

UF HEALTH SHANDS HOSPITAL
MEDICAL STAFF BYLAWS

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Board of Directors, Effective

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MEDICAL STAFF BYLAWS

DEFINITIONS

1. “Administrator”: the Chief Executive Officer of (“UF Health Shands Hospital”)
2. “Allied Health Professional”: a non-physician health practitioner who is granted clinical privileges in accordance with the Allied Health Policy on Clinical Privileges.
3. “Attending”: any Medical Staff member primarily responsible for the patient or for a particular aspect of the patient’s care.
4. “Board”: the Board of Directors, or the appropriate Committee of the Board, of UF Health Shands.
5. “Board Certification”: certification by the appropriate specialty board(s), as set forth in the Medical Staff Bylaws.
6. “Chief Executive Officer” or “CEO”: the Chief Executive Officer of UF Health Shands.
7. “Chief of Staff” or “COS”: An officer of the Medical Staff and Chair of the Medical Executive Committee.
8. “Days”: calendar days, unless otherwise specified.
9. “Ex-officio”: a non-voting member of a committee appointed by virtue of his/her office.
10. “Hospital”: all parts recognized as part of UF Health Shands by CMS, including, UF Health Shands Hospital, UF Health Shands Cancer Hospital, UF Health Shands Rehab Hospital, UF Health Shands Psychiatric Hospital, UF Health Shands Heart & Vascular Hospital, UF Health Neuromedicine Hospital, UF Health Florida Surgical Center, UF Health Shands Emergency Center-Springhill, UF Health Shands Emergency Center-Kanapaha, UF Health Endoscopy Center, and UF Health Children’s Surgical Center.
11. “Medical Executive Committee” or “MEC”: a committee of the Medical Staff as described in Chapter 1, Article V, and Section 2 of these Bylaws.
12. “Medical Staff” or “Staff”: medical and osteopathic physicians, dentists and podiatrists who have received an appointment by the Board in accordance with these Bylaws.
13. “Notice”: deemed given when a written communication is: (a) hand delivered to the addressee’s business office, as indicated by signature of addressee or addressee’s office staff member, or (b) deposited with any type of delivery service offered by USPS, FED EX or other commercial express delivery service to be delivered to the addressee’s last known business or home address with proof of delivery, or (c) transmitted by facsimile or e-mail to the addressee’s last known business fax or e-mail address.
14. “Peer”: an appropriate Practitioner in the same professional discipline.

15. “Physicians”: doctors of either medicine or osteopathy, including when appropriate as indicated by context, residents and fellows.
16. “Practitioner”: unless otherwise indicated by context, a physician, dentist or podiatrist.
17. “Professional Review Body”: the Board, the Credentials Committee, the MEC, or any other committee or panel which has the authority to make an adverse recommendation or take an adverse action against a Practitioner in accordance with the Medical Staff Bylaws.
18. “Quality and Operations Committee”: a committee of the Medical Staff as described in Chapter 1, Article V, Section 3, of these Bylaws.
19. “Students”: individuals participating in internship or practicum phases of healthcare related degree programs in the Hospital.
20. “Telemedicine”: the use of medical information exchanged from one site to another via electronic communication for use in treatment of a patient. The originating site is the site at which the patient is receiving care. The distant site is the site from which the prescribing or treating services are provided.
21. “Unrestricted license”: fully active license without any conditions that limit or otherwise restrict the individual’s ability to practice independently.

PREAMBLE

The UF Health Shands Hospital Medical Staff will be responsible for the quality and appropriateness of the professional performance and ethical conduct of Medical Staff members, as well as oversight of the quality of care, treatment, and services delivered by Allied Health Practitioners. In fulfilling its duties the Medical Staff is accountable to the UF Health Shands Board of Directors.

METHODS OF ADOPTION AND AMENDMENT

- A. The Medical Staff Bylaws and any proposed amendments may be originated by the MEC or another standing committee, or by an Active Staff member. Such proposed Bylaws or amendments must be reviewed and voted upon by the Quality and Operations Committee and the MEC. Favorable recommendations by the MEC will be presented for a vote to the Active Staff.
- B. Medical Staff Bylaws and any proposed amendments may also be originated by petition of an Active Staff member(s) signed by at least thirty percent (30%) of the Active Staff, and presented to the Quality and Operations Committee and the MEC for their review and recommendation. After the MEC has reviewed, the proposed Bylaws or amendments will be presented, including the MEC’s recommendation and comments, for a vote to the Active Staff.
- C. The proposed amendment and ballot shall be distributed to all Active Staff members at least 14 calendar days prior to the required return date of the ballot.

- D. Each member of the Active Category of the Medical Staff will be eligible to vote on the proposed amendment via either printed or electronic ballot. An amendment will be deemed approved by a majority of affirmative votes of the returned ballots.
 - 1. If an amendment recommended by the MEC fails to be approved by vote of the Active Staff, the MEC may implement the conflict management process in these Bylaws.
 - 2. If an amendment proposed by petition of the Active Staff pursuant to paragraph B that is not recommended by the MEC gets approved by vote of the Active Staff, the MEC may implement the conflict management process.
- E. The MEC may, provisionally, without vote by the Medical Staff, recommend to the Board such amendments to Chapter 3 of these Bylaws (Rules and Regulations) as are, in the committee's judgment and as documented in the minutes urgently required in order to comply with any federal, state, or local law or regulation.
 - 1. Upon adoption of the recommendation by the Board, the MEC must promptly notify the Medical Staff of the amendment, and provide the Active Staff members an opportunity to submit comments to the MEC regarding the amendment within 14 days of notification.
 - 2. If comments received indicate disapproval of the provisional amendment by at least thirty percent (30%) of the Active Staff, the MEC will implement the conflict management process.
 - 3. If the conflict management process results in a recommendation for repeal or revision of the provisional amendment, such repeal/revision is subject to Board approval.
- F. Changes made by the MEC or Board merely for the purpose of reorganization or renumbering, or to correct punctuation, spelling or other errors of grammar or expression are not considered amendments for the purpose of this Section, and may be made without approval of the Active Staff.
- G. Any amendment deemed approved by the Active Staff in accordance with paragraph D or recommended by the MEC in accordance with paragraphs E or F shall become effective only after approval by the Board. In the event of implementation of the conflict management process under paragraph D, final approval by the Board shall be postponed until conclusion of the process.

CONFLICT MANAGEMENT

The following process should be implemented to resolve (1) any dispute between members of the Active Staff and the MEC regarding the adoption of or amendment to these Bylaws or any provision thereof, or (2) upon a petition signed by thirty percent (30%) of the Active Staff with regard to any other Medical Staff matter.

- A. The Active Staff engaged in the dispute and the MEC should first make reasonable efforts to manage and, when possible, resolve the matter collegially and informally through discussion. Three designated representatives from the Active Staff will be invited to meet with the Chief of Staff to discuss the concerns of the Active Staff.

- B. If informal efforts at conflict management are not successful, or the Active Staff or the MEC believes that those efforts would be ineffective in a particular circumstance, either group may request that the CEO convene a Conflict Resolution Committee.
- C. A Conflict Resolution Committee will consist of up to five representatives of the Active Staff engaged in the conflict and an equal number of representatives from the MEC designated by the COS. The CEO or his/her designee will be an ex-officio non-voting member of the Conflict Resolution Committee.
- D. The Conflict Resolution Committee will gather information regarding the conflict, discuss the disputed matter, and work in good faith to resolve the differences between the MEC and the Active Staff in a manner that protects and enhances quality and safety and assures compliance with relevant laws and standards.
- E. Any recommendation that is approved by a majority of each party's representatives will be submitted to the Board for its consideration and final action.
- F. If the committee is unable to make a recommendation, one MEC representative and one Active Staff representative from the Conflict Resolution Committee will jointly make a report of the unresolved differences to the Board for its consideration and final decision regarding the matter in dispute.
- G. Disputes between leaders or segments of the Medical Staff will be resolved in accordance with the Hospital policy on Conflict Management.

CHAPTER 1

ARTICLE 1. MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff is a privilege which shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards and requirements set forth in these bylaws and associated policies of the Medical Staff, the Hospital and UF Health Shands.

SECTION 1. QUALIFICATIONS FOR MEMBERSHIP

- A. Minimum Required Qualifications: Membership and/or clinical privileges shall only be granted to physicians, dentists, and podiatrists who can document and continuously maintain:
 1. Current, unrestricted, Florida license or medical faculty certificate/dental teaching permit;
 2. Current, federal drug enforcement registration(s) unless not required for the Practitioner's practice;
 3. Experience, education, training and judgment;

4. Current clinical competence;
 5. Adherence to professional ethics and conduct in accordance with UF Health Shands professional standards;
 6. Ability to care for patients safely and effectively;
 7. Reasonable communication skills;
 8. Satisfaction of financial responsibility to pay claims and associated ancillary costs through professional liability insurance, maintenance of a letter of credit, or escrow arrangement, of a type and in an amount established by the Board of Directors;
 9. Completion of an Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), Council on Podiatric Medical Education (CPME), or American Dental Association (ADA) approved residency.
 10. Board certification in the specialty within which the Practitioner will primarily practice by the American Board of Medical Specialties, American Osteopathic Association, American Board of Podiatric Orthopedics and Primary Podiatric Medicine, American Board of Podiatric Surgery, or the American Dental Association, as appropriate; except that for those having completed training within the previous five (5) years, certification within five (5) years of completion of the training in the specialty within which the Practitioner will primarily practice. Practitioners appointed to the Medical Staff prior to November 1, 2009 who were not at that time Board Certified or whose board certification was allowed to lapse are exempt from the above requirement, except that for those Practitioners who were appointed subject to the requirement that they become Board Certified within 5 years of their appointment. Practitioners are expected to maintain Board certification, in the specialty in which they will primarily practice,
 11. Ability to conduct oneself in a professional and cooperative manner, treating all persons with courtesy, respect and dignity to promote a culture within which patients can receive quality care and the Hospital and its Medical Staff will be able to operate in an orderly manner.
 12. Ability to be on site in approximately 30 minutes in order to attend to an urgent need of his/her patient or when on call.
 13. Status indicating that s/he is not permanently or temporarily excluded, suspended, or debarred from Medicare or Medicaid.
 14. Continuously meet the requirements of a Medical Staff Category
- B. Waivers to the minimum required qualifications may be granted only by the Board. A request for a waiver to any of the above requirements should be supported by evidence of unique contributions of the applicant and/or to address identified patient care needs.

Time-limited Board certification waivers require a written plan from the Practitioner, signed by their Department Chair, to obtain certification with a specified timeframe. Failure to pass Boards is not considered a reason for additional waivers. Waivers may not extend beyond two years.

- C. No Practitioner shall be entitled to membership on the Medical Staff or to exercise particular clinical privileges merely by virtue of licensure, certification by or membership in any professional organization, or privileges at any other healthcare organization.

SECTION 2. NONDISCRIMINATION

UF Health Shands does not discriminate in granting Staff appointment and/or clinical privileges on the basis of race, religion, color, gender, national origin, disability, age, marital status, sexual orientation, or gender identity.

SECTION 3. CONDITIONS AND DURATION OF APPOINTMENT

- A. Initial appointments and reappointments to the Medical Staff shall be made by the UF Health Shands Board of Directors. The Board shall act on appointments and reappointments only after there has been a recommendation from the MEC.
- B. Appointments to the Medical Staff will be for no more than twenty-four months.

SECTION 4. RESPONSIBILITIES OF EACH MEMBER

- A. Each Staff member must provide appropriate, timely and continuous care of his/her patients, shall be responsible for the actions of other physicians, dentists, podiatrists, and allied health professionals under his/her supervision, and shall discharge in a responsible and cooperative manner the responsibilities and assignments associated with Medical Staff membership.
- B. Each Staff member must participate in quality and performance improvement activities and in discharging other Staff functions as may be required from time to time.
- C. Each Staff member must abide by and comply with the bylaws, policies, procedures, and rules and regulations of UF Health Shands, the Hospital, and the Medical Staff.
- D. Each Staff member must comply with relevant provisions concerning appointment and clinical privileges contained in Chapter 2 of these Bylaws.
- E. Each Staff member must, upon request of the Hospital or its Medical Staff, and in accordance with federal and state law and the Hospital's call schedules, provide appropriate and necessary emergency medical treatment, within the scope of such Practitioner's privileges, regardless of a patient's ability to pay.

SECTION 5. MEDICAL STAFF MEMBER RIGHTS

- A. Each Practitioner on the Medical Staff has the right to an audience with the MEC upon presentation of a written request.

- B. Any Practitioner may initiate a petition for a special meeting of the Medical Staff, upon presentation of a petition signed by 100 members of the Active Staff, which shall be scheduled in accordance with Article VI, Section 1 of this chapter.
- C. A Practitioner may propose a change of the Bylaws in accordance with the Methods of Adoption and Amendment.
- D. This Article does not pertain to issues involving corrective action, denial of requests for appointment or clinical privileges or any other matter relating to individual membership or privileging actions. The Bylaws, Chapter 2, provides procedures for these matters.

ARTICLE II. CATEGORIES OF THE MEDICAL STAFF

SECTION 1. THE ACTIVE CATEGORY

- A. Qualifications: Appointees to the Active category must be involved in the treatment of at least 25 patients (annually) in the Hospital or actively engaged in quality improvement and/or Medical Staff leadership activities. Prerogatives: Appointees to the Active Category may:
 - 1. Exercise such clinical privileges, including admitting privileges, as are granted by the Board of Directors.
 - 2. Be appointed members of Medical Staff committees and vote on all matters presented by the Medical Staff and by the appropriate committee of which (s) he is a member.
- B. Responsibilities: Appointees to the Active Category shall:
 - 1. Actively participate in the organizational and administrative affairs of the Medical Staff, including, but not limited to: quality review and performance improvement; risk management; committee and departmental meetings.
 - 2. Serve on Medical Staff and Hospital committees and/or hold office as assigned, appointed or elected in accordance with these Bylaws; and discharge other Staff functions as may be required from time to time.
 - 3. Care for unassigned patients, regardless of payment status, and participate in the on-call coverage for hospitalized patients and emergency patients in accordance with the Hospital and Staff's responsibilities under applicable law and with the Medical Staff Bylaws and Hospital Policies and Procedures. On-call coverage shall be considered a responsibility, but not a right of an Active Staff member.
 - 4. Fulfill any meeting attendance requirements as established by the Medical Staff Bylaws.
 - 5. Practice and act in a manner consistent with the UF Health Shands mission.

SECTION 2. THE COURTESY CATEGORY

- A. Qualifications: Appointees to the Courtesy Category are Practitioners who do not meet the eligibility requirements for the Active Category, but whom occasionally (at least 6 patients per year) provide services to hospitalized patients.
- B. Prerogatives: Appointees to this category may:
1. Exercise such clinical privileges, including admitting privileges as are granted by the Board of Directors. Courtesy Staff may be involved in the treatment of not more than an average of 24 patients a year during any appointment period. Courtesy Staff appointees who provide emergency call coverage may, without limitation, admit patients who are seen in the Emergency Department to the service of the Active Staff appointee for whom they are taking call. On call coverage is neither a responsibility nor a right of a Courtesy Staff member.
 2. Attend meetings of the Medical Staff and Medical Staff committees, and any Medical Staff or Hospital education programs.
- C. Responsibilities: Appointees to the Courtesy category must:
1. Participate in quality review and performance improvement and risk management activities.
 2. Practice and act in a manner consistent with the UF Health Shands mission.

SECTION 3. THE HONORARY CATEGORY

Appointees to the Honorary Category are former Active Staff members whom the Board and Medical Staff wish to honor. Honorary Staff members are not eligible for clinical privileges and are therefore no longer required to meet the minimum required qualifications in Article I, Section 1 of this chapter. They may attend Medical Staff meetings, be involved in teaching, and may be appointed as voting members to committees. They may not hold office.

ARTICLE III. OFFICER

SECTION 1. OFFICER OF THE MEDICAL STAFF- THE CHIEF OF STAFF

- A. There shall be one officer of the Medical Staff, the Chief of Staff.
- B. The Chief of Staff must be a member in good standing of the Active Category, indicate a willingness and ability to serve, and have excellent administrative and communication skills.
- C. The Chief of Staff shall:
1. serve as the chief medical-administrative officer of the Hospital;

2. call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;
3. serve as Chairperson of the MEC and Quality and Operations Committees;
4. take administrative actions for the MEC, when necessary, in between meetings;
5. be responsible for the application and enforcement of the bylaws, policies, and rules and regulations of the Hospital and its Medical Staff;
6. be responsible for compliance by the Medical Staff with all requirements of applicable licensure, accreditation, and regulatory agencies dealing with the Hospital; and
7. fulfill such other duties as may be specified in the Medical Staff Bylaws.

D. In the event of an absence, the Assistant Chair of Quality and Operations Committee (Article V, Section 3 of this chapter) shall be the Acting Chief of Staff, or if no Assistant Chair has been appointed, the Chief of Staff shall appoint an Acting Chief of Staff from the Active membership to perform any necessary duties and have the authority of the Chief of Staff during his/her absence.

SECTION 2. SELECTION OF THE CHIEF OF STAFF

The Chief of Staff shall be appointed jointly by the CEO and the Dean of the University Of Florida College Of Medicine with confirmation by the Board of Directors.

SECTION 3. TERM OF OFFICE

Upon appointment, the Chief of Staff serves a term of three (3) years which shall be automatically renewed unless another appointment is recommended to and confirmed by the Board of Directors.

SECTION 4. VACANCY OF OFFICE

A vacancy in the office of the Chief of Staff shall be filled in the same manner as an initial appointment to serve for the remainder of the term.

SECTION 5. REMOVAL FROM OFFICE

The Medical Staff may request the removal of the Chief of Staff by petition of 100 members of the Active Staff. Such petition will be submitted to the MEC for review and recommendation to the Board. The Board may remove the Chief of Staff from office by its own motion, but only after consultation with a majority of the MEC. Removal shall be for failure to conduct those responsibilities assigned within these Bylaws or other policies and procedures of the Medical Staff; an automatic or summary suspension; or for conduct that is damaging to UF Health Shands, its goals, or programs.

ARTICLE IV. CLINICAL DEPARTMENTS

SECTION 1. ORGANIZATION OF DEPARTMENTS

The following clinical departments shall be organized for the conduct of patient care: Anesthesiology, Community Health/Family Medicine, Dentistry, Dermatology, Emergency Medicine, Medicine, Neurology, Neurosurgery, Obstetrics/Gynecology, Ophthalmology, Orthopaedics, Otolaryngology, Pathology, Pediatrics, Psychiatry, Radiation Oncology, Radiology, Surgery and Urology. Each clinical department shall be organized as a separate part of the Medical Staff and shall have a Chair.

SECTION 2. QUALIFICATIONS/SELECTION OF CLINICAL DEPARTMENT CHAIRS

- A. Each Chair shall be a member of the Active staff qualified by training, experience and demonstrated ability for the position. Each Department Chair shall be Board Certified by an appropriate specialty board, or shall establish comparable competence as defined by the Medical Staff Bylaws.
- B. The Chair shall be recommended by the Dean of the College of Medicine or Dentistry as appropriate. The appointee will serve as the clinical department Chair in the hospital with the concurrence of the Quality and Operations Committee, MEC, and the Board of Directors.

SECTION 3. FUNCTIONS OF THE CLINICAL DEPARTMENT CHAIRS

Each clinical department Chair is an essential element in the line of authority within the Medical Staff organization. As such, he/she shall be accountable to the Quality and Operations Committee and the MEC for the following:

- (1) the integration of the clinical and administrative activities of the department into the larger organization;
- (2) all clinically related activities of the department;
- (3) all administratively related activities of the department, unless otherwise provided for by the hospital;
- (4) recommendations for the criteria for clinical privileges in the department's area(s) of patient care, recommendations for clinical privileges of each member of the department, and ongoing monitoring of the professional performance of all individuals who have delineated clinical privileges in the department's area(s) of patient care. Chairs of Staff members who provide trauma services shall seek input from the Medical Director of the Trauma Service when making recommendations regarding the clinical privileges of such Staff;
- (5) the determination of the qualifications and competence of department personnel who are not credentialed under a Medical Staff process, but provide patient care services;

- (6) the development and implementation of policies and procedures that guide and support the provision of services;
- (7) recommendations for a sufficient number of qualified and competent persons to provide care/service;
- (8) the continuous assessment and improvement of the quality of care, treatment and services provided, including Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE);
- (9) recommendations to the relevant hospital authority regarding off-site sources for needed patient care services not provided by the department/service or the organization;
- (10) maintenance of quality control programs, as appropriate;
- (11) the orientation and continuing education of all persons in the department or service;
- (12) recommendations for space and other resources needed by the department or service.

SECTION 4. FUNCTIONS OF CLINICAL DEPARTMENTS

- A. The functions of the clinical departments shall be to:
 1. In accordance with hospital policies, implement and conduct specific peer review and evaluation activities that contribute to the preservation and improvement of the quality, appropriateness, safety and efficiency of patient care provided under the department.
 2. Provide periodic reports to the Quality and Operations Committee, as required or as appropriate, concerning (1) the department's review and evaluation activities, actions taken thereon, and the results of such action; and (2) recommendations for maintaining and improving the quality of care provided in the department and hospital.
- B. Each department may formulate its own policies, rules and regulations, and/or clinical guidelines for the conduct of its affairs and the discharge of its responsibilities. Such policies, rules and regulations, and guidelines shall not be inconsistent with the Medical Staff Bylaws or hospital policies.

ARTICLE V. COMMITTEES

SECTION 1. DESIGNATION

There shall be a Medical Executive Committee and such other standing and ad hoc committees as established by the MEC. Those functions requiring participation of, rather than direct oversight by, the Staff may be discharged by Medical Staff representation on such Hospital committees as are established to perform such functions.

SECTION 2. MEDICAL EXECUTIVE COMMITTEE

The MEC has the primary authority for activities related to self-governance of the Medical Staff and for performance improvement of the professional services provided by the Medical Staff and other Practitioners privileged through the Medical Staff process.

- A. **COMPOSITION:** The MEC shall consist of the Chief of Staff and at least six (6) Active Staff members one each of whom shall be from the following general specialty areas: hospital-based, medicine, pediatrics and surgery. The other members shall be from specialty areas deemed appropriate by the Chief of Staff. Ex-officio members will be the CEO or designee, Chief Nursing Officer, Chief Quality Officer, (“CQO”) Associate Dean for GME, CEO of UF Health Physicians, and Chair of the Credentials Committee. The Chief of Staff will be the chairperson of the MEC.
- B. **APPOINTMENT:** The Chief of Staff shall recommend members of the MEC for approval by the Quality and Operations Committee. Each appointee shall serve a two year term. The members of the MEC shall be eligible for reappointment for successive terms. Upon any early vacancy, the Chief of Staff shall appoint an Active Staff member to complete the two-year term. MEC members may be removed at the recommendation of the Chief of Staff with approval by the Quality and Operations Committee.
- C. **DUTIES:** The duties of the MEC shall be to:
1. receive and act upon reports and recommendations from the Medical Staff Committees, departments and other assigned activity groups concerning patient care quality, evaluation and monitoring functions, and the discharge of delegated administrative responsibilities, and recommend to the Board specific programs and systems to fulfill these functions;
 2. submit recommendations to the Board concerning all matters relating to appointments, reappointments, Staff categories, clinical privileges and corrective action;
 3. review findings of the assessment and performance improvement, including information about adverse privileging decisions, as part of the ongoing evaluation of a credentialed Practitioner’s competence;
 4. account to the Board and to the Staff for the overall quality and efficiency of patient care in the Hospital and the participation of the Medical Staff in organization performance improvement activities;
 5. assure professionally ethical conduct and competent clinical performance on the part of Medical Staff members by initiating appropriate investigations and taking or recommending corrective action, when warranted;
 6. make recommendations to the Board on medical-administrative and Hospital management matters;
 7. act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;
 8. formulate and/or recommend Medical Staff Bylaws to the Board; and

9. review the Medical Staff Bylaws and recommend such changes thereto as may be necessary or desirable;
10. make recommendations concerning the structure of the Medical Staff, the mechanism by which Medical Staff membership may be terminated and the mechanisms for fair hearing procedures;
11. ensure that the findings, conclusions, recommendations, and actions taken to improve performance are communicated to appropriate Medical Staff members and the Board.

D. **MEETINGS:** The MEC shall meet as required to perform its assigned functions, but at least quarterly. Minutes and a record of attendance shall be maintained.

SECTION 3. MEDICAL STAFF QUALITY & OPERATIONS COMMITTEE

A. **COMPOSITION:** The Committee shall consist of the Chief of Staff, the Chair of each of the Clinical Departments, the Dean of the College of Medicine (COM) and the Dean or designee of the Colleges of Dentistry and Public Health and Health Professions, the COM Senior Associate Dean and CEO of UF Health Physicians, the COM Senior Associate Dean of Education, the COM Senior Associate Dean of Financial Services, the President of the UF COM Faculty Council, the President UF Health Shands and Senior Vice President of Health Affairs, the Chair of the COM Department of Aging, the CEO, COO, Chief Information Officer, CQO, General Counsel, Chief Financial Officer and the Vice President of Nursing.

The Chair will be appointed jointly by the CEO and the Dean of the College of Medicine, with confirmation by the Board of Directors for an appointment term of three years, which will be automatically renewed unless another recommendation is confirmed by the Board of Directors. An Assistant Chair may be appointed in a like manner. The Assistant Chair shall assist the Chair in carrying out the responsibilities designated below, and shall be empowered to act for the Chair in his or her absence consistent with Article III, Section 1 of this chapter. The Chair/Assistant Chair appointment may be terminated at any time by mutual consent of the Dean of the College of Medicine, and the CEO.

B. **DUTIES:** The Quality and Operations Committee operates in support of the MEC. The Committee will be responsible for recommendations regarding development and maintenance of standards of medical practice within the Hospital, evaluation and supervision of such practice, and coordination of patient care. Additionally, the Quality and Operations Committee shall monitor compliance with and enforce the Medical Staff Rules and Regulations (Chapter 3 of these Bylaws), and make recommendations to the MEC on Rules and Regulations. Specifically, the Quality and Operations Committee shall:

1. Assure that the Medical Staff participates in the measurement, assessment, and improvement of patient care processes, including:
 - a. medical assessment and treatment of patients;
 - b. use of medications;

- c. use of blood and blood components;
 - d. use of operative and other procedure(s);
 - e. appropriateness of clinical practice patterns; and
 - f. significant departures from established patterns of clinical practice;
 - g. education of patients and families;
 - h. coordination of care, treatment, and services with other Practitioners and Hospital personnel, as relevant to the care, treatment, and services of an individual patient; and
 - i. accurate, timely, and legible completion of patients' medical records.
2. Assure that the Medical Staff, in collaboration with other appropriate Hospital staff, develops and uses criteria that identify deaths in which an autopsy should be performed.
 3. Assure that performance improvement mechanisms, measurements, and/or assessments include the use of sentinel events and/or patient safety data.
 4. Provide oversight for the following clinical quality functions:
 - a. monitoring of indicators related to clinical care, as evidenced by performance in comparison to appropriate benchmarks (e.g. University Health System Consortium, Centers for Medicare and Medicaid Services, Agency for Health Care Administration, The Joint Commission, National Surgical Quality Improvement Program);
 - b. establishment of quality, safety, and patient satisfaction priorities and accountabilities for inpatient care;
 5. Make recommendations to the MEC regarding the establishment of standards and measures of effectiveness in patient care by each of the respective health disciplines and the implementation of a coordinated patient care program, including review and analysis of the quality and efficiency of clinical services and programs and the effectiveness of patient care monitoring and evaluation activities;
 6. Approve and implement action plans developed by interdisciplinary teams;
 7. Remove barriers to implementation of action plans developed by interdisciplinary teams);
 8. Review ongoing results related to action plans and quality priorities and report to the MEC;
 9. Resolve issues identified by Medical Staff committees and report to MEC;
 10. Participate in the establishment of patient care priorities and long-term goals as related to patient care within the clinical setting of the Hospital, and advise the CEO, or designee, on priorities;
 11. Assist and make recommendations where appropriate regarding long-range budgeting, facility planning, quality assurance and improvement recommendations from departments and Medical Staff committees, and similar related functions.

- C. **MEETINGS:** The committee shall meet as required to perform its assigned functions, but at least quarterly. Minutes and a record of attendance shall be maintained and a report of actions, recommendations shall be made to the MEC as appropriate.

SECTION 4. CREDENTIALS COMMITTEE

- A. **COMPOSITION:** The Credentials Committee shall consist of nine (9) or more members of the Active Staff, two each from hospital-based services, pediatrics, medicine and surgery and one member from psychiatry. The other members shall be from specialty areas deemed appropriate by the Chief of Staff. Members shall be appointed by the Chief of Staff upon the recommendation of the Quality and Operations Committee and concurrence by the MEC.
Each appointee to the Credentials Committee shall be appointed for a two (2) year term and shall be eligible for reappointment for successive terms. The Credentials Committee shall elect one of its members to serve as Chair for a one year term, who may be re-elected for successive terms.
- B. **DUTIES:** The duties of the Credentials Committee shall be to:
1. Review the credentials of all applicants for Medical Staff appointment, reappointment, and clinical privileges, to investigate and interview such applicants as may be necessary and make report of its findings and recommendations to the MEC.
 2. Review the credentials of all applicants for clinical privileges as Allied Health Professionals, and to investigate and interview such applicants as may be necessary, and make report of its findings and recommendations to the MEC.
 3. Review the Hospital's criteria for granting privileges and the application forms relating to Medical Staff and Allied Health Professional appointment, reappointment, and/or clinical privileges, and other credentialing matters, and make recommendations regarding same to the MEC.
 4. Each member of the Credentialing Committee is responsible for the timely review and evaluation of credentialing files assigned.
- C. **MEETINGS:** The Credentials Committee shall meet as required to perform its assigned functions, but at least quarterly. Minutes and a record of attendance shall be maintained.

Review and voting related to "clean" credentialing files and policies may be done without meeting, using secure email or other electronic transmissions in accordance with Article VI. A record of issues/concerns and voting will be maintained.

SECTION 5. ADDITIONAL COMMITTEES

- A. Additional standing or ad hoc committees may be established or dissolved by the MEC as are necessary for the Medical Staff to carry out its various functions effectively. Such committees shall be defined as appropriate in the Medical Staff Committee Manual. Any function required

to be performed by these Bylaws not assigned to a standing or ad hoc committee shall be performed by the MEC.

B. Committee Appointments

1. The Chief of Staff shall appoint the Chairs of the Medical Staff committees with the approval of the MEC and CEO. The Chairs shall serve at the pleasure of the Chief of Staff, but will generally be appointed for a term of three years, which will be automatically renewed unless another appointment is made by the COS. Unless otherwise specified, the committees shall report to the Quality and Operations Committee.
2. Recommendations for members of the committees shall be made to the COS by the Committee Chairs and/or Hospital Administration, as appropriate.
3. Committee appointments shall be made for three-year terms. Unless otherwise required herein, or requested by the Quality & Operations Committee, each Medical Staff committee shall submit an annual report of its activities to the Quality and Operations Committee in a prescribed format.
4. Subcommittees (standing or ad hoc) may be established to assist the committee in meeting its duties and responsibilities. The Chairs and members of the subcommittees shall be appointed by the Committee Chair in like manner as the COS makes committee appointments.
5. Other Practitioners may be invited to attend meetings at the discretion of the Chair of the Committee to provide expertise on specific issues, but will not be considered voting members unless otherwise appointed in accordance with the membership description of this section.

ARTICLE VI. MEETINGS

Except as otherwise specified, the action of a majority of the voting members present at a meeting at which a quorum is present is the action of the group. Action may be taken without a meeting by the Staff or Committee by presentation of the question to each member eligible to vote, in writing. Such vote shall be binding so long as a vote is returned in writing by at least the number of voting members of the group that could constitute a quorum.

SECTION 1. MEDICAL STAFF MEETINGS

- A. An Annual meeting of the Medical Staff shall be held at the discretion of the MEC. Notice of an annual meeting shall be sent to all Medical Staff members.
- B. The Chief of Staff may call a Special Meeting of the Medical Staff at any time. The Chief of Staff shall call a special meeting within 20 days of receipt of a petition signed by at least 100 of the Active Staff members, or upon a resolution by the MEC. Such request or resolution

shall state the purpose of the meeting. The Chief of Staff shall designate the time and place of any Special Meeting.

- C. Notice stating the time, place and purposes of any Special Meeting of the Medical Staff shall be sent to each member of the Medical Staff at least 7 days before the date of such meeting, except as provided in Section 6 of this Article for emergency special meetings. No business shall be transacted at any Special Meeting except that stated in the notice of such meeting.

SECTION 2. COMMITTEE AND DEPARTMENT MEETINGS

- A. Committees may, by resolution, provide the time for holding regular meetings without further notice. Department chairs shall hold meetings as needed to carry out department business.
- B. A special meeting of any committee or department may be called by or at the request of the chairperson or by the Chief of Staff.

SECTION 3. QUORUM

- A. Medical Staff Meetings: Those Active members present shall constitute a quorum.
- B. MEC and Credentials Committee Meetings: Fifty percent (50%) of the voting members of the committee.
- C. Committee and Department Meetings: Those voting members present shall constitute a quorum.

SECTION 4. ATTENDANCE REQUIREMENTS

- A. MEC and Credentials Committee Meetings: Members of the MEC and Credentials Committee are expected to attend at least fifty percent (50%) of the meetings held.
- B. Other Committee/Departmental Meetings: No minimum meeting attendance is required but frequency of attendance will be considered in reappointments to committees.

SECTION 5. PARTICIPATION BY CHIEF EXECUTIVE OFFICER

The Chief Executive Officer or his/her designee may attend any committee meeting of the Medical Staff.

SECTION 6. NOTICE OF MEETINGS

- A. Notice stating the date, time and place of any Special Meeting or of any regular meeting not held pursuant to resolution shall be delivered or sent to each member of the committee not less than seven (7) days before the time of such meeting by the person or persons calling the meeting. If

an emergency Special Meeting is deemed necessary by the Chief of Staff or other appropriate chair, such emergency Special Meeting may be held upon 2 days written or verbal notice.

- B. Emergency meetings of the MEC may be held at any time without advance notice and action taken as long as a quorum is present.
- C. The attendance of a member at a meeting shall constitute a waiver of Notice of such meeting.

SECTION 7. ACTION AT MEETINGS

The recommendation of a majority of the voting members present at a meeting at which a quorum is present shall be the action of a committee.

SECTION 8. MINUTES

Minutes and a record of each Medical Staff meeting activities shall be maintained. The minutes shall be signed by the presiding officer.

CHAPTER 2

ARTICLE I. INITIAL APPOINTMENT

SECTION 1. TERM OF APPOINTMENT

Appointments to the Medical Staff shall be made by the Board, for a period not to exceed twenty- four months.

SECTION 2. APPLICATION FOR INITIAL APPOINTMENT AND CLINICAL PRIVILEGES

A. Pre-application

A pre-application may be used to ascertain whether a Practitioner appears to meet the minimum objective criteria for appointment as set forth in the Medical Staff Bylaws.

B. Application

The prescribed electronic application for Medical Staff appointment must be submitted no more than six months in advance of the anticipated start date of practice and signed by the applicant. The application shall include a request for specific clinical privileges desired by the applicant and shall require detailed information concerning the applicant's professional qualifications, including, at a minimum:

1. the names and current contact information of at least four professionals who have knowledge of the applicant's current clinical competency. Not more than one may be in a professional practice with which the applicant is about to be associated except for those applying directly from a University of Florida ("UF") training program. At least one reference shall be from the same professional and specialty area as the applicant; and none of the references may be related to the applicant;
2. the names and complete addresses of any and all hospitals and other healthcare organizations at which the applicant has had privileges, trained, or worked in the profession in which he or she is requesting clinical privileges;
3. information as to whether there have been any previously successful or currently pending challenges including investigations or inquiries, that have or may result in any of the following being either temporarily or permanently denied, voluntarily or involuntarily surrendered, suspended, reduced, revoked, relinquished, withdrawn, or not renewed, for any reason: membership status and/or clinical privileges at any hospital or healthcare institution; membership in a local, state, or national professional organization; specialty Board Certification; license(s) to practice any profession in any jurisdiction; or Drug Enforcement Agency (DEA) Registration;
4. information as to whether the applicant has ever been subjected to any other corrective or quality-related action (whether disciplinary or not) by any of the institutions or agencies above, including, , mandatory chart review, requirements for CME credits, proctoring or probation (subsequent to initial probation period upon first application) ; Focused Professional Practice Evaluation (FPPE) initiated other than for initial or additional privileges;
5. information regarding the applicant's current professional liability insurance coverage, and the amounts and classifications of such coverage;
6. information about whether the applicant has ever had any settlements paid by the applicant or on the applicant's behalf;
7. information about whether any professional liability carriers have ever denied, cancelled, limited, or not renewed the applicant's liability coverage;
8. information about whether any malpractice actions, arbitrations, or other judicial, quasi- judicial, or administrative proceedings based on the applicant's medical practice have ever been instituted against the applicant;
9. information about whether any Notices of Intent have ever been filed against the applicant;
10. information about whether the applicant has any physical, medical (including substance abuse), mental or emotional condition that could affect the applicant's ability to exercise the clinical privileges requested safely and competently;
11. information about whether the applicant has ever been denied enrollment, reprimanded, censured, excluded, suspended, had privileges suspended, or been disqualified by any private health insurance plan/program, or any federal or state program (in any state) or employed by a corporation, business or professional association that has been suspended or excluded from any such program in any state;

12. information about whether the applicant has ever been convicted of or had adjudication withheld on a felony, pleaded guilty or nolo contendere to a felony, entered into a pre-trial agreement for a felony, or is presently under indictment for a felony;
13. information about whether the applicant has engaged in or been treated for the use or misuse of prescription drugs, use of illegal substance chemicals or any substance that could impair the applicant's ability to perform his/her professional or medical practice duties;
14. information about whether the applicant has ever been the subject of any investigation by a state license board, Medicare, Medicaid, or any other federal or state program, hospital or other healthcare or managed care organization;
15. information about whether the applicant has ever held or currently holds a contract with the Physician Resource Network or other similar health care professional recovery program;
16. information about whether the applicant has ever had any license subject to restriction, suspension, stipulation, limitation, reprimand, fine, letter of guidance, probation, revocation, or voluntary or involuntary surrender;
17. information about whether the applicant has ever had a confirmed/founded report of abuse or neglect of a patient;
18. a copy of the Educational Council for Foreign Medical Graduates (ECFMG) Certificate, if applicable;
19. a copy of Board Certification or Board Admissibility letter;
20. a copy of any supporting documentation required to meet criteria for requested privileges, if applicable;
21. a copy of the current certificate of liability coverage that denotes UF Health Shands as the Certificate Holder, provides the effective dates of the policy, identifies the applicant by name, coverage exclusions, if any, and provides for either claims made or occurrence based coverage of \$250,000 per claim, \$750,000 in the aggregate, or appropriate confirmation/evidence of an unexpired irrevocable letter of credit that satisfies the Practitioner's licensure requirements in an amount of not less than \$250,000 per claim, with a minimum aggregate availability of credit of not less than \$750,000;
22. The applicant's dated signature on the prescribed Statement of Authorization and Release form;
23. such other information as the Credentials Committee, MEC, or Board may require.

C. Undertakings

Each applicant must specifically agree to the following undertakings as a condition of consideration of the application for appointment/reappointment and as a condition of continued Medical Staff appointment:

1. an agreement to be bound by the policies, procedures, bylaws and rules and regulations of the Medical Staff, Hospital and/or UF Health Shands ;

2. an acknowledgement that the applicant has the burden of producing adequate information, for a proper evaluation of the applicant's competence, character, ethics, health status and other qualifications and for resolving any questions about such qualifications;
3. an agreement to appear for an interview, if requested;
4. completion of a Criminal Background Screening;
5. an acknowledgement that failure to produce requested information or appear for a requested interview will prevent the application from being evaluated and acted upon and may result in application expiration.
6. an agreement to undergo a physical and/or mental health examination at any time, at the request of the Credentials Committee, MEC or the Board. Such request must be supported by a statement of reasons;
7. an attestation that the information in the application is true, complete and correct, and an agreement to notify the Hospital, in writing and within thirty days, of any changes or additions to the information provided by the applicant, including:
 - a. denial or voluntary surrender, suspension, reduction, revocation, relinquishment, withdrawal, or non-renewal, either temporarily or permanently, for any reason, of: 1) membership status and/or clinical privileges at any hospital or healthcare institution; 2) Specialty Board Certification; 3) Drug Enforcement Agency registration; 4) license to practice any profession in any jurisdiction; or, 5) professional liability coverage; including any changes in coverage; 6) CMS eligibility status
 - b. any malpractice actions, arbitrations, or other proceedings based on the Practitioner's practice, including any Notices of Intent;
 - c. any changes in physical or mental condition that could prevent the applicant, with or without reasonable accommodation, from performing professional or medical practice duties required for the privileges requested and/or granted; or
 - d. any convictions, indictments, pleadings of guilty or nolo contendere to any crimes (excluding minor/non-criminal traffic offenses);
8. an acknowledgement that as a condition of making an application, any misrepresentation, misstatement, or omission, may constitute cause for automatic and immediate rejection of the application, and that, in the event that approval has been granted prior to the discovery of such misrepresentation, misstatement, or omission, such discovery may result in immediate termination of privileges;
9. an agreement to provide or arrange for the provision of continuous quality patient care for her/his patients if granted appointment and/or clinical privileges, which shall include an agreement to self-report any physical, medical, psychiatric, or emotional impairment which may result in an inability to perform her/his professional responsibilities;

D. Burden of Providing Information

The applicant shall have the burden of providing sufficient information for a proper evaluation of her/his competence, character, ethics, and other qualifications, and of resolving any questions

about such qualifications. The applicant shall have the burden of providing evidence that all statements made and information given on the application are true, complete and correct. An application is not considered complete until all information requested by the Hospital has been received, including: an application form with all required responses provided; verification of all necessary information; adequate responses from references; and any other additional information deemed necessary for evaluation of the application or the applicant's qualifications. It is the responsibility of the applicant to ensure that the application is complete, including the direct payment of any unusual verification charges.

1. An application that is not accompanied by the initial required supporting documents will be deemed expired if not complete within three months.
2. An application will be deemed incomplete if at any time during the evaluation the need arises for new, additional, or clarifying information. Such application will not be further processed until all requested information is received. Applications which are not complete because of a failure of an applicant to provide requested additional information shall be deemed expired within two months of the request.
3. Should information provided in the application for appointment or reappointment change during the course of an appointment, the Practitioner must provide written notice within 30 days of such change and sufficient information about such change for the Credentials Committee's review and evaluation.

E. Authorization to Obtain Information

The following conditions, which shall be included on the application form, are applicable to any Medical Staff applicant, any appointee to the Medical Staff, and to all others having or seeking clinical privileges in the Hospital. By applying for appointment, reappointment, or clinical privileges, the applicant expressly accepts these conditions during the processing and consideration of his/her application, whether or not he/she is granted appointment or clinical privileges. This acceptance also applies during the time of any appointment or reappointment.

1. Authorization to Obtain Information: The applicant must authorize UF Health Shands to inspect all records and documents that may be material to evaluating the applicant's professional qualifications and competence and to carry out the clinical privileges requested, as well as the applicant's moral and ethical qualifications. The applicant shall authorize UF Health Shands and its authorized representatives to consult with any individual(s) and/or entities who may have information, including otherwise privileged or confidential information, bearing on the professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter bearing on the satisfaction of the criteria for granting of membership and/or clinical privileges and on the applicant's ability to perform her/his professional responsibilities. The applicant must authorize said individual(s) and/or entities, including, as applicable: (a) insurance companies; (b) The National Practitioner Data Bank; (c) The Federation of State Medical Boards; (d) professional references; (e) specialty boards; (f) health care plans; (g) schools; (h) employers; (i) hospitals or facilities with which the applicant has been in association; (j) state licensing boards; (k) claims adjusters, attorneys or others who may have information regarding professional liability claims or lawsuits; and (l) professional training

programs, to release said information to UF Health Shands , upon request and receipt of a copy of the applicant's consent and release form.

2. Immunity: The applicant must agree to extend immunity to and release from any and all liability, to the fullest extent permitted by law, all individuals and organizations who provide information to UF Health Shands , including otherwise privileged and confidential information concerning the professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter bearing on the satisfaction of the criteria for granting of clinical privileges requested.
3. Authorization to Release Information: The applicant must authorize UF Health Shands to release information to managed care organizations with which UF Health Shands is or may become affiliated, and release UF Health Shands from any and all liability for providing information concerning the applicant's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other qualifications for staff appointment/reappointment and/or clinical privileges, including otherwise privileged and confidential information, so long as such release of information is given without malice and in good faith.

The applicant must authorize UF Health Shands to disclose and make available to any UF Health Shands hospital/facility/program to which the applicant has made or makes application any and all information contained in her/his application and/or obtained as a result thereof.

SECTION 3. PROCESSING APPLICATIONS

A. Department

1. After receipt of references, verifications and all other information or materials deemed pertinent, the application and all supporting materials will be transmitted to the appropriate Department Chair. The Department Chair shall provide the Credentials Committee with a recommendation regarding the appointment and/or privileges of the applicant, within ten (10) days of receipt of a complete application.
2. If the application is that of a Department Chair, the review and recommendation shall be sought from the COS.

B. Credentials Committee

The Credentials Committee shall review the application, the supporting documentation, Chair/COS recommendation, and any other information available that may be relevant to consideration of the applicant's qualifications for the staff category and clinical privileges requested. All recommendations to approve appointment and/or grant privileges must also recommend the specific clinical privileges to be granted. The Credentials Committee shall then forward a report of its recommendations to the MEC for review and to the Quality & Operations Committee as information.

C. MEC

1. After considering the report from the Credentials Committee, the MEC shall recommend action upon each application and/or request for privileges. If a recommendation is

favorable to the applicant, the recommendation shall be forwarded to the Board for final action.

2. If an adverse recommendation is made, either with respect to appointment or the scope of privileges, the recommendation, including a statement of the reason for such recommendation, supported by reference to the application and other documentation considered by the MEC, shall be forwarded to the Administrator or his/her designee. The Administrator or her/his designee shall promptly give Notice to the applicant of the adverse recommendation and of the applicant's right to a hearing, if any, in accordance with the Fair Hearing procedure set forth in Article X of this chapter.
3. If the applicant waives her/his right to a hearing, or does not have such right pursuant to Article X, the Administrator or her/his designee shall forward the MEC recommendation with supporting documentation to the Board for final action. If the applicant exercises her/his right to a hearing, the MEC may reconsider its adverse recommendation after receiving the Hearing Panel report and recommendation, and forward its final recommendation to the Board.

D. Deferral

When the recommendation of the Credentials Committee or the MEC is to defer consideration of the application to obtain additional information, the committee must make a subsequent recommendation within 60 days.

E. Board Approval

1. The Board of Directors has final responsibility for approval or disapproval of all applications for membership, continued membership, and/or privileges.
2. In accordance with the UF Health Shands Bylaws, the Professional Staff Credentials Committee of the Board (PSCC) is responsible for acting upon applications for membership, continued membership, and/or privileges for all applications except that:
 - a. Any application for which the MEC has made a final recommendation that is adverse shall be forwarded to the full Board with the Professional Staff Credentials Committee recommendation.
 - b. The following applications will usually result in ineligibility for the expedited review by the PSCC, and must be evaluated by the PSCC for appropriateness of expedited review on a case-by-case basis:
 - (1) There is current challenge or a previously successful challenge to licensure or registration;
 - (2) The applicant has received an involuntary termination of Medical Staff membership at another organization;
 - (3) The applicant has received involuntary limitation, reduction, suspension, denial, or loss of clinical privileges;
 - (4) There has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant;

Notice of the Board's decision shall be sent to the applicant within 30 days unless otherwise required in accordance with the hearing and appeals procedures of Article X or delayed by the Board for good cause.

F. Time for Final Action

Once received from the Department Chair (or for Chairs, from the COS), an application must be acted upon by the Credentials Committee and the MEC and presented to the Board within 90 days, unless the process has been delayed by a hearing or by the need to obtain further information, or unless an extension is approved by the Board upon a show of good cause.

SECTION 4. APPLICATIONS PRIOR TO RESIDENCY COMPLETION

An otherwise complete application may be processed prior to the completion of residency training. In such cases, Medical Staff appointment and all clinical privileges will be contingent upon confirmation of residency completion.

ARTICLE II. CLINICAL PRIVILEGES

SECTION 1. GENERAL

Medical Staff appointment or reappointment alone does not confer any clinical privileges or right to practice in the hospital. However, except as provided in Sections 3 and 5 of this Article and the Allied Health Professional Policy on Clinical Privileges, only Practitioners who have been given an appointment to the Medical Staff shall be entitled to exercise clinical privileges granted by the Board. The clinical privileges recommended to the Board shall be based upon the applicant's education, training, experience, current clinical competence and ability to perform those privileges requested, the availability of hospital resources and personnel to support the privileges requested, and other relevant information. The applicant shall have the burden of establishing her/his qualifications for and competence to exercise the clinical privileges requested.

Only those individuals who have requested and been granted admitting privileges may admit patients.

SECTION 2. APPLICATION FOR INCREASED CLINICAL PRIVILEGES

Whenever, during the term of an appointment to the Medical Staff, an individual desires additional clinical privileges, s/he shall make the request in writing, on the prescribed application for additional privileges. The applicant shall have the burden of providing sufficient information for a proper evaluation of his/her qualifications and for resolving any questions about such qualifications in accordance with Article I, Section 2D of this chapter. The request will be processed in the same manner as an application for initial clinical privileges (see Article I, Section 3 of this chapter).

SECTION 3. TEMPORARY PRIVILEGES

- A. Upon the recommendation of a Department Chair, and the concurrence of the COS, the CEO or her/his designee may, at her/his sole discretion, grant temporary privileges to a Practitioner for a specified period of time. Such Practitioner is not a member of the Medical Staff for the purposes of any rights set forth in the Bylaws.
- B. A Practitioner may be granted temporary privileges in the following circumstances:
1. to fulfill an important patient care, treatment, and/or service need, the primary examples being to:
 - a. prevent a significant decrease in ability to provide services;
 - b. proctor a member of the Medical Staff;
 - c. assist on a specific case; or
 - d. serve as locum tenens for a member of the Medical Staff; or,
 2. when a new applicant for appointment with a complete application that raises no significant quality or professionalism concerns is awaiting review and approval by the Credentials Committee, MEC and/or the Board.
- C. A new applicant with a complete application awaiting review and approval is automatically ineligible for temporary privileges if the applicant has: a current or previously successful challenge to licensure or registration; been subject to involuntary termination of Medical Staff membership at another organization; cannot demonstrate current (within past two years) clinical practice; experienced an excessive number of malpractice claims resulting in a judgment; or been subject to any involuntary limitation, reduction, suspension, denial, or loss of clinical privileges at another organization; received unfavorable peer reviews related to Quality or Behavior.
- D. In order to be granted privileges under (B1.), the Practitioner must submit the prescribed application for temporary privileges. The following documentation shall have been acquired within the previous 90 days: (1) a query of the National Practitioner Data Bank; (2) proof of current unrestricted Florida licensure; (3) evidence of professional liability coverage as indicated by the Medical Staff Bylaws; (4) current competence for the privileges requested, and (5) verification of education and training either through primary source verification or by a review of the AMA, AOA or other appropriate Profile.
- E. The term of temporary privileges to fulfill important patient care, treatment, and/or service needs will be set as appropriate for the circumstances. Each term requires a separate written request. The total period of temporary privileges shall not exceed 180 days in any rolling 365 day period; except that extensions may be granted by the CEO under extraordinary circumstances.

Temporary privileges for new applicants shall not exceed 120 days.

SECTION 4. TERMINATION OF TEMPORARY CLINICAL PRIVILEGES

- A. Temporary clinical privileges may be terminated by the Chair of the Board, the CEO, the Administrator, or the COS at any time with or without cause. The granting, denial, or termination of temporary privileges does not entitle the Practitioner to any of the procedural rights provided in this policy with respect to hearings or appeals.
- B. Temporary privileges shall be automatically terminated at such time as the Credentials Committee or MEC makes an adverse recommendation with respect to a Practitioner's application for clinical privileges.
- C. The responsibility for the care of any patients under the care of a Practitioner whose temporary privileges are terminated shall be transferred by the COS to a member of the Medical Staff. In making such a transfer, the wishes of the patient shall be considered whenever possible.

| SECTION 5. EMERGENCY & DISASTER PRIVILEGES

- A. **Emergency Privileges for Life-Saving Measures:** In the case of an emergency, any member of the Medical Staff with clinical privileges shall be permitted to provide any type of patient care necessary as a life-saving measure or to prevent serious harm, regardless of his or her clinical privileges, provided that the care rendered is within the scope of the individual's license. For the purpose of this section, an "emergency" is defined as a condition which without immediate medical intervention could reasonably be expected to result in placing the life of the patient in serious jeopardy or in serious or permanent harm to a patient.

- | B. **Disaster Privileges:** In disaster circumstances during which the emergency management plan has been activated and the Hospital is unable to meet immediate patient needs, the CEO or his/her designee may approve the use of a modified credentialing and privileging process to grant temporary disaster privileges to Practitioners who are not members of the Medical Staff to provide services during the emergency.

An individual requesting temporary privileges in these circumstances must produce his/her pocket license to practice medicine (or a copy of the license), a valid photo ID issued by a state or federal agency, such as passport; membership in ESAR-VHIP (Emergency System for Advance Registration of Volunteer Health Professionals, MRC (Medical Reserve Corps, DMAT (Disaster Management Assistance Team); the name of her/his malpractice insurance carrier, and the name and telephone number of a hospital where she/he currently has privileges or has recently practiced.

In granting Disaster privileges in this circumstance, the Hospital shall make every effort to verify current licensure directly with the appropriate state-licensing agency within 72 hours from the time the volunteer Practitioner presents to the Hospital. In addition, the Hospital shall attempt to contact the facility at which the Practitioner has recently practiced to verify that she/he is in good standing.

Once the Disaster situation is under control, the Hospital shall verify all information in accordance with Article II, Section 3 of this chapter.

Privileges granted in such situations are the core privileges in the volunteer's specialty. All individuals granted Disaster privileges under these circumstances must follow the

Hospital's Disaster Plan procedures. The Practitioner granted Disaster_privileges must have oversight by a credentialed Practitioner currently on staff who has a similar specialty, and who will oversee the professional performance of the volunteer. At all times, the volunteer must wear identification, which identifies her/him as a volunteer.

Within 72 hours of initial granting of privileges, a decision must be made regarding continuation of privileges, based on information acquired regarding the professional practice of the volunteer. A Practitioner's privileges, granted under this Disaster_situation, may be terminated at any time without any reason or cause. Termination of these privileges shall not give rise to a hearing or appellate review.

SECTION 6. TELEMEDICINE PRIVILEGES

The Hospital may rely on credentialing information provided by the Practitioner's distant site for credentialing and privileging decisions if that site is a Joint Commission accredited organization.

When the applicant's distant site is not a Joint Commission accredited organization, a Practitioner providing any telemedicine services must be fully credentialed in accordance with this Policy.

ARTICLE III. REAPPOINTMENT SECTION 1.

APPLICATION

Each Practitioner who wishes to be reappointed to the Medical Staff shall be responsible for returning a completed electronic reappointment application, accompanied by all required supporting documents, by the specified date. Applications received after the requested date are subject to a late fee as established by the UF Health Shands Hospital Credentialing Office and may result in expiration of the appointment and clinical privileges, if there is insufficient time to process the application before the current appointment expires. Failure to return the reappointment application will result in expiration of the appointment and clinical privileges. In applying for reappointment, the Practitioner shall have the burden of producing adequate information to assure that s/he continues to meet those criteria outlined in Chapter 1 of these Bylaws. If granted by the Board, reappointment shall be for a period not to exceed twenty-four months and may be to the same or different category and may limit or modify the clinical privileges to be extended.

SECTION 2. FACTORS TO BE CONSIDERED

Each recommendation concerning reappointment of a Practitioner and renewal of privileges shall be based, at a minimum, upon the member's:

- (1) current clinical competence, clinical judgment quality of patient care, and clinical activity level at UF Health Shands Hospital;
- (2) compliance with the Medical Staff and Hospital bylaws, policies and procedures, and rules and regulations;
- (3) ethical behavior and compliance with professional conduct expectations as reflected in Article VI of this chapter;
- (4) ability to perform the clinical privileges requested;
- (5) member's attestation regarding the completion of the appropriate State of Florida licensing board's mandated continuing education requirements for the individual's most recent license renewal period, with an affirmation that a majority of the required hours were related to the individual's clinical privileges, specialty and/or subspecialty; and,
- (6) any other findings relevant to the Practitioner's competence and ability to perform her/his professional duties and responsibilities.

SECTION 3. REAPPOINTMENT PROCEDURE

The completed application and supporting documents shall be forwarded to the Department Chair or for Department Chair applicants to the COS for evaluation of her/his demonstrated competence, professional performance, judgment, and clinical/technical skills, as indicated by FPPE, OPPE and other quality monitoring and assessment activities. Peer recommendations may be solicited and considered by the Chair or COS in recommending Medical Staff reappointment and/or continuation of specific clinical privileges. Upon completion of the evaluation, the procedure provided in Article I, Section 3 of this chapter will be followed.

ARTICLE IV. STATUS CHANGES

SECTION 1. LEAVE OF ABSENCE

- A. Medical Staff members may be granted leaves of absence for up to one year upon approval of the Board.
- B. Prior to return from a leave of absence, the Practitioner may request reinstatement by completing the prescribed return from leave of absence form.
 1. If a Practitioner engaged in clinical activity during the leave of absence; verification may be obtained from the practice site.

2. A practitioner not engaged in clinical activity during a LOA who cannot demonstrate current clinical competence related to the privileges requested shall be required to have a re-entry plan developed by his/her Department Chair submitted with the request for reinstatement. The completed form and any required supporting documentation will be processed in accordance with Article I, Section 3 of this chapter.
- C. Practitioners who have been absent from clinical practice for more than 30 days due to a Medical LOA are required to provide a signed release from their medical provider prior to return to active practice.
 - D. In acting upon the request for reinstatement, the Board may approve or disapprove reinstatement, either to the same or a different staff category, and/or may limit or modify the clinical privileges to be extended and/or may take any other action deemed necessary to assure quality of care and patient safety.
 - E. Staff members granted leave for a year who does not request a return to active practice will be automatically terminated from the Medical Staff unless a request for an extension is made and approved by the Board for extenuating circumstances.
 - F. Upon return from LOA, the Practitioner must provide evidence that he/she meets the Bylaws' requirement for continuous satisfaction of financial responsibility to pay claims.
 - G. See The Medical/Allied Health Staff Leave of Absence Policy for additional information.

SECTION 2. CHANGE IN CATEGORY

Whenever, during the term of an appointment to the Medical Staff, an individual desires to change her/his category, s/he shall make the request in writing, stating in detail the reasons for the change. The request will be processed in accordance with Article I, Section 3 of this chapter.

ARTICLE V. MEDICAL STAFF HEALTH ASSISTANCE

SECTION 1. GENERAL

In order to fulfill its obligation to protect patients, health care providers and other persons present in the Hospital from harm, the Medical Staff adopts the following process to identify and manage individual Medical Staff health matters that have the potential of adversely affecting patient care. This process is designed to focus on assisting the impaired Practitioner by facilitating confidential diagnosis, treatment, and rehabilitation of Practitioners who suffer from a potentially impairing condition, in order to permit him/her to retain or regain optimal professional functioning, without recourse to the Medical Staff disciplinary process. The process also aims to provide education about Practitioner health and address prevention of physical, psychiatric, or emotional illness.

- A. The impaired Practitioner is one who is unable to practice medicine with reasonable skill and safety or unable to work professionally and harmoniously with others within the Hospital, by

reason of mental/emotional illness or deficiency, physical illness or condition, or use/abuse of drugs or alcohol.

- B. Upon appointment to the Medical Staff, Practitioners shall receive information regarding illness and impairment recognition.

SECTION 2. REFERRAL

- A. As part of her/his commitment to provide or arrange for the provision of continuous quality patient care for her/his patients each Practitioner has a responsibility to self-report any physical, psychiatric or emotional impairment which may compromise her/his ability to perform her/his professional responsibilities.
- B. Whenever a Medical Staff member has cause to question her/his own ability to perform her/his professional responsibilities due to physical, psychiatric or emotional illness or impairment, s/he should report confidentially to the COS. The COS, shall facilitate a referral to the appropriate internal or external resource(s) for diagnosis, treatment and/or rehabilitation and notify the Administrator of such referral.
- C. If the COS or the Administrator receives information from a Practitioner or a Hospital staff member indicating the possibility of impairment of a Medical Staff member, the COS/Administrator, or her/his designee, shall request a written report from the concerned Practitioner/Hospital staff member describing the specific incident(s)/circumstance(s) (including witnesses) which has led to the belief that the affected Practitioner is impaired.
- D. The COS/Administrator shall discuss the information with the affected Practitioner and, if appropriate, facilitate a referral to the appropriate internal or external resource(s) for evaluation and/or treatment.
- E. The affected Practitioner shall cooperate fully with the COS/Administrator to assure that patient care is not compromised, including the voluntarily relinquishment of privileges if necessary.

SECTION 3. CONFIDENTIALITY

The referral of any Medical Staff member for assistance pursuant to Section 2 of this Chapter shall be kept confidential, except as limited by law, ethical obligation, or as necessary to ensure patient safety. To the greatest extent possible and considering principles of fairness, the identity of the reporting Practitioner or Hospital staff member shall remain confidential.

SECTION 4. INVESTIGATION OF COMPLAINTS OR CONCERNS

- A. In the event that a Medical Staff member is not fully cooperative with the COS's referral for evaluation under Section 2, concerns regarding the Medical Staff member's physical, psychiatric or emotional illness or impairment shall be investigated in accordance with Article IX of this chapter.
- B. If the investigation indicates that the Practitioner may be affected by an illness or impairment

that may compromise her/his ability to perform her/his professional responsibilities, a referral to the appropriate professional internal or external resource(s) for physical, psychiatric or emotional diagnostic and/or treatment or rehabilitative program shall be facilitated.

- C. If the affected Practitioner does not cooperate with the COS/Administrator regarding the referral after investigation, appropriate corrective action pursuant to Article IX of this chapter shall be taken in order to protect patients and maintain the orderly operation of the hospital.

SECTION 5. MONITORING

- A. Any recommendation for action shall provide for Hospital monitoring of the affected Practitioner to the extent necessary to assure patient safety. Such monitoring may include, but is not limited to the following: chart review; mandatory consultation; interviews with staff working with the affected Practitioner; and reports from a Practitioner recovery or other treatment/rehabilitation program.
- B. In order to facilitate appropriate monitoring, the affected Practitioner shall provide the COS/Administrator, either directly or through execution of the appropriate release form, with the terms of the contract and/or status reports from any Practitioner recovery or other treatment, rehabilitation or other monitoring program in which s/he is participating.
- C. Monitoring conditions agreed to pursuant to this Article are not subject to the hearing and appeals procedures under Article X of this chapter. Monitoring conditions imposed pursuant to an investigation under Article IX of this chapter may be subject to hearing and appeals as provided in Article X.
- D. If the affected Practitioner's privileges have at any time during the process been limited, either voluntarily or involuntarily, or a leave of absence effected, reinstatement of privileges shall be made only at such time as the affected Practitioner can demonstrate that s/he can practice safely. A finding from the Practitioner's treatment/rehabilitative/physician recovery program that s/he is able to practice without compromising patient safety shall be required. All other factors usually considered when a Practitioner requests reinstatement of privileges (such as proof of current competency) are also relevant.
- E. If the affected Practitioner disagrees with a decision regarding the reinstatement of her/his voluntarily restricted/relinquished privileges, s/he may request a fair hearing regarding that issue in accordance with Article X of this chapter.

SECTION 6. RELINQUISHMENT OF PRIVILEGES

If at any time during the referral, investigation or monitoring phase of the process under Sections 2, 4, or 5 above, it is determined that a Practitioner is unable to safely perform the privileges s/he has been granted, the affected Practitioner shall be granted the opportunity to voluntarily relinquish her/his privileges or take a leave of absence. If s/he does not voluntarily relinquish his/her privileges or take a leave of absence, the matter shall be referred for appropriate corrective action in accordance with Article IX of this chapter.

ARTICLE VI. PROFESSIONAL CONDUCT

SECTION 1. GENERAL

The UF Health Shands has adopted the framework of a fair and just culture. In the Just Culture environment, the organization is accountable for safe system designs and for responding to staff behaviors in a fair and just manner. Likewise, staff is accountable for reporting errors and unsafe conditions, and for following all procedures and policies created to safeguard patients, within a learning environment focused on designing safer healthcare systems.

The Just Culture framework provides a structured method to standardize the investigation of medical errors and management of staff behavioral choices in order to nurture and advance a culture of patient safety, and improve reliability and patient outcomes.

Intimidating behaviors and behaviors that undermine a culture of safety can foster medical errors, contribute to poor patient satisfaction and result in adverse outcomes. In addition, such behavior may increase the cost of care, and may cause qualified clinicians, administrators and managers to seek new positions in more professional environments. Safety and quality of patient care are dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, the Medical Staff is committed to addressing the problem of behaviors that threaten the performance of the health care team. The Medical Staff shall work to ensure optimum patient care by fostering desirable behavior in order to promote a safe, cooperative and professional healthcare environment. Episodes of unprofessional behavior shall be addressed and appropriate action taken to eliminate behaviors that undermine a culture of safety.

SECTION 2. DESIRABLE BEHAVIOR

All individuals granted privileges in the hospital must conduct themselves in a professional and cooperative manner, treating all persons with courtesy, respect and dignity. Failure to do so may result in corrective action, up to and including suspension or termination of privileges in accordance with this Chapter. Expected behaviors shall include:

- (1) timely communication, involving the appropriate person(s), in an appropriate setting;
- (2) communications, including spoken remarks, body language, written documents, and emails that are honest, direct, professional, constructive, and respectful;
- (3) appropriate preparation for telephone conversations and meetings by gathering all necessary information, organizing questions or comments, and coordinating with others to effect efficient communication regarding all necessary issues;
- (4) cooperation and availability when on call. When individuals are paged, they must respond promptly and appropriately to the issue(s) at hand;
- (5) an understanding that a variety of experience levels exists, and tolerance for those who are learning.

SECTION 3. BEHAVIORS THAT UNDERMINE A CULTURE OF SAFETY

A. Behavior that undermines a culture of safety is defined as conduct, whether verbal or physical, that negatively affects or may affect patient care, including behavior that:

1. disrupts the operation of the hospital;
2. affects the ability of others to perform their jobs;
3. has the effect of being personally degrading to others in the workplace;
4. creates a hostile work environment;
5. interferes with an individual's ability to practice competently;

Appropriate criticism offered in an appropriate place and manner, with the aim of improving patient care should not be construed as behaviors that undermine a culture of safety.

B. Specific examples of behaviors that undermine a culture of safety include :

1. Attacks or outbursts – verbal or physical – leveled at anyone, including: shouting or yelling; use of profanity; and slamming or throwing objects in anger or disgust, whether or not directed at a specific individual;
2. Comments (or illustrations) made in patient medical records or other official documents that are unnecessary for patient care, impugn the quality of care in the hospital, or attack particular individuals or hospital policies;
3. Refusal to accept Medical Staff assignments or refusal to participate in committee or departmental affairs in a professional and appropriate manner;
4. Hostile, condemning, or demeaning communications, including: 1) criticism of performance and/or competency that is delivered in an inappropriate location and not aimed at performance improvement; and, 2) criticism leveled at the recipient in such a way that it intimidates, undermines confidence, belittles, or implies stupidity or incompetence;
5. Other behavior demonstrating disrespect, or intimidation, or disrupting the delivery of patient care (e.g., reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions);
6. Retaliation against any person who addresses or reports unacceptable behavior.

SECTION 4. REPORTING EPISODES OF BEHAVIORS THAT UNDERMINE A CULTURE OF SAFETY

Any person may report conduct perceived as undermining to a culture of safety to a Hospital manager and/or COS, as appropriate, by providing the following information:

- (1) A factual and objective description of the situation and the questionable behavior (including date and time);
- (2) A statement of whether the behavior affected or involved a patient in any way; and, if so,

- information identifying the patient;
- (3) Persons present during the incident; and,
 - (4) Any immediate response to the situation.

SECTION 5. PROCESSING REPORTED EPISODES OF BEHAVIORS THAT UNDERMINE A CULTURE OF SAFETY

- A. Upon receipt of a report of behavior that undermines a culture of safety, the Hospital manager and/or COS shall conduct an inquiry to confirm details of the incident with witness interviews as appropriate.
- B. Upon completion of the inquiry, the report and documentation of the inquiry shall be forwarded to the COS for her/his review.
- C. If it is determined that a violation of the policy has not occurred, the individual bringing the complaint shall be notified.
- D. If it is determined that there appears to have been an episode of behavior that undermines a culture of safety, the COS shall request that the Practitioner provide him/her with a written response to the allegation and after review of such response may,
 - 1. meet with the Practitioner for discussion and collegial counseling (including identification of methods and resources for structuring professional and working relationships and resolving problems without behaviors that undermine a culture of safety) and document the discussion and any specific actions the individual has agreed to take, with a copy forwarded to the credentialing file; or,
 - 2. if the Practitioner has had previous occurrences, forward to the MEC for consideration of further action either under Article V or Article IX of this chapter; except that,
 - 3. all instances of egregious behavior that undermines a culture of safety shall automatically go to the MEC for consideration under Article V or IX of this chapter.
- E. Whenever an episode of behavior that undermine a cultures of safety has been confirmed:
 - 1. A copy of this Article shall be provided to the offending individual.
 - 2. The offending individual shall also be informed that the Medical Staff and Board of Directors require compliance with this Article and that attempts to confront, intimidate, or otherwise retaliate against the individual(s) who reported the behavior in question, by the involved Practitioner will be considered a violation of this Article and grounds for further disciplinary action.
 - 3. The approach during such an initial intervention should be collegial and helpful to the individual.
- F. A single egregious incident, such as sexual harassment (physical or verbal), assault, a fraudulent act, stealing, or damaging Hospital property, or inappropriate physical behavior, may result in corrective action in accordance with Article IX of this chapter up to and including suspension

and/or termination of privileges or Medical Staff appointment.

- G. All documented episodes of behavior that undermines a culture of safety shall be filed in the individual's credentialing file.

ARTICLE VII. FOCUSED PROFESSIONAL PRACTICE EVALUATION

SECTION 1. PURPOSE

The purpose of the Focused Professional Practice Evaluation (FPPE) is to establish:

- (1) a systematic review and evaluation process for assuring that individuals who have been granted initial or additional privileges are performing those new privileges competently and;
- (2) a deliberate and focused professional practice evaluation when indicated by Ongoing Professional Practice Evaluation (OPPE) mechanisms or by other Hospital or Medical Staff quality monitoring mechanisms.

SECTION 2. PERFORMANCE OF THE FPPE

The FPPE will be performed:

- (1) Upon the grant of initial privileges or additional privileges (new privileges); or,
- (2) When indicated by OPPE thresholds, or other quality indicators or sources of information that raise questions regarding a Practitioner's ability to competently perform his/her privilege(s).

SECTION 3. REQUIREMENTS FOR NEW PRIVILEGES

- A. Each clinical department chair must develop monitoring specifications to evaluate privilege-specific competence of every Practitioner granted new privileges in his/her department. Such monitoring may include chart review, monitoring clinical practice patterns, simulation, proctoring, or discussions with other Practitioners involved in the care of each patient. The monitoring process shall include:
 - 1. a recommended minimum period of time and/or number of procedures for review; and
 - 2. identification of circumstances under which monitoring by an external source is required.
- B. The timeframe for completion of the FPPE shall be no greater than six months unless an extension is granted by the MEC. The overall initial FPPE evaluation period cannot be extended beyond one year in total, except in extenuating circumstances approved by MEC.
- C. At the conclusion of the monitoring period for new privileges, the chair shall review the data and report to the MEC any Practitioner that has not adequately demonstrated his/her competence, with appropriate recommendations for further evaluation/action.

SECTION 4. REQUIREMENTS FOR QUALITY TRIGGERED FPPE

- A. Each department must develop specific thresholds for OPPE indicators that will trigger an FPPE and/or a recommendation to the COS for a more comprehensive review of the Practitioner's competency, as appropriate. FPPE initiated through other Hospital or Medical Staff quality monitoring mechanisms will follow the process set forth in the applicable document(s).
- B. The OPPE indicators and thresholds must be consistently implemented and applied.
- C. The results of an FPPE under this section will be reviewed by the department chair, and/or the MEC as required or otherwise appropriate under the Bylaws. If indicated, a specific performance improvement and/or corrective action plan shall be implemented to assure patient safety and quality care.

ARTICLE VIII. ONGOING PROFESSIONAL PRACTICE EVALUATION

SECTION 1. PURPOSE

The purpose of the OPPE is to establish a process for ongoing evaluation of each privileged Practitioner's practice to determine whether privileges continue to be performed competently.

SECTION 2. PERFORMANCE OF THE OPPE

- A. An OPPE will be conducted on all individuals privileged through the Medical Staff process.
- B. An OPPE report will be generated for each privileged Practitioner at 8 month intervals.

SECTION 3. REQUIREMENTS

- A. Each department chair must identify:
 - 1. the type of data to be collected for each privileged Practitioner to support the Practitioner's competency to maintain his/her privileges;
 - 2. when applicable, at least one Centers for Medicare and Medicaid Services/The Joint Commission "Core" measure that is a reliable indicator of the Practitioner's competency to maintain his/her privilege in his/her department will be included in the data to be collected for each privileged Practitioner;
 - 3. a threshold for each of the above elements that will result in a Chair review to determine the necessity for an FPPE or performance improvement intervention, as appropriate to ensure patient safety and quality care.
- B. Indicators recommended by the department chairs shall become effective upon approval of the

MEC. Every two years, each Chair shall review the type of data collected for his/her department and make recommendations for revisions to the MEC as indicated to assure that they continue to be reliable measures of competency.

- C. Results from routine peer review, conducted in accordance with hospital policy, will also be incorporated into the OPPE report of each privileged Practitioner. The MEC will establish a threshold for initiating Chair review of routine peer review results.

SECTION 4. REVIEW

- A. Each department chair shall timely review each 8-month OPPE report for his/her department and determine whether there is cause to initiate an FPPE.
- B. At the time of reappointment, the department chair shall consider the Practitioner's OPPEs in making his/her recommendation for continuation of specific privileges to the Credentials Committee.

ARTICLE IX. CORRECTIVE ACTIONS

The Medical Staff is responsible not only for establishing, but for maintaining patient care standards and providing oversight of the quality of care rendered by Practitioners privileged through the Medical Staff process. The procedures set forth below provide guidelines for the Medical Staff to evaluate complaints or concerns regarding patient care, including the orderly functioning of the hospital, to formulate corrective action, and to monitor performance.

SECTION 1. GROUNDS FOR INITIATING AN INVESTIGATION

- A. Whenever, on the basis of information and belief, the COS, the chair of a clinical department, the chair or a majority of any Medical Staff committee, a Medical Staff member, the Chair of the Board, or the Administrator has cause to question:
 - 1. the clinical competence or performance of any Medical Staff member;
 - 2. the care or treatment of a patient(s) or management of a case(s) by any Medical Staff member;
 - 3. the conduct of any Medical Staff member with regard to applicable ethical or professional standards, including expected behavior as set forth in these Bylaws, and the bylaws, policies, procedures, rules or regulations of the Hospital and Board, including, but not limited to the Hospital's quality improvement, risk management, and utilization review programs;

A written request for an investigation of the matter shall be addressed to the COS, or if the COS is the requester he/she shall address the request to the MEC, making specific reference to the incident(s), activity (ies) or conduct that constitutes the basis for the request. The COS shall promptly notify the Administrator of all such requests and proceed in accordance with the investigation procedures outlined in Section 3 of this chapter.

- B. Nothing in this Article is meant to restrict the ability of any medical review or peer review committee to conduct a review or informal investigation of a member's practice in connection with such committee's quality improvement and/or assurance responsibilities.

SECTION 2. SELF REFERRAL

Whenever a Practitioner has cause to question his/her own ability to perform his/her professional responsibilities due to physical, psychiatric or emotional illness, the COS, shall assist in facilitating a referral to the appropriate agency in accordance with Article V of this chapter. The physician shall cooperate with the COS, to assure that patient care is not compromised.

SECTION 3. INVESTIGATIVE PROCEDURE

If, after receiving a request for investigation, the COS determines:

- A. the request contains sufficient information to support a recommendation, s/he shall make a recommendation for action to the MEC, with or without a personal interview with the member; or
- B. the request does not contain sufficient information to support a recommendation, the COS shall promptly appoint a subcommittee of the MEC to investigate, appoint an ad hoc investigating committee, or present to the MEC for investigation as a committee.
 - 1. An Investigating Committee shall consist of at least three individuals, any of whom may or may not hold an appointment to the Medical Staff. If possible, this committee should not include partners, associates, or relatives of the subject of the investigation, nor Practitioners in direct economic competition with the subject of the investigation.
 - 2. The Investigating Committee shall have available to it the full resources of the Medical Staff and the Hospital to aid in its work, as well as the authority to use external consultants, as necessary.
 - 3. The Investigating Committee may require a physical and/or mental examination of the Practitioner under review by a physician(s) satisfactory to the committee and the results of such examination must be made available for the committee's consideration.
 - 4. The subject of the investigation shall have an opportunity to meet with the Investigating Committee before it completes its report. At this meeting (but not, as a matter of right, in advance of it) the member will be informed of the general nature of the evidence supporting the investigation and will be invited to discuss, explain or refute it. This interview does not constitute a hearing, and none of the procedural rules provided in these Bylaws with respect to hearings, including the right to have legal counsel present, apply. A summary of such interview shall be made by the Investigating Committee and included with its report to the MEC.
 - 5. The Investigating Committee shall submit a report to the MEC that includes the evidence reviewed and its findings

SECTION 4. SUMMARY SUSPENSIONS

A. Prior to Investigation

1. Upon a reasonable belief that failure to take such action may result in imminent danger to the health and/or safety of any individual, the COS, the chair of a department, the Administrator, or in her/his absence, her/his designee, or the Chair of the Board shall each have the authority to summarily suspend or restrict all or any portion of the clinical privileges of a Medical Staff member.
2. Upon a reasonable belief that failure to take such action may compromise the health, safety or welfare of trauma patients, the Medical Director of the Trauma Service shall have the authority to summarily suspend or restrict all or any portion of the clinical privileges of a Medical Staff member.
3. Prior to implementation of such summary suspension or restriction, the Administrator, her/his designee, the Chair of the Board or Trauma Medical Director, shall, whenever practicable, consult with the COS.
4. Any individual who exercises authority under Paragraph 1 or 2 to summarily suspend clinical privileges must assure that the Administrator and COS are both notified.
5. The COS shall initiate an investigation of the matter prompting the summary suspension in accordance with Section 3 of this Article.

B. During an Investigation

At any time during an investigation, the COS, the Administrator, or the Chair of the Board may suspend all or any part of the clinical privileges of the member being investigated upon a reasonable belief that failure to take such action may result in an imminent danger to the health and/or safety of any individual.

C. General Requirements for Summary Suspensions

1. A summary suspension shall become effective immediately upon imposition and remain in effect unless or until modified by the Administrator or the Board.
2. An investigation must be completed within 14 days of the suspension or reasons for the delay must be transmitted to the Board so that it may consider, as soon as practicable, whether the suspension should be lifted prior to its completion.
3. Immediately upon the imposition of a summary suspension, the appropriate department chair, or in her/his absence, the COS shall transfer the care of the suspended member's patients to another Medical Staff member. In making such a transfer, the wishes of the patient shall be considered whenever possible.
4. It shall be the duty of the COS and the department chair to cooperate with the Administrator in enforcing all suspensions.

5. Summary suspension under this section shall be deemed an interim precautionary step in the professional review activity and shall not imply a final finding of responsibility for the situation that prompted the suspension.

D. Request for Review of Summary Suspension

1. When a summary suspension is initiated pursuant to this section, the Administrator will provide the affected Practitioner with Notice of her/his right to a review of the suspension as soon as possible.

This notice shall contain:

- a. a statement of the general reasons for the initial suspension;
 - b. a statement that the individual has a right to request review of the summary suspension and two (2) days from receipt of the Notice to request such review in writing;
 - c. a statement that failure to request a review in the time and manner specified will result in a waiver of the Practitioner's right to a review of the summary suspension; and
 - d. a statement that the Practitioner may meet with the review panel to rebut the need for the summary suspension.
2. The affected Practitioner shall have two (2) days from the date of receipt of such Notice, as indicated by proof of delivery, to submit a written request for a review to the Administrator.
 3. If the affected Practitioner does not submit a written request for a review within two (2) days of receipt of the Notice, s/he shall be deemed to have waived her/his right to such review and the suspension shall remain in effect until modified by the Administrator or by the Board.
 4. If the affected Practitioner requests a review, it shall be deemed to have waived her/his right to a hearing on any summary suspension initiated under this section in effect for 30 days or less.
 5. Upon receipt of an appropriate request for a review, the Administrator, in consultation with the Chief of Staff, shall promptly appoint an ad hoc review panel composed of three members of the Credentials Committee, schedule the review as soon as practicable, and give Notice to the Practitioner of its date, time, and place. Every reasonable effort should be made to schedule the review within twenty-seven (27) days of the initial suspension. The notice must also list the patient records and/or other information supporting the initiation of the summary suspension.
 6. The only matter to be considered during the interview and review is the reasonableness of initiating a summary suspension to address the imminent risk to the health or safety of a patient or others. The individual initiating the suspension will provide the ad hoc panel with a summary of the reason for initiation prior to its interview with the affected Practitioner. After interviewing the Practitioner, the ad hoc review panel may recommend continuation of the suspension, termination of suspension or a modification of its terms. A recommendation for termination or modification of the summary suspension may be made only if the review panel concludes that the basis for the suspension did not reasonably meet

the requirements of this Policy. The Panel's recommendation and the reasons therefore will be provided to the Administrator and the Chief of Staff as soon as possible after the interview for their consideration.

7. The summary suspension shall remain unchanged until and unless modified by the Administrator or the Board.

SECTION 5. RECOMMENDATIONS FOR CORRECTIVE ACTIONS

- A. After review of the Investigative Committee report, the MEC may recommend any appropriate action in furtherance of safe, quality care and performance improvement, including but not limited to:
 - no action;
 - further evaluation;
 - a written warning;
 - a letter of reprimand;
 - proctoring;
 - consultation;
 - reduction or revocation of clinical privileges;
 - remedial education;
 - referral to the appropriate professional internal or external resource, including physical, psychiatric or emotional diagnostic and/or rehabilitative programs;
 - termination of membership.
- B. A recommendation for action will provide for monitoring of the affected Practitioner to the extent necessary to assure patient safety.
- C. If the recommendation of the MEC would entitle the affected member to a hearing in accordance with Article X of this chapter, the recommendation shall be forwarded to the Administrator, who shall promptly give Notice to the affected member. The Administrator shall then hold the recommendation until after the member has exercised or waived her/his right to a hearing and appeal as provided in Article X. At that time, the Administrator shall forward the MEC's recommendation, together with all supporting documentation, to the Board. The COS or her/his designee shall be available to the Board to answer any questions that may be raised with respect to the recommendation.
- D. If the recommendation of the MEC includes a recommendation for the imposition of an immediate suspension or restriction of clinical privileges based on the reasonable belief that failure to take such action may result in imminent danger to the health and/or safety of any individual, the recommendation will take effect immediately and remain in effect until modified by the Administrator or Board. The COS must promptly give Notice to the affected member of the recommended suspension/restriction, its immediate effect, and her/his right to the hearing and appeals process provided in Article X.
- E. If the recommendation of the MEC would not entitle the individual to a hearing, in accordance with Article X, the action shall take effect immediately. A report of the action taken and reasons

therefore shall be made to the Board through the Administrator and the action shall stand unless modified by the Board.

- F. In the event the Board considers modification of an MEC action given immediate effect pursuant to Subsection E, and such modification would entitle the individual to a hearing, the affected member, will be given Notice by the Administrator, and no final action thereon shall be taken by the Board until the individual has exercised or waived her/his right to a hearing and appeal.

SECTION 6. AUTOMATIC TERMINATION OF MEMBERSHIP AND/OR SUSPENSION OF PRIVILEGES

- A. Termination of membership and/or suspension of all clinical privileges shall occur automatically as indicated upon the occurrence of any of the following events:
 1. Failure to report to the Hospital any licensure action that limits the member's authority to practice in the State of Florida within seven (7) days of imposition of such action.
 2. Revocation or restriction of license to practice shall result in automatic termination of membership.
 3. Suspension of license to practice or revocation or suspension of DEA registration shall result in automatic summary suspension of all clinical privileges and prompt investigation in accordance with this Article. A summary suspension based on suspension of license to practice will be in effect, at a minimum, for a period concomitant with State action without a right to a hearing and appeal.
 4. Failure to take appropriate steps to cause license or DEA registration renewal, thereby rendering the license or DEA registration inactive, shall result in automatic suspension of all clinical privileges. For license renewals, privileges will be terminated if license is not renewed within 30 days. In the case of DEA registration, suspension will remain until waiver is requested and obtained from the Board, the granting of which waiver is within the sole discretion of the Board.
 5. Failure to appear at a Medical Staff or Hospital committee meeting to which the Medical Staff member has been invited, and at which a discussion of the Medical Staff member's clinical or professional practice is scheduled, unless excused by the MEC upon a showing of good cause, shall result in automatic suspension of privileges. Such suspension will be automatically rescinded upon the Medical Staff member's participation in a rescheduled conference; provided that the Practitioner makes a request within 14 days of the original conference date to reschedule. Upon failure to request the rescheduling within 14 days, the Medical Staff member's membership will be automatically terminated.
 6. Failure to undergo a medical, psychological and/or psychiatric examination/evaluation at the request of the Credentials Committee, MEC or Board shall result in automatic suspension of privileges. Such suspension will be automatically rescinded upon the member's agreement to comply with the request; provided that the Practitioner commits within 14 days of the suspension. Upon failure to agree to comply with the request within 14 days, the Medical Staff member's membership will be automatically terminated.

7. Failure to complete medical records in a timely fashion, in accordance with the requirements of the Bylaws, Chapter 3 and Hospital Policy, shall result in automatic suspension of all clinical privileges (except for patients currently under his/her care) until such time as completion has occurred.
 8. Failure to maintain the minimum profession liability insurance coverage (including, if appropriate, NICA coverage), established by the Board shall result in automatic termination of membership, unless the Medical Staff member has requested waiver of such requirement from the Board and is awaiting final action on such request.
 9. Failure of the appointee to maintain a practice or residence in sufficient proximity to the hospital as required by these Bylaws shall result in automatic termination of membership, unless the appointee has requested waiver of such requirement from the Board and is awaiting final action on such request.
 10. Exclusion or suspension (temporary or permanent) from participation in any federal program shall result in automatic termination of membership.
 11. Lack of patient care activity as indicated by the most recent two (2) OPPE reports shall result in automatic termination of membership unless such person qualifies for Honorary Staff membership or in special circumstances when such person remains actively engaged in quality improvement and/or Medical Staff leadership.
 12. Failure to acquire Board Certification within the timeframe established in these Bylaws, or failure to maintain current Boards in primary specialty shall result in automatic termination of membership unless the appointee has requested waiver of such requirement from the Board and is awaiting final action on such request.
 13. Failure to continuously meet the requirements of a Medical Staff category established in these Bylaws shall result in automatic termination of membership.
 14. Failure to request a return to active practice after a one-year Leave of Absence, in accordance with Article IV, Section 1 of this chapter, will result in automatic termination of membership.
- B. Upon the occurrence of any of the foregoing events, the Administrator, or her/his designee, shall promptly give Notice of the automatic termination or suspension to the affected Medical Staff member, and the specific grounds for the termination/suspension. Within ten (10) days of receipt of such Notice, the affected Medical Staff member may present written evidence to the Administrator that negates the grounds for the automatic suspension or termination. If the Administrator determines, in his/her sole discretion, that the written evidence is sufficient to negate the grounds for the automatic suspension or termination, s/he shall give Notice to the affected Medical Staff member and the automatic suspension or termination shall be considered void from the beginning. Unless otherwise provided in this section, any automatic suspension that is not corrected within thirty (30) days shall result in automatic termination, without further notice. Automatic terminations not imposed due to a pending request of a board waiver will take effect immediately upon denial of the request.
- C. Practitioners terminated due to lack of clinical activity or failure to return reappointment applications will not be able to reapply to UF Health Shands for a period of one year.

- D. It is the responsibility of the COS and the Administrator, to enforce all automatic suspensions and terminations.

SECTION 7. CONFIDENTIALITY AND REPORTING

All minutes, reports, recommendations, communications, and actions made or taken pursuant to these Bylaws are deemed confidential and/or privileged pursuant to federal and/or state statutes providing protection to peer review or related activities and to such policies regarding confidentiality as may be adopted by the Hospital. Furthermore, the committees and/or panels charged with making reports, findings, recommendations or investigations pursuant to these Bylaws shall be considered to be acting on behalf of the Hospital and its Board when engaged in such professional review activities and thus shall be deemed the "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986.

Reports of actions taken pursuant to this Policy shall be made by the Administrator to such governmental agencies as may be required by law.

ARTICLE X. FAIR HEARING AND APPEALS PROCEDURES

SECTION 1. INITIATION AND SCHEDULING OF A HEARING

A. Right to Hearing

Except as provided in Paragraph B of this section, a Practitioner is only entitled to a hearing whenever any of the following adverse recommendations, or adverse actions, have been made or taken by the MEC, or the Board:

1. denial of Medical Staff appointment or reappointment;
2. revocation of Medical Staff membership;
3. denial of requested clinical privileges;
4. revocation of clinical privileges;
5. suspension of clinical privileges;
6. imposition of mandatory concurring consultation requirement.

No Practitioner shall be entitled to more than one hearing with respect to the subject matter of any proposed adverse recommendation or action giving rise to a hearing right. A hearing right provided as to an initial or proposed adverse recommendation or action by the MEC satisfies the requirements for a hearing right as to the final recommendation or action by the Board that is based on the same subject matter.

B. Actions Not Giving Rise to Hearing Right

Recommendations for, or imposition of, any of the following actions by the MEC or Board do not constitute grounds for a hearing:

1. denial of Medical Staff, appointment or reappointment, or revocation of Medical Staff appointment based on an inability to meet any one of the minimum objective criteria for appointment set forth in Chapter 1 of these Bylaws;
2. automatic suspension of privileges or termination of membership pursuant to Article IX, Section 6 of this chapter;
3. revocation of clinical privileges as a result of change and/or elimination of services offered by the Hospital;
4. summary suspension pursuant to Article IX, Section 4 of this chapter, unless such suspension remains in effect for more than 14 days and the affected Practitioner has not requested a review of the summary suspension pursuant to Article IX Section 4;
5. denial or termination of temporary privileges under Article II, Sections 3 and 4, or emergency privileges under Article II, Section 5, of this chapter;
6. Any other corrective action which does not restrict the clinical privileges of the Practitioner, including but not limited to;
 - a. general consultation or corrective counseling requirement;
 - b. issuance of a letter of warning, admonition or reprimand;
7. denial of a request for waiver from the Board of any appointment criteria set forth in Article I, Section 1 of Chapter 1;

C. Notice of Adverse Recommendation or Action and Request for Hearing

1. When a recommendation is made or action is taken that entitles an individual to a hearing prior to final action of the Board, the affected Practitioner shall promptly be given written Notice by the Administrator. This Notice shall contain:
 - a. a statement of the recommendation/action and the general reasons for it;
 - b. a statement that the individual has a right to a hearing on the recommendation/action and thirty (30) days from receipt of the Notice to request such hearing;
 - c. a statement that failure to request a hearing in the time and manner specified will result in a waiver of the Practitioner's right to a hearing and acceptance of the adverse recommendation/action;
 - d. a summary of the Practitioner's rights during the hearing as provided for in Section 2, Paragraph C of this Article; and
 - e. if the hearing is regarding a summary suspension pursuant to Article IX Section 4 of this chapter, a statement that the hearing is limited to the reasonableness of initiation of the suspension.

2. The affected Practitioner shall have thirty (30) days from the date of receipt of such Notice, as indicated by proof of delivery, to submit a written request for a hearing to the Administrator.
3. If the affected Practitioner does not submit a written request for a hearing within thirty (30) days of receipt of the notice, s/he shall be deemed to have waived her/his right to such hearing and to have accepted the recommendation and/or action, and any action taken by the Board shall be deemed final.

D. Scheduling and Notice of Hearing

Within fifteen (15) days of receipt of the affected Practitioner's written request for a hearing, the Administrator must schedule the hearing and give Notice to the Practitioner of its time, place and date. The hearing must begin as soon as practicable, but no sooner than thirty (30) days from the date of Notice, unless an earlier hearing date has been specifically agreed to in writing by the affected Practitioner.

1. The Notice must also:
 - a. include a concise statement of the specific reasons for the recommendation(s) giving rise to the hearing;
 - b. list the patient records and other information supporting the recommendation(s);
 - c. in accordance with Paragraph E of this Section, list the witnesses who are expected to testify or present evidence at the hearing in support of the recommendation, and inform the Practitioner of her/his obligation to provide the Administrator within fifteen (15) days of receipt of the notice with a list of witnesses s/he expects to testify or present evidence on her/his behalf; and
 - d. inform the Practitioner of her/his right to be represented at the hearing by an attorney or other person of her/his choice and her/his obligation to advise the Administrator within fifteen (15) days of receipt of the notice of the name and address of such attorney or other person.
2. The statement of reasons and list of supporting documents may be amended or supplemented at any time, even during the hearing, provided the new material is relevant to the appointment or clinical privileges of the affected Practitioner, and that the Practitioner and her/his counsel have sufficient time to study the new information and rebut it.

E. Exchange of Witness Lists

A written list of the names, titles and/or professional affiliation(s) of the individuals expected to give testimony or present evidence in support of the recommendation(s) giving rise to the hearing shall be provided to the affected Practitioner with the notice of hearing. Within fifteen (15) days of receiving the notice of the hearing, the affected Practitioner must provide a written list of names, titles and/or professional affiliations of the individuals expected to give testimony or present evidence at the hearing on her/his behalf. The witness list of either party may be supplemented or amended at any time prior to the hearing, provided that notice of the change is given to the other party.

SECTION 2. HEARING PROCEDURE

The purpose of the hearing shall be to recommend a course of action to the Board, and the duties of the Hearing Panel shall be so defined. The hearing is to be conducted in as informal a manner as possible, subject to the rules and procedures set forth in this policy.

A. Appointment of Hearing Panel

1. When a hearing is requested, the Administrator, after considering the recommendations of the COS (and that of the Chair of the UF Health Shands Quality Committee of the Board, if the hearing is occasioned by a Board determination), shall appoint a Hearing Panel.
2. A Hearing Panel shall be composed of not less than three individuals, who may or may not be members of the Medical Staff and must include peer representation. Medical Staff appointees to the Hearing Panel shall not have actively participated in consideration of the matter involved at any previous level; knowledge of the matter involved, however, shall not preclude any individual from serving as a member of the Hearing Panel. Nor shall the Hearing Panel include any individual who is in direct economic competition with the affected Practitioner, nor any individual who is related to the Practitioner. The Administrator shall designate a Chair of the Hearing Panel.

B. Appointment of Presiding Officer

1. The Administrator shall select a person to act as the Presiding Officer during the hearing.
2. The Presiding Officer may either be the Chair of the Hearing Panel, or an individual who is not a member of the hearing panel, including an attorney, who:
 - a. did not actively participate in consideration of the matter involved at any previous level. Knowledge of the matter involved, however, shall not preclude any individual from serving as the Presiding Officer;
 - b. is not in direct competition with the affected Practitioner;
 - c. is not related to the affected Practitioner.
3. The Presiding Officer shall:
 - a. act to ensure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral testimony and/or documentary evidence and that decorum is maintained throughout the hearing;
 - b. determine the order of proceeding throughout the hearing;
 - c. have the authority and discretion to make rulings, consistent with this Policy, on all questions of procedure and admissibility of evidence; and
 - d. have the authority to remove any person who is disruptive to the orderly and professional process of the hearing.

The Presiding Officer may be advised on these matters by legal counsel to the Hospital.

4. The Presiding Officer must not act as a prosecuting officer, or as an advocate for either side at the hearing. S/he may participate in the private deliberations of the Hearing Panel and act as advisor to it, but shall not be entitled to vote on its recommendations, unless s/he is the Chair of the Hearing Panel.

C. Rights of Affected Practitioner and Hospital

During the hearing, both the affected Practitioner and the Professional Review Body whose recommendation prompted the hearing have the right to:

1. representation by an attorney or any other person of her/his choice; except that, if the affected Practitioner is not represented by an attorney, the Hospital will not be either;
2. call, examine and cross-examine witnesses;
3. present evidence, unless it is determined to be irrelevant by the Presiding Officer; and
4. submit a written statement at the close of the hearing, in accordance with Paragraph I (5) of this Section.

D. Requests for Documents

1. At least 5 days prior to the hearing, each party must provide to the other party documents in its possession that it plans to rely on as evidence at the hearing. Such documents may be supplemented at any time prior to the conclusion of the hearing, as long as the receiving party has sufficient time to study the new information and rebut it.
2. Providing documents to the other party shall not waive any privilege or confidentiality provided by law or policy to those documents; all documents will remain subject to such privilege and confidentiality protections.

E. Postponement of Hearing

Upon agreement by both parties, the hearing may be postponed beyond the time originally Noticed. If the parties cannot agree, postponement will be permitted only by the Presiding Officer, upon a showing of good cause by the requesting party.

F. Failure to Appear and Participate

The personal presence of the affected Practitioner at the hearing is required. Failure of the affected Practitioner to appear and participate at the hearing, without good cause as determined by the Presiding Officer, shall be deemed to constitute acceptance of the recommendation(s) or action(s) pending. Such recommendation(s) or pending action(s) shall become final and effective upon Board action.

G. Attendance by Panel Members

It is preferable to have all members of the Hearing Panel continually present during the hearing; however, to assure conclusion of a hearing within a reasonable timeframe, the hearing may continue even though all members of the Hearing Panel are not present at all times. The fact

that not all panel members were physically present at all times during the hearing shall not invalidate it.

H. Hearing Record

1. A record of the hearing shall be documented by a court reporter or by an electronic recording of the proceedings. The cost of such reporter shall be borne by the Hospital, but copies of the transcripts or electronic recording shall be provided upon request to the affected Practitioner at her/his expense.
2. The Hearing Panel may, but shall not be required to, order that oral evidence be taken only on oath or affirmation administered by a person authorized to notarize documents in this State.

I. Presentation of Evidence

1. The Professional Review Body whose recommendation prompted the hearing shall present its evidence first. Upon completion of its presentation, the affected Practitioner shall present her/his evidence. The Professional Review Body shall then have an opportunity to rebut any evidence presented by the affected Practitioner.
2. Both parties to the hearing shall be permitted to present evidence, unless it is determined not to be relevant by the Presiding Officer, regardless of the admissibility of such evidence in a court of law. The Presiding Officer shall admit any evidence which is commonly relied upon by reasonably prudent persons in the conduct of serious affairs.
3. The Hearing Panel may interrogate the witnesses, call additional witnesses, or request documentary evidence.
4. The Hearing Panel shall have the discretion to take official notice of any relevant matters as to which the Panel believes there can be no reasonable dispute. Official notice may also be taken of generally recognized technical or scientific facts within the Hearing Panel's members' specialized knowledge. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.
5. At the close of the hearing, each party shall have the right to submit a written statement concerning any issue, procedure, or alleged fact. Such written statement may take the form of a memorandum of points and authorities. The Hearing Panel may request that such a statement or memorandum be filed by either party.

J. Standard of Proof

The affected Practitioner has the burden of proving that the recommendation that prompted the hearing was unreasonable or not supported by substantial evidence. Unless s/he so proves, the Hearing Panel must recommend in favor of the Professional Review Body.

K. Adjournment and Conclusion

The Presiding Officer may, without special notice, adjourn and reconvene the hearing at the convenience of the participants. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed.

L. Deliberations and Recommendation of the Hearing Panel

1. Within twenty (20) days after conclusion of the hearing, the Hearing Panel must:
 - a. conduct its deliberations outside the presence of any other person, except the Presiding Officer, and upon the request of the Hearing Panel, appropriate Hospital support personnel (including the Hospital's attorney);
 - b. render a report containing a recommendation(s) and a concise summary of the reasons supporting the recommendation. The recommendation shall be based on material allowed into evidence at the hearing, which may include: oral testimony of witnesses; documentary evidence; all officially noticed matters; any other evidence that has been admitted. In addition, the Hearing Panel shall consider any written statement or memorandum of points and authorities submitted by the parties. The recommendation shall comport with the burden of proof requirement set forth in Subsection J. Agreement by a majority of the members of the Hearing Panel is required for the issuance of its report;
 - c. deliver its report to the Administrator.
 - d. Upon its receipt, the Administrator shall promptly provide the Hearing Panel's report to the affected Practitioner by any manner permitted for a Notice. The Administrator shall also send a copy of the report to the Professional Review Body whose adverse recommendation prompted the hearing, and the MEC. Once the affected Practitioner exhausts or waives any appeal rights, the Administrator shall promptly forward the Hearing Panel report to the Board for final action.
 - e. The Administrator shall make available to the Board all supporting documentation and transcripts of the hearing at the time of its review.

SECTION 3. APPELLATE REVIEW

A. Request for Appellate Review

Within 10 days of notification by the Administrator of an adverse recommendation from the Hearing Panel, the affected Practitioner may request appellate review, unless the Hearing Panel recommendation is one that would not be subject to Hearing as per Section 1B of this Article. The request must be in writing and delivered to the Administrator with receipt acknowledged by signature, and shall include a brief statement of the facts supporting grounds for the appeal. The Administrator shall promptly forward the request to the Chair of the Board. If such appellate review is not requested in a timely fashion and in the manner required, the affected Practitioner shall be deemed to have waived the right to an appeal and to have accepted the adverse recommendation of the Hearing Panel.

B. Grounds for Appeal

The grounds for an appeal are that:

1. there was substantial failure on the part of the Hearing Panel to comply with these Bylaws, and such failure significantly prejudiced the affected Practitioner; or
2. the recommendations of the Hearing Panel were arbitrary or capricious; or
3. the recommendations of the Hearing Panel were not supported by the evidence.

C. Scheduling and Notice of Appellate Review

1. Within 10 days of receipt of a request for an appeal, the Administrator shall schedule and arrange for an appellate review. The date of appellate review must not be less than 20 days, nor more than 45 days, from the date of receipt of the request; provided, however, that when a request for appellate review is from a Practitioner who is under a suspension then in effect, the appellate review must be held as soon as the arrangements may reasonably be made. The Administrator shall give the affected Practitioner Notice of the time, place, and date of the appellate review.
2. The time set for the appellate review may be postponed by the Chair of the Board beyond the time originally Noticed upon a showing of good cause by the Appellate Review Panel.

D. Appointment of Appellate Review Panel

1. The Chair of the Board shall appoint a Review Panel composed of not less than three nor more than five persons, who may be members of the Board or others, including reputable persons outside the hospital, but must include at least one peer, to consider the record upon which the Hearing Panel recommendation was made.
2. Appointees to the Appellate Review Panel must not have actively participated in the consideration of the matter involved at any previous level; knowledge of the matter involved, however, shall not preclude any individual from serving as a member of the Appellate Review Panel. Nor shall it include any individual who is in direct economic competition with the affected Practitioner, nor any individual who is related to the Practitioner. The Chair of the Board shall designate a Chair of the Appellate Review Panel.

E. Attendance by Appellate Review Panel Members

A majority of the members of the Appellate Review Panel must be present at each meeting of the Panel. The Chair of the Appellate Review Panel may, without special notice, adjourn and reconvene the review meeting at the convenience of the participants.

F. Purpose and Standard of Appellate Review

1. The purpose of the Appellate Review is to ascertain the fairness of the hearing procedure and to determine whether the recommendation of the Hearing Panel is supported by the evidence submitted at the hearing. The Appellate Review Panel shall review the hearing record, including all documentary evidence and any written statements submitted by the parties before making its determinations and recommendations to the Board.
2. The Appellate Review Panel must uphold the recommendation of the Hearing Panel unless it finds that:

- a. the Hearing Panel's recommendation was not supported by substantial evidence in the record, or was arbitrary or capricious;
- b. the procedures followed in reaching the recommendation were not fair or not in substantial compliance with these Bylaws and such unfairness or lack of compliance significantly prejudiced the affected Practitioner.

G. Additional Evidence

The Appellate Review Panel may not accept additional oral or written evidence, unless so directed by the Board upon a good faith belief that the affected Practitioner was unfairly denied the opportunity to present such evidence at the hearing, except that the Appellate Review Panel may, in its sole discretion, invite the affected Practitioner to appear and make a statement.

H. Recommendation of the Appellate Review Panel

1. Within fourteen (14) days of the date Noticed for the Appellate Review, the Appellate Review Panel shall render a written report containing a recommendation in accordance with this Section and a concise summary of the reasons supporting its recommendation and forward such report to the Board and the Administrator. The recommendation shall comport with the standard of review set forth in Subsection F of this Section. If the Appellate Review Panel's recommendation does not uphold the Hearing Panel's recommendation, it may recommend referral back to the Hearing Panel or the MEC, as appropriate, with instructions for remedial action. Agreement by a majority of the members of the Appellate Review Panel is required for the issuance by the Panel of any recommendation or report. In the preparation of its written report with recommendation, the Appellate Review Panel may obtain assistance from the Hospital support staff (including the Hospital attorney).
2. Upon its receipt, the Administrator shall forward the Appellate Review Panel's report with recommendation to the Hearing Panel, the Professional Review Body whose adverse recommendation prompted the hearing, the MEC and communicate the report with recommendation by Notice to the affected Practitioner.

SECTION 4. FINAL DECISION OF THE BOARD

A. Final Board Action

1. The Board may affirm, modify or reverse the recommendation presented to it for final action, after exhaustion or waiver of hearing and appeal rights by the affected Practitioner, or, in its sole discretion, refer the matter for further review and recommendations, to be completed within 30 days or less, as per the Board's direction.
2. If the Board proposes an adverse final action inconsistent with that of the final recommendation before it, the Chair of the Board shall consult with the COS before taking such final action.

3. The Administrator shall promptly give Notice of the final Board action to the affected Practitioner, and inform the Panel providing the recommendation and the COS, who shall distribute to the MEC.

B. Further Review

Final Board action shall be effective immediately and is not subject to further review. No Practitioner shall be entitled as a matter of right to more than one hearing or appellate review on any single matter.

SECTION 5. REAPPLICATION AFTER ADVERSE FINAL ACTION

In the event that the Board denies initial appointment or reappointment to the Practitioner, or revokes or terminates the Practitioner's Medical Staff appointment and/or clinical privileges, the Practitioner may not again apply for Medical Staff appointment or clinical privileges at this Hospital for a period of five years, unless the Board provides otherwise in its written final decision.

CHAPTER 3

ARTICLE I - ADMISSION, TRANSFER AND DISCHARGE OF PATIENTS

SECTION 1. ADMISSIONS

A. Admitting Practitioners and Their Responsibilities:

1. Each patient shall be accepted and/or admitted only upon order of a Medical Staff member with admitting privileges. The admitting Practitioner may order the patient's status to be determined in accordance with the Case Management Protocol. See Core Policy and Hospital Guideline CP1.76 and CP1.76g, *Level of Care Designation for Patients*, Core Policy and Hospital Guideline CP 2.73 and CP2.73g, *Case Management Admission Protocol*
2. All admissions shall be made in accordance with these Rules and Regulations and the requirements of Core Policy and Hospital Guideline CP1.10 and CP1.10g, *Patient Acceptance, Admission, Transfer and Discharge*.

B. Practitioners without Admitting Privileges: Active or Courtesy Medical Staff who practice in specialties that do not generally require admitting privileges shall not be privileged to admit patients to the hospital without specific request for and grant of admitting privileges. Such Practitioners include, but are not limited to, those in the following specialties: Anesthesia, Emergency Medicine, General Dentistry, Pathology, and Radiology.

C. Provisional Diagnosis: Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency such statement shall be recorded as soon as possible.

D. Emergency Admissions and On-Call Responsibilities:

1. Practitioners admitting emergency cases shall be prepared to demonstrate to the COS and to the Hospital Admissions Office, that the admission was an emergency. The history and physical examination must clearly justify the emergency admission and these findings must be recorded in the patient's medical record as soon as possible after admission.
2. An on-call Attending list shall be maintained by each department or service. A patient to be admitted on an emergency basis through the Emergency Department who does not have an otherwise designated admitting Practitioner will be assigned to the on-call Attending in the appropriate department or service.
3. The on-call Attending, or his/her designee, must respond to a call (page) from the ED, Transfer Center or an inpatient unit within thirty (30) minutes. If the on-call Practitioner is requested by the Emergency Department Attending to appear in person, s/he must do so as soon as possible to personally evaluate and/or care for the patient.
4. The on-call Medical Staff member who will knowingly be unavailable to care for emergency patients must arrange for an appropriate alternate Medical Staff member to cover emergency call during the period of unavailability, except where such unavailability is a result of the on-call Medical Staff member's engagement in an emergency. The Medical Staff member making such an arrangement maintains the ultimate responsibility for call.

E. Psychiatric Admissions: For psychiatric patients the admitting Practitioner shall be responsible for providing such information as may be necessary to assure the protection of the patient from self-harm and the protection of others.

SECTION 2. UTILIZATION REVIEW

- A. The Attending is required to document the need for continued hospitalization after specific periods of stay as identified by the Utilization Management Committee. This documentation must contain:
1. An adequate written record of the reason for continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient;
 2. The estimated period of time the patient will need to remain in the hospital;
 3. Plans for post hospital care.
- B. In instances where the Utilization Management Committee determines that admission or continued stay is not justified based upon review of the medical record, the Attending must provide written justification of the necessity for admission or continued hospitalization, including an estimate of the number of days of stay expected. This documentation must be accomplished within 24 hours of request. Should the Attending be unable to provide justification for admission or continued stay, hospitalization will be denied and the Attending must discharge the patient within 24 hours and/or notify the patient that third party payment will not fund the stay.

SECTION 3. ADMISSION LABORATORY SCREENING

- A. All patients being admitted must have a laboratory admission screen performed in accordance with the Attending's orders appearing on the "Request for Hospital Admission and Physician's Orders" form.
- B. Pre-admission laboratory screens performed by licensed and appropriately accredited (College of American Pathologists, COLA, The Joint Commission) laboratory facilities in the State of Florida may be accepted in lieu of the admission screen upon the approval of the Attending and the Director of Laboratory Services. These test results must accompany the patient and be immediately available upon admission. Each such laboratory report should clearly state the patient's full name and other identifying information including laboratory of origin.

SECTION 4. TRANSFER OF INPATIENT RESPONSIBILITIES

Transfers of inpatient responsibility must be done in accordance with the requirements of Core Policies and Hospital Guidelines CP1.10, CP2.61 *Patient Acceptance, Admission, Transfer and Discharge* and *Hand-Off Communication*.

SECTION 5. DISCHARGES

Patients shall be discharged only upon a written order of the patient's Attending physician or dentist or his/her resident, and in accordance with Core Policy and Hospital Guideline CP1.10 *Patient Acceptance, Admission, Transfer and Discharge*.

SECTION 6. PATIENT DEATHS

See also Core Policies and Hospital Guidelines CP1.13 *Death of a Patient – Required Procedures, Notifications and Consents*, and CP1.44.

- A. Pronouncement: Pronouncement of death must be made within a reasonable time. The pronouncement of death must be made by the appropriate Attending or his/her designee Physician, except that in the case of an anticipated or expected death, pronouncement may be made by an Advanced Practitioner (PA or ARNP). The deceased body shall not be moved until a pronouncement of death has been documented.
- B. Autopsy: It shall be the duty of all Staff members to secure autopsies whenever appropriate and possible. An autopsy may be performed only with appropriate consent. All autopsies performed in the hospital shall be performed by a pathologist who is a member of the Medical Staff. A provisional anatomic diagnosis shall be recorded in the medical record within three days and the completed autopsy protocol must be made a part of the medical record within sixty days except in extenuating circumstances. An autopsy should be considered for:
 - 1. Unexpected deaths, including deaths under the following circumstances:
 - a. admission for elective surgical procedure;

- b. admission for trauma or an acute medical condition where the prognosis was considered favorable or the initial course indicated favorable response to therapy;
 - c. admission for therapy of a chronic condition where discharge was expected;
 - d. during diagnostic or therapeutic procedures (if case waived by medical examiner);
2. Deaths where significant diagnostic uncertainties exist or where the cause of death is not clinically certain;
 3. Deaths where family and/or public health concerns exist;
 4. Deaths of patients on clinical study protocols;
 5. Death on arrival (DOA), provided the case is waived by the medical examiner, or death within 24 hours of admission;
 6. All obstetrical deaths;
 7. All perinatal and pediatric deaths;
 8. Deaths where the illness may have a bearing on surviving family members or a transplant recipient;
 9. Deaths from known or suspected environmental or occupational hazards;

These criteria are meant to provide guidance to the Medical Staff, rather than mandate that a request for autopsy be made in each of these cases. Medical Staff are advised to document in the medical record when an autopsy is requested, but not approved.

ARTICLE II - MEDICAL RECORDS

SECTION 1. GENERAL REQUIREMENTS

- A. Medical Record Entries: all credentialed providers and residents must directly access the electronic medical record to appropriately document the provision of care. Prior to obtaining access to the medical record, all credentialed providers and residents must be trained to use the electronic medical record. All entries in the medical record must be made in accordance with Core Policy CP1.95, *Medical Record Documentation Requirements*. Entries must contain essential information only, recorded in a scientific and professional manner.
- B. Co-Signature: Co-signature of an entry signifies acknowledgement by the co-signer that the entry was made and concurrence with the statements or conclusions contained in the entry. If there is a disagreement with the conclusion of the author, the co-signer should record his/her differing conclusions or expand on the entry as appropriate.

SECTION 2. MEDICAL RECORD CONTENT

- A. The Attending is responsible for the accurate, timely, and legible completion of a medical record for each patient he/she admits or for whom he/she provides care.

- B. Each medical record must contain at least the following information, as appropriate:
 - 1. the patient's name, address, date of birth, and the name of any legally authorized representative;
 - 2. for patient's receiving mental health services the patient's legal status;
 - 3. emergency care provided to the patient prior to arrival;
 - 4. the record and findings of the patient's assessment;
 - 5. a medical history and physical examination including a statement of the conclusions or impressions;
 - 6. the diagnosis or diagnostic impression;
 - 7. the reason(s) for admission or treatment; the goals of treatment and the treatment plan with episodic review;
 - 8. evidence of known advance directives;
 - 9. evidence of informed consent;
 - 10. reports of operative and other procedures, tests and their results;
 - 11. records of donation and receipt of transplants or implants;
 - 12. diagnostic and therapeutic orders;
 - 13. all diagnostic and therapeutic procedures and tests performed and the results;
 - 14. progress notes that include clinical observations and the patient's response to medications and care provided;
 - 15. all reassessments;
 - 16. consultation reports;
 - 17. medications ordered or prescribed during treatment or upon discharge;
 - 18. all diagnoses established during the course of care;
 - 19. conclusions at the termination of hospitalization;
 - 20. discharge summary, or a final progress note or transfer summary;
 - 21. discharge instructions to the patient or family;
 - 22. referrals and communications made to external or internal care providers and to community agencies; and

23. autopsy results.

- C. In all instances the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result.

SECTION 3. HISTORY AND PHYSICAL

A. General requirements:

1. A history and physical examination must in all cases, except normal obstetrical and newborn cases, be dictated or electronically created, signed, and available in the Electronic Health Record prior to the performance of any invasive procedure (whether inpatient or outpatient) or within twenty-four (24) hours after admission of the patient, whichever occurs earliest, or for emergency admissions, as soon as conditions permit. In addition, a history and physical examination is required for observation patients within 24 hours or before discharge. If the H&P has been performed by a Resident Physician, ARNP or PA, the Attending should review the H&P and enter a note of concurrence. For inpatients, an H & P performed at admission may be used for all subsequent inpatient procedures. If an H&P is performed and dictated within 24 hours after admission, the Practitioner performing the H&P must make an entry in the record stating the H&P has been performed and dictated.
2. If a history and physical examination has been performed by a Medical Staff member, Resident Physician, ARNP, or PA within thirty (30) days prior to the admission/procedure. The Attending should review the H&P and enter a letter of concurrence. A legible copy of the H&P may be used in the patient's medical record; provided that, at the time of admission/the procedure, an appropriate assessment is performed and documented, including a physical examination of the patient, to update any components of the patient's current medical status that may have changed since the prior H & P or to address any areas where more current data is needed. The update note must also confirm that the necessity for the care/procedure is still present and the H&P is still current. The update note must be on or attached to the full H & P, or when the H & P is accessed on-line by the Practitioner, must refer specifically to the date of the H & P being updated. Updates may be done by the Attending or his/her Resident or appropriately privileged ARNP or PA.
3. A history and physical that was performed within thirty (30) days prior to admission/procedure by a non-credentialed (non-resident) Practitioner must be reviewed by a Medical Staff member and a note of concurrence entered into the medical record.
4. Dentists are responsible for the part of their patients' history and physical examinations that relate to dentistry. Podiatrists are responsible for the part of their patients' history and physical examinations that relate to podiatry. A credentialed M.D. or D.O. must confirm the findings and conclusions of the H&P and assessment of risk(s) of any proposed operative or other procedure requiring written informed consent pursuant to hospital policy, done by a Dentist (except an Oral and Maxillofacial Surgeon) or Podiatrist, when the patient involved has a severe systemic disease that is considered a constant threat to the life of the patient.

B. H&P Required Elements

1. For inpatients, the history and physical must include, at a minimum: chief complaint; history of present illness; medications; allergies; adverse drug reactions; past medical history; social history; family history; review of systems, and a relevant physical examination. A comprehensive assessment should integrate the elements from the history and physical examination that support the reason for admission or need for intervention followed by the treatment plan.
2. For outpatient procedures, a history and physical must include, at a minimum: chief complaint; history of present illness; medications; allergies; adverse drug reactions; past medical history; review of relevant systems, including pain assessment and relevant physical examination that supports the need for intervention followed by the treatment plan.
3. If anesthesia or sedation is planned, the anesthesia assessment shall include, at a minimum: medication history, including drug allergies; previous experience with sedation and analgesia; results of relevant diagnostic studies; physical status assessment; airway assessment; and NPO status.

SECTION 4. PRE-PROCEDURE DOCUMENTATION

- A. Pre-procedure verification (including site marking and time out) must be performed and documented in accordance with Core Policy CP2.56, *Pre-Procedure Verification Process (Universal Protocol)*.
- B. No anesthesia shall be given, nor invasive/significant risk procedure started, until the history and physical examination, pre-procedure diagnosis, indicated laboratory/diagnostic tests and informed consent are on the chart, unless the Attending documents in the Medical Record that delay would be detrimental to the patient's health. In an emergency, the Practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of procedure, including at a minimum, heart rate, respiratory rate, and blood pressure.

SECTION 5. ADMISSION NOTES

In addition to the dictated history and physical, an admission note must be written for all inpatients and admitted observation patients. The admission note must include the reason for admission, pertinent findings, conclusions and plan of care. A handwritten update to a history and physical dictated within the past 30 days may be considered the admission note.

SECTION 6. PRE-ANESTHESIA ASSESSMENT

Within 48 hours prior to the procedure a pre-anesthesia assessment of each patient for whom anesthesia is contemplated shall be performed and a determination made and documented by the Anesthesiologist that the patient is an appropriate candidate to undergo the planned anesthesia. Immediately prior to induction, an evaluation of the patient must be completed and documented.

SECTION 7. POST OPERATIVE DOCUMENTATION AND DISCHARGE FROM RECOVERY AREA

- A. The patient's postoperative status is to be assessed on admission to and discharge from the post-anesthesia recovery area.
- B. If discharge criteria are to be used for patient discharge from post anesthesia care, they must be approved by the Medical Staff.
- C. Postoperative documentation includes at least: a record of vital signs and level of consciousness; medications (including intravenous fluids); blood and blood components; any unusual events or postoperative complications, including drug and transfusion reactions, and the management of those events; identification of all care providers; the patient's discharge from the post-anesthesia care area including documentation of the responsible discharging Physician or, if discharge was by criteria, documentation of criteria used to determine patient readiness.
- D. In addition, for inpatients, a post-anesthesia evaluation must be completed and documented by a qualified anesthesia provider within 48 hours following anesthesia.

SECTION 8. OPERATIVE REPORTS

- A. Operative reports shall include:
 - 1. Name and medical record number of the patient;
 - 2. Date and time of surgery;
 - 3. Pre and post-operative diagnosis(es);
 - 4. Name of the surgical procedure(s) performed;
 - 5. Type of anesthesia administered;
 - 6. Complications, if any;
 - 7. Identification of participating surgeons and other practitioners;
 - 8. Findings;
 - 9. A description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/Practitioner (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices or altering tissues);
 - 10. Prosthetic devices, grafts, tissues, transplants or devices implanted, if any;
 - 11. Specimens removed;
 - 12. Estimated blood loss.

- B. Operative reports must be dictated; except that, with the exclusion of tracheostomies, procedures done at bedside may be handwritten or dictated. All tracheostomies, regardless of where performed, must be dictated.
- C. Operative reports shall be dictated, or when permitted, written as soon as possible after surgery.
- D. When the operative report is not placed in the medical record immediately after surgery, a progress note is entered in the patient's medical record immediately (before the patient moves to the next level of care). The immediate post-operative progress note must include at a minimum: date of procedure, pre-op diagnosis, post-op diagnosis, procedure(s) performed, surgeon(s) and assistant(s) names, findings, complications, estimated blood loss, specimens removed, surgeon's signature and provider ID number.

SECTION 9. PROGRESS NOTES

Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. An Attending or his/her Resident, PA or ARNP shall enter a progress note in the medical record at least daily. Each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment.

SECTION 10. CONSULTATIONS

- A. The name of the requesting Practitioner, and the date and time of the request, must appear on all consultation requests.
- B. All consultation requests are to be responded to by Practitioners or other appropriate healthcare professionals within 24 hours, unless a shorter time frame is important for a positive patient outcome, either through the completion of a consultation report form, or documentation in the progress note labeled "Consultation".
- C. Consultations shall be provided upon request without regard to the patient's insurance or payment status.
- D. See Article III, Section 10 of this chapter for a delineation of circumstances under which consultations are required. The consultation report/note must include:
 1. The name of the requesting Physician;
 2. The name of the responding service;
 3. Reason for the consultation;
 4. Evidence of a review of the patient's record;
 5. Pertinent findings on examination;
 6. Consultant's opinion and recommendations;
 7. Signature, date and time by the consultant.

- E. A limited statement such as “I concur” does not constitute an acceptable report of consultation.
- F. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.
- G. Follow-up consultations must be designated as such and again signed by the consultant.

SECTION 11. OBSTETRICAL RECORD

The obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the referring Practitioner’s office record transferred to the hospital before admission, but an admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

SECTION 12. DISCHARGE PROGRESS NOTE

A Discharge progress note must be written prior to discharge of the patient that includes: principal and secondary diagnoses, major procedures, list of current medications (after reconciliation in compliance with Hospital Policy PM02-49, *Medication Reconciliation*) and instructions to the patient, including medication instructions and prescriptions given. The note must be signed, dated and timed by the Attending or his/her resident.

SECTION 13. DISCHARGE SUMMARY

- A. Immediately prior to or within forty-eight (48) hours of discharge, a discharge/death summary shall be dictated for all observation patients and inpatients, except that for normal newborns, observation obstetrical patients, and obstetric patients with uncomplicated deliveries a final progress note including the final diagnosis(es), procedures, patient’s condition at discharge, discharge instructions, and follow-up care may be substituted for the summary. The summary should concisely recapitulate: a complete listing of final diagnoses; the reason for hospitalization; the significant findings; the procedures performed and treatment rendered; the condition of the patient on discharge and any specific instructions given to the patient and/or family, *e.g.*, instructions relating to physical activity; complete current medication list(after reconciliation in compliance with Hospital Policy PM02-49, *Medication Reconciliation*); diet and follow-up care. All summaries must be signed by the Attending.
- B. The discharging Attending is responsible for appropriate communication regarding treatment of the patient to the referring and/or next treating practitioner.

SECTION 14. SYMBOLS AND ABBREVIATIONS

Only symbols and abbreviations recognized by an approved reference source designated by the Patient Record Committee may be used. A list of prohibited abbreviations can be found in Core Policy and Hospital Guideline CP2.53, *Abbreviations*. Abbreviations on the prohibited abbreviations' list must not be used in any handwritten medical order, medication related documents or on pre-printed forms.

SECTION 15. REMOVAL OF MEDICAL RECORDS

Original records may not be removed from the hospital except as required by court order, subpoena or statute. All records are the property of the hospital and shall not otherwise be removed without permission of the Director of the Health Information & Record Management Department. Unauthorized removal of a record from the hospital is grounds for disciplinary action in accordance with the Medical Staff Bylaws.

SECTION 16. RELEASE OF MEDICAL RECORDS

Written consent of the patient or surrogate is required for release of medical information to persons not otherwise authorized by law to receive this information. Refer to Core Hospital Policies (CP3 series, CP1.35, CP1.18, and CP1.11).

SECTION 17. COMPLETION OF MEDICAL RECORDS

- A. Medical records of discharged patients are to be completed promptly. Physicians are expected to electronically complete all medical records including dictations, Physician queries, and electronic signatures in all systems at least once every seven days. Failure to do so may be cause for disciplinary action including suspension of clinical privileges according to these Bylaws and the procedures established by the Department of Health Information Management.
- B. Medical Staff members shall not complete a medical record for a patient who has not been under his/her care. If the Attending is unavailable for completion of the record and no other Physician is adequately familiar with the care to allow completion of the record, it will be closed in accordance with the policy established by the Health Record Shared Governance Committee.

ARTICLE III - GENERAL CONDUCT OF CARE

The management and care of each patient's care, treatment, and services is the responsibility of a Medical Staff member with appropriate clinical privileges.

SECTION 1. RESIDENTS AND NON-FACULTY PATIENTS

- A. UF fellows, residents, and students will not be involved in the evaluation or treatment of non-faculty Medical Staff member patients, except that in an emergency, UF fellows and resident physicians will assist in providing the necessary care until the patient's physician's arrival.
- B. Non-faculty Attendings desiring assistance from UF faculty Attendings shall request consults in accordance with Section 10 of this Article.

SECTION 2. INFORMED CONSENT

Informed consent must be obtained prior to any non-routine treatment or procedure, except in emergency situations when the patient is incapacitated and a surrogate/proxy, or parent if the patient is a minor, cannot be immediately reached. Written informed consent shall be obtained in conformance with Core Policy CP2.10 and Hospital Guideline CP2.10g, *Consent for Treatment* prior to any diagnostic or therapeutic procedure or treatment (1) that entails significant risk to the patient or (2) for which it is otherwise required by law, regulation or Hospital policy. The Attending scheduled to perform the procedure or another Physician designated by the Attending is required to obtain such consents.

SECTION 3. DISCLOSURE OF UNANTICIPATED EVENTS

In accordance with Core Policy, CP1.43, *Disclosure of Unanticipated outcome of Care or Adverse Incident*, in order to be designated an "appropriately trained physician", all Attendings must complete the Self Insurance Program training concerning disclosure.

SECTION 4. ORDERS

- A. Orders for treatment may only be given by Attendings, residents and fellows, and by ARNPs /PAs within the authority of their clinical privileges to practice, and in accordance with Core Policy CP2.58 and Hospital Guideline CP2.58g, *Medical Orders*. Orders that are illegible or improperly written shall not be carried out until rewritten and understood by the healthcare professional responsible for implementing the order.
- B. Orders for Restraint or Seclusion must be given in accordance with Core Policy CP2.21 and Hospital Guideline CP2.21g, *Restraints and Seclusion*.
- C. Verbal orders must be given in accordance with Core Policy CP2.58 and Hospital Guideline 2.58g, *Medical Orders*.
- D. For DNR order procedures, refer to Core Policy CP2.12, *Do Not Resuscitate Orders*, or Core Policy

CP2.13, *Withholding or Withdrawing Life Prolonging Treatment or Measures*.

- E. Orders written by medical Students cannot be executed without the co-signature of a Practitioner with authority to give that order, in which case the order is deemed to be that of the co-signing Practitioner.

SECTION 5. ADVANCE DIRECTIVES

Advance directives should be reviewed by the Attending or another Physician designated by the Attending with the patient or his/her proxy/surrogate at the time of each admission, when there is a significant change in the patient's condition, or at the patient's request. This discussion should be documented in the progress notes and, if appropriate, a new advance directive should be executed. Unless otherwise provided for by law, advance directives or a proxy/surrogate's decision on behalf of a patient shall be honored. See also Core Policy, CP 2.29, *Advance Directives*.

SECTION 6. PERMITTED MEDICATIONS

- A. All drugs, diagnostic agents, and commercially available dietary supplements administered to patients shall be listed in the latest edition of the USP-NF (United States Pharmacopoeia/National Formulary) or American Hospital Formulary Service. Medications listed in these compendia that have been deemed unavailable for safety or cost reasons by the Pharmacy and Therapeutics Committee will not be administered to patients.
- B. Drugs for IRB approved clinical investigations may be exceptions. These shall be used in full accordance with the "Statement of Principles Involved in the Use of Investigational Drugs in Hospitals" and all regulations of Federal Drug Administration. All drugs used for patient care will be issued or verified by the hospital Pharmacy Department. All compounded injectable medication and narcotics will be supplied by the Pharmacy.
- C. A patient may bring in his or her own formulary or non-formulary medications for use during his/her hospitalization only in accordance with the provisions of Hospital Policy, PM02-37, *Patient Medication Brought into UF Health Shands*.

SECTION 7. SEDATION BY NON-ANESTHESIA PROVIDERS

Sedation and analgesia for procedures shall be ordered and supervised only by Medical Staff privileged to do so, and only in accordance with Core Policy CP2.22, *Sedation by Non-Anesthesiologists/Non-CRNAs for Procedures* and Hospital Guideline CP2.22g, *Sedation of Patient for Procedure*.

SECTION 8. STUDENTS

All students must work directly under the supervision of a licensed or registered professional.

SECTION 9. TISSUE REMOVAL

All tissues removed at the operation, except those approved by the Perioperative Governance Committee

and Quality and Operations Committee shall be sent to the hospital pathologist who shall make such examination as he/she may consider necessary to arrive at the tissue diagnosis. His/her authenticated report shall be made a part of the patient's medical record.

SECTION 10. CONSULTS

- A. High quality medical practice includes the proper and timely use of consultation. Judgment as to the serious nature of the illness, and the question of doubt as to the diagnosis and treatment, rests with the Attending. Each clinical service should exercise its judgment regarding the specific conditions for which consultations are to be obtained.
- B. Any qualified Practitioner with clinical privileges/scope of practice in this hospital must respond to a request for a consultation within his/her area of expertise within 24 hours, unless a shorter timeframe is important for a positive patient outcome.
- C. Except in an emergency situation, consultation must be obtained at a minimum in the following situations:
 - 1. To confirm the appropriateness of proceeding with a planned operation or treatment, despite the fact that the patient may not be a good risk for said operation/treatment;
 - 2. Where the diagnosis is unclear after diagnostic procedures have been completed;
 - 3. Where there are questions regarding the choice of therapeutic measures;
 - 4. In cases where skills beyond the scope of the Attending may be needed, or where a second Attending's presence is advisable, e.g., complex, high risk surgery;
 - 5. Prior to medical or surgical intervention when the patient exhibits severe psychiatric symptoms;
 - 6. When requested by the patient or his/her proxy or surrogate;
 - 7. When an ethics consult appears to be indicated such as disagreements between or amongst the healthcare team and the patient and/or patient's proxy or surrogate on treatment issues. See also Core Policy, CP2.28 and Hospital Guideline CP2.28g, *Ethics Consultation*;
 - 8. In all instances of attempted suicide and drug overdose, psychiatric consultation shall be obtained.

SECTION 11. PRACTITIONER SELF CARE OR CARE OF IMMEDIATE FAMILY MEMBER

- A. Physicians generally should not treat themselves or immediate family members (parents, sibling, children, or spouses); however there may be occasions where this is acceptable and appropriate.
- B. Any Physician, who desires to provide treatment to him/herself or a family member must first contact the Chair of his/her, assigned department or the Chair of the Quality and Operations Committee. The Physician shall provide a memo to the Chair describing the nature of the problem and/or the intended treatment and advise the Chair of the reason that a non-related Physician is not providing the care. The Chair must provide the requesting Physician with the American Medical Association's Code of Ethics statement on this issue, which is appended (Appendix A) to these

Rules and Regulations.

- C. If, after reviewing the AMA Code of Ethics, the Physician informs the Chair of his/her intent to proceed with the delivery of care to self or family members, the Chair shall notify Quality Management and initiate a concurrent chart review of the care.

ARTICLE IV - GENERAL RULES REGARDING DENTAL CARE

A patient admitted for dental care is the responsibility of both the dentist and a Physician or oral and maxillofacial surgeon.

SECTION 1. DENTIST'S RESPONSIBILITIES

- A. A detailed dental history justifying hospital admission;
- B. A detailed description of the examination of the oral cavity and pre-operative diagnosis;
- C. A complete operative report, describing the findings and techniques. For tooth extractions, the dentist shall clearly state the number of teeth and fragments removed. All tissue and teeth fragments shall be sent to pathology in accordance with Article III, Section 9 of this chapter;
- D. A discharge of the patient, including Discharge Order and Summary, in accordance with requirements of Article II of this chapter, *Medical Records*.

SECTION 2. PHYSICIAN'S OR ORAL AND MAXILLOFACIAL SURGEON'S RESPONSIBILITIES

- A. A medical history and physical in accordance with Article II of this chapter, *Medical Records*;
- B. Supervision of the patient's general health status while hospitalized.

APPENDIX A

American Medical Association's Code of Ethics Self-

Treatment or Treatment of Immediate Family Members

Physicians generally should not treat themselves or members of their immediate families. Professional objectivity may be compromised when an immediate family member or the Physician is the patient; the Physician's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered. Physicians may fail to probe sensitive areas when taking the medical history or may fail to perform intimate parts of the physical examination. Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the Physician is an immediate family member. This discomfort is particularly the case when the patient is a minor child, and sensitive or intimate care should especially be avoided for such patients. When treating themselves or immediate family members, Physicians may be inclined to treat problems that are beyond their expertise or training. If tensions develop in a Physician's professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the Physician.

Concerns regarding patient autonomy and informed consent are also relevant when Physicians attempt to treat members of their immediate family. Family members may be reluctant to state their preference for another Physician or decline a recommendation for fear of offending the Physician. In particular, minor children will generally not feel free to refuse care from their parents. Likewise, Physicians may feel obligated to provide care to immediate family members even if they feel uncomfortable providing care.

It would not always be inappropriate to undertake self-treatment or treatment of immediate family members. In emergency settings or isolated settings where there is no other qualified Physician available, Physicians should not hesitate to treat themselves or family members until another Physician becomes available. In addition, while Physicians should not serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems.

Except in emergencies, it is not appropriate for Physicians to write prescriptions for controlled substances for themselves or immediate family members. (I, II, IV) Issued June 1993.