility for the policies governing and the operation of all undergraduate medical education, graduate medical education (GME) and continuing medical education activities and the activities of the Clinical Research Center carried on at the hospital relating to the medical staff, subject to the approval by the President and the governing body. Each Graduate Medical Education Program will have one member to serve as its Program Director of Education, and each such Program Director of education will serve as a member of the Medical Education Department. Associate Program Directors may be appointed. Program Directors or Associates will be selected by the program sponsor in conjunction with the

Department of Medical Education, or appointed by the Department of Medical Education with approval by the program. Following the submission of a final nominee by the sponsor for Program Director (or Assoc/Asst Program Director), the Department of Medical Education, MVH shall review the qualifications of the nominee with the clinical chair and vice chair of the clinical department involved. The Clinical Department will have at least 60 days to advise and consent or object to the nominee before any appointment is made by the sponsor. The Department of Medical Education shall consist of such program directors of education and a chair of the Department of Medical Education who shall be appointed by the President with the approval of the Executive Committee

(b) CHAIR'S DUTIES. The chair of medical education shall:

1. Be a member of the active medical staff;
2. Be responsible administratively to the President or the President's designee and clinically responsible to the Chief of Staff;
3. Supervise all aspects of medical education at Miami Valley Hospital;
4. Upon appointment by the governing body, serve as an ex officio, nonvoting member of the Joint Conference Committee;
5. Supervise the activities of the directors of education;
6. In conjunction with the program and departmental directors of education, be responsible, along with the medical staff, for securing medical and dental residents; and
7. Be an ex officio, nonvoting member of all standing committees of the medical staff.

(c) PROGRAM DIRECTORS (OR ASSOCIATE). Each program director (or associate director) of education shall be:

1. A member of the active staff;
2. Directly responsible to the chair of medical education or the chair's designee;
3. Responsible for developing, directing and supervising the educational programs for his/her department/section;
4. Responsible for selecting, assisting and directing the teaching staff;
5. Primarily responsible for resident recruitment and selection;
6. Responsible for establishing the process and procedure for assessing GME quality, and for measuring and evaluating the performance and quality of residents and the other house staff assigned to his/her department/section;
7. Responsible for the provision of the system of supervision by the teaching staff for residents.
8. Responsible for meeting residency review committee and specialty board requirements and maintaining program accreditation.

(d) ELIGIBILITY TO HOLD OFFICE. Neither the chair of medical education nor the program directors of education need to be qualified to hold office under Article IV, Section 3 in order to serve in these capacities.

(e) MEETINGS. The department will have regular meetings and such special meetings as called by the chair of medical education or by the Chief of Staff. (Approved: 12/1/98)

(f) CLINICAL RESEARCH CENTER AND OTHER RESEARCH COMMITTEES. The Clinical Research Center is a part (subdivision) of the Department of Medical Education. Appropriate committees for the satisfactory function of the Research Center will be formed under supervision of the Research Center.

(g) SPECIAL CONDITIONS FOR RESIDENTS OR FELLOWS-IN-TRAINING. Residents or Fellows-in-Training in the hospital shall not normally hold membership on the medical staff and shall not normally be granted specific clinical privileges. Rather, they generally shall be permitted to function clinically only in accordance with the written training protocols developed by the Chair of the Department of Medical Education, as approved from time to time by the governing body. Such protocols are currently set forth in the Resident House Staff Manual, and in the Miami Valley Hospital Supplement and Reference Document for Supervision and Competency Skills in Graduate Medical Education. Such protocols shall delineate the roles, responsibilities and patient care activities of Residents and Fellows, including which types of Residents may write patient care orders, under what circumstances they may do so, and what entries (if any) a Supervising Physician must counter-sign. Such protocols shall also describe the mechanisms through which Resident Directors and Supervisors make decisions about a Resident's progressive involvement and independence in delivering patient care.

The Chair of the Department of Medical Education shall communicate periodically with the Medical Staff Executive Committee and the governing body (through the Joint Conference Committee) about the performance of Residents, patient safety issues, and quality of patient care and shall work with the Medical Staff Executive Committee to ensure that all Supervising Physicians possess clinical privileges commensurate with their supervising activities. (approved: 12/4/01)

Section 7. Sections of Medical Staff Departments

(a) GENERAL. A section is defined as a group of members of the medical staff having common clinical interest who may be organized as a specialty subdivision responsible to the department within which it functions.

1. The Department of Medicine shall include the following sections:
 - a. Cardiology

- b. Critical Care Medicine
 - c. Dermatology
 - d. Endocrinology and Metabolism
 - e. Gastroenterology
 - f. General Internal Medicine
 - g. Nephrology
 - h. Neurology
 - i. Rehabilitative Medicine
 - j. Rheumatology
 - k. Pulmonary Medicine
 - l. Medical Oncology and Hematology
2. The Department of Surgery shall include the following sections:
- a. General Surgery
 - b. Neurosurgery
 - c. Ophthalmology
 - d. Otorhinolaryngology
 - e. Plastic Surgery
 - f. Proctology/colon rectal
 - g. Thoracic and Cardiovascular Surgery
 - h. Urology
 - i. Trauma Surgery
3. The Department of Medical Imaging shall include the following sections:
- a. Diagnostic Radiology
 - b. Radiation Oncology
 - c. Nuclear Medicine
 - d. Vascular and Interventional Radiology
 - e. Breast Imaging
4. The Department of Anesthesiology shall include the following sections:
- a. General Anesthesiology
 - b. Obstetrical Anesthesiology
 - c. Cardiothoracic Anesthesiology
 - d. Acute and Chronic Pain
 - e. Ambulatory Anesthesiology
5. The Department of Neuropsychiatry shall include the following section:
- a. Psychology
6. The Department of Orthopaedic Surgery shall include the following section:
- a. Podiatry
 - b. Orthopaedic Trauma
7. The Department of Emergency Medicine shall include the following section:
- a. Occupational Medicine

(b) ADDITIONAL SECTIONS. Other sections may be created within a department of the medical staff upon recommendation of that department, approval by the Executive Committee and approval of the governing body.

(c) OFFICERS. Each section of a department may select a qualified chair and a vice chair in the same manner and with the same restrictions as such officers are selected in departments. The chair of each section shall supervise clinical work within the section and be responsible to the chair of the department for the functions outlined in Section 3 of this Article.

(d) DELEGATION AUTHORITY. When delegated by the appropriate department, a section and the chair of that section shall carry out the functions enumerated in Sections 3 and 4 of this Article.

(e) ATTENDANCE AT MEETINGS. Members of a section shall attend department and/or section meetings in accordance with the provisions of Article XIII, Section 5 (a). For those sections that meet, monthly meetings shall be held, unless less frequent meetings are approved by the Executive Committee.

Section 8. Medical Staff Ongoing Professional Practice Evaluation Policy and Procedure

a. PURPOSE. The purpose of ongoing professional practice evaluation (OPPE) is to promote continuous improvement of the quality of care provided by the Medical Staff and affiliates at Miami Valley Hospital. The role of the Medical Staff in ongoing professional practice evaluation is to provide evaluation of performance to ensure the effective and efficient evaluations of the care and services provided by the members of the Medical Staff.

b. SCOPE OF SERVICES. Applies to all practitioners holding clinical privileges or affiliate status at Miami Valley Hospital.

c. RESPONSIBILITY. Each Medical Staff department is responsible for ongoing professional practice review activities. OPPE

activities, as delineated in item e.5. of this Article, will be monitored by the respective department/section and reported through the Medical Staff Executive Committee to the Joint Conference Committee of the Board of Trustees. Oversight is delegated to the Medical Staff Executive Committee.

d. CONFIDENTIALITY. The (OPPE) activities are immune to discoverability according to the state statutes. All activities are to be kept confidential. Except as detailed in Article VIII Section 1 (g) of these Bylaws, only authorized persons have access to the monitoring data and/or retrieval of this information. Authorized persons include Medical Staff leaders, hospital administration, Medical Staff services personnel, and Quality Management personnel, as appropriate. (Approved: 5/05)

e. MEDICAL STAFF. The Medical Staff uses an effective mechanism designed to involve Medical Staff members in activities to measure, assess, and improve performance on an organizational as well as individual practitioner basis. This mechanism is designed to:

1. Collect data, on an ongoing basis, on processes and outcomes and to assess performance in relation to design specifications of processes, determine the level of functioning of processes, identify opportunities for improvement, and review outcomes in relation to expectations.
2. Communicate to appropriate Medical Staff members the findings, conclusions, recommendations, and actions taken to improve organizational performance.
3. If relevant, identify individual performance as a result of the evaluation process. When such a determination has been made, steps for further review, final recommendations, any actions taken, and follow-up are required.
4. When the findings of the evaluation process are relevant to an individual's performance, the Medical Staff is responsible for determining their use in peer review and/or the ongoing evaluations of a licensed independent practitioner's competence, in accordance with the standards on renewing or revising clinical privileges.
5. The Department/Section Chair/designee(s) shall analyze individual members of their respective department/section utilizing an array of quality measures including, but not limited to, those delineated in the next paragraph. Results of individual performance data shall be generated for each Medical Staff member at least biannually and shall be used as part of members' biennial reappointment review.

The Medical Staff OPPE process involves the collection of data using a variety of methods. These methods include, but are not limited to, computer and manual log entries, ICD-9 codes, DRG's, medical record information, radiology, endoscopy, operative and pathology reports, autopsy logs and reports, internal and external databases, direct observation, proctoring and referral from Medical Staff and/or hospital personnel. This data collection is done on an ongoing basis and is reported to or by the Quality Management Department.

f. An unfavorable trend as identified through the OPPE process could result in a focused professional practice evaluation (FPPE) in any of the following areas:

1. Credentials/Competency
2. Invasive, Operative, and Non-invasive Procedures that place patients at risk
3. Blood and Blood Product Usage
4. Medication Use and Monitoring
5. Mortality & Morbidity Review
6. Safety Management
7. Risk Management
8. Infection Control
9. Integrated Care Management
10. Customer Satisfaction, Complaint Review, Communication
11. Occurrence Report Trends
12. Pathology & Clinical Laboratory/Autopsy Results
13. Assessment of Patients
14. Education of Patients and Family
15. Management of Information
16. Leadership
17. Sentinel/adverse event(s)
18. Other evidence which may indicate a practitioner's performance is not within an accepted standard of care

g. Definition. "Peer Review" for each department is defined by the departmental process itself. In reference to an external or internal expert, a "peer" is defined as any qualified practitioner of similar training or experience who can render an unbiased opinion on the

quality of conduct of care for the case.

h. Process. Each Department/Section Chair may designate a member or a committee to review peer data:

1. Outliers will be reviewed to decide if their initial data is truly out of norm based on the type of practice they perform.
2. If it is determined that they are truly an outlier after the secondary peer evaluation, the Department/Section Chair will decide on a course of corrective action.
3. Individuals who are judged to be true outliers will be informed and shown their data compared to their peers.
4. The MSEC will ultimately oversee and monitor each Department's corrective action program and report quarterly to the Joint Conference Committee of the Board of Trustees.
5. Physicians/affiliates that ultimately become true outliers and fail to improve to a satisfactory level will have their privileges impacted in accordance with Article VIII of these Bylaws.
6. On occasion, an outside independent reviewer may be employed if the Department Chair and the peer being reviewed feel that it would be impossible to have an unbiased in-house review. The cost of this out-of-hospital expert may be paid for by the hospital or the person being reviewed, depending upon the circumstances involved.
7. If one department is required to review the performance of a physician in another department, then the mandate should be to determine whether or not there has been a deviation from the standard of care.
8. If a department or committee requests a chart to be reviewed by another department, then the mandate should be to determine whether or not there has been a deviation from the standard of care. (12/08)

ARTICLE XII. COMMITTEES

There shall be both standing and special committees of the medical staff. All committees other than the Executive Committee shall be appointed by the Chief of Staff.

Unless otherwise provided herein, only Active medical staff members shall have voting privileges at medical staff committee meetings. Unless otherwise provided herein, only Active medical staff members shall chair medical staff committees. (Approved: 11/25/97)

A. Standing Committees.

Section 1. Executive Committee

(a) MEMBERSHIP. The Executive Committee shall consist of the Chief of Staff who shall act as chair, Chief of Staff Elect, and the chair of each of the following departments: Medicine, Surgery, Obstetrics and Gynecology, Pediatrics, Neuropsychiatry, Emergency Medicine, Family Practice, Pathology, Medical Imaging, Anesthesiology, Orthopaedic Surgery, and Oral and Maxillofacial Surgery/ Dentistry. The President and the Vice President for Academic Affairs shall be ex officio members without vote. Additionally an ex-officio, non-voting physician appointed to represent the Wright State University School of Medicine shall be appointed to the committee for a non-repeating term. The vice chair of the department shall be permitted to attend and vote at any meeting in the absence of the chair. In the absence of the chair and vice chair, a designee may attend without vote. In addition to the membership set forth above, the Chief of Staff shall appoint one Member At Large of the Executive Committee. The member at large may be a physician or other licensed independent practitioner. Such member shall be appointed from among all of the members of the Active Medical Staff, shall have one vote, and shall serve for one two year term only. (Approved: 12/08)

(b) DUTIES. The Executive Committee shall have the following duties:

1. To represent and to act on behalf of the medical staff, subject to such limitations as may be imposed by these Bylaws;
2. To coordinate the activities and general policies of the various departments;
3. To receive and act upon committee reports;
4. To implement policies of the medical staff not otherwise the responsibility of the departments/ sections; (i.e. medical staff structure)
5. To ensure effective communication among the medical staff, hospital administration, and governing body.
6. To recommend action to the President on matters of a clinical administrative nature;
7. To make recommendations on hospital management matters (for example, long range planning) to the governing body through the President;
8. To fulfill the medical staff's accountability to the governing body for the medical care to patients in the hospital in any hospital deliberation affecting the discharge of medical staff responsibilities;
9. To ensure that the medical staff is kept abreast of the accreditation program and informed of the accreditation status of the hospital;
10. To review the credentials of all applicants received from the Credentials Committee and to make recommendations to the

governing body for staff membership, assignments to departments/sections and delineation of clinical privileges;

11. To review periodically all information available regarding the performance and clinical competence of staff members and other practitioners with clinical privileges, and at least quarterly all pertinent related quality assurance activities, and as a result of such reviews to make recommendations for reappointments and renewal of or changes in clinical privileges to the governing body;
12. To make rules and regulations for hospital operations subject to the approval of the governing body;
13. To take reasonable steps to promote professionally ethical conduct and competent clinical performance on the part of all members of the medical staff, including the initiation of and/or participation in medical staff corrective or review measures when warranted;
14. To resolve conflicts of interest in any instance where a member of the medical staff has such conflict of interest in any matter which comes before any medical staff meeting. (Approved: 5/05)

(c) MEETINGS. The Executive Committee shall meet at least once a month and maintain a permanent record of its proceedings and actions.

(d) VOTING. Each member of the Executive Committee shall have one vote for each Active Staff, voting member represented by the member. The Chief of Staff Elect will have no vote and the Chief of Staff will decide any tie vote. A simple majority vote shall decide any issue of the Executive Committee. Numbers of votes allotted to all departments will be delegated annually in January. On any given vote, the member will cast all designated votes with splitting of votes prohibited.

Section 2. Credentials Committee.

(a) MEMBERSHIP. The Credentials Committee shall consist of thirteen (13) members of the active staff represented by one member from each of the clinical departments, as well as one advance practice or master's trained nurse and one Physician's Assistant who shall serve with *vote. (*see (d) Meetings of this section.)(1/22/08)

(b) TERM. Each member shall be appointed for a two year term and any member may serve additional consecutive terms. One member shall be appointed as chair by the Chief of Staff.

(c) DUTIES. The Credentials Committee shall have the following duties:

1. Review the credentials of all applicants as received from the departments/sections and to make recommendations for membership and delineation of clinical privileges in conformity with these Bylaws;
2. Review periodically all information available regarding the competence and meeting attendance requirements of staff members and affiliates and as a result of such reviews, to make recommendations for the granting of privileges, reappointments and the assignment of practitioners to the various departments/ sections or services as provided by these Bylaws;
3. Report to the Executive Committee on each applicant for appointment, reappointment, and clinical privileges, including specific consideration of the recommendations from the departments/ sections in which such applicant requests such privileges;
4. To investigate any alleged breach of ethics that is reported to it; and
5. To review reports that are referred by the Executive Committee, Medical Staff Performance Improvement Committee and Chief of Staff, and evaluate the performance of practitioners. Cases may be referred to the Executive Committee, if this is considered desirable, for the purpose of reviewing all information available regarding the competence of practitioners.

(d) MEETINGS. The Credentials Committee shall meet monthly or as required and shall maintain a permanent record of its proceedings and actions. The meeting shall be divided into two parts with the first portion of the meeting containing action/discussion items pertinent to the Advance Practice/Master's Trained Nurse and Physician's Assistant. The APN and PA representatives will not attend the second portion of the meeting which will consist of medical staff action/discussion items. (1/22/08)

Section 3. Joint Conference Committee.

The medical staff shall be represented on the Joint Conference Committee as established and defined by the Code of Regulations of the hospital.

Section 4. Oncology Committee.

(a) MEMBERSHIP. The Oncology Committee shall consist of representatives from all medical specialties involved in the care of cancer patients, including representatives from surgery, internal medicine, medical oncology, gynecologic oncology, diagnostic and therapeutic radiology, gynecology, diagnostic and radiation oncology, pathology and family practice; and the Cancer Liaison Physician. Representatives from hospital operations, nursing service, social service, Pastoral Care, quality management, rehabilitation service, pharmacy, and the cancer registry may be added as ex officio members without vote.

(b) DUTIES. The Oncology Committee shall have the following duties:

1. Review, evaluate and make recommendations to the Executive Committee concerning the entire spectrum of care for all cancer

patients admitted to the hospital, including diagnosis, treatment, rehabilitation, follow up and reporting of results;

2. Supervise and direct clinical or basic research in the field of oncology;
3. Report regularly to the Executive Committee.
4. Make certain that tumor board conferences include major cancer sites yearly and are primarily patient oriented and prospective;
5. Ensure that consultative services are available to patients with cancer through multidisciplinary physician attendance at conferences;
6. Make certain that patients have access to consultative services in all major disciplines;
7. Monitor and evaluate patient care, either directly or by interaction with and review of audit data from other committees;
8. Actively supervise the Oncology Information Center for quality control of abstracting, staging and reporting;
9. Identify two patient care evaluation studies, one long term and one short term, to be done during the current year for release in the Annual Report;
10. Serve as the Oncology Information Center's physician advisor(s).
11. Publish and distribute the Annual Report.

(c) MEETINGS. The Oncology Committee shall meet no less than six times a year and shall maintain a record of its proceedings and actions.

Section 5. Organizational Performance Improvement Committee.

(a) Membership. The Organizational Performance Improvement Committee is a collaborative and interdisciplinary committee of the hospital with members representing both the medical staff and hospital staff. Unless otherwise indicated herein, all are voting members of the committee. The committee shall consist of:

Medical Staff

- Chief of Staff-Elect as chair
- Vice President for Medical Affairs
- Chair, Continuum of Care Committee
- Chair, Department of Medical Education
- At least eight representatives of the medical staff each appointed by the Chief of Staff for a two year term
- Chief of Staff as ex-officio member with vote;

Hospital Staff

- Chief Operating Officer as vice-chair
- Two Senior Vice Presidents or Vice Presidents of Hospital Operations
- Vice President over Nursing
- Vice President over Information Systems
- Vice President over Human Resources
- Vice President over Reimbursement/Managed Care
- Vice President, Quality Management
- Director, Risk Management
- Director, Consumer Relations
- Nursing PI Coordinator
- Manager, Quality Management
- Coordinators in Quality Management as non-voting members

(b) Duties. To improve the quality of patient care and organizational performance through both collaborative and interdisciplinary approaches to planning, designing, measuring, assessing, and improving performance of functions within the committee's purview. Within the flow of information, any peer review issues will be forwarded in writing to the appropriate medical staff department/section chair, the Medical Staff Executive Committee, the appropriate Vice President or Director for further review and evaluation, as directed by the committee chair.

(c) Responsibilities.

1. Systematic measurement and assessment for a comprehensive set of performance measures.
2. Receive reports from Strategic Performance Improvement Teams identified in the comprehensive set of performance measures.
3. Maintain inventory of Operational Team Projects.
4. Identify performance trends, variances, and opportunities for improvement.
5. Encourage collaboration and interdisciplinary approach to performance improvement projects.

Results of operational performance teams are reported to the appropriate medical staff department/section chair, the Medical Staff Executive Committee, the appropriate hospital Vice President as directed by the committee chair. The Medical Staff Executive Committee and Management Forum shall receive information from the minutes as indicated by the council. The committee is accountable to the Quality Council.

(d) Meetings. The committee shall generally meet twice monthly and maintain a permanent record of its proceedings and actions. The agenda will be prepared and appropriate meeting materials distributed at the meeting. The agenda will be coordinated through the Chair and Vice Chair of the committee. (Approved: 5/5/98)

Section 6. Quality Council

(a) Membership. The Quality Council is a collaborative and interdisciplinary council of the hospital with members consisting of both the medical staff leadership and hospital leadership. The council shall consist of the following members:

Hospital Staff (with vote)

1. The President and Chief Executive Officer as chair
2. The Executive Vice President and Chief Operating Officer
3. Chief Financial Officer
4. Senior or Vice President over Nursing
5. Senior or Vice President of Hospital Operations
6. Vice President of Quality Management

Medical Staff(with vote)

1. Chief of Staff as vice chair
2. Chief of Staff-Elect
3. Vice President of Medical Affairs
4. Three members of the medical staff appointed at the discretion of the Chief of Staff, possibly to include the immediate Past Chair and/or immediate Past Chief of Staff.(12/06)

Consulting (non-voting)

1. Senior Management Engineer
2. Quality Management Coordinators

(b) Duties. The purpose of the council is to encourage and promote both collaborative and interdisciplinary approaches to planning, designing, measuring, assessing and improving the performance of projects within the committee's purview.

(c) Responsibilities. The council will:

1. Review and update the Performance Improvement Plan
2. Establish hospitalwide improvement priorities, identified through consensus, based upon review of the annual self assessment and other clinical, service, or community measures which support the overall mission and strategic goals of the hospital.
3. Identify performance indicators, targets and reporting processes to monitor performance and hold gains
4. Ensure staff receive appropriate training for performance improvement activities

The council receives information from the OPIC on strategic performance improvement projects with unfavorable variances. The Medical Staff Executive Committee and Council on Health Administration shall receive information from the minutes as indicated by the council. The council is accountable to the Joint Conference Committee of the Board of Trustees. (Approved 5/5/98)

Section 7. Surgical Case Review Committee.

(a) MEMBERSHIP. The Surgical Case Review Committee shall be a multidisciplinary review committee.

(b) DUTIES. The purpose of the committee is to review the following five processes for operative and invasive procedures:

1. Selection of the appropriate procedure
2. Patient preparation for the procedure
3. Performance of the procedure and patient monitoring
4. Post procedural care
5. Post procedure patient/family education

The committee will also review cases referred from the pathology department for reasons such as unexpected pathology findings and incongruent pre and post operative diagnosis.

(c) MEETINGS. This committee shall meet at least quarterly and shall maintain permanent records of its findings, proceedings and actions. The record of the committee's activities shall be submitted to the Executive Committee and applicable departments and sections of the medical staff (revisions approved 9/97)

Section 8. Pharmacy and Therapeutics Committee.

(a) MEMBERSHIP. The pharmacy and therapeutics committee shall consist of at least seven representatives of the medical staff, one of whom shall be the chair of the committee as well as one representative each from nursing service and hospital administration, a clinical pharmacist, a clinical dietitian, a respiratory therapist, and the Director of Microbiology. The director of pharmacy services shall be a member of the committee and shall act as secretary.

(b) DUTIES. This committee shall be responsible for the development and surveillance of all drug utilization policies and practices within the hospital in order to ensure optimum clinical results and to reduce the potential for hazard. The committee shall assist in the formation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the hospital.

(c) MEETINGS. The committee shall meet at least quarterly and shall maintain permanent records of its findings, proceedings and actions. The committee shall report to the Executive Committee and applicable departments and sections of the medical staff.

Section 9. Radioisotope and Radiation Safety Committee.

(a) MEMBERSHIP. Membership must include an authorized user of each type of user permitted by the license. The physician members include at least one member of the Radiation Oncology Section, at least one member of the Nuclear Medicine Section and at least one other member of the Medical Imaging Department. Non-physician members must include a Radiation Safety Officer, a nurse service representative, and a representative of management who is neither an authorized user nor a Radiation Safety Officer. The physician chair should be one of the authorized users listed by the institutional license. Other members may be included as deemed appropriate by the chair and the Chief of Staff.

(b) DUTIES. The duties of the committee are listed in Section § 35.22 Radiation Safety Committee of the Nuclear Regulatory Commission's Rules and Regulations. Briefly, to oversee the use of licensed radioactive material the committee reviews the program to maintain radiation exposure As Low As Reasonable Achievable (ALARA). Reviews on the basis of safety the credentials of individuals to be included as authorized users. Approves or disapproves changes in the radiation safety procedures. Reviews incidents involving radionuclides with respect to cause and subsequent actions taken.

(c) MEETINGS. The committee shall meet at least quarterly. To establish a quorum at least one-half of the membership must be present, including the Radiation Safety Officer and the management's representative. Copies of the minutes and other pertinent documents will be provided to the committee members and to the Medical Staff Executive Committee. A copy will be kept in the Medical Staff Office for the duration of the license. (Approved: 12/3/02)

Section 10. Perinatal Mortality and Morbidity Committee.

(a) MEMBERSHIP. The perinatal mortality and morbidity committee shall consist of members of the departments of Obstetrics and Gynecology, Family Practice, Pediatrics, Anesthesiology and Pathology. Nursing personnel from the labor and delivery areas and the intensive care and observation nurseries shall also be represented on the committee.

(b) DUTIES. The purpose of the committee is peer review, determination of preventability factors, education of attending staff and residents, and preparation of perinatal statistics.

(c) MEETINGS. The committee shall meet at least monthly and maintain a permanent record of its findings, proceedings and actions. The committee shall report to the Executive Committee and applicable departments and sections of the medical staff.

Section 11. Blood Utilization Review Committee.

(a) MEMBERSHIP. The Blood Utilization Review Committee (BUR) shall be a multidisciplinary, consisting of physicians from various specialties, Quality Management Coordinators and the Blood Transfusion Service manager.

(b) DUTIES. Responsibilities of the committee include:

1. To investigate possible cases of transfusion transmitted disease.
2. To intensively review all confirmed transfusion reactions and complications of transfusion.
3. To monitor blood and blood product usage.
4. To review ordering practices for blood and blood products (Crossmatch/Transfusion ratio.)
5. To evaluate Blood Transfusion Service performance according to the needs of the patients and medical staff.
6. To evaluate the appropriateness of transfusion of blood and blood products to patients using criteria approved by the Executive Committee.
7. To approve policies and procedures related to testing, distribution and administration of blood and blood products.
8. To inform the medical staff of new developments and procedures in Blood Transfusion Medicine. (Approved: 5/30/95)

(c) MEETINGS. The committee shall meet every other month and it shall maintain a permanent record of its findings, proceedings and actions. The record of the committee's activities shall be submitted to the Executive Committee and applicable departments and sections of the medical staff.

Section 12. Quality of Documentation Committee.

(a) MEMBERSHIP. The quality of documentation committee shall be an interdisciplinary committee including of members of the medical staff appointed by the Chief of Staff. Representatives from health information management services, and nursing services and other patient, diagnostic and treatment services shall also serve as members of this committee.

(b) DUTIES. The quality of documentation committee shall review medical record results and make recommendations regarding record completion and documentation activities.

(c) MEETINGS. The quality of documentation committee shall meet bimonthly and shall maintain a record of its findings, proceedings and actions. The record of such activities shall be submitted to the Executive Committee and applicable departments and sections of the medical staff. (Approved: 5/03)

Section 13. Operating Room Committee.

(a) MEMBERSHIP. The operating room committee shall be composed of the chairs from the sections of surgical and anesthesia specialties and general surgery, and the departments of oral and maxillofacial surgery/dentistry, surgery, anesthesia, orthopaedic surgery and obstetrics and gynecology. Additionally, a representative of the surgical training program will also serve on the committee. Hospital personnel shall be represented on the operating room committee by the supervisor of surgery and a nursing services representative. The chair of the committee shall rotate among the chair of the departments of surgery, obstetrics and gynecology and orthopaedic surgery.

(b) DUTIES. The purpose of the operating room committee is to make recommendations for the improvement in the operations of the operating suite in accordance with the purposes as outlined in the operating room policy manual. The operating room committee shall have the authority to make decisions concerning appropriate operating room issues. The operating room committee shall be responsible to the Medical Staff Executive Committee and will forward any recommendations for policy changes to the Medical Staff Executive Committee for approval prior to implementation.

(c) MEETINGS. The operating room committee shall meet monthly and shall maintain a written record of its findings, proceedings, and actions.

(d) VOTES. Votes on the operating room committee shall be limited to medical staff members with each member allocated one vote. Should a regular member not be in attendance, the vice chair of the member's department/section may at the member's direction attend the meeting in the member's absence and vote.

Section 14. Research Committees.

(1) INSTITUTIONAL REVIEW BOARD (IRB)

a. MEMBERSHIP. The IRB committee shall consist of at least five members of sufficiently diverse backgrounds, including consideration of racial and cultural backgrounds of members and sensitivity to issues such as community attitudes; shall include persons who are able to ascertain the acceptability of research applications in terms of institutional commitments, applicable law and professional standards; shall include members of both sexes; shall include at least one member whose primary concerns are in nonscientific areas; shall consist of members representing more than one profession; shall include a member who is not affiliated or related to a person who is affiliated with the institution; shall include persons who are primarily concerned with the welfare of vulnerable subjects; may invite individuals with competence in special areas to assist in the review of complex issues; and may not have a member participate in the IRB's initial or continuing review of any project in which the member has a conflicting interest, except to provide information requested by the IRB. The regulations authorize each IRB to use consultants to assist in review of

complex issues which require expertise not available on the IRB. Under appropriate circumstances, the Chief of Staff may appoint a non-medical staff member to act as Chair of the IRB. (Approved: 11/25/97)

b. DUTIES. The responsibilities of the IRB shall be to review, report, monitor and evaluate research activities. These shall be primarily those matters of patient protection and informed consent where patients are a part of research work. These responsibilities include those with respect to benefits, potential harm or abuse, safety, and care of subjects (patients) who are entered into investigational research; the matters of patient protection and informed consent will be especially important responsibilities.

c. MEETINGS. The committee shall meet quarterly and shall maintain a permanent record of its findings, proceedings and actions.

d. QUORUM. A quorum is not less than a majority of the members and must include a licensed physician, a nonphysician scientist, and one member whose primary activities are in a nonscientific field. All members of this committee are allotted a vote.

e. ADMINISTRATIVE RESPONSIBILITY. The IRB will collaborate with appropriate committees of the MVH Research Center and be represented on those committees.

2. Other Research Committees.

Appropriate committees for the satisfactory function of the Research Center will be formed under supervision of the Research Center.

Section 15. Effectiveness Committee.

There is hereby established a Hospital Impaired Practitioner Committee. This committee is established by these Bylaws as a peer review organization pursuant to the Ohio Revised Code, Section 2305.25. and Section 4731.22.4.

This program is entirely independent of any other committee, and entirely separate from any disciplinary or enforcement activities established or authorized by these Bylaws.

Members of the Medical Staff, (including self referral) Nursing Leaders, Pharmacists, as well as other hospital employees, are encouraged to report to the Committee, the chair or any member of the committee, any instance of suspected functional and professional impairment because of alcoholism, drug dependency, or mental, physical or aging problem that has or could give rise to injury to a patient.

If the Committee receives a report of conduct that might suggest impairment where a patient may be unreasonably at risk, the chair should be notified immediately, who in turn will notify the Chief of Staff. If no risk to a patient is perceived, the chair of the committee shall notify the Chief of Staff of the impairment and the progress of the intervention within 14 days.

If the Committee is unsuccessful in establishing an effective intervention then it reports to the Chief of Staff and Hospital Administrator for appropriate disciplinary proceedings, including notifying the Ohio State Medical Board.

(a) COMPOSITION. The committee will be composed of experienced, respected physicians including a representative from each of the following: Family Practice, Anesthesiology, Emergency Medicine, Neuropsychiatry. In addition, a recovering physician may also serve. The committee members shall be appointed biannually by the Chief of Staff with no limitation on the number of terms they may serve. A physician shall not serve on both this Committee and a committee which has disciplinary authority over members of the medical staff.

The chair of the committee shall be appointed by the Chief of Staff and must attend or have attended a state or a national meeting on physician impairment or be board certified in addiction medicine.

(b) DUTIES. The Duties of the Committee shall include:

1. To receive complaints about members of the medical staff from all sources, including practitioners, spouses or relatives of the alleged impaired physician, nurses, pharmacists, patients or other interested persons. Confidentiality of the informant making a referral to the committee shall be maintained. (1/22/08)
2. After the complaint is investigated, documented and determined to be well founded, to select an intervention team either from the committee members or members of the Ohio State Medical Association Physician's Effectiveness Committee or Montgomery County Medical Society Physician's Effectiveness Committee to contact the physician in question to enter a voluntary treatment program.
3. To receive periodic reports every seven days from each intervention team concerning the status, progress, and prognosis of each impaired physician, and to forward same to the Chief of Staff.
4. To prepare and implement a re entry program to reinstate the physician without humiliation or rejection by other members of the medical staff, upon successful completion of a treatment program by a formerly impaired physician.
5. The committee should not actively search out instances of impairment.
6. To be advisory to the Executive Committee.

(c) INTERVENTION.

1. Composition of the Intervention Team. The Committee shall appoint two of its members at a time to do the intervention. If necessary, the committee may seek the help of the Montgomery County Medical Society Physicians Effectiveness Committee and/or the

Ohio State Medical Association Physician's Effectiveness Committee to assist with an intervention.

2. DUTIES. The duties of an intervention team shall be as follows:

- a. To meet with the physician in question, demonstrate that complaints have been received about the physician's professional conduct and impairment, express the desire to offer help, encourage the physician to seek help, and offer assistance with entering a treatment program.
 - b. To report to the chair or the committee every seven days, the status, progress and prognosis of each impaired physician.
 - c. To attempt to provide any requisite assistance if the impaired physician asks for help or agrees to enter into a treatment program.
 - d. To regularly check on the status of the treatment program, and report any significant change or refusal to undergo treatment, to the full committee.
 - e. To make reasonable recommendations to assist the impaired physician to continue to perform professional duties or provide for a limited practice, as deemed feasible and proper by the physician in charge of the treatment program.
3. Records. Record keeping shall be sufficient to document meetings and activities of the committee. The confidentiality of the records will be protected under Ohio laws concerning peer review/quality assurance.
4. Meetings. The committee should meet as frequently as required to fulfill its responsibilities in accordance with its policies and procedures.
5. Education. Members of the committee will be encouraged to attend local, state and national programs on impairment. Periodic educational programs for the medical staff shall be sponsored by the MVH Physician's Effectiveness Committee and hospital staff geared toward impairment recognition issues specific to licensed practitioners (i.e. at risk criteria) shall be sponsored by the MVH Physician's Effectiveness Committee. (1/22/08)

(d) CONFIDENTIALITY; MANDATORY REPORTING. Generally, the activities of the Committee shall be confidential, and shall not be disclosed except as required by law or with written consent of the physician in question unless one of the following circumstances exist:

- a. The physician does not cooperate with the referral for examination or the Committee's determination that the physician enter a treatment program;
- b. The Committee has probable cause to believe the physician has violated a provision of Ohio law not related to substance abuse, or any rules of the Ohio State Medical Board not related to substance abuse.

In the event disclosure is made necessary by reason of one of the above, the Committee shall promptly inform the Chief of Staff for purposes of corrective action and/or appropriate discipline under these Bylaws.

B. Special Committees

As hospital interests in services require, special committees of the medical staff shall develop appropriate committees to direct, monitor, review and/or analyze these services on a regular basis. The following list of special committees is therefore representative rather than exclusive:

1. The library committee shall be responsible for an analysis of the changing needs of the hospital's library service. Composition of the committee shall be determined by the complexity of the services provided.
2. The medical staff bylaws committee shall be responsible for making recommendations relating to revisions and updating of the Bylaws, rules and regulations of the medical staff. The committee shall meet no less than once annually at the call of the chair to review the Bylaws, rules and regulations of the medical staff and either approve the documents as written or recommend amendments as provided under Article XV herein.
3. The disaster committee shall be responsible for the development of the hospital's ability to manage internal and external disaster situations.
4. The fiberoptic endoscopy committee shall have a chair appointed by the Chief of Staff and the President with members representing the departments of medicine and surgery. Other members may be appointed as the need arises. The functions of this committee shall be to formulate guidelines for the use of flexible fiberoptic endoscopes outside the surgical suite.
5. The nutrition committee shall be composed of a chair and physicians representing various departments of the medical staff appointed by the Chief of Staff. The hospital personnel assigned to the committee represent Nutrition Services, Nursing Services, the Nutrition Support Team and Administration. The committee is responsible for review and recommendation of policies related to medical nutrition therapy for patients which includes the MVH Handbook of Nutrition and the Nutrition Support Team. (5/27/97)

ARTICLE XIII. MEETINGS

Section 1. Annual Meeting.

The annual meeting of the medical staff shall be held on or about the first Tuesday in May of each year. Reports and review of the work done in the clinical departments/ sections and medical staff committees in the performance of the required medical staff

functions may be submitted to the Chief of Staff for distribution to members of the medical staff prior to this meeting. The selection of the Chief of Staff Elect, when appropriate, shall be announced at this annual staff meeting.

Section 2. Special Meetings.

Special meetings of the medical staff may be called at any time by the Chief of Staff or at the request of the governing body, the Executive Committee, or any twenty five (25) members of the voting medical staff. At any special meeting, no business shall be transacted except that included in the notice calling for the meeting.

Section 3. Notice of Meetings.

Notice of any annual or special meeting of the medical staff stating the date, time and place of such meeting shall be given by ordinary mail, post marked at least five days prior to the meeting. The Chief of Staff shall select and provide for the date, time and place of the meeting.

Section 4. Attendance Requirements.

DEPARTMENT POLICY. Any department/ section may impose reasonable attendance requirements on all staff categories.(5/06)

Section 5. Quorum.

Except as otherwise provided in these Bylaws, a quorum at medical staff department, section, committee/subcommittee, annual, regular and special meetings shall be those Active Staff members present. Fifty percent (50%) of the voting members shall represent a quorum at Medical Staff Executive Committee and Credentials Committee meetings. (Approved: 12/5/00)

Section 6. Conduct of Meetings.

The most current revision of Robert's Rules of Order shall prevail at all medical staff meetings except as modified in these Bylaws.

Section 7. Agenda.

(a) ANNUAL The agenda for the annual meeting shall include (as applicable):

- a. Call to order
- b. Moment of silence for members who expired since last Annual Meeting
- c. Acceptance of or correction of the minutes of the last annual and/or all special meetings
- d. Unfinished business
- e. Vote on duly proposed Amendments to the Medical Staff Bylaws
- f. Communications
- g. Awards and Recognitions
- h. Report from the Hospital President
- i. Report from the Chief of Staff
- j. Installation of the Chief of Staff and Chief of Staff-Elect (as noted in Article X. Section 4 of these Bylaws)
- k. Adjournment.

Only those business items listed on the printed agenda prepared and/or approved by the Chief of Staff shall be transacted at the meeting.

(b) SPECIAL MEETING. The agenda at any special meeting shall be:

1. The reading of the notice calling the meeting;
2. Transaction of the business for which the meeting was called;
3. Adjournment.

(c) RECORD. Minutes of all meetings shall be prepared and shall include a record of attendance, and the vote then taken of each matter brought before the membership. Minutes shall be signed by the Chief of Staff and maintained in a permanent file.

Section 8. Conflict of Interest

In any instance where an officer, committee chairperson, department chair, or member of the medical staff has a conflict of interest in any matter that comes before any medical staff meeting, or in any instance where any such individual brings a complaint against another medical staff member or is the subject of such complaint, such individual shall not participate in the discussion or vote on the issue, and shall absent himself/herself from any deliberative portion of a meeting concerning the issue, although such individual may answer any questions put to him/her by members concerning the matter.(Approved: 5/05)

ARTICLE XIV. CONDITIONS OF APPLICATION & APPOINTMENT

Section 1. General Standards.

By applying for, or exercising clinical privileges or providing specified patient care services within this hospital, a practitioner:

- (a) Authorizes representatives of the hospital and medical staff to solicit, provide and act upon information bearing on his professional ability and qualifications;
- (b) Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative who acts in accordance with the provisions of this Article and these Bylaws.
- (c) Acknowledges that the provisions of this Article are express conditions to his/her application for, and/or acceptance of, staff membership and the continuation of such membership, or to his/her exercise of clinical privileges or provision of specified patient services at this hospital.

Section 2. Confidentiality of Information.

Information with respect to any practitioner submitted, collected or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality, or contributing to clinical research shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than authorized representative nor be used in any way except as provided herein or except as otherwise required by law. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall not become part of any particular patient's file or of the general hospital records except the practitioner's confidential file which shall be maintained on each practitioner by the Chief of Staff.

Section 3. Immunity from Liability.

(a) GENERAL. No representative of the hospital or medical staff shall be liable to a practitioner for damages or other relief for any action taken or statement or recommendation made within the scope of his/her duties as a representative, if such representative acts in good faith after a reasonable effort under the circumstances to ascertain the truthfulness of the facts and in the reasonable belief that the action, statement, or recommendation is warranted by such facts. Regardless of the provision of state law, truth shall be an absolute defense in all circumstances.

(b) RELEASE OF INFORMATION. Release of any confidential or privileged information concerning a practitioner of this hospital or medical staff or by any other health care facility or organization of health professionals, may be provided only when the practitioner agrees to the transmission of the information by a signed, written release that the information can be released except where required by law, specifically demanded by court order, as outlined in Article VIII, Section 1 (g) of these Bylaws, or determined by the President and the Chief of Staff that failure to release the information could endanger the life or health of any individual and the practitioner refuses or is unavailable to authorize such release. In all such instances, no representative of the hospital or medical and no third party shall be liable to a practitioner who is or has been a member of the hospital staff or who did or does exercise clinical privileges or prerogatives or provide specified services of this hospital when such information has been released in good faith, and with due respect to the practitioner's prevailing right of privacy and the public's right to competent health care services. Any information which is a part of a patient's record is not included in this provision. (Approved: 5/05)

Section 4. Activities and Information Covered.

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

- a. Applications for appointment, clinical privileges or specific services;
- b. Periodic reappraisals for reappointment, clinical privileges or specified services;
- c. Corrective action;
- d. Hearings and appellate reviews;
- e. Patient care audits;

- f. Utilization reviews;
- g. Hospital, department, committee or staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct both in this hospital and any other health care facility;
- h. Any other activities including but not limited to professional societies, local, state or federal licensing, certifying, registering or enforcing boards and agencies, professional certification boards and the like brought to the attention of the hospital but not included above.

Section 5. Disclosure of Medical Staff Information Prohibited

No member of the Medical Staff participating in or involved with any medical staff committee meeting or function shall be permitted to testify in any action or to voluntarily disclose to any third party any evidence, reports, recommendations or disclosures performed or made in connection with any matter produced or presented during the proceedings of such committee, except as may be authorized by these bylaws or as ordered by the courts. Negligent or intentional disclosure of said information shall constitute grounds for corrective action, including, without limitation, summary suspension, as provided for pursuant to Article III of these bylaws. Moreover, this medical staff may exercise a right of action similar to that which a patient may have against an attending physician for misuse of medical staff information, data reports or records arising out of the patient physician relationship, against a member of a hospital medical staff committee for misuse of any such information, evidence, data, report, communication, finding, evaluation, recommendation or record furnished to such committee.

Section 6. Cumulative Effect.

Provisions in these Bylaws and in application forms relating to authorizations, confidentiality of information and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof, and in the event of conflict, the applicable law shall be controlling. Should any sections of this Article or of any Article, be rules in violation of the law by a court of competent jurisdiction, then such sections or Articles shall be invalid until amended but the remainder of these Bylaws shall continue in full force and effect.

Section 7. Indemnification and Insurance

(a) INDEMNIFICATION. Miami Valley Hospital shall indemnify medical staff officers, department and section chairs, and committee members who act in good faith within the scope and course of their respective duties assigned by these Bylaws, against expenses actually and necessarily incurred by them in connection with the defense or settlement of any action, suit or proceeding in which they are made parties, by reason of their acting, or having acted in such representative capacity, except for matters as to which any such officer, chair, or member shall be adjudged in such action, suit or proceeding to be guilty of or liable for willful misconduct in the performance of such duty and to such matters as shall be settled by agreement predicated on the existence of such liability.

(b) INSURANCE. Miami Valley Hospital shall, at its option, purchase and maintain insurance on behalf of any and all medical staff officers, department and section chairs, and committee members against any liability or settlement based on liability asserted to have been incurred by them by reason of their acting or having acted in such representative capacity.

ARTICLE XV. SEXUAL HARASSMENT

Sexual harassment constitutes illegal discrimination under Title VII of the Civil Rights Act of 1964. It is and has been the policy of Miami Valley Hospital that sexual harassment of or by employees, patients, medical staff and others has no place and will not be tolerated in this hospital. Sexual harassment is defined as follows:

Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when (1) submission to such conduct is made, either explicitly or implicitly, a term or condition of an individual's employment; (2) submission to or rejection of such conduct by an individual is used as a basis for employment decisions affecting such individual; or (3) such conduct has the purpose or effect of substantially interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment.

Section 1. Reports of Sexual Harassment

a. A complaint of sexual harassment committed by a medical staff member, from one who has been the victim of sexual harassment shall be made in writing and signed by the complainant. The complaint shall include:

1. Date and time of the incident;
2. The names of the parties involved;
3. A factual, objective description of the conduct; and
4. The name of any other individuals present when the incident occurred.

- b. A report of sexual harassment committed by a hospital employee shall be processed in accordance with hospital personnel policies.
- c. A report of sexual harassment committed by a medical staff member that is filed by a hospital employee shall be submitted to the employee's supervisor, who shall forward it to the Chief Executive Officer.
- d. The Chief Executive Officer shall immediately notify the Chief of Staff of the report.

Section 2. Meetings with Individual Who Filed Report

- a. The Chief Executive Officer, the Chief of Staff (or their respective designees) and (if applicable) the supervisor shall interview the individual who filed the report, and when possible, others who were present when the incident occurred.
- b. If, after interviewing the individual who filed the report and others who were present, the investigators determine that the report of sexual harassment is credible, the Chief Executive Officer (or designee) shall schedule a meeting with the medical staff member involved. Should the medical staff desire, he/she may be accompanied at the meeting by legal counsel of his choosing, subject to the restrictions set forth in Article IX of these Bylaws. At that meeting, the medical staff member shall be advised of the nature of the complaint(s). The Chief Executive Officer (or designee) shall protect the identify of a complainant if, in his sole judgment, that is necessary and appropriate.
- c. The medical staff member shall be given an opportunity to respond to the allegations.
- d. If, at the conclusion of this meeting, it is believed that no alleged misconduct occurred, no further action is necessary. If, at the conclusion of this meeting, it is believed that the alleged misconduct did in fact occur, the medical staff member shall be informed orally, with subsequent follow up via letter, that:
 - 1. The conduct violates federal law and will not be tolerated;
 - 2. The offending behavior must cease and, if appropriate, an apology must be offered to the individual; involved; and
 - 3. Further incidents of a similar nature will result in correction action including, if appropriate, termination of staff membership and loss of clinical privileges.
 - 4. A copy of the letter shall be placed in the medical staff member's credentials file.

Section 3. Corrective Action

If the Chief of Staff determines that the conduct in question is particularly egregious, or if there are any further reports of harassment, the Chief of Staff shall refer the matter to the medical staff member's department for investigation and, if appropriate, corrective action. All subsequent action, including summary suspension of the medical staff member shall then be conducted pursuant to Articles VII and IX of these Bylaws. (12/5/95)

ARTICLE XVI. AMENDMENTS

These Bylaws may be amended or revised after notice given by the Chief of Staff or any twenty five (25) members of the voting medical staff at any regular, annual or special meeting of the medical staff. Such notice to amend or revise these Bylaws may also be given via regular mail to all members of the Active Staff if such notice is sent prior to thirty (30) days of the regular, annual or special meeting of the medical staff at which the vote will be taken. Such notice shall be referred to a special committee appointed by the Chief of Staff which shall report at the next duly convened regular, annual or special meeting, and a two thirds majority of those present of the voting medical staff who vote shall be required for adoption. Amendments so made shall be effective when approved by the governing body.

The rules and regulations of the medical staff shall be adopted, revised, amended and become effective upon recommendation of the Executive Committee of the Medical Staff and approval of the Governing Body. (1/22/08)

ARTICLE XVII. ADOPTION

These bylaws shall be adopted at any annual, regular or special meeting of the voting medical staff by a two thirds majority vote of those present of the voting medical staff who vote, shall replace any previous bylaws, and shall become effective when approved by the governing body of the hospital. Neither body may unilaterally amend the medical staff bylaws.

The governing body may amend the Bylaws and Rules and Regulations on their own authority in the event that a conflict with a legal or regulatory authority is identified. An amendment made in this manner will subsequently be processed through the routine approval process noted in the first paragraph of this Article. (1/22/08)

Approved by the voting Medical Staff on 5/2/95

Approved by the Board of Trustees of Miami Valley Hospital on 5/30/95

Revised: 8/4/98, 1/26/99, 2/2/99, 6/22/99, 12/7/99, 5/2/00, 12/5/00, 5/1/01, 12/01/01, 6/25/02, 1/28/03, 6/24/03; 1/20/04; 6/22/04; 12/25/05; 6/30/05; 6/20/06, 1/30/07, 1/22/08; 1/22/09

