

**MEDICAL STAFF BYLAWS
AND
RULES AND REGULATIONS
OF
LEONARD J. CHABERT MEDICAL CENTER**

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February, 2003
May, 2006
July, 2007
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September, 2009

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July, 2002
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January, 2005
April, 2005

LEONARD J. CHABERT MEDICAL CENTER

SUBJECT:
Bylaws, Rules and Regulations of the Medical Staff
Effective:

RESOLUTION:

WHEREAS, the revised Bylaws, Rules and Regulations of the Medical Staff of Leonard J. Chabert Medical Center (LJCMC) have been presented to this Governing Body for approval; and

WHEREAS, these revised Bylaws, Rules and Regulations have received a two thirds (2/3) vote of the voting members of the Medical Staff. Such Rules and Regulations and amendments thereto shall become effective when approved by the Hospital Director, and the Governing Body. Such amended and approved Rules and Regulations shall replace any previous Rules and Regulations. When approved, these Rules and Regulations are equally binding on the Medical Staff, the Hospital Director, and the Governing Body. These Rules and Regulations shall be reviewed and approved annually by the Medical Staff and the Governing Body.

NOW THEREFORE, BE IT RESOLVED, that the LSU HCSD Governing Body approves the amended Bylaws, Rules and Regulations of the Medical Staff of Leonard J. Chabert Medical Center;

FURTHER RESOLVED, that by reason of such approval, the LSU HCSD Governing Body does not relinquish or delegate its authority to adopt other conditions or criteria relating to Staff membership or privileges. The Medical Staff Bylaws, Rules and Regulations, as adopted and/or amended by the Medical Staff and approved by the Governing Body may not be unilaterally adopted or amended.

Approved by the
LJCMC Medical Staff and Medical Executive Committee: __September 24, 2009

Signature of Medical Director _____

Approved by the
LJCMC Chief Executive Officer: _____ 2009

Signature of CEO: _____

Approved by the
LSU HCSD Governing Body: _____ 2009

Signature of LSU HCSD Chief Executive Officer: _____

**LEONARD J. CHABERT MEDICAL CENTER
MEDICAL STAFF BYLAWS AND RULES & REGULATIONS**

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**BYLAWS OF THE MEDICAL STAFF
LEONARD J. CHABERT MEDICAL CENTER**

PREAMBLE

The Academic and other members of the Medical staff of the Leonard J. Chabert Medical Center (LJCMC), Houma, Louisiana, (formerly South Louisiana Medical Center, created by Act 38 of 1973 and Act 25 of 1974 of the Louisiana Legislature), hereafter referred to as the Hospital, are responsible to the Louisiana State University Health Care Services Division, by the provisions in the annually approved contract between the South Louisiana Medical Associates, hereafter referred to as SLMA, and LSU/HCSO.

SLMA is a Professional Medical Corporation registered in the State of Louisiana and is governed by a Board of Directors. SLMA is an educational affiliate of the Ochsner Clinic Foundation, New Orleans, Louisiana. Not all members of the Medical Staff are members of the SLMA.

Act III of the Louisiana State Legislature empowered the LSU Board of Supervisors to provide management of the state charity hospital system through the LSU Health Sciences Center, Health Care Services Division, and effective July 1, 1997.

The Board of Supervisors of Louisiana State University and Agricultural and Mechanical College have ultimate responsibility for the administration and control of the functions of LSU Health Sciences Center/Health Care Services Division.

The Leonard J Chabert Medical Center, Houma, Louisiana (Hospital) is not a corporation but is a unit of the Health Care Services Division of the Louisiana State University by Act III of the Regular Legislative session of 1997. The term LSU/HCSO shall apply to the Louisiana State University /Health Care Services Division. Persons statutorily designated and legally responsible for the conduct of the Hospital carry out the functions of the Governing Body. The Chief Executive Officer of Leonard J Chabert Medical Center and the Chief Executive Officer of the Health Care Services Division constitute representatives of the Governing Body who have established principles of regulation by which the Hospital is and shall be operated. These individuals serve at the pleasure of the Board of Supervisors of the LSU, in accordance with the rules and regulations of the State Department of Civil Service and by policies, rules, and regulations of the Louisiana State University Health Care Services Division. The Chief Executive Officer shall have actual authority of administration of the Hospital and shall serve as liaison between the Medical Staff and the Governing Body.

The members of the Medical Staff of LJCMC support the Mission, Vision, and Intent of the Hospital:

Mission: To provide the best quality of care in a safe environment to everyone who comes into our sphere of influence

Vision: To be a recognized community medical center that is values driven, financially self sufficient, and in the forefront of health care delivery, education, and practice

Intent: To serve as a community medical center of excellence where knowledge heals and people care.

ARTICLE ONE
CREATION AND PURPOSES

1.1 CREATION

There is hereby created an organization to be known as the Medical Staff of Leonard J Chabert Medical Center, Houma, Louisiana. The Medical Staff Bylaws, Rules, and Regulations, as adopted and/or amended by the Medical Staff and approved by the Governing Body, create a system of mutual rights and responsibilities between the members of the Medical Staff and the Hospital. Neither body may unilaterally adopt or amend these Bylaws, Rules, and Regulations.

1.2 PURPOSES

The purposes of the organization shall be:

1. To be a single organized, self-governing Medical Staff that has the overall responsibility for the provision of patient care and safety provided by individuals within the scope of their clinical privileges, as well as the responsibility of accounting to the Governing Body.
2. To insure that all patients admitted to the Hospital, or treated as outpatients, receive the best possible medical care in a safe environment regardless of age, sex, race, religion, national origin, handicap, veteran, or financial status and that such care is based on a framework of clinically sound standards.
3. To provide a means whereby medical-administrative problems or opportunities to improve patient and/or safety are shared with the Medical Staff and with the Administration of the Hospital.
4. To provide educational opportunities and to maintain educational programs and their standards in keeping with the role of the Hospital as a teaching facility.
5. To continuously improve the safety and quality of health care provided to the public through the provision of health care accreditation and related services that support performance improvement and a proactive approach to risk assessment in health care organizations.

ARTICLE TWO
MEDICAL STAFF COMPOSITION

2.1 MEMBERSHIP

No applicant shall be denied membership on the basis of sex, race, creed, color, national origin, or on the basis of any other criterion lacking professional justification.

The Medical Staff shall be composed of fully Licensed Independent Practitioners, House Staff members, and Allied Health Personnel who continuously meet the requirements, qualifications, and responsibilities set forth in these Bylaws and who are appointed by LSUHCS Governing Body.

A Licensed Independent Practitioner is any individual permitted by law and by the Hospital to provide patient care services without direction or supervision within the scope of the individual's license and consistent with individually granted privileges. All Licensed Independent Practitioner's have delineated clinical privileges that define the scope of patient care services they may provide independently in the Hospital.

No Licensed Independent Practitioner shall admit or provide services to patients in the Hospital unless he/she is a member of the Medical Staff or has been granted privileges in accordance with the procedures set forth in these Bylaws.

- A. Physicians must be graduates of approved medical or osteopathic schools, legally licensed to practice medicine in the State of Louisiana, professionally qualified for membership in the Louisiana State Medical Society. Board certification and re-certification are not requirements for membership on the Medical Staff, but are encouraged. In the instance of Honorary Staff Members (Article 2 Section 2.2-A), the qualifications of licensure and practice may be waived.
- B. Dentists must be graduates of approved dental schools, legally licensed to practice dentistry in the State of Louisiana and qualified for membership in the Louisiana State Dental Society.
- C. House Staff Members (Article 2 Section 2.2-F) must be graduates of approved medical or osteopathic schools and actively participating in an approved postgraduate medical training program. The House Staff members will be assigned to function under the direction and supervision of the Attending Medical Staff as part of the Medical Staff.
- D. Allied Health Personnel are individuals who are 1) allowed by state to practice in a clinical setting 2) licensed to practice by the State of Louisiana in their clinical area(s) under appropriate supervision, collaboration, or direction of an appropriate Medical Staff member(s) within the scope of the individual's society or its equivalent. These practitioners may include, but not limited to, Optometrists, Chiropractors, Psychologists, Nurse Practitioners, Physician Assistants, and Certified Registered Nurse Anesthetists.

2.2 CATEGORIES OF THE MEDICAL STAFF

The Governing Body shall make appointments to the Medical Staff after recommendation from the Medical Executive Committee of the Medical Staff and the Chief of Service.

Categories of the Medical Staff serve to designate and describe individuals who are appointed to the Medical Staff and have certain Clinical Privileges in connection with their level of participation in the Hospital and their responsibilities as members of the Medical Staff. Appointment to the Medical Staff includes a designation of Medical Staff category. There is no review or appeal for a recommendation or decision to appoint an individual from one category to another since category designation is simply a description of the commitment and the level of attachment any one individual has to the Hospital.

The Medical Staff shall be divided into the following categories:

- A. Honorary Staff
- B. Consulting Staff
- C. Attending Staff, divided into:
 - 1) Active Staff
 - 2) Academic Staff
 - 3) Courtesy Staff
- D. Visiting Academic Staff
- E. Temporary and Disaster Staff
- F. House Staff
- G. Allied Health Personnel
- H. Affiliated Courtesy Staff
- I. HCSD Affiliated Medical Staff

A. THE HONORARY STAFF

The Honorary Medical Staff shall consist of physicians who have retired or have emeritus positions. These Medical Staff members who have retired from active medical practice do not need to reside in the region or community.

The Honorary Staff shall be appointed by the General Medical Staff on their own initiative or on a recommendation of the Attending Staff or Medical Executive Committee, without a formal application from the individual. They shall have no assigned duties or responsibilities. They shall not be eligible to vote or hold office and shall not have the privilege of admitting patients to the Hospital for care or treatment.

B. THE CONSULTING STAFF

The Consulting Staff shall consist of recognized specialists who are physicians or dentists who have signified their willingness to accept such appointments. Members of the Consulting Staff shall not have the privilege of admitting patients to the Hospital. Consulting Staff will act only in the capacity of a consultant (advice and recommendations only), will have clinical privileges and will not provide primary patient care. All Consulting Staff members perform their duties in conjunction with an Attending Medical Staff member. The Consulting Staff member will not be allowed to vote or hold office on the Medical Staff.

C. THE ATTENDING STAFF

(1) Active Staff

Any qualified physician or dentist may make application for membership in the Active Staff, who are competent in their field(s), and who is eligible under the requirements of these Bylaws. Such application will be processed in the manner prescribed and, if approved by the Medical Executive Committee and the Governing Body in the manner herein set forth in these Bylaws, the applicant shall be duly notified and may become a member of the Active Staff.

Members of the Active Staff shall have the privilege of admitting patients to their care in the Hospital. Within the limits imposed by the Laws of the State of Louisiana and these Medical Staff Bylaws, Rules, and Regulations, each member of the Active Staff shall have full discretion in the management of all patients admitted to his/her care. The Active Staff member will accept responsibility to provide for the medical care of any patient admitted to his/her service and will take an active part in the educational programs of the Hospital and will serve on committees if requested to do so by the Medical Director.

Active Staff members shall have the privilege to vote on Medical Staff matters and may serve on committees.

(2) Academic Staff

The Academic Staff has been created to meet the needs of resident training in approved training programs at LJCMC.

In addition to the privileges of the Active staff, Academic Staff members may hold office on the Medical Staff.

Members of the Academic Staff must qualify as members of the Active Staff, but meet the additional requirement of affiliation with the academic institution sponsoring the approved training program.

The eligibility of a physician or dentist for Academic Staff membership will require affiliation with the Leonard J. Chabert Medical Center, Louisiana State University, and Ochsner Clinic Foundation Graduate Medical Education and Training Programs, or the educational affiliates, the South Louisiana Medical Associates, or other educational institutions recognized by the Medical Executive Committee.

(3) Courtesy Staff

In order to have Courtesy Staff Privileges, a physician must complete an application and possess a valid current license to practice in the State of Louisiana.

The Courtesy Staff shall consist of those practitioners who are approved for Medical Staff membership, have admitting privileges, but admit twelve (12) or fewer patients to the Hospital during a one year period of time. Courtesy Staff members who admit more than twelve (12) patients in a one-year period of time will be required to seek Active Staff status upon reappointment.

Courtesy Staff members will abide by the LJCMC Medical Staff Bylaws, Rules, and Regulations.

Courtesy Staff members may not attend Medical Staff meetings, vote on Medical Staff matters, nor hold office.

Courtesy Staff members may order ancillary tests such as laboratory tests and radiology procedures for those patients who are actually admitted to the Hospital or who are seen and examined by the Courtesy Staff member in the outpatient facilities or Emergency Department of the Hospital.

House Staff participation will be determined by the Chief of Service of each specialty upon admission on a case-by-case basis.

The Courtesy Staff member must have an after hour phone number or answering service to communicate critical laboratory values and other critical findings.

The Hospital reserves the right to limit, curtail, or suspend Courtesy Staff privileges based on demand, utilization, equipment, and staff availability without notice.

D. THE VISITING ACADEMIC STAFF

The visiting Academic Staff category has been created to meet the needs of resident training in approved training programs at LJCMC. The Visiting Academic Staff shall not have admitting privileges or voting rights on the Medical Staff. They may not be elected to office. All duties shall be in conjunction with an Academic Staff member. Visiting Academic Staff members shall qualify for Medical Staff membership when properly credentialed as

outlined in Article III of these Bylaws, Rules, and Regulations. These members shall also meet the additional requirement of an affiliation with the academic institution sponsoring the approved training program.

E. THE TEMPORARY AND DISASTER STAFF

The Temporary and Disaster Staff shall be appointed in the manner described in Article 4, Section C-3, of these Bylaws, Rules, and Regulations.

The Temporary and Disaster Staff member will be a temporary member of the Medical Staff whose term is defined by Article 4, Section C-3, of these Bylaws, Rules, and Regulations.

The Temporary and Disaster Staff member shall not be entitled to vote or hold office on the Medical Staff.

F. THE HOUSE STAFF

The House Staff shall consist of those practitioners who have completed a medical or dental degree and who are interns, residents, or fellows of approved Graduate Medical Education programs leading to board eligibility or equivalent competency.

Appointments and reappointment of interns, residents, or fellows for training in the various specialties of the ACGME approved training programs are the sole responsibility of the sponsoring institution.

In the event of controversy concerning the appointment or reappointment of a House Staff member, the sponsoring institution's decision is final.

Each intern, resident, or fellow will agree to carry out the assignments prescribed for him/her by the training program in accordance with the Medical Staff Bylaws, Rules, and Regulations of the Hospital. House Staff members may have a job description, not individually, but for the level of care that person is allowed to perform.

House Staff members shall be supervised, in terms of patient care related activities, by the appropriate Academic Staff member. Each individual House Staff member may admit to the service of his or her supervising Attending Active or Provisional Medical Staff member and his/her supervised clinical duties shall be defined by the appropriate Academic Staff member and the appropriate Chief of Service on an individualized basis. (See Number 3, Rules, and Regulations).

Each House Staff member shall agree in writing to abide by the Medical Staff Bylaws, Rules, and Regulations of the Hospital at the time of orientation.

House Staff members may serve on Medical Staff committees as directed to do so by the Medical Director, but are not eligible to vote or hold office with the exception of the Graduate Medical Education Committee.

House Staff members are subject to Disciplinary Actions, as outlined in Article 5 Section 5.3 of these Bylaws, Rules, and Regulations.

G. ALLIED HEALTH PERSONNEL (AHP's)

Allied health personnel are practitioners such as Physician Assistant (PA), Nurse Practitioner (NP), Certified Registered Nurse Anesthetist (CRNA), Psychologist and other allied health professionals who are approved by the Credentials Committee and the Governing Body. Initially the applicant's application and request for clinical privileges are reviewed by the respective department chief and, if approved, it is referred to the Credentials Committee for approval or denial. Ongoing monitoring and evaluation of

performance are performed within the individual's respective department utilizing appropriate performance evaluation criteria and peer review information.

All entries completed by Allied Health Personnel must be counter signed by a member of the Medical Staff, with the exception of Nurse Practitioners in the outpatient setting. Ten percent (10%) of the outpatient records must be reviewed and counter signed.

H. AFFILIATED COURTESY STAFF

The affiliated Courtesy Staff shall consist of physicians or dentists in the community who have patients that need laboratory and routine radiological services. These patients will have their studies performed at this facility but will receive follow-up care at their physician's office.

- a. In order to have affiliated Courtesy Staff privileges, a physician must meet the eligibility requirements and comply with all provisions as stated in the LSU HCSD Ancillary Referral Policy.
- b. Affiliated Courtesy Staff are not able to admit patients to the hospital, treat patients in the clinic or the emergency room, attend staff meeting, fill appointments to hospital committees or hold medical staff offices.
- c. Leonard J. Chabert Medical Center reserves the right to limit, curtail, or suspend affiliated Courtesy privileges based on demand, utilization, equipment, staff availability without notice.
- d. Affiliated Courtesy Staff may not vote or hold office.

I. HCSD AFFILIATED MEDICAL STAFF

The HCSD Affiliated Medical Staff consists of those physicians, dentists, clinical psychologists, podiatrists and other licensed practitioners whose association with this facility is for the sole purpose of referring patients for ancillary testing, consultation, and other non-admit patient services.

Members of the HCSD Affiliated Medical Staff do not have admitting privileges, are not eligible or required to attend medical staff meetings, and are not eligible to vote or to hold office. Nor are they required to participate in medical staff committees at hospitals where they do not have an active staff appointment.

2.3 PROVISIONAL STATUS

All initial Medical Staff appointees to the Active, Courtesy, Attending Academic, or appointees to the Active, Courtesy or Attending Academic staff after termination of a prior appointment, shall be in provisional status. Active, Courtesy, or Attending Academic members in provisional status shall be assigned to a Clinical Service in which their performance shall be evaluated to determine their eligibility for advancement to non-provisional status in the Active, Courtesy, or Attending Academic Staff. The requirement of this Section 2.3 shall not apply to re-appointees when there has been no prior termination of appointment or to Honorary, Consulting, Visiting or Affiliated appointees.

A. QUALIFICATIONS

Active, Courtesy, Attending Academic Staff members in provisional status shall consist of those physicians who meet the Membership Criteria set forth in Section 2.4, but who have not completed the proctoring requirements set forth in Section D below, if applicable, and/or has been in provisional status for less than twelve (12) months.

B. TERM

All applicants approved for membership to the Medical Staff shall serve an initial Provisional Appointment for a period of twelve (12) months after which time regular staff membership shall be conferred unless information becomes evident that the individual does not fully meet the qualifications for continued Medical Staff membership, including information derived from the Medical Staff's Performance Improvement activities.

C. PREROGATIVES AND RESPONSIBILITIES

A Medical Staff member in provisional status shall have all the prerogatives and responsibilities of the Attending members, as appropriate, in non-provisional status.

D. PROCTORING

Each member in provisional status shall complete such proctoring as may be required by the Clinical Service. Proctoring may include direct observation of performance and/or chart review. Proctoring may be waived only if the applicant is a recent (within two years) resident or fellow at LJCMC or had been a member of the Medical Staff within the last two years. A member in provisional status shall remain subject to proctoring until the Service Chief has determined that proctoring has been successfully completed based on Clinical Service criteria. Documentation attesting to such shall be signed by the Service Chief, along with an evaluation of performance, and a statement as to whether the Member meets all of the qualifications and has discharged all of the responsibilities of the category to which he/she was appointed.

2.4 ETHICAL OBLIGATIONS OF THE MEDICAL STAFF

Each patient is entitled to care that is provided by a qualified Licensed Independent Practitioner who will be subject to review as part of the Medical Staff Performance Improvement activities.

Provide for continuous quality care and management (including treatment and the performance of operative and other procedures) of his/her patients within their scope of practice and clinical privileges. Refrain from delegating the responsibility for diagnosis and care of patients to another practitioner who is not qualified to undertake this responsibility and who is not adequately supervised.

Perform his/her responsibilities as members of Clinical Services, committees, and other Hospital functions as directed by appointment, election, or delegation by the appropriate authority.

Prepare and complete in a timely manner the medical and other required records for all patients for whom he/she is responsible.

Abide by the Medical Staff Bylaws, Rules, and Regulations and by all other lawful standards and policies of the Hospital.

Adhere strictly to the ethics of their professions, work cooperatively with others, and strive to uphold and advance standards of excellence and efficiency in patient care. In this context, the Medical Staff member shall agree in general to Principles of Medical Ethics, developed by the American Medical Association, whether or not he/she is a physician (physician in the context of these principles also refers to any Medical Staff professional in cases of non-physicians) and whose text follows:

1. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
2. A physician shall deal honestly with patients and colleagues, and try to expose those physicians deficient in character or competence, or who engage in fraud or deception.
3. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements, which are contrary to the best interests of the patient.
4. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.
5. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
6. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.
7. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

Agree to provide medical services to patients without regard to age, sex, race, religion, national origin, handicap, veteran or financial status.

Agree to follow the Hospital's guidelines, rules, and policies for financial class and billing.

Agree to the integrity of clinical decisions is based on the identified needs of the patient and not on the financial compensation of the provider.

There may be certain problems which do not reach the threshold of clinical error or issues of quality improvement but which nonetheless raise the question of poor performance in clinical judgment, performance or relationships with patients, families, professional or administrative staff or colleagues. In such instances a focused review may be necessary. The Medical Director will perform this review in conjunction with the chief of service within two weeks of becoming aware of the practitioner's performance. If their assessment leads them to recommend a broader review then the Medical Executive Committee will appoint a committee of peers free of conflict of interest. Such committee will complete a review and make recommendations to the Medical Executive Committee within thirty days. The involved practitioner will be notified of the focused review and be invited to provide comment to the committee and to be present during the discussion of the results, but not during the fact-finding phase.

ARTICLE THREE
APPOINTMENT AND REAPPOINTMENT TO THE MEDICAL STAFF

3.1 PROCEDURE FOR APPLICATION

The appropriate application forms are available in the Medical Director's Office, Leonard J. Chabert Medical Center, 1978 Industrial Boulevard, Houma, Louisiana 70363, Telephone (985) 873-1265, Fax (985) 873-2172.

Every applicant for appointment or reappointment to the Medical Staff shall:

- A. Be subject to the application and reappointment process set forth in these bylaws, policies and procedure.
- B. Submit a properly completed application, including all waivers and attestations, signed by the applicant, to the Medical Director, on the forms prescribed for the purpose of the hospital; properly completed means that all provisions have been completed or an explanation provided of any that are not, and all required supporting documentation has been submitted. It shall contain specific acknowledgement of the applicant's obligation to provide for continuous quality care and supervision of his/her patients, to accept consultation assignments, and the applicant's willingness to abide by the Medical Staff Bylaws, Rules, and Regulations.
- C. Acknowledge that he/she will notify the Medical Director of any changes in the information provided in the application during the application period or at any subsequent time.
- D. Primary Source Verification for medical (or other) school, residency training, fellowship training (the Master file of the American Medical Association may be utilized in instances where this information is not available from the primary source), and current licensure with the State of Louisiana is obtained on all initial and reappointments by the Credentialing Coordinator.
- E. The completely processed application shall include information regarding:
 - Any previously successful or pending challenges to licensure, DEA registration, or voluntary relinquishment of such licensure.
 - Voluntary/involuntary termination of medical staff membership or voluntary/involuntary limitation, reduction, or loss of clinical privileges at any institution/hospital/society/organization.
 - Any involvement in a professional liability action, including final judgments and settlements.
- F. As required by the Health Care Quality Act of 1986, the National Practitioner Data Bank will be queried for all applicants. Any previously successful or currently pending challenges to any license or registration shall be reported at this time and will be a consideration in the appointment process. Any involvement in a professional liability action shall be reported (see K).
- G. The completely processed application shall include the statement that by applying for appointment to the Medical Staff, the applicant signifies his/her willingness to appear for interviews in regard to his/her application and authorizes the Hospital to consult with members of other medical staffs or hospitals with which the applicant has been associated and with others who may have information bearing on the applicant's competence, character, and ethical qualifications. The applicant also consents to the Hospital's inspection of all

documents and records that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges that he/she has requested as well as his/her moral and ethical qualifications for Medical Staff membership.

- H. The applicant further releases from liability all representatives of the Hospital, Medical Staff, and the Governing Body for their acts, performed in good faith and without malice, in connection with the evaluation of the applicant and his/her credentials and releases from liability all individuals, institutions, and organizations who provide information to the Hospital, in good faith and without malice, concerning the applicant's competence, ethical and moral behavior, character, or other qualifications for Medical Staff appointment and clinical privileges.
- I. The applicant shall have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethical and moral behavior, physical and mental well being, or other pertinent qualifications and for resolving any doubts about such qualifications.
- J. Completed applications for membership to the Medical Staff will be approved or disapproved within ninety (90) days by the Governing Body, and the applicant notified in writing of the decision (see Article 3 Section 3.5).
- K. An applicant who has been denied Medical Staff appointment may request in writing to appear before a Hearing Committee to petition for reconsideration, (see Article 6).
- L. The application may be waived in the case of those to be designated as Honorary Staff members.
- M. Malpractice Actions, per se, are not an indication to deny: 1) initial Medical Staff appointment; 2) reappointment; 3) approval of initial clinical privileges; or 4) reconfirmation, revision, restriction, or denial of clinical privileges. However, the number, frequency, cause and award amounts (whether or not malpractice actions are/were based on problems with patient relations, billing practices, or other patient related problems) shall be considered by the Medical Executive Committee in the credentialing process. The burden to demonstrate that the above considerations should not negatively influence the Medical Executive Committee's decision(s) rests with the applicant or Medical Staff member.
- N. An expedited governing body approval process may be used for initial appointment and reappointment to the medical staff and for granting privileges when criteria for that process are met.

Expedited Privileges: An applicant for privileges is ineligible for the expedited process if any of the following has occurred:

- a. The applicant submits an incomplete application
- b. The medical staff executive committee makes a final recommendation that is adverse or has limitations

The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process:

- a. There is a current challenge or a previously successful challenge to licensure or registration.
- b. The applicant has received an involuntary termination of medical staff membership at another hospital.
- c. The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges.
- d. The hospital determines that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

The organized medical staff uses the criteria developed for the expedited process when recommending privileges.

3.2 PROCEDURES FOR INITIAL MEDICAL STAFF APPOINTMENT

- A. All communications during the application and initial appointment phases should be directed to the Medical Director's Office (Article III, Number 4.)
- B. Applicant must obtain, complete and sign the Medical Staff application and must present original copies (which will be verified by the Medical Executive Committee) in accordance to the policies and procedures of the hospital.
 - 1. License to practice in the State of Louisiana
 - 2. Controlled Substance Registration Certificate (DEA)
 - 3. Controlled Dangerous Substance License, Louisiana State Board of Pharmacy
 - 4. Board Certification Certificate, if applicable
 - 5. Any Certifications of Special Competency
- C. The Credentialing Coordinator, under the direction of the Medical Director, will send three (3) letters to peer references provided by the applicant.
- D. The Credentialing Coordinator, under the direction of the Medical Director, will send an inquiry to the National Practitioner Data Bank.

The hospital may consider additional information concerning the applicant from other sources, including the Federation of State Boards Physician Disciplinary Data Bank.
- E. The Medical Director will assign the Applicant to a Clinical Service(s).
- F. The Chief(s) of Service of the appropriate Clinical Service(s) will review the application and the request for criteria-based clinical privileges when the appropriate verified information is available. The Chief(s) of Service will determine qualifications and ability to perform requested clinical privileges and forward this determination to the Chairman of the Medical Executive Committee with a favorable or non-favorable recommendation. An interview with the appropriate Chief of Service(s) and /or the Medical Director may be required.
- G. The Medical Executive Committee will receive the completed application for Medical Staff appointment and request for criteria-based clinical privileges, along with the recommendation of the appropriate Chief(s) of Service, review all the information, and report a favorable or non-favorable recommendation to the Hospital Director, who will forward the application to the Governing Body for final approval.
- H. Action on an individual's application for the initial appointment to the Medical Staff and the initial request for criteria-based clinical privileges will be withheld until the required information is available and verified.

3.3 TERMS OF INITIAL APPOINTMENT

The Medical Executive Committee shall make recommendations for appointments to the Medical Staff to the Governing Body.

3.4 PROCEDURES FOR REAPPOINTMENT TO THE MEDICAL STAFF

A request for reappointment to the Medical Staff should be obtained from the Medical Director's Office.

A. Reappointment to the Medical Staff requires:

1. Evidence of maintenance of current professional licensure, which includes the following:
 - (a) Acts 1999, No. 661 of Regular Session of the Louisiana Legislature and authorized the Board to require continuing education as a condition to the renewal and/or reinstatement of any license or permit issued by the Board. Pursuant to such rules, commencing of January 1, 2002, and annually thereafter, physicians must document that in the preceding year they have obtained **twenty (20) hours** of Board approved CME as a prerequisite to renewal or reinstatement of license. They should relate, at least in part, to the privileges granted.
 - (b) Ten of the above mentioned hours can be from other forms of continuing medical education which can be obtained through attendance at various educational meetings, conferences, seminars, home study, board certification or re-certification, personal professional publications in peer reviewed journals, awards and professional honors, successful completion of competency examinations, or other programs recognized by national societies or organizations related to the member's specialty. Programs offered locally may also qualify, especially those at Leonard J. Chabert Medical Center relating to the Graduate Medical Education programs of the LJCMC, Louisiana State University, Ochsner Clinic Foundation and those programs which involve the Performance Improvement activities of the Medical Staff.
2. Adequate health status, confirmed by the appropriate Chief of Service or the Medical Director;
3. Two (2) professional peer appraisals in support of the Medical Staff member with regard to professional performance, judgment, ability to continue to perform the current requested clinical privileges based on the results of Hospital and/or Medical Staff Performance Improvement activity, and moral and ethical behavior. Peer is an individual from the same discipline (for example, physician and physician, dentist and dentist) and with essentially equal qualifications. One must be from the Chief of Service or the Medical Director. If there are no peers on the medical staff who are knowledgeable about the applicant, a peer recommendation is obtained from outside the hospital, such as the local parish or regional medical society, or a practitioner in the community or on the medical staff of another hospital.
4. Practitioners showing no hospital activity in the previous 12 months, at the hospital's discretion, may **not** be sent a reappointment application.
5. When the reappointment of a Medical Staff member is in question due to health status, an evaluation by someone other than the appropriate Chief of Service or Medical Director may be necessary to resolve the issue. The request for such an evaluation rests with the Medical Executive Committee and the final determination to reappoint by the Governing Body.
6. Any previously successful or pending challenges to any licensure or registration (state or district, Drug Enforcement Administration) or the voluntary / involuntary relinquishment of such licensure or registration.
7. Any voluntary or involuntary termination medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital/institution/society; and involvement in a professional liability action, including final judgments and settlements.
8. Request for the renewal or revision of criteria-based clinical privileges shall be evaluated as a separate and distinct decision of the reappointment process.

9. All final judgments, settlements, or other professional liability actions on an applicant's behalf are to be reported by the Medical Staff member to the Medical Director.
10. The National Practitioner Data Bank will be queried at the time of reappointment.
11. In the recommendation of the Medical Executive Committee to the Governing Body to reappoint to the Medical Staff, consideration of the member's quality of care to his/her patients, patient satisfaction, professional performance, clinical judgment, peer evaluation, and technical skills will be evaluated. This decision to reappoint must include the affirmation of the Chief of Service(s) and the Medical Director. In lieu of a LIP with no admits, we will use a peer to peer evaluation.
12. At the time of reappointment, the Medical Staff member shall agree in writing to the most current Medical Staff Bylaws, Rules, and Regulations.

3.5 TERMS OF REAPPOINTMENT TO THE MEDICAL STAFF

Reappointment to the Medical Staff shall be for a maximum of two (2) years.

3.6 DENIAL OF REAPPOINTMENT

If a member or members of the Attending Medical Staff, a member or members of the Medical Executive Committee, the Hospital Director, or the Governing Body wish to recommend that a specific appointment be not be renewed or wishes that the individual Medical Staff member's clinical privileges be limited, reduced revoked, or suspended, the recommendation is to be submitted in writing to the Medical Executive Committee at least sixty (60) days prior to the individual member's recommendation. If it appears likely that the appointment will not be renewed or a reduction or suspension of clinical privileges will be recommended, the Medical Staff member who holds this appointment will be so notified by Certified or Registered mail with return receipt requested and shall have the right of audience with a Hearing Committee prior to a final recommendation to the Governing Body. (See Article 6, Fair Hearing and Appellate Procedures)

ARTICLE FOUR
CLINICAL PRIVILEGES

4.1 PRIVILEGES EXTENDED TO THE MEDIAL STAFF

A. Initial Determination of Clinical Privileges

When an applicant meets the criteria for appointment to the Medical Staff, specific Clinical Privileges based on criteria* are granted based on the applicant's training and experience. Board Certification will be considered in the determination of clinical privileges. Applicants will be required to submit any reasonable evidence of his/her current ability to perform the requested clinical privileges. Any previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration) or the voluntary/involuntary relinquishment of such licensure or registration; any voluntary or involuntary termination of medical staff membership; or limitation, reduction or loss of clinical privileges at another hospital; and any involvement in a professional liability action will be considered. Request for the renewal or revision of clinical privileges shall be evaluated as a separate and distinct decision of the reappointment process.

Privileges for specific operations, procedures, and activities can only be granted if the Hospital has adequate and appropriate facilities, equipment, and the appropriate number and type(s) of qualified support personnel and necessary support process.

The Medical Executive Committee will receive the request for clinical privileges, along with the recommendation of the appropriate Chief(s) of Service, review all the information, and report a favorable or non-favorable recommendation to the Hospital Director, who will forward the application to the Governing Body for final approval.

Once privileges are successfully approved the individual is subject to malpractice coverage (See Rules and Regulations 24).

* Criteria for clinical privileges include the following:

- Current licensure and/or certification, as appropriate, verified with the primary source
- The applicant's specific relevant training, verified with the primary source
- Evidence of physical ability to perform the requested privilege
- Data from professional practice review by an organization(s) that currently privileges the applicant (if available)
- Peer and/or faculty recommendation
- When renewing privileges, review of the practitioner's performance within the organization

(Source – Joint Commission CAHM 2007)

B. Focused Professional Evaluations

A period of focused professional practice evaluation will be implemented for all initially requested privileges. Information for focused professional practice evaluation may include chart review, monitoring clinical practice patterns, simulation, proctoring, external peer review, and discussion with other individuals involved in the care of each patient (e.g. consulting physicians, assistants at surgery, nursing or administrative personnel). Other focused evaluations will be conducted for triggers that indicate the need for performance monitoring as defined in the Focused Practice Evaluation medical staff policy.

C. Revocation, Revision, or Renewal of Clinical Privileges at the Time of Reappointment to the Medical Staff

A request for a revocation, revision, or renewal of clinical privileges based on criteria should be obtained from the Medical Director's Office.

1. Reconfirmation or revision of existing Clinical Privileges is a distinct and separate process from the determination of reappointment to the Medical Staff.
2. After a member of the Medical Staff has been approved for reappointment, clinical privileges are determined based on:
 - (a) Ability to perform privileges requested. The applicant's ability to perform privileges requested must be evaluated. This evaluation is documented in the individual's credentials file. Such documentation may include the applicant's statement that no health problems exist that could affect his or her practice. Documentation regarding an applicant's health status and their ability to practice should be confirmed. Initial applicants may have his or her health status confirmed by the director of a training program, the chief of services or chief of staff at another hospital at which the applicant holds privileges, or a currently licensed physician approved by the organized medical staff.
 - (b) an individual's competence in the prior period, further training and/or experience, preceptorship, case records, results of treatment
 - (c) Performance Improvement activities whose criteria are directly related to patient care rendered by that individual
 - (d) any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the medical staff member
 - (e) Peer evaluation
 - Sources for peer recommendations may include:
 - an organization performance improvement committee, the majority of whose members are the applicant's peers;
 - a reference letter(s) or documented telephone conversation(s) about the applicant from a peer(s) who is a member of the hospital's medical staff or who is from outside the hospital, but knowledgeable about the applicant's competence;
 - a department or major clinical service chairperson who is a peer; or
 - the medical staff executive committee, the majority of whose members are the applicant's peers
 - (f) The individual may be required to submit reasonable evidence of his/her ability to perform the requested privileges. Reconfirmation or revision of Clinical Privileges must receive the affirmative recommendation of the appropriate Chief of Service, Medical Executive Committee and approved by the Governing Body.
3. Privileges must receive the affirmative recommendation of the appropriate Chief of Service and Medical Director.
4. Exercise of Clinical Privileges is subject to the Medical Staff Rules, Regulations, and Policies. Individuals with such clinical privileges are accountable to the Chief of that Service.
5. Clinical Privileges may be denied or revoked if the Hospital no longer has adequate facilities, equipment, or the appropriate number or type(s) of qualified support personnel and necessary support services.
6. The determination of clinical competence of Medical Staff members with little or no Hospital activity may be accomplished by having letters or questionnaires sent to other facilities to attest to an individual's competence in certain areas. For specialties that are primarily outpatient based, recommendations shall be sought from peers that have

utilized the individual's services on an outpatient basis or an inpatient consultative capacity.

D. Temporary Clinical Privileges

There are three occasions in which temporary privileging can occur:

1. Patient Need

Temporary privileges are granted when there is a specific need for which the hospital does not have adequate staff. The hospital director (CEO) or his/her designated appointee can grant temporary privileges based on the recommendation of the clinical section chairperson or the medical director. Primary source verification of licensure and current competence is required before granting temporary privileges. A documented phone call is acceptable. All temporary privileges are time limited, expiring when the need ends.

2. New Applicants

Temporary privileges can be granted by the hospital director (CEO) and the Medical Director when a new applicant for appointment or privileging awaits review and recommendation by the Medical Executive Committee for approval by the Governing Body. This is to be used in very limited circumstances. Certain areas of application process are required before any privileges can be granted, including verification of the following:

- Current licensure
- Relevant training and experience
- Current competence
- Ability to perform privileges requested
- Results from the National Practitioner Data Bank

If the application is complete, all the necessary information is present, and the applicant has no adverse results, a hospital may consider granting temporary privileges to the individual for a period not to exceed 90 days.

If an individual awaits reappointment and re-privileging and the hospital has a patient need requiring his or her expertise, the LIP can be temporarily privileged to address the patient need, provided he or she meets the required criteria for patient need.

3. Disaster Privileging

If there is a disaster and the hospital's emergency management plan has been implemented, the hospital director or whomever he or she appoints may grant temporary privileges to any LIP who has any of the following:

- (a) A current picture hospital ID card from a JC accredited hospital.
- (b) A current medical license and a valid state, federal, or regulatory agency picture ID.
- (c) Identification indicating membership in a Disaster Medical Assistance Team (DMAT).
- (d) Identification from federal, state, or municipal entity indicating the individual has been granted authority to render patient care in emergency circumstances.

- (e) Presentation by current hospital or medical staff members with personal knowledge regarding the practitioner's identity.

Verification of an individual's credentials and privileges will begin as soon as the immediate situation is under control. A mechanism is established to monitor the performance and the activities of the individuals who receive disaster privileges. This is outlined in the medical staff policy "Disaster Credentialing and Privileging" along with the process for granting temporary privileges.

In an emergency, any medical staff member who has clinical privileges is permitted to provide any type of patient care necessary as a life-saving measure or to prevent serious harm - regardless of his or her medical staff status or clinical privileges - provided that the care provided is within the scope of the individual's license.

In facilities with approved graduate medical education programs, properly supervised members of the house staff may provide such emergency care.

E. Telemedicine/Teleradiology

Telemedicine/Teleradiology providers who are not associated with a Joint Commission accredited organization are credentialed and privileged in the same manner as "Active" staff members as described in these bylaws. Those providers who are affiliated with a Joint Commission accredited organization will be credentialed and privileged by proxy. The Joint Commission accredited organization will submit a copy of the provider's file, including all adverse outcomes related to sentinel events and complaints from patients, licensed independent practitioners, or staff to Leonard J Chabert Medical Center.

4.2 DETERMINATION OF INITIAL OR RECONFIRMATION OR REVISION OF CLINICAL PRIVILEGES IN MORE THAN ONE CLINICAL SERVICE

In certain instances, an applicant or Medical Staff member may request Clinical Privileges in more than one Clinical Service. In this case, the individual will follow the above requirements as if he/she were seeking privileges in each department separately. Each appropriate Chief of Service will consider the request and make a recommendation to the Medical Executive Committee. The Medical Director may request an applicant or Medical Staff member to seek privileges in more than one Clinical Department.

ARTICLE FIVE
DISCIPLINARY ACTION AND ITS ENFORCEMENT

5.1 ATTENDING STAFF DISCIPLINARY ACTION

- A. If a Medical Staff member is recommended for suspension or curtailment of privileges, the Medical Director may temporarily suspend or curtail these privileges in situations where the health or life of a patient or staff member may be in jeopardy.
- B. Summary Suspension of Medical Staff privileges will occur when the action(s) of a Medical Staff member constitutes an immediate threat to the health or safety of a patient, Medical Staff member, Hospital employee, or visitor.
- C. Automatic Involuntary Suspension of Medical Staff Clinical Privileges may result from the acute loss of professional skill, physical or mental skill, gross personal negligence, and loss of license of practice, conviction of a felony involving fraud, violence, or careless disregard for human safety. Voluntary, temporary curtailment or reduction in Clinical Privileges may occur at any time, and these Clinical Privileges may be reinstated by the Medical Executive Committee upon resolution of the matter, which caused the voluntary curtailment or reduction in Clinical Privileges.
- D. In instances of a Summary or Automatic Suspension of Clinical Privileges, the alleged offender is entitled to a preliminary hearing with the Medical Director for a focused review of the suspension or curtailment of Clinical Privileges on the first working day following the action to suspend or curtail Clinical Privileges. In all other cases, the Hospital Director shall first warn the alleged offender in writing (with a copy to the Medical Director) and should contain the specifics of the allegation. If the warning is not heeded within the time limit set by the Hospital Director, the Hospital Director may request a hearing with the Medical Executive Committee within seven (7) days following the lack of compliance with the time limit. The purpose of this hearing shall be to determine whether the alleged offender's Medical Staff Privileges should be terminated or curtailed, or other corrective action is to be taken. These may include, but not limited to, education, positive incentives, focused education on identified problems, concurrent monitoring, direct investigation, observation, mandatory pre-procedure second opinion, mandatory presence of another Medical Staff member, temporary loss of privileges, curtailment of Medical Staff privileges, suspension of Medical Staff membership, denial of reappointment, denial of appointment after provisional appointment, change in Medical Staff status, leave of absence, medical , psychiatric, or substance abuse referral for evaluation and/or treatment, dismissal, or substance abuse referral for evaluation and/or treatment, dismissal, or revocation. The determination made at this hearing shall be subject to appellate review (See Article 6).

5.2 APPOINTMENT, TERMS, AND REMOVAL OF THE MEDICAL DIRECTOR OF THE HOSPITAL

The Medical Director of the Hospital is appointed by the Board of Directors of South Louisiana Medical Associates, according to Contract between South Louisiana Medical Associates and the Governing Body, and is subject to the annual approval of the Governing Body. The Governing Body reserves the right to terminate the services of any individual under such contract after appropriate notice and the concurrence of the Board of Directors of South Louisiana Medical Associates. Failure of the Governing Body to annually approve the continued service of the Medical Director shall be taken to approve his/her continued service. The dismissal of the Medical Director of the Hospital shall not occur without just cause and then only upon the documentation of unsatisfactory performance. Should disagreement regarding the dismissal of the Medical Director occur between the Governing Body and the Board of South Louisiana Medical Associates, a hearing within thirty (30) days of the written notice of disagreement will be held between representatives of the Board of Directors of South Louisiana Medical Associates and the Board of Supervisors of the Louisiana State University Health

Sciences Center, with counsel present if requested by either side. In this hearing, the weight of the unsatisfactory performance shall be evaluated and verified, and consideration of a lesser penalty than dismissal or no penalty shall be considered. In any case, the decision of the Governing Body by majority vote of the Board of Supervisors of the Louisiana State University Health Sciences is final. This determination will in no way affect the Medical Director's status of Medical Staff membership or delineation of Clinical Privileges.

5.3 HOUSE STAFF DISCIPLINARY ACTION

A. Participating Graduate Medical Education Programs

House Staff members shall be subject to disciplinary action by the Hospital Director and the Medical Director who collectively shall have the authority to summarily suspend from the Medical Staff or reduce or curtail Clinical Duties for actions of the House Staff member's part that would constitute an immediate threat to the health or safety of a patient, Medical or Hospital staff member or employee, or visitor. Automatic suspension of Clinical Duties shall occur as a result of the acute loss of a professional skill, physical or mental skill, gross personal negligence, loss of license to practice, conviction of a felony(s) involving fraud, violence, or careless disregard for human safety.

Upon Summary or Automatic suspension of Clinical Duties, the House Staff member is entitled to a hearing before the Medical Executive Committee on the first working day following the suspension or reduction of Clinical Duties. The purposes of this hearing are to: 1) confirm the allegations that resulted in the suspension or reduction of Clinical Duties and 2) notify the House Staff member and the appropriate Graduate Medical Education Program Director and the Chairman of the appropriate Department of the sponsoring training program that action has been taken. The determination made at this hearing is subject to appellate review by an appropriate representative of the Graduate Medical Education program, a representative of the Medical Executive Committee, the Medical Director or a representative, the Hospital Director or a representative, and a representative of the Governing Body (the CEO or COO of the Louisiana State University Health Sciences Center/Health Care Services Division or his delegate). The decision of this appellate body is final.

In all other cases of disciplinary action, the Hospital Director and/or the Medical Director may recommend to the Medical Executive Committee that a House Staff member have their clinical duties curtailed or suspended or recommend other punitive actions. In this instance, the Committee shall review the action(s) leading to the recommendation and may confirm or amend the proposed punitive action. The decision of these bodies may be appealed in a hearing to be held within thirty (30) days of the decision to a body consisting of the Program Director of the appropriate Graduate Medical Education program or his representative, a representative of the Medical Executive Committee, the Medical Director or his representative, the Hospital Director or his representative, and a representative of the Governing Body appointed by the Louisiana State University Health Sciences Center. The issues will be reviewed and the decision of this body is final.

B. Leonard J. Chabert Medical Center Sponsored Graduate Medical Education Program

House staff sponsored by LJCMC shall be subject to the Fair Hearing and Appellate Procedures in Article 6 of these Bylaws.

5.4 DENIAL OR NON-RENEWAL OF APPOINTMENT AND DENIAL, NON-RENEWAL OR INVOLUNTARY REDUCTION IN CLINICAL PRIVILEGES

If a member of the Attending Medical Staff, Hospital Director, or Governing Body wishes to recommend that a specific appointment not be renewed, or that a new application for Medical staff membership be denied, or that an involuntary reduction in Medical Staff Clinical Privileges be invoked, the recommendation shall be submitted in writing to the Medical Executive Committee; in the case of non-renewal of appointment or involuntary reduction in Medical Staff Clinical Privileges, preferably at least sixty (60) days prior to the date of reappointment and in the case of

denial of initial appointment within thirty (30) days. The Medical Executive Committee will hold a preliminary hearing on the recommendation and the decision shall be subject to appellate review (see Article 6).

ARTICLE SIX

FAIR HEARING AND APPELLATE PROCEDURES

6.1 RIGHT TO FAIR HEARING

A. Notice of Changes

The applicant or Medical Staff member, including house staff sponsored by LJCMC, as the case may be, shall be notified promptly by the Medical Director with a written communication sent by certified or registered mail, return receipt requested. Such notice shall inform the practitioner: (a) of the recommendation or action, (b) the reasons therefore; (c) that such action or recommended action, if adopted, shall be taken and reported to the Louisiana State Medical Society and/or National Practitioner Data Bank, if required by law; (d) that he/she has a right to request a hearing within thirty (30) days; and (e) of his/her rights with respect to such hearing.

The applicant or member shall have thirty (30) days following the date of the mailing of the notice within which to request a hearing by a Hearing Committee, as defined in a subsection of this Article. The applicant or member shall also be given a copy of Article Six Fair Hearing and Appellate Procedures. The request for a hearing shall be made in writing and sent by certified or registered mail, return receipt requested to the Medical Director.

In the event the applicant or member does not request a hearing within thirty (30) days following mailing of notice to him/her and in the manner described within this subsection, he/she shall be deemed to have accepted this action.

B. Grounds for Hearing

Any one or more of the following actions shall constitute grounds for a hearing:

1. Denial of application for Medical Staff membership or reappointment.
2. Denial, revocation, suspension, restriction, or involuntary reduction of Medical Staff Privileges.
3. Denial of requested advancement of Medical Staff membership.
4. Demotion to a lower staff category.
5. Involuntary imposition of significant consultation or proctoring requirements (excluding proctoring incidental to provisional staff status, or the granting of new privileges, or imposed because of insufficient activity, or proctoring or consultation that does not restrict the Practitioner's Privileges).
6. Any other disciplinary action or recommendation must be reported to the Louisiana State Medical Society.
7. Suspension or summary suspension of Privileges (excluding Visiting Privileges).

6.2 HEARING PREREQUISITES

A. Hearing Committee Appointment

When a hearing is requested, the Medical Director shall appoint a Hearing Committee which shall be composed of not less than three (3) members of the Attending Medical Staff who shall have actively participated in the consideration of the matter involved at any previous level. The Hearing Committee shall consist of individuals who are not in direct economic competition with the members or applicant involved, and shall include, where feasible, an individual practicing the same specialty as the affected member or initial applicant. The Hearing Committee shall nominate, from amongst its members, a Chair.

A Hearing Officer may be appointed pursuant to Section 6.3 C below. Knowledge of the matter involved shall not preclude a member from serving on the Hearing Committee.

B. Time and Place of Hearing

Within fifteen (15) days of a request for a hearing, the Medical Director shall schedule a hearing and give written notice, delivered in person or sent registered or certified mail, return receipt requested, to the member of the time, place, and date of the hearing. The date of

commencement of the hearing shall not be less than thirty (30) days, nor more than sixty (60) days from the receipt of the request by the Medical Director for a hearing unless the member who requested the hearing voluntarily waived the minimum time limit and requests a shorter waiting period in writing, and the Hearing Committee, or its Chair acting on its behalf, concurs.

The date of commencement of the hearing shall not be more than sixty (60) days from the date of receipt by the Medical Director of the request for hearing unless extended by the Hearing committee or its Chair; provided, however, that when the request is received from a member who is under summary suspensions, the hearing shall be scheduled to commence on a date not more than forty-five (45) days from the date of receipt of the request.

C. Witnesses

Each party shall have the right to present witnesses. If either party by notice to the other requests a list of witnesses, the recipient, at least fifteen (15) days prior to the hearing, shall furnish to the other a list in writing of the names and addresses of the individuals, so far as is then reasonably known, who will give testimony or evidence at the hearing. If a party fails to provide names and addresses of witnesses, the hearing office in his/her discretion may preclude the testimony of witnesses whose names have not been disclosed.

6.3 HEARING PROCEDURES

A. Appearances

If a person requesting the hearing fails to appear and proceed at such a hearing, this will constitute that person's voluntary acceptance of the recommendations or actions involved, and these recommendations or actions will become final and effective immediately.

B. Representation

The hearings provided for in these Bylaws are for the purpose of inter-professional resolution of matters bearing on conduct or professional competency. Accordingly, the person requesting the hearings may be represented by the person or legal counsel of his/her choice; however, the person requesting the hearing must notify the Medical Director in writing, of his/her intention to be so represented no later than then (10) days after submission of the request for a hearing. If the affected member or applicant is represented by an attorney, the body whose recommendation prompted the hearing may also be represented by an attorney. The body whose recommendation prompted the hearing may not be represented by an attorney if the affected member or applicant is not.

The Hearing Officer shall determine the role of attorneys and may eject any attorney whose activities at the hearing, in his or her judgment, disrupt the proceedings. When attorneys are not allowed, both parties may be represented at the hearing by a member of the Medical Staff licensed in Louisiana who is not also an attorney. Postponements and extensions of time beyond those expressly state herein shall be granted on agreement of the parties, or by the Hearing Officer, on a showing of good causes.

C. The Hearing Officer

The Hearing Committee may appoint a Hearing Officer, who may be an attorney at law, to preside at the hearing. The hearing officer shall not act as a prosecuting officer nor as an advocate for the Medical Staff of the Medical Center and shall gain no director financial benefit from the outcome. If requested by the Hearing Committee, he/she may participate in the deliberations of such body, but he/she shall not be entitled to vote. The Chair of the Committee shall be the hearing officer if the Hearing Committee has chosen not to appoint a hearing officer and he/she shall be entitled to vote. The hearing officer shall act to assure that all participants in the hearing have a reasonable opportunity to be heard, to present all oral and documentary evidence, and to insure that decorum are maintained. The hearing officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure, or admissibility of evidence. If the hearing officer determines that

either party in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary actions as seem warranted by the circumstances.

D. Rights of Parties

At a hearing, both parties shall have the following rights: to inspect and copy, at their own expense, any documentary information that either party has under his/her control that is relevant to the charges, as soon as practicable after receipt of the request for hearing; to be present; to call and examine witnesses.; to introduce exhibits; to cross-examine any witness on any matter relevant to the issues; to impeach any witness; to be provided with all information made available to the Hearing Committee; and to rebut any evidence. The failure by either party to provide access to information within fifteen (15) days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend individually identifiable licentiates other than the affected member or initial applicant under review.

The Hearing Officer or presiding officer shall consider and rule upon any request for access to information, and may impose any safeguards that the protection of the peer review process and justice require. If the affected member or applicant does not testify on his/her own behalf, he/she may be called and examined as if under cross-examination. Both parties to the proceedings shall have a right to submit a written statement at the close of the hearing. The hearing shall be confidential and close to the public.

E. Continuances

Continuances shall be granted upon agreement of the parties or upon a showing of good cause.

F. Evidence

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses and presentation of evidence need not apply to a hearing conducted under this Article. Any relevant evidence shall be admitted by the hearing officer if it is the sort of evidence of which responsible persons are accustomed to reply in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The body whose recommendation prompted by the hearing may object to the introduction of evidence that was not produced by the Petitioner proves that he or she previously acted diligently and could not have previously produced it. The Hearing Committee may interrogate the witnesses or call additional witnesses if it deems it appropriate.

G. Burden of Proof

Initial applicants shall bear the burden of persuading the Hearing Committee by a preponderance of the evidence of their qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubt concerning their current qualifications for staff Privileges, membership, or employment. Initial applicants shall be responsible for going forward with their evidence first.

Except as provided above for initial applicants, the body whose action resulted in the charges being brought shall bear the burden of persuading the Hearing Committee by a preponderance of the evidence that the action or recommendation is reasonable and warranted shall be responsible for going forward with the evidence first.

H. Record of Hearing

The Hearing Committee shall maintain a record of the hearing by either a tape-recording or by the use of a court reporter and the cost borne by the Hospital. Access to the records of the Hearing Committee shall be limited to the Medical Director, the Medical Executive Committee and the staff assigned to conduct the investigation. The records shall be maintained by the Medical Staff Department. Copies of the transcript shall be available at the affected member or applicant's expense.

I. Deliberation and Decision

Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Committee shall thereupon, at a time convenient to itself within seven (7) days after hearing closure, or at which time the hearing records are available for review (which may be designated at the time the Hearing Committee receives the hearing transcript or any post-hearing statements, whichever is later) conduct its deliberations outside of the presence of any person other than the Hearing Officer. Upon conclusion of its deliberations, the hearing shall be declared finally adjourned and the Hearing Committee, within fourteen (14) days thereafter shall forward to the Medical Director and Chief Executive Officer, a written report of its findings and recommendations, along with all supporting documentation, to the Governing Body for further action.

Upon receipt of the recommendation from the Hearing Committee, the Medical Director shall thereafter, within seven (7) days, forward to the individual who requested the hearing and the Medical Executive Committee a copy of the recommendation of the Hearing Committee. At the same time, a copy of the decision shall be delivered to the applicant or member who requested the hearing either in person or by registered or certified mail, return receipt requested.

The decision of the Hearing Committee shall be final, subject only to the right of appeal as outlined in section 6.4 of this Article.

6.4 APPEAL PROCEDURE

A. Time for Requesting Appeal

Within twenty (20) days after receipt of the decision of the Hearing Committee, either party may request an appellate review by a Review Committee. This request shall be delivered either in person or by certified or registered mail, return receipt requested, to the Governing Body. If such appellate review is not requested within such period, the Hearing Committee's decision shall be final and effective immediately upon expiration of that twenty-day period.

B. Grounds for Appeal

A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be:

1. Substantial non-compliance with the procedures required by these Bylaws or applicable law which has created demonstrable prejudice.
2. The decision was not supported by substantial evidence based upon the hearing record.
3. The decision is not sustainable in light of new evidence as may be permitted pursuant to Section 6.4 E.

C. Time, Place, and Notice

In the event of any appeal to the Review Committee as set forth in the preceding subsection, the Governing Body shall, within fifteen (15) days after receipt of such notice of appeal, schedule and arrange for an appellate review if he/she determines that valid grounds exist for review. The Governing Body, or his/her designee, shall cause the applicant or member to be given notice of the time, place, and date of the appellate review or that the request for appellate review is denied. The date of appellate review shall not be more than thirty (30) days from the date of receipt of the request for appellate review; provided, however, that when a request for appellate review shall be held as soon as the arrangement may reasonably be made. The time within which appellate review will be held may be extended by the Review Committee for good cause.

D. Review Committee

A committee shall hear all appeals and be comprised of the Governing Body CEO or designee and two additional members from the Medical Staff who have not been involved in any aspect of the case to be heard and who are selected by the Medical Director. Knowledge of the matter involved shall not preclude any person from serving as a member of the Review Committee so long as that person did not take part in a prior investigation or hearing on the same matter. The Review Committee may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal.

E. Review Procedure

The proceeding by the Review Committee shall be in the nature of an appellate review, based upon the record before the Hearing Committee; provided that the Review Committee may accept new oral or written evidence, subject to a foundational showing that such evidence is not cumulative and could not have been made available to the Hearing Committee in the exercise of reasonable diligence. Presentation of such evidence shall be subject to the same rights of cross-examination or confrontation provided to the Hearing Committee. The Review Committee may remand the matter to the Hearing Committee for the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel in connection with the appeal and to present a written statement in support of his/her position on appeal. The parties shall have the right to appear and to respond. The Review Committee may conduct deliberations outside the presence of the parties and their representatives.

F. Final Decision

Within fifteen (15) days, or as soon thereafter as reasonably possible at the conclusion of the proceedings, the Review Committee shall render a final decision in writing and shall deliver copies to the parties and to the Medical Executive Committee in person or by certified or registered mail, return receipt requested. The final decision of the Review Committee shall be effective immediately.

ARTICLE SEVEN

CLINICAL SERVICES

7.1 The Clinical Services of the Medical Staff shall include:

- Medicine (which includes Internal Medicine and its subspecialties: Cardiology, Endocrinology, Gastrointestinal, Nephrology, Pulmonary, Critical Care, Hematology/Oncology, Infectious Disease, Geriatrics, Rheumatology, and Allergy)
 - Family Practice
 - Neurology
 - Psychiatry
- Obstetrics and Gynecology
- Pathology
- Pediatrics
- Radiology
- Surgery (which includes General Surgery and all surgical subspecialties: Ophthalmology, Orthopedics, Urology, Oral Maxillary, Vascular, Thoracic)
- Emergency Medicine
- Anesthesiology
- Telemedicine
 - The medical staff recommends which clinical services are appropriately delivered by licensed independent practitioners through this medium.
 - The clinical services offered are consistent with commonly accepted quality standards.

These clinical services shall be represented and functional upon full operation and staffing of the Hospital. Rather than the Clinical Services meeting as individual Services, the collective Clinical Services will meet as a whole to discharge the business of the individual Clinical Services as well as the business of the Medical Staff in general. Each Clinical Service shall be under the direction of a Chief of Service. The care of patients on these Services shall be delegated to Medical Staff members and other personnel under the supervision of members of the appropriate Service who have been granted such Clinical Privileges. The members of the Medical Staff in these Clinical Services shall be well skilled in their specialties but need not be certified specialists.

Services not included will be referred to the appropriate agency for their individual needs.

7.2 Chief of Service

The Chief of each Clinical Service shall be appointed by the Medical Director and shall be a member of the Academic Staff, in good standing. He/she shall be board certified, with exceptions granted by the Medical Director. The Chief of a Clinical Service is responsible for the organization of the Service, all clinical, administrative, and related activities, both inpatient and outpatient and any, if established, off site locations of the Service, and reports to the Medical Director. The Chief of a Clinical Service shall: 1) Establish, along with the medical and hospital administrative staff, the types and numbers of personnel, recommendations as to utilization of space and other resources and equipment, and scopes of services (both intra and interdepartmental that conform to the Hospital's Mission, Vision, and Intent) that are required to meet the needs of patients and the hospital and to assure that all patients receive the same level of care in a safe environment within their service; 2) Develop, update and orient members to, and implement the necessary policies and procedures (guidelines, methods) for the provision of services within the Service. 3) Recommend to MEC (credentials committee) professional clinical privileges criteria for the determination of Clinical Privileges within the Service. 4) Assess applications for clinical privileges from initial applicants and

from current service members for additional clinical privileges. Report on whether entry-level qualifications match individual's clinical privileges requests. 5) Use data and daily observations provided by the quality/performance office to assess the performance of Service members. The chief is required to be responsible for performance evaluations to the satisfaction of the MEC. 6) Provide for the continuous assessment and improvement of quality of care, service and safety issues of Service members, always striving to have a proactive approach to reduce risk. 7) Assist the Medical Executive Committee and the Medical staff as a whole in Quality Management/Performance Improvement activities and quality control programs as appropriate. 8) Integrate and coordinate cross-disciplinary activities necessary to provide good care to patients. 9) Assign the Medical Staff members, if appropriate, to serve in the outpatient areas for the provision of ambulatory care; 10) Ask executive management staff to provide for off-site clinical services needed by patients of service members when those services are not available by patients of Service members when those Services are not available in the hospital. Ensure that off-site clinical services are timely, of high quality; and cost-effective. 11) Determine the qualifications and competence of all Service personnel who provide Clinical Services; 12) Provide for the orientation, supervision and continuing education of all persons on the Service; 13) Provide continuous surveillance of the professional performance of all individuals in the department who have delineated clinical privileges, including newly appointed Medical Staff members.

If a new service that is deemed necessary by the Medical Executive Committee is created for which no qualified Medical Staff member is available, the Hospital will compensate an appropriate individual to provide such temporary oversight, until it is determined by the Chief of Service that is oversight is no longer necessary.

7.3 Organization of Services (Subsections)

Each service may be divided into subsections according to recognized specialties or subspecialties. The decision to subdivide rests with the Chief of the Service and the Medical Director. The Subsection may have a Director to oversee its functions and the duties of this Director will be the same as for the Chief of the Service as outlined above, but limited in scope to the Subsection. The Chief of the Service shall appoint the Director of the Subsection with concurrence of the Medical Director.

7.4 Medico-administrative Positions

In some instances, a member of the Medical Staff may be appointed to an administrative position. The Medical Director makes all administrative medical appointments. The dismissal from a medico-administrative position for grounds unrelated to his/her professional clinical activities are accomplished at the sole discretion of the Medical Director. This dismissal will in no way affect the individual Medical Staff member's appointment or reappointment to the Medical Staff or affect in any way the reconfirmation, revision, limitation, or reduction of Clinical Privileges. If a Medical Staff member's appointment or reappointment to the Medical Staff or sustains a substantial reduction or denial of Clinical Privileges, then his/her medico-administrative position shall be terminated as well.

7.5 Emergency Services

The delivery of care in the Emergency Department of the Hospital shall be under the direction of the Chief of the Service of Emergency Medicine. The care of such patients shall be delegated to Medical Staff members of this Service and by other medical personnel under the supervision of the members of the Emergency Medicine Service who have been granted such Clinical Privileges. All members of this Service shall participate in committee activities and Quality Management/Performance Improvement activities when directed to do so by the Chief of the Service of Emergency Medicine or the Medical Director. Medical Staff members possessing only Clinical Privileges in the Service of Emergency Medicine may not admit patients to the Hospital.

7.6 Ambulatory Care Services

The Medical Director is responsible for the overall direction of Ambulatory Care as well as Emergency Care Services. The members of the Medical Staff who have been granted such Clinical Privileges shall perform the delivery of care in the outpatient setting. Necessary medical Care may be provided by these Medical Staff members or other medical personnel under the supervision of appropriate Medical Staff members. The Chief of the appropriate service shall be responsible for the delivery, organization, and assignment of appropriate members of the Medical Staff to the ambulatory outpatient care areas, relative to the scope of care rendered by that Service. The full-time ambulatory care Medical Staff member shall participate in committee activities and Quality Management/Performance Improvement activities as directed to do so by the appropriate Chief of Service or Medical Director. Medical Staff members possessing only Clinical Privileges in ambulatory care may not admit patients to the Hospital.

7.7 Ambulatory Surgery Services

The delivery of care and the performance of procedures in an ambulatory setting shall be provided by those members of the Medical Staff that have Clinical Privileges to do so. The Chief of Surgery shall be responsible for the direction, supervision, and assignment of the appropriate Medical Staff members and other medical personnel under the supervision of the appropriate medical staff members. Any medical staff member who performs procedures in the ambulatory surgical care areas must be eligible for and must have the medical staff status and the appropriate delineation of clinical privileges to admit patients to the Hospital.

By definition, patients admitted to the ambulatory surgical care settings must have a stay of twenty-four (24) hours or less. An appropriate complete History and Physical Examination must occur and be documented in the patient's record prior to the surgical procedure by a qualified member of the Medical Staff. The Chief of Anesthesiology shall be responsible for the determination of anesthetic risk and may delegate this determination to the members of that Section who are appropriately qualified to do so and to document this risk prior to the surgical procedure.

ARTICLE EIGHT
OFFICERS OF THE MEDICAL STAFF

8.1 OFFICERS

The officers of the Medical Staff shall be chosen from among the Academic Staff members. The officers shall be a: 1) Medical Director; 2) an Associate Medical Director; and 3) Chief Academic Officer (Designated Institutional Official). All officers shall be members of the Medical Executive Committee. Each officer is subject to the same procedure for Clinical Privileging as any other member of the Medical Staff. Officers of the Medical Staff may be removed from office for failure of performance of their duties. Removal from office will in no way affect his/her status on the Medical Staff or his/her Clinical Privileges.

The Board of Directors of South Louisiana Medical Associates shall appoint the Medical Director, with the concurrence of the Governing Body, as provided for in the annually approved Contract between these parties. SLMA and the Governing Body shall determine the Medical Director's qualifications. The Medical Director shall serve an unlimited term but is subject to the provisions in Article 5, Section 5.2 of these Bylaws, Rules, and Regulations. The Medical Director should reside in the local medical community. The Medical Director shall serve as the Medical Director of the Hospital and as the Medical Director (President) of the Medical Staff. Termination of the Medical Director's tenure will terminate both of these duties, but not in any way affect his/her status on the Medical Staff for appointment or reappointment, or affect in any way his/her Clinical Privileging. The *Job Description* of the Medical Director may change from time to time; however the Medical Director shall, but not be limited to:

- Presiding at all meetings of the General Medical Staff as Chairman
- Serving as Chairman of the Medical Executive Committee
- Serving as an ex-officio member of all Hospital Staff and Medical Staff Committees
- Serving as a member of the Hospital Director's (Leadership) Committee, the Quality Management Council, and the Graduate Medical Education Committee
- Having overall responsibility for Ambulatory Care Services
- Overseeing the Performance Improvement activities of the Medical Staff
- Presiding over Medical Staff Disciplinary Actions
- Serving as the liaison between the Medical Staff, the Hospital Director, and the Governing Body

The **Associate Medical Director** shall be appointed by the Medical Director and serve an unlimited term and is subject to Article 5 Section 5.1 of these Bylaws, Rules, and Regulations. The Associate Medical Director should reside in the local medical community. The Associate Medical Director shall perform such duties as may be assigned to him/her by the Medical Director. In the absence of the Medical Director or his/her ability to perform his/her duties, the Associate Medical Director shall assume these duties and have the authority of the Medical Director.

The **Chief Academic Officer/Designated Institutional Official (DIO)** shall be appointed by the Medical Director and serve an unlimited term and is subject to Article 5 Section 5.1 of these Bylaws, Rules and Regulations. The DIO shall have the authority and responsibility for the oversight and administration of the Sponsoring Institution's ACGME-accredited programs and who is responsible for assuring compliance with ACGME Institutional Requirements. The DIO is to establish and implement procedures to ensure that s/he reviews and cosigns all program information forms and any correspondence or document submitted to the ACGME by the program directors that either addresses program citations or requests changes in the programs that would have significant impact, including financial, on the program or institution. The DIO shall be the chairman of the Graduate Medical Education Committee. The DIO shall present an annual report to the Organized Medical Staff and the governing body of the major participating Joint Commission accredited hospitals in which the GME programs of the Sponsoring Institution are conducted. This annual report will review the activities of the GMEC during the past year with attention to resident

supervision, resident responsibilities, resident evaluation, and the Sponsoring Institution's participating hospitals' and programs' compliance with the duty-hour standards. The GMEC should receive concerns of the Organized Medical Staff related to the items listed above. The GMEC and the Organized Medical Staff should regularly communicate about the safety and quality of patient care provided by the residents.

ARTICLE NINE
COMMITTEES AND FUNCTIONS

9.1 GENERAL INFORMATION ON COMMITTEES AND FUNCTIONS

- A. The committees of the Medical Staff shall be determined by the Medical Director in accordance with the administrative, regulatory, and functional needs and duties of the Medical Staff and the Hospital. The proceedings of committees and their derivative documents are confidential and protected from discoverability. Committee members have a duty to preserve this confidentiality. The Medical Staff Committees should be interdisciplinary, where appropriate.
- B. The Medical Director shall appoint the Medical Staff committee members and the committee chairpersons. The committee members shall be members of the Attending Medical Staff; however House Staff members may serve on committees but shall not have voting privileges. No member of the Attending Medical Staff is ineligible for committee assignment solely on the basis of professional discipline or specialty.
- C. The Hospital Director shall be an ex-officio member without voting privileges on all committees.
- D. The terms of all Standing committee members and chairpersons, except the General Medical Staff, shall be for three (3) years, beginning in July of the appropriate year. Committee members and chairpersons may serve unlimited, successive terms. The Medical Director shall determine continuity of committee membership. Termination of committee assignment will automatically occur with loss of Medical Staff appointment, the attainment of another category of Medical Staff membership other than Attending Staff, or, in the judgment of the Medical and Hospital Directors, the failure of a committee member to fulfill his/her duties to the committee.

9.2 Organization of Committees

The committees shall be divided into an administrative committee, standing committees, and ad hoc committees. The *Administrative Committee* shall be the Medical Executive Committee. All Standing and ad hoc committees shall report to the Medical Executive Committee. The *Standing Committees* shall include: the General Medical Staff Committee, Blood Utilization, Clinical Research, Critical Care Committee, Graduate Medical Education, Infection Prevention and Control, Quality Management Council, Pharmacy and Therapeutics, and Utilization Management/HIM. The *ad hoc Committees* shall include the Ethics Committee and other committees that may be necessary.

9.3 Administrative Committee

A. Medical Executive Committee

- 1. The Medical Executive Committee (MEC) has its responsibilities delegated to it by the Medical Staff. The MEC is delegated the primary authority over activities related to the functions of the Medical Staff, self governance and Performance Improvement activities related to the services provided by Medical Staff members. Organizing the medical staff's organization performance-improvement activities and establishing a mechanism designed to conduct, evaluate, and revise such activities;
- 2. The MEC shall function at those times when it is neither feasible nor appropriate for the entire Medical Staff to do so. The MEC creates a forum for the discussion of mutual rights and obligations between members of the Medical Staff and the Hospital. The MEC shall represent the Medical Staff and recommend policy to the Hospital Director and the Governing Body. The MEC shall serve as a mechanism for keeping the Medical Staff informed of the overall condition of the Hospital.

3. Membership on the Medical Executive Committee shall consist of the following voting members:

- | | |
|----------------------------------|----------------------------------|
| 1.) Medical Director (Chairman) | 7.) Chief of Pathology |
| 2.) Associate Medical Director | 8.) Chief of Radiology |
| 3.) Chief Academic Officer (DIO) | 9.) Chief of Medicine |
| 4.) Chief of Anesthesiology | 10.) Chief of Emergency Medicine |
| 5.) Chief of Surgery | 11.) Chief of Pediatrics |
| 6.) Chief of OB/GYN | |

Non-voting members of the Medical Executive Committee shall be:

- 1.) Hospital CEO/Administrator or designee
- 2.) Director of Nursing
- 3.) Director of Quality Management

4. No medical staff member actively practicing in the hospital is ineligible for membership on the executive committee.
5. The Medical Executive Committee shall meet at least ten (10) times per year and maintain a permanent record of its proceedings and actions.
6. A quorum shall consist of at least a majority of the voting membership. Each voting member is entitled to only one vote even if he/she holds more than one position.
7. The Medical Executive Committee is responsible for the credentialing function of the Medical Staff. The MEC shall act in this capacity as agents of the Hospital when acting in their appropriate scope of duties as outlined by these Bylaws, Rules, and Regulations, policies, or job descriptions. The MEC shall review and make recommendations to the Governing Body on all applications for appointment or reappointment to the Medical Staff and on all determinations related to Clinical Privileges. Members of the MEC should excuse themselves and abstain from participating in either discussion or voting on the recommendations to appoint, reappoint, and provide for initial or subsequent reconfirmation, revision, restriction, or denial of Clinical Privileges in instances where conflict of interest may be present.
8. The Medical Executive Committee will facilitate the oversight and direction to unresolved ethical issues in the Hospital. The MEC shall act as a body to determine if a clinical or other ethical or non-ethical issue exists and if so, may convene the Ethics Committee on an ad hoc basis.
9. The MEC will organize the medical staff's performance improvement activities and establish a mechanism designed to conduct, evaluate, and revise such activities.
10. The Medical Executive Committee is responsible for the Medical Staff Performance Improvement activities. The MEC shall oversee all patient care related activities of the Hospital. Information from the various committees, sections, Quality Management Department and other assigned activity groups shall be reviewed and recommendations/actions proposed in their regard.
11. The Medical Executive Committee is responsible for handling Medical and other professional Medical Staff disciplinary hearings with regard to determining limiting, curtailing, reducing, withdrawing, or terminating Medical or professional Medical Staff Clinical Privileges or Medical Staff membership. Disciplinary hearings must be held separately from the regular MEC meetings and may be held at any time as deemed necessary by the Medical or Hospital Directors. Attendance at these hearings is limited to the voting members of the Committee and the Hospital Director.
12. The Medical Executive Committee shall approve and annually review any outside Clinical Laboratory, Anatomical Pathology Laboratory, or any other outside clinical service. The Medical Executive Committee shall also approve and annually review all contracted Hospital

clinical services, taking into consideration performance, reliability, availability, and meeting contract specifications.

9.4 Standing Committees

A. Blood Usage Review Committee

The Blood Usage Function consists of quarterly reports and semi-annual committee meetings. The Performance Improvement findings are reported to QMC then, to the Medical Executive Committee. The Medical Director shall select the Chairperson of the committee.

The Committee shall:

- Consist of at least two (2) members of the Medical Staff, one of whom shall be a member of the Section of Pathology and other medical and hospital personnel as deemed necessary. The members of the committee shall be appointed by the medical director.
- A quorum shall consist of a representative of the Section of Pathology and a representative of the Medical Staff.
- Evaluate the appropriateness of all cases in which patients were administered blood or blood products, especially when administered when not indicated, not administered when indicated, or administered incorrectly.
- Evaluate all confirmed blood or blood product transfusion reactions or any adverse effect on patients.
- Develop and approve all policies and procedures relating to the distribution, handling, dispensing, use, and administration of blood and blood products.
- Review the adequacy of the transfusion service to meet the needs of the patients.
- Review the ordering practices for blood and blood products.
- Review policies relating to blood or blood product on an annual basis, or as needed.

The results of blood usage reviews and studies are used for practitioners and House Staff education, to maximize patient safety, to minimize waste of blood products, and to improve processes in the use of blood and blood products.

B. Clinical Research Committee

The Clinical Research committee shall meet at least quarterly and on an as needed basis to review all protocols involving Clinical Research in this facility. The Hospital Director or his/her designee shall be a member of this subcommittee.

The Institutional Review Board of the Ochsner Clinic Foundation or the Louisiana State University School of Medicine, New Orleans or both, as deemed necessary by the Governing Body, shall be consulted and approve any protocols prior to the implementation of any research protocol. Studies that are delivered to the committee with Central IRB approval may not need any additional approvals.

The committee shall report these recommendations to the Pharmacy and Therapeutics Committee and secure the recommendation of this Committee, if appropriate. The collective recommendations of these groups shall then be made known in writing to the Medical Executive Committee whose approval must be obtained prior to the commencement of any clinical research protocol.

All such protocols shall have a description of the potential discomforts and risks, a description of alternative services that might also prove advantageous to the patient, a full explanation of the procedures to be followed, and an assurance of the patient's right to refuse to participate in any research protocol.

C. Critical Care Committee

- The Critical Care Committee shall be composed of five (5) members of the Medical Staff, a representative of the Hospital Director, and other personnel as deemed necessary to function as a multidisciplinary committee.
- The Chairperson shall determine the voting members.
- The Committee shall meet at least quarterly and report their proceedings to the Quality Management Department and to the Medical Executive Committee.
- A quorum shall be defined as the presence of three (3) Medical Staff members and at least one member representing the Hospital.
- The Committee shall:
 - Recommend policies, procedures, rules, and/or regulations concerning the critically ill or injured. The areas of the Hospital that are most likely to care for these patients include the Intensive Care Unit (Medical, Surgical and Cardiac), The Emergency Department, the Post Anesthesia Recovery Unit, the Neonatal Intensive Care Unit and Cardiovascular Services including the Non-Invasive Imaging Laboratory and the Catheterization Laboratory.
 - Monitor the activities of the above Units or Departments.
 - Be responsible for the Performance Improvement activities on the critically ill and injured and report all recommendations to the Medical Executive Committee.
 - Ongoing review & analysis of codes.
 - Make recommendations relative to policies and procedures for the admission, ongoing care, and discharge of the critically ill and injured.
 - Make recommendations relative to the equipment needs, space needs, manpower needs, and other needs of the critically ill and injured.

D. General Medical Staff

The General Medical Staff shall consist of all the members of the Medical Staff. The Honorary and Consulting Staff, the House Staff, and Allied Health Professionals shall be non-voting members and are not entitled to hold office. It shall meet at least annually whenever necessary and maintain a permanent record of its proceedings. The Medical Director shall serve as Chairman. A quorum shall consist of no less than fifty (50) percent of the active, voting membership. It shall function as a body to receive and act on information from the Administrative Medical and Hospital Committees and provide information and recommendations to the Administrative Medical and Hospital Committees. Medical Staff Bylaws, Rules, and Regulations are adopted by the Medical Staff and approved by the Governing Body before becoming effective. Neither body may unilaterally amend the Medical Staff Bylaws, Rules, and Regulations. When necessary, the Medical Staff Bylaws, Rules, and Regulations are revised to reflect the hospital's current practices with respect to medical staff organization and functions. If significant changes are made in the Medical Staff Bylaws, Rules, and Regulations, or policies, Medical Staff members and other individuals who have delineated clinical privileges are provided with revised texts of the written materials. The Bylaws will be reviewed, and/or revised annually.

E. Graduate Medical Education Committee (GMEC)

The Graduate Medical Education Committee shall be comprised of the Designated Institutional Official (DIO), residents nominated by their peers, representative program directors, and administrators. It may also include other members of the faculty or other members as determined to represent all graduate medical education sponsor programs affiliated with the hospital. The Chair shall be the DIO and all members shall be voting members.

The GMEC must meet at least quarterly and maintain written minutes.

This Committee's responsibilities are to establish and implement policies and procedures regarding the quality of education and the work environment for the residents in all programs. These policies and procedures include:

1. Stipends and position allocation
2. Communication with program directors
3. Resident duty hours
4. Resident supervision
5. Communication with Medical Staff
6. Curriculum and evaluation
7. Resident status
8. Oversight of program accreditation
9. Management of institutional accreditation
10. Oversight of program changes
11. Experimentation and innovation
12. Oversight of reductions and closures
13. Vendor interactions

Internal Review

The GMEC shall develop, implement, and oversee the internal review process.

Library

The GMEC shall be responsible for the oversight of the Medical Library. The Committee shall periodically survey the Medical and Hospital Staff to determine their needs and report these findings to the Medical Executive Committee, via the GMEC Committee reports.

Continuing Medical Education

This committee will also function to oversee the continuing medical education of the Medical Staff.

F. Infection Prevention and Control Committee

- The Infection Control Committee shall consist of at least four (4) members of the Attending Staff, a representative of the Hospital Director, the Hospital Infection Control Coordinator, and other Hospital personnel that are deemed necessary.
- The committee shall meet at least nine (9) times per year and submit to the Quality Management Department and the Medical Executive Committee a report of its activities in writing to be made part of the permanent record.
- A quorum is defined as at least two (2) physician members and the Infection Control Coordinator.
- Only the Medical Staff members are entitled to vote, unless the Chairperson of the committee deems otherwise.
- The Performance Improvement Function of the committee shall be to survey, prevent, and control and thereby reduce the risks of acquiring and transmitting infections among patients, employees, physicians and other health care workers, contract service workers, volunteers, students, and visitors. The infection control process shall be based on sound epidemiological principles. The process shall take into consideration the Hospital's geographic location, patient volume, population served, the Hospital's clinical focus, and the number of employees. Specific monitoring of device-related infections, surgical post-operative infections, nosocomial infections, infections due to antibiotic-resistant microorganisms, tuberculosis, vaccine-preventable diseases, and other infections reportable to the Center for Disease Control, the State Department of Public Health, and infections in the neonate. The committee shall devise strategies to ensure appropriate follow-up of patients with and others exposed to communicable diseases. The committee shall recommend action in cases of outbreaks of nosocomial infection. The committee shall oversee the sterilization and disinfections techniques and procedures in the Hospital and outpatient areas. The committee shall be responsible for the oversight of Hospital Employee and Medical Staff Health and related matters, especially preventive health and communicable diseases.

G. Pharmacy and Therapeutics Committee

- The Pharmacy and Therapeutics (P&T) Committee shall be composed of four (4) members of the Medical Staff, a representative of the Hospital Director, the Director of Pharmacy Services in the Hospital, and other personnel as deemed necessary in order to form a multidisciplinary Committee.
- The Committee Chairperson shall determine the voting members.
- The Committee shall meet at least quarterly and more often as deemed necessary and report their proceedings and performance improvement activities to the Quality Management Department and to the Medical Executive Committee.
- A quorum shall be present when two (2) Medical Staff members and the Director of the Hospital Pharmacy, or his/her representative, are present.
- The Committee shall:
 - Have a mechanism in place to assure the safe use of medications. This shall include the prescribing and ordering of medications, preparing and dispensing of medications, the administration of medications, the monitoring of the effects of medications, and insure safe storage, handling, and control of medications.
 - Review and evaluate drug usage.
 - Review the appropriateness of empirical and therapeutic use of drugs through the analysis of individual and/or aggregate patterns of practice.
 - Review and approve policies relating to the selection, distribution, use, and administration of drugs and diagnostic testing materials and devices, where appropriate.
 - Review all significant untoward drug reactions.
 - Maintain and periodically review the Hospital formulary.
 - Review, evaluate, and recommend approval of clinical research protocols concerned with the use of investigational or experimental drugs or devices, where appropriate.

H. Quality Management Council, including Patient Safety

The Quality Management Council shall be composed of the Hospital Director, the Director of Nurses, the Hospital Quality Management Director, the Director of Hospital Support Services, the Director of Hospital Rehabilitative Services, the Director of Human Resources, the Medical Director, the Associate Medical Director, Chief Academic Officer, the Standing Medical Staff Committee Chairmen, and Residents selected by their Program Director.

Data from Performance Activities, all Standing Medical Staff and Hospital Committees, and hospital departments is sent to the Quality Management Council, which reports to the Medical Executive Committee and Governing Body.

Sensitive or confidential information regarding Medical Staff member(s) shall be forwarded from the Quality Management Department directly to the Medical Executive Committee.

This collaborative effort ensures implementation of processes to measure, assess, and improve the performance of the hospital's governance, management, clinical, and support processes.

The hospital Patient Safety Program to improve safety and reduce risks to patients/visitors/employees through an environment that encourages recognition, reporting and acknowledgement of risks to patient/visitor and employee safety and medical /health care failures; that focuses on processes and systems; and promotes non-punitive environment for reporting and follow-up on medical failures, is included in the performance improvement data reported by the Quality Management Council.

I. Utilization Management/HIM Committee

- The Utilization Management/HIM Committee shall be composed of three (3) members of the Medical Staff, and assisted by other disciplines as appropriate. At a minimum,

the membership will include the Utilization Management Coordinator, Director of Health Information Management, and the Hospital Administrator, as well as representatives from Nursing, Fiscal, Social Services and Admissions. Other personnel will be included as deemed necessary to carry out the functions of this Committee.

- The Committee shall meet at least quarterly.
- A quorum shall consist of two (2) members of the Medical Staff and the Hospital Director, or his/her representative, are in attendance.
- The Committee will meet as needed, at least quarterly and submit to the Quality Management Council/Medical Executive Committee a report of its activities.
- The Committee Chairperson shall determine the voting members.
- The Committee shall:
 - Insure that the medical records are sufficiently complete at all times as to facilitate continuity of care and communication between all those providing patient care services in the Hospital and ambulatory care areas.
 - Insure that the medical records meet the standards of patient care usefulness and are of the historical validity required by the Medical Staff and by acknowledged authorities including, but not limited to, the Joint Commission, CMS, etc.
 - Insure that the medical records are adequate in form and content to permit patient care audit and other quality maintenance activities to be performed.
 - Review Medical Staff and Hospital policies, rules, and regulations relating to medical records completion, filing, indexing, storage, retention, availability, and recommend methods of enforcement thereof and changes thereto.
 - Shall assess the necessity of admissions, appropriate use of resources, need for continued stay and timeliness of discharge planning. In addition, it will focus on those diagnoses, departments, procedures, and/or practitioners with identified or suspected utilization problems.
 - The committee will have the authority to review medical records and other pertinent information for a thorough review. The Committee shall use the LSU HCSD and Hospital's Utilization Management Plan as a guide for their proceedings
 - This Committee shall participate in performance improvement activities to ensure compliance with stated objectives

9.5 Ad Hoc Committees

A. Ethics Committee

Unresolved ethical conflict or ethical issues will be referred to the Medical Executive Committee via the Medical Director or his designee to facilitate the oversight and direction of the facility.

- The Medical Executive Committee shall review the alleged ethical issue, and if found to be valid, shall convene the ad hoc Ethics Committee.
- This Committee shall exist only for a specific ethical issue and shall consist of representatives of the voting members of the Medical Executive Committee, the Hospital Director, and other personnel as deemed necessary by the Medical Executive Committee. These may include, but not be limited to, a representative(s) of the Governing Body, the appropriate Hospital personnel and other Medical Staff members, member(s) of the Clergy, a patient and /or the patient's family, legal counsel for the Hospital, social worker, and/or an ethicist.

- All members of the Committee shall consider the use of the publication by the American Medical Association, Code of Medical Ethics, and Current Opinions with Annotations (the current edition) as a guide in their deliberations.
- The Committee shall render a recommendation on a specific ethical issue to the person or entity requesting the determination. Should legal action be required, the Governing Body shall be so notified and their decision to proceed is final.

B. Hearing Committee

(See Article 6)

C. Other

Other ad hoc committees may be convened under the direction of the Medical Director as needed.

ARTICLE TEN
MEDICAL STAFF MEETINGS AND THEIR CONDUCT

General Medical Staff meetings and other Medical Staff Committee meetings shall be held in their defined frequency, by the defined membership, and with the quorum defined by each committee. The Medical Director in consultation with the appropriate Chairperson shall determine their location and time.

The Medical Director shall call special meetings of the Medical Staff, General Medical Staff, or other Medical Staff Committees when necessary. Five (5) members of the Attending Medical Staff may also petition the Medical Director for a special meeting of the Medical Staff or selected Medical Staff members on a single issue. Due notice of each special meeting shall be given not less than forty eight (48) hours or two (2) working days in advance. At any special meeting, no business shall be transacted except that stated in the notice.

Teaching Conferences are not considered as special meetings and may be held at intervals deemed appropriate by the Medical Director, the appropriate Chief of Service, or the Continuing Medical Education Committee. Honorary and Consulting Staff are invited and encouraged to participate in Teaching Conferences.

Attendance of the Medical Staff, who are required to attend meetings, are expected to attend at least fifty (50) percent of the regularly scheduled and special called meetings of the various committees of the Medical Staff. Attendance at less than fifty (50) percent of the Medical Staff Committee meetings, without legitimate excuse, shall be grounds for disciplinary action, including the member's removal from the committee in question and may be a negative factor in consideration for appointment or reappointment to the Medical Staff.

The Agenda of any regular meeting of the Medical Staff or its committees shall be:

- 1.) Call to order
- 2.) Determination of attendance and quorum status
- 3.) Reading, Accepting, and/or Correcting of Prior Committee Minutes
- 4.) Unfinished Business
- 5.) Presentation of Performance Improvement Activities
- 6.) Communications
- 7.) New Business
- 8.) Announcements
- 9.) Adjournment

Any unresolved issue concerning procedure or process or point(s) of order are resolved according to Robert's Rules of Order, Newly Revised 1990 Edition, notwithstanding any contrary notation in statute or these Bylaws, Rules, and Regulations.

ARTICLE ELEVEN

ADOPTION AND AMENDMENT OF THESE BYLAWS

These Bylaws may be adopted or amended at any meeting of the General Medical Staff and shall replace any previous Bylaws and shall become effective when approved by the Medical Staff, the Medical Director on behalf of the Medical Staff, the Hospital Director, and the Governing Body. The Bylaws, when approved shall be equally binding on the Medical Staff, the Medical Director, and the Governing Body. Neither body may unilaterally amend the bylaws. These Bylaws shall be reviewed not less than annually and approved not less than annually by the Medical Staff and the Governing Body.

ARTICLE TWELVE

CREATION, ADOPTION, AND AMENDMENT OF THE RULES AND REGULATIONS

There is hereby created that section of this document that shall be known as the Rules and Regulations section of the Medical Staff Bylaws. The Attending Staff shall adopt from time to time such rules and regulations not inconsistent with these Bylaws as may be necessary for the proper conduct of its work.

These Rules and Regulations may be revised, amended, or added to at any meeting of the General Medical Staff without prior notice on a two thirds (2/3) vote of the voting members present but in no case, less than fifty (50) percent of the voting members of the Medical Staff. Such Rules and Regulations and amendments thereto shall become effective when approved by the Hospital Director, and the Governing Body. Such amended and approved Rules and Regulations shall replace any previous Rules and Regulations. When approved, these Rules and Regulations are equally binding on the Medical Staff, the Hospital Director, and the Governing Body. These Rules and Regulations shall be reviewed and approved annually by the Medical Staff and the Governing Body.

RULES AND REGULATIONS

General Staff Conduct

Quality patient care is the first priority of the organization. The challenge to the physicians is to balance patient expectations, patient needs, and available resources to achieve patient satisfaction and safe quality care.

Medical staff members shall sign a statement that they have read and agree to abide by these Medical Staff Bylaws, Rules, and Regulations, Policies and Procedures and by the current Hospital Policies that apply to their activities as medical staff members that are consistent with these Bylaws, Rules, and Regulations.

The Medical Staff Bylaws, Rules, and Regulations are made available to all medical staff members on the LSU HCSD website <http://www.lsuhs hospitals.org/Hospitals/LJC/LJC-directory.htm> Each medical staff member shall sign an agreement to abide by them. Failure to do so within thirty (30) days from the time that they are received shall result in loss of Clinical Privileges.

The Medical Staff shall take a leadership role in Performance Improvement Activities.

A medical staff member shall be free to choose whom to associate with and whom to provide medical services to in non-emergency cases as long as the decision is not based on age, sex, race, religion, national origin, handicap, financial or veteran status.

A variance is any event or circumstance not consistent with the standard routine operations of the hospital and its staff or the routine care of a patient/visitor. The person identifying the event shall be responsible initiating the Incident or Patient Safety Occurrence Form prior to the end of their scheduled shift.

The **ACGME Core Competencies** for Residents will also apply to the Medical Staff.

1. **Patient Care** – must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health
2. **Medical Knowledge** – must demonstrate knowledge about established and evolving biomedical, clinical, and cognitive sciences and the application of this knowledge to patient care
3. **Practice Based Learning and Improvement** – must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices

4. **Interpersonal and Communication Skills** – must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients' families, and professional associates
5. **Professionalism** – must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population
6. **Systems Based Practice** – must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value

The following Physician Attributes and Educational Objectives serve as a core for Graduate Medical Education at LJCMC and therefore are also applicable to the Medical Staff.

Physicians must be:

Altruistic

1. Knowledge of the theories and principles that govern ethical decision-making, and of the major ethical dilemmas in medicine, particularly those that arise at the beginning and the end of life and those that arise from the rapid expansion of knowledge of genetics.
2. Compassionate treatment of patients, and respect for their privacy and dignity.
3. Honesty and integrity in all interactions with patients' families, colleagues, and others whom physicians interact in their professional lives.
4. An understanding of, and respect for, the roles of other health care professionals, and the need to collaborate with others in caring for individual patients and in promotion health of defined populations.
5. A commitment to advocate at all times the interest of one's patient over one's own interest.
6. An understanding of the threats to medical professionalism posed by the conflicts of interest in various financial and organizational arrangements for the practice of medicine.
7. The capacity to recognize and accept limitations in one's knowledge and clinical skills, and a commitment to continuously improve one's knowledge and ability.

Knowledgeable

1. Knowledge of the normal structure and function of the body (as an intact organism) and each of its major organ systems.
2. Knowledge of the molecular, biochemical, and cellular mechanisms that is important in maintaining the body's homeostasis.
3. Knowledge of the various causes (genetic, developmental, metabolic, microbiologic, autoimmune, neoplastic, degenerative, and traumatic) of maladies and the ways in which they operate on the body (pathogenesis).
4. Knowledge of the altered structure and function (pathology and pathophysiology) of the body and its major organ systems that are seen in various disease and conditions.
5. An understanding of the power of the scientific method in establishing the causation of the disease efficacy of traditional and nontraditional therapies.
6. An understanding to engage in lifelong learning to stay abreast of relevant scientific advances, especially in the disciplines of genetics and molecular biology.

Skillful

1. The ability to obtain an accurate history that covers all essentials of the history, including issues related to age, gender, and socioeconomic status.
2. The ability to perform both a complete and organ system specific examination, including a mental status examination.
3. The ability to perform routine technical procedures including, at a minimum, venipuncture, inserting an intravenous catheter, arterial puncture, inserting a nasogastric tube, inserting a Foley catheter and suturing lacerations.
4. The ability to interpret results from commonly used diagnostic procedures.
5. Knowledge of the most frequent clinical, laboratory, roentgen logic, and pathologic manifestations of common maladies.
6. The ability to reason deductively in solving clinical problems.

7. The ability to construct appropriate management strategies (both diagnostic and therapeutic) for patients with common conditions, both acute and chronic, including medical, surgical and psychiatric conditions and those requiring short and long-term rehabilitation.
8. The ability to recognize patients with immediately life threatening cardiac, pulmonary, or neurological conditions regardless of etiology and to institute appropriate initial therapy.
9. The ability to recognize and outline an initial course of management for patients with serious conditions that require critical care.
10. Knowledge about relieving pain and ameliorating the suffering of patients.
11. The ability to communicate effectively, both orally and in writing, with patients, patients' families, colleagues, and others with whom physicians must exchange information in fulfilling their responsibilities.

Dutiful

1. Knowledge of the non-biological determinants of poor health and of the economic, psychological, and social, and cultural factors that contribute to the development and/or continuation of maladies.
2. Knowledge of the epidemiology of common maladies within a defined population, and the systematic approaches useful in reducing the incidence and prevalence of those maladies.
3. The ability to identify factors that place individuals at risk for disease or injury, to select appropriate tests for disease or injury, to select appropriate tests for detecting patients at risk for specific diseases or in the early stage, and to determine strategies for responding appropriately.
4. The ability to retrieve (from electronic databases and other resources), manage, and use biomedical information for solving problems and making decisions that are relevant to the care of the individuals and populations
5. Knowledge of the various approaches to the organization, financing, and delivery of health care.
6. A commitment to provide care to patients who are unable to pay and to advocate for access to health care for members of traditionally undeserved populations

2. Emergency Staff Actions

In the case of an emergency, any Medical Staff member shall be permitted to institute measures to save a patient's life or to save a patient from serious harm, regardless of Medical Staff status or Clinical Privileges as long as the care that is provided is within the scope of the individual's license to practice. In so acting, the Medical Staff member is obligated to summon all available consultative aid deemed necessary. Properly supervised House Staff may also provide such care.

3. Teaching and House Staff Concerns

In keeping with the role of the Hospital as a teaching hospital, all Services shall be teaching Services. Those Services may be composed on one (1) or more House Staff and one (1) or more Academic Staff members, who serve in a responsible, supervisory role. House Staff may write orders without co-signature by the supervising physicians. In the spirit of Graduate Medical Education, independent thinking and decision-making is strongly encouraged but closely monitored and supervised. For example, House Staff are expected to round on their assigned patients and create daily progress notes documenting their findings and concerns. The Academic Staff also perform daily rounds in the presence of their assigned House Staff. This interaction allows for an atmosphere of discovery, learning, and discussion of medical problems and treatment strategies. Through this arrangement, the Academic Staff maintains responsibility for the supervision of the medical care provided by the House Staff while allowing for successful medical education without compromising patient care. Please refer to hospital policy "Resident Supervision and Scope of Practice". The management of each patient's care, treatment, and services (including patients under the care of participants in professional graduate education programs) is the responsibility of a licensed independent practitioner with appropriate clinical privileges.

4. Admission Criteria

Patients are admitted to the hospital as an inpatient or accepted for observation services or ambulatory care procedures only on the recommendation and order of a qualified member of the Medical Staff who has been granted admitting privileges.

The admit order must specify the type: (1) Observation, (2) Outpatient Surgery, or (3) Inpatient based on the current medical condition of the patient.

A change in Admission Type requires a new order.

Except in emergencies, no patient shall be admitted to the hospital until a provisional diagnosis had been stated. In the case of emergencies, the provisional diagnosis shall be stated as soon as possible after admission, but in no case, more than twenty-four (24) hours after admission.

The Medical Staff member shall be responsible at the time of admission for providing to the Nursing Supervisor, Security, and/or other appropriate personnel such information as may be necessary to enable the hospital to protect the patient from self-harm and to protect other patients, staff and visitors from possible sources of danger.

It shall be the responsibility of the Medical Staff member to report all cases of reportable communicable diseases to the Infection Control Department in accordance with Title 51 of the Public Health Sanitary Code and Hospital Infection Control Policies and Procedures.

The section of the medical record known as the History and Physical Examination shall contain patient identifying data, chief complaint, history of the present illness, the past medical and surgical history (including any known allergies or adverse reactions to any substances and present medications or therapies), review of symptoms, the recording of the findings of the physical examination, the initial impression or assessment, and the diagnostic and treatment plan, and may include the social and family histories. This section of the medical record shall be completed within twenty-four (24) hours after admission to the Hospital.

If a History and Physical Examination was performed within thirty (30) days prior to admission, a durable and legible copy of this report may be used in the patient's medical record, that an updated medical record entry documenting an examination for any changes in the patient's condition is completed. This updated examination must be completed and documented within the patient's medical record within 24 hours after admission (Centers for Medicare and Medicaid Services), but prior to surgery (Joint Commission), except in the case of an emergency.

The History and Physical for non-inpatient services shall include: chief complaint and history of present illness, physical exam and plan of care. Outpatient clinic records qualify for H&P however, if the history and physical was performed greater than thirty (30) days prior to the non-inpatient service a new H&P must be written.

Dentists are responsible for that part of the History and Physical Examination that relates to Dentistry within his/her scope of practice and licensure.

In the case of a preoperative evaluation, a qualified physician shall provide the History and Physical Examination.

Qualified Oral and Maxillofacial Surgeons may perform History and Physical Examinations in order to assess medical, surgical, and anesthetic risk.

5. Medical Records

The **attending physician** shall be held **responsible** for the preparation of a medical record for each patient and for having the **entire record completed within thirty (30) days** from the date of the patient's discharge from the Hospital. All chart entries must be **written clearly**.

Unless otherwise stated in these Rules and Regulations, the content, form, nomenclature, permitted abbreviations, and timeliness requirements of all portions of and entries in the patient's medical record shall be as stated in the Hospital's Policies and Procedures governing medical records.

All entries must be legible, timed, dated and authenticated, including review and electronic signature by the individual making the entry (CMS).

Medical student entries must include identification of student status and be counter-signed by a licensed supervising physician

A list of unapproved abbreviations has been approved by the Medical Staff. Use of not approved abbreviations has the potential to negatively impact patient care. The physician will be contacted if the order's intention is unclear.

Medical records of patients that involve sensitive or confidential issues shall be segregated in the office of the Hospital Director.

The Medical Records and Medical Executive Committees shall file no medical record until it is complete, except in exceptional circumstances and then only after approval.

In the event that a Medical Staff member fails to complete a medical record in a timely manner, and the Medical Staff member is no longer residing in the area or is otherwise incapacitated, the medical record shall be completed by the appropriate Chief of Service, if possible, or referred to the Medical Records Committee to be filed as incomplete, with the approval of the Medical Executive Committee. In the case of the Medical Staff member's leaving the area, any inquiries regarding application for Medical Staff appointment or delineation of Clinical Privileges at another Hospital or institution shall reflect the Medical Staff member's disregard of these Bylaws, Rules, and Regulations, if failure to complete the Medical Record was in his/her control.

In the event that a House Staff member fails to complete a medical record in a timely manner, that medical record shall be completed by his/her supervising Academic Staff member and a letter to the sponsoring Graduate Medical Education program will be sent giving notification of the House Staff member's failure to comply with the Medical Staff Bylaws, Rules, and Regulations.

In the event a Medical Staff member fails to complete a medical record in a timely manner, notification shall be given to the Medical Staff member, the Medical and Hospital Directors of the delinquency. Perpetual delinquency in the preparation and timely completion of the medical record shall be taken into consideration in the determination reappointment to the Medical Staff.

Entries in the medical record may be made by a medical, nursing, or other allied health student (if properly cosigned by the appropriate supervisor), House Staff and Medical Staff members, licensed nurses, licensed physician extenders, licensed dietitians, social workers, pharmacists, respiratory, speech, physical, and occupational therapists, laboratory and other allied health technicians, and clergy (after appropriate orientation). All medical record entries are dated, timed and authenticated and their authors are identified.

Any patient admitted for behavioral health services shall have a legal status and an authorized representative identified at the time of admission if possible but in no case more that twenty four (24) hours after admission. Information pertaining to the State Mental Health Advocacy Service is provided on admission to the unit.

Advanced Directives should be identified on admission and will be a part of the patient's permanent medical record. Physician shall assist patients in making decisions about advanced directives by

providing information to make an informed decision, review advance directives and record review in the medical record.

The Medical Staff shall assist the Hospital in its efforts to maintain individual medical records and to keep such records confidential, secure, and complete. All original medical records, including radiology films, are the property of the Hospital and shall not be taken from the campus except by court order, statute, or subpoena. Copies of the medical record may be released from the Hospital only with the permission of the patient.

All final, established diagnoses shall be recorded in the discharge summary.

A final progress note is substituted for the discharge summary only for those patients with problems or interventions of a minor nature who require less than a forty eight (48) hour period of hospitalization, including observation and admission hours, and in the case of normal newborn infants and uncomplicated obstetric deliveries, seventy two (72) hours. Normal newborns that remain hospitalized due to mothers extended stay require only a final progress note.

A transfer summary may be substituted for the discharge summary in the case of the transfer of a patient to another facility for a different level of care.

Operative Procedures and Dictation

A qualified Licensed Independent Practitioner, within their scope of clinical practice and licensure records a preoperative diagnosis and a pre-anesthesia evaluation prior to surgery.

Operative reports are **dictated or written** in the medical record **immediately** after surgery. The names of the primary surgeon and any assistants, a description of the findings at the time of surgery, the technical procedure(s) used, and the specimens removed, estimated blood loss and the postoperative diagnosis shall be reported.

The responsibility for having tissue reviewed by a Pathologist lies with the Attending Surgeon. A Pathologist must examine all tissues or specimens removed at the time of surgery.

A **Brief Operative Note** shall be **written immediately** after the surgery and placed in the medical record.

A detailed Operative Report is dictated on the day of surgery, authenticated by the surgeon, and filed in the medical record as soon as possible following the surgery. This applies to outpatients as well as inpatients, including organ or tissue donors and recipients.

Postoperative documentation records the patient's vital signs, level of consciousness, medications (including intravenous fluids, blood, or blood products), any unusual events or postoperative complications, and the management of such events. Postoperative documentation records the patient's discharge from the post-anesthesia care by a responsible Licensed Independent Practitioner or according to discharge criteria.

Ambulatory Care Record

For patients receiving continuing ambulatory care services, the medical record shall contain a summary list initiated for each patient by the third visit to the Ambulatory Care areas and shall be maintained thereafter and include:

- Significant diagnoses, conditions, pain
- Significant operative and invasive procedures
- Adverse or allergic drug or food reactions
- Medication prescribed or used by the patient

Emergency, Urgent, or Immediate Care Records

- Notes the time and means of arrival
- Notes when a patient leaves against medical advice
- Notes the conclusions at termination of treatment, including final disposition, condition at discharge, and instructions for follow-up care
- A copy of the Emergency Services provided is available to the practitioner or medical organization providing follow-up care.
- Notes any medical care delivered prior to arrival in the Emergency Department.

6. Morbidity and Mortality Review

All Hospital deaths are reviewed and classified. The Chief of the appropriate Service reviews deaths that are unexpected. These reports are forwarded to the Medical Executive Committee for review. These reports from the Chief of the appropriate Section are to include unusual complications on their services in association with the mortality review.

7. Informed Consent

The practitioner planning to perform the procedure must obtain the consent of the patient or his/her legal representative for diagnostic and therapeutic procedures. Informed Consent implies an understanding by the patient of the procedure anticipated, the reason the procedure is recommended, the degree of debility which may be reasonably expected to ensue, the benefits which may reasonably be expected, the risks and benefits of not having the procedure, and alternative procedures and their risks and benefits. The practitioner in the medical record shall document information about the patient's counseling.

If, by using all reasonable means available, the legal representative cannot be located and the patient's condition precludes his/her ability to give informed consent, Two LIPs shall have the authority to give consent to surgery or potentially hazardous diagnostic or therapeutic procedures on behalf of the patient. Both LIPs must sign the consent and document the nature of the emergency in the patient's progress notes.

(Refer to Act 648 of 1995, LA R.S. 40: 1299.40)

Release consent must be signed before photography, video, audio, or cinematography recording shall be done by anyone.

8. Anesthesia Evaluations

A **pre-anesthesia assessment** is performed for each patient before anesthesia induction. The patient is **reevaluated immediately before anesthesia induction**. A written **post-anesthesia evaluation** shall be performed and recorded in the patient's medical record. A post-anesthesia visit shall be made and at least one written progress note describing the presence or absence of anesthesia-related complications shall be recorded in the patient's medical record. Except for outpatient surgical patients, this post-anesthesia visit shall be made after the patient has been transferred from the Post Anesthesia Recovery Unit or area.

9. Automatic Cancellation Orders

All previous orders are automatically canceled when a patient goes to surgery or is transferred to another service. Orders must be rewritten legibly and completely. The use of the terms "Renew, Repeat, or Continue" previous orders are not acceptable and will not be performed until confirmed and rewritten by the prescribing physician.

10. Automatic Stop Orders

The Medical Staff and the Pharmacy and Therapeutics Committee of the Hospital have adopted a stop order policy on the following class of medications: Antibiotic- 5 days; Oxytocics -3 days; Anticoagulants-7 days; Steroids -10 days

11. Verbal Orders for Treatment

Verbal orders are considered potentially hazardous to the patient and must be ***dated, timed and authenticated*** by the ordering practitioner or another practitioner who is responsible for the care of the patient **within forty-eight (48) hours**. The receiver ***reads*** verbal ***orders back*** for ***verification***.

All orders for treatment shall be in writing. An order shall be considered to be in writing if dictated to a licensed nurse, dietitian, pharmacist, respiratory, occupational, speech, or physical therapist and, with the exception of the licensed nurse, shall be limited to their specific area.

12. Verbal Admission and Discharge Orders

No verbal or verbal phone orders shall be accepted for patient admissions to any Nursing Care area(s) of the Hospital.

An Attending Staff physician may give verbal orders to a licensed nurse until such time as he/she is available to provide such written orders, if circumstances occur where the Attending Staff physician is admitting the patient and is temporarily unable to provide written orders. In no instance shall the time frame be greater than twelve (12) hours. Under these circumstances, the Attending Staff physician must complete the Admit Authorization Form and the condition of the patient must be stable enough as to permit a delay in the writing of orders. This provision does not apply to any patient admitted to the Intensive Care or other Critical Care Units of the Hospital.

Verbal discharge orders are permitted as long as all discharge criteria have been met.

13. Orders for Rehabilitative Services

The referring physician must sign all orders for rehabilitative services.

14. Restraint and Seclusion Orders

Restraint use within the hospital is limited to those situations with adequate, appropriate clinical justification. A restraint is defined as use of any object or device that voluntarily restricts the patient's movement and access to his/her body. This is a functional definition and is not based on the device used. A drug used, as a restraint is a medication used to control behavior or to restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition. The Medical Staff adheres to hospital policies and procedures regarding restraints.

15. Radiology and Other Reports

The practitioner making the interpretation must sign all reports of radiology and other reports related to diagnostic evaluations.

16. Laboratory Services

Standing orders to receive a multi-channeled chemical analysis of his/her blood for baseline and the ongoing monitoring of Total Parental Nutrition shall be automatically performed every three (3) days on patients over ninety (90) days of age.

As far as practical, the Hospital shall provide laboratory services to do necessary laboratory examinations.

17. Consultations for Inpatients

Consultations from the appropriate specialty practitioner may be initiated on any and all patients.

When initiated, a Consultation Form should be completed and placed on the front of the patient's medical record (chart). The consulting practitioner is responsible for notifying the consultant.

All Pediatric patients admitted to the Intensive Care Unit require a Pediatric consultation.

Written consultations with another qualified practitioner shall be obtained in all cases in which, according to the judgment of the Attending Physician, 1) the patient is not a good surgical risk; 2) the diagnosis is obscure; 3) there is doubt as to the best therapeutic means to be utilized; 4) a second opinion is requested by the patient, family, referring physician, payer, or governmental agency.

The consultant shall record his/her findings and recommendations in the medical record on the Consultation Form. This form shall be signed and dated by the consultant.

Emergency consultations shall be answered upon receipt of the request, either verbal or written. Urgent consultations should be **answered within twenty four (24) hours** of the receipt of the request, either verbal or written. **Routine consultations** should be **answered within forty eight (48) hours** of the receipt, either verbal or written, unless the requesting practitioner feels the consultation is less urgent.

18. Discharge of Patients from the Hospital

Patients shall be discharged from the Hospital only by order of a physician. If a patient chooses to leave against the advice of the physician, the physician shall document this in the patient's medical record. An AMA form should be completed and signed by the patient. If the patient refuses to sign the AMA form, the physician shall complete his/her portion of the form and indicate that the patient refused to sign.

To discharge patients effectively, efficiently and to allow for optimal utilization of resources, patient discharges shall occur by twelve noon.

19. Ethical Conflicts and Issues

Unresolved ethical conflict or ethical issues will be referred to the Medical Executive Committee via the Medical Director or his designee to facilitate the oversight and direction of the facility. The Medical Executive Committee shall review the alleged ethical issue, and if found to be valid, shall convene the ad hoc Ethics Committee.

The Medical Director or the Hospital Director or their designees shall be notified when urgent ethical issues or urgent conflict resolution is necessary and cannot be resolve at a staff level. Either person may assemble or consult with the necessary individuals in a multidisciplinary framework to promote a resolution to the matter at hand.

20. Interdisciplinary Treatment Plans

Physicians and other qualified licensed practitioners shall participate in their appropriate interdisciplinary treatment plans for the patient's continuum of care during pre-admission, during admission, while hospitalized, prior to discharge, and at discharge to insure appropriate follow up care.

21. Comparable Quality of Patient Care

Patients are entitled to receive a comparable level of care for the same condition regardless of which appropriate Service renders that care, regardless of which qualified practitioner provides that care, or regardless of the appropriate setting in which that care occurs. This comparability of the

quality of patient care may be quantified via Performance Improvement activities of the appropriate Services and be achieved by the standardization of the delineation of Clinical Privileges by the appropriate Services, as well as by other means.

22. Transfer of Patients

The transfer of a patient from the Emergency Department to another facility or organization is based on the patient's assessed needs by the appropriate health care practitioner, is conducted according to the established policies and procedures of the Hospital and the Emergency Department, and is carried out with the patient's or legal representative's informed consent.

Inter-facility transfer of patients requires a patient transfer and/or referral record, as well as those documents addressed in the Hospital transfer policy. A physician-to-physician conversation regarding the transfer should occur when possible.

Transfer of patients between units of the Hospital requires a written transfer summary. If a change of Service is involved, a physician-to-physician conversation regarding the transfer should occur when possible.

23. Practice Guidelines

Practice guidelines may be created and implemented by the appropriate Clinical Service(s), with approval of the appropriate Chief of Service and others as appropriate.

24. Malpractice Insurance

"Malpractice Insurance" is provided to the Medical Staff by the State of Louisiana under Act 786 (R.S. 40: 1299.39) of 1988. Under this provision, the Medical Staff member is not guaranteed a review before a Malpractice Review Panel, as the State of Louisiana does not participate in the Patient Compensation Fund. This "Malpractice Insurance" applies only to care rendered in the Hospital or Hospital affiliated facilities.

25. Professional Liability Reporting

Each Medical Staff member is required to report involvement in any professional liability action to the Medical Director and Hospital Director.

26. Moderate Sedation

Each Medical Staff member must be so privileged to administer moderate sedation. The Chief of Anesthesiology or his designee will evaluate competency. The Hospital Policy outlining management of patients receiving moderate sedation shall be followed.

27. Pain Management

The Medical Staff plans, supports, and coordinates activities and resources to assure the pain of all individuals is recognized and addressed appropriately.

28. Safety

The hospital is a smoke free facility. No medical staff may smoke in the institution.

All approved safety policies and procedures in the hospital Environment of Care Manual shall be followed.

The Medical Staff will adhere to all policies and procedures related to Joint Commission National Patient Safety Goals and Joint Commission Sentinel Alerts.

The introduction or possession of weapons on state property is prohibited. Weapons include, but are not limited to firearms, explosives, knives with blades six or more inches in length, and straight razors.

29. Infection Control

The Infection Control Blood borne Pathogen Control Plan, Isolation Guidelines, and TB Control Plan shall be followed. Observed infractions shall be called to the attention of the offender.

30. Organ Donations

To obtain organs for transplantation and maintain confidentiality for donor/recipient information, the Louisiana Organ Procurement Agency Organ Donation policy shall be followed.

31. AJCC Staging Forms

The managing physician shall complete American Joint Committee on Cancer (AJCC) cancer staging forms. The staging form will be attached to the pathology report in the lab section of the chart. AJCC staging manuals are available in all clinic areas if further clarification is necessary. The purpose of proper classification and staging cancer is to allow physicians to determine treatment more appropriately, to evaluate results, and to compare worldwide statistics on a local, regional, and national basis more confidently.

32. Outcomes of Care

Physicians are responsible for determining the need to recall patients for further examination or treatment as a result of missed appointments for high risk diagnosis and/or abnormal test results.

The licensed independent practitioner or his or her designee informs the patient and when appropriate, the patient's family about these outcomes of care, including unanticipated outcomes.

33. Conflict Resolution

Abide by hospital policies, following the chain of command.

34. Medical Screening Examination

Appropriate medical screening will be provided by a licensed independent practitioner or other qualified professional with the appropriate clinical privileges to all individuals seeking emergency services to determine the presence or absence of an emergency medical condition.

35. Complaints

Physician related Patient Complaints shall be analyzed and responded to on an individual basis.

36. Medication Management

Sample medications are stored, controlled and distributed in accordance with federal and state guidelines and hospital policies and procedures.

All hospital medication management policies and procedures shall be followed.

37. Abortions

Per Louisiana RS 40:1299.34.5, specifically and expressly forbid the performance of an abortion in a state health care facility other than to prevent the death of the mother or in cases of rape or incest.

38. Drug Testing

Medical Staff will adhere to the LSUHCS and hospital policy and procedures regarding drug testing.

38. Rules of Conduct

Medical Staff will adhere to the hospital policy and procedures regarding the Rules of Conduct.

39. Compliance Program

Medical Staff shall follow the LSUHCS and hospital policies and procedures regarding the Compliance Program.

Signature copy kept in Medical Directors Office