

MINUTES

Meeting of the Board of Trustees
Of the Medical University Hospital Authority

December 14, 2007

It Is Understood That The Minutes Herein Recorded Have Not As
Yet Been Approved and Cannot Be Considered as Official Action
of the Board Until Such Approval Has Been Given

101 Colcock Hall
Medical University of South Carolina
Charleston, South Carolina

MINUTES
MEDICAL UNIVERSITY HOSPITAL AUTHORITY
BOARD OF TRUSTEES MEETING
December 14, 2007

The Board of Trustees of the Medical University Hospital Authority convened Friday, December 14, 2007, with the following members present: Dr. Charles B. Thomas, Jr., Chairman; Thomas L. Stephenson, Esquire, Vice Chairman; Dr. Stanley C. Baker, Jr.; Mr. Melvyn Berlinsky; Mr. William H. Bingham, Sr.; Dr. Cotesworth P. Fishburne, Jr.; Dr. E. Conyers O'Bryan, Jr.; Dr. Thomas C. Rowland, Jr.; Mr. Charles W. Schulze; The Honorable Robin Tallon; Dr. James E. Wiseman, Jr.; Mrs. Claudia W. Peeples, Emerita; The Honorable Phillip D. Sasser, Emeritus, Mr. Allan E. Stalvey. Excused Absences: Mr. William B. Hewitt; Dr. Donald R. Johnson II; Dr. Paula E. Orr.

The following administrative officials were present: Dr. Raymond S. Greenberg, President; Dr. John Raymond, Vice President for Academic Affairs and Provost; Dr. Jerry Reves, Vice President for Medical Affairs, and Dean, College of Medicine; Mr. Stuart Smith, Vice President for Clinical Operations and Executive Director, MUHA; and Dr. Frank Clark, Vice President for Information Technology and CIO.

The following deans were present: Dr. Jack Sanders, College of Dental Medicine; Dr. Mark Sothmann, College of Health Professions; Dr. Perry Halushka, College of Graduate Studies; Dr. Jerry Reves, College of Medicine; Dr. Gail Stuart, College of Nursing; Dr. Arnold Karig, MUSC Campus Dean, College of Pharmacy; Dr. Joseph DiPiro, Executive Dean, South Carolina College of Pharmacy.

Item 1. Call to Order-Roll Call.

There being a quorum present, Chairman Thomas called the meeting to order. Ms. Celeste Jordan called the roll.

Item 2. Secretary to Report Date of Next Meeting.

The date of the next regularly scheduled meeting is Friday, February 8, 2008.

Item 3. Approval of Minutes of the Regular Meeting of the Medical University Hospital Authority of October 12, 2007.

Board Action: It was moved that the Minutes be approved. The motion was seconded, voted on and unanimously carried.

RECOMMENDATIONS AND INFORMATIONAL REPORTS OF THE PRESIDENT

OLD BUSINESS: None.

NEW BUSINESS:

Item 4. General Informational Report of the President.

Dr. Greenberg asked Dean Reves to introduce the speaker. Dean Reves introduced Dr. Iain Sanderson who was recently recruited to MUSC as the Endowed Chair of Medical Informatics in the Center of Health Care Quality (CHQ). He also serves as the new Chief Medical Information Officer for the state-wide Health Sciences South Carolina (HSSC).

Dr. Sanderson will oversee the development of the information technology infrastructure, data linkages and protocols needed for the CHQ to design, implement, and oversee the SC Health Data Portal and the Data Coordinating Center. This will enable member institutions of the HSSC to share data for clinical trials and translational research.

He was educated at Oxford and came to MUSC from Duke University where he served in the Department of Anesthesiology for nearly 15 years. For the last several years he served as Associate Chief Information Officer of the perioperative systems for the Duke University Health System.

Dr. Sanderson talked about his background; medical informatics; why he decided to come to the University and HSSC and his work in the Center for Health Care Quality.

Recommendation of Administration: That the report be received as information.

Board Action: Received as information.

Item 5. Other Business. None.

MEDICAL UNIVERSITY HOSPITAL AUTHORITY OPERATIONS AND FINANCE COMMITTEE.
CHAIRMAN: DR. STANLEY C. BAKER, JR. (Detailed committee minutes are attached to these minutes).

OLD BUSINESS: None.

NEW BUSINESS:

Item 6. MUSC Medical Center Status Report.

Statement: Mr. Stuart Smith reported statistics through October all of which have increases except admission which has flattened out. That number is expected to increase with the opening of the new hospital.

He said he reported to the Committee about MUSC Excellence which program the Board approved two years ago. He briefed the Committee on methods to improve patient and employee satisfaction and leader accountability. He said Joan Herbert's team has lead a process to increase leader accountability which has resulted in an expected change in leader evaluations.

He said he is pleased that the COM, UMA and many parts of the University have also become involved in the MUSC Excellence program.

He also reported on a program the SC Hospital Association has called Every Patient Counts. It is the industry's attempt to demonstrate that the industry is interested in patient safety and will be leaders in this area. This program also makes a commitment to public disclosure of this information.

Recommendation of Administration: That the report be received as information.

Recommendation of Committee: That the report be received as information.

Board Action: Received as information.

Item 7. MUSC Medical Center Financial and Statistical Report.

Statement: Dr. Baker said Lisa Montgomery reported to committee on financial and statistical information. Ms. Montgomery also presented a Resolution which allows the Hospital Authority to effect a restructuring of the Medical University Facilities Corporation Central Energy Plant, LLC bond financing.

Recommendation of Administration: That the Resolution which allows the Hospital Authority to effect a restructuring of the Medical University Facilities Corporation Central Energy Plant, LLC bond financing be approved.

Recommendation of Committee: That the Resolution which allows the Hospital Authority to effect a restructuring of the Medical University Facilities Corporation Central Energy Plant, LLC bond financing be approved.

Board Action: A motion was made, seconded and unanimously carried to approve the Resolution which allows the Hospital Authority to effect a restructuring of the Medical University Facilities Corporation Central Energy Plant, LLC bond financing.

Item 8. MUSC Medical Center Policies.

Statement: Dr. Baker asked for approval of the MUHA Policy C-13 Resuscitation Orders and Policy C-23 Withholding/Withdrawing Life Sustaining Treatment.

Recommendation of Administration: That the policies be approved.

Recommendation of Committee: That the policies be approved.

Board Action: A motion was made, seconded and unanimously voted to approve the Medical Center policies as presented.

Item 9. Report on Quality and Patient Safety.

Statement: Dr. Baker stated the committee had received an update from Dr. Pat Cawley on quality and patient safety as an informational item.

Recommendation of Administration: That this report be received as information.

Recommendation of Committee: That this report be received as information.

Board Action: Received as information.

Item 10. Report of the Vice President for Medical Affairs and Dean, College of Medicine.

Statement: Dr. Baker stated that Dean Reves provided a report that was received as information by the Committee.

Recommendation of Administration: That the report be received as information.

Recommendation of Committee: That the report be received as information.

Board Action: Received as information.

Item 11. Report on University Medical Associates.

Statement: Dr. Baker stated the committee had received a report on outreach activities from Dr. Feussner. Dr. Feussner had requested approval for the following:

- Purchase of neurosciences equipment, urology equipment, dermatology equipment.
- Approval of two leases.
- Purchase of two facilities in Mt. Pleasant.
- For the UMA leadership to continue discussion of land for future development at a future meeting.

Recommendation of Administration: That the purchase of equipment, leases, facilities purchases, and UMA leadership to continue discussion of land for future development at a future meeting be approved.

Recommendation of Committee: That the purchase of equipment, leases, facilities purchases, and UMA leadership to continue discussion of land for future development at a future meeting be approved.

Board Action: The motion was seconded, voted on and unanimously carried to approve the purchase of equipment, leases, facilities purchases, and for UMA leadership to continue discussion of land for future development at a future meeting.

Item 12. Legislative Update.

Statement: Dr. Baker stated there was no report to committee.

Recommendation of Administration: That this report be received as information.

Recommendation of Committee: That this report be received as information.

Board Action: Received as information.

Item 13. Other Committee Business. None

Item 14. Medical University Hospital Authority Appointments, Reappointments and Delineation of Privileges (Consent Item).

Statement: Appointments, reappointments and delineation of privileges to the medical staff were presented for approval.

Recommendation of Administration: That the appointments, reappointments and delineation of privileges to the medical staff be approved.

Recommendation of Committee: That the appointments, reappointments and delineation of privileges to the medical staff be approved as presented.

Board Action: Dr. Baker moved that the appointments, reappointments and delineation of privileges to the medical staff be approved. The motion was seconded, voted on and unanimously carried.

Item 15. Medical Executive Committee Minutes (Consent Item).

Statement: Minutes of the Medical Executive Committee meetings of September and October 2007 were presented for information.

Recommendation of Administration: That this be received as information.

Recommendation of Committee: That this be received as information.

Board Action: Received as information.

Item 16. Medical Center Contracts and Agreements (Consent Item).

Statement: Contracts and Agreements which have been signed since the last board meeting were presented for information.

Recommendation of Administration: That this be received as information.

Recommendation of Committee: That this be received as information.

Board Action: Received as information.

MEDICAL UNIVERSITY HOSPITAL AUTHORITY PHYSICAL FACILITIES COMMITTEE.
CHAIRMAN: MR. WILLIAM H. BINGHAM, SR. (Detailed committee minutes are attached to these minutes).

OLD BUSINESS: None

NEW BUSINESS:

Item 17. Facilities Procurements/Contracts Proposed.

Statement: Mr. Bingham presented the following for approval:

- Replacement of Children's Hospital Air Handling Unit #4: Total project cost: \$3,300,000.
- Lease of 2,100 square feet of clinical space at 200 Rutledge Avenue: 5 year lease totaling \$277,914.

Recommendation of Administration: That the Procurements/Contracts be approved.

Recommendation of Committee: That the replacement of the Children's Hospital Air Handling project be approved as presented. The lease at 200 Rutledge Avenue was originally approved; however, subsequently Mr. Berlinsky made a motion to withdraw the approval which was seconded and unanimously voted. The committee recommended further review of space on campus to accommodate Forensic Psychiatry's space needs and bring the lease back at a later date.

Board Action: A motion was made, seconded and unanimously voted to approve the replacement of the Children's Hospital Air Handling project as presented. The lease at 200 Rutledge Avenue not approved and the Board recommended further review of space on campus to accommodate Forensic Psychiatry's space needs and asked that the lease be brought back to the Board after further review.

Item 18. Update on Projects.

Statement: Mr. Bingham stated Mr. Dennis Frazier had provided an update on the new hospital.

Recommendation of Administration: That this report be received as information.

Recommendation of Committee: That this report be received as information.

Board Action: Received as information.

Item 19. Other Committee Business.

Statement: Mr. Bingham reported that Mr. Stuart Smith had provided to the Committee an update on the Children's Hospital Addition and the Adult Emergency Department Renovation.

Recommendation of Committee: That the report be received as information.

Board Action: Received as information.

Item 20. Facilities Contracts Awarded (Consent Item).

Statement: Facilities contracts awarded since the last board meeting were presented for information.

Recommendation of Administration: That this be received as information.

Recommendation of Committee: That this be received as information.

Board Action: Received as information.

MEDICAL UNIVERSITY HOSPITAL AUTHORITY AUDIT COMMITTEE. CHAIRMAN: THOMAS L. STEPHENSON. ESQUIRE (Detailed committee minutes are attached to these minutes).

OLD BUSINESS: None

NEW BUSINESS:

Item 21. MUHA External Audit Report.

Statement: Mr. Stephenson reported the Committee had received a report from the external auditors and he said it was a clean report, as usual.

Recommendation of Administration: That this be received as information.

Recommendation of Committee: That this be received as information.

Board Action: Received as information.

Item 22. Report of Internal Auditor.

Statement: No report was given.

Recommendation of Administration: That this be received as information.

Recommendation of Committee: That this be received as information.

Board Action: Received as information.

Item 23. Other Committee Business. None.

OTHER BUSINESS FOR THE BOARD OF TRUSTEES:

Item 24. Approval of Consent Agenda.

Statement: Approval of the Medical University Hospital Authority consent agenda was requested.

Recommendation of Administration: That the consent agenda be approved.

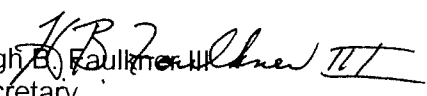
Board Action: It was moved, seconded and unanimously voted that the consent agenda be approved.

Item 25. New Business for the Board of Trustees. None

Item 26. Report from the Chairman. None

There being no further business, the Hospital Authority meeting was adjourned.

Respectfully submitted,


Hugh B. Faulkner III
Secretary

/wcj

Attachments

**Medical University Hospital Authority
Operations and Finance Committee
Board of Trustees
Minutes
December 13, 2007**

Attendees:

Dr. Stanley Baker, Chair
Thomas Stephenson, Esq.
Mr. Melvyn Berlinsky
Mr. William Bingham
Dr. Cotesworth Fishburne
Mr. William Hewitt
Dr. E. Conyers O'Bryan
Dr. Thomas Rowland
Mr. Charles Schulze
Hon. Robin Tallon
Dr. James Wiseman
Mr. Alan Stalvey
Dr. Raymond Greenberg
Mr. Stuart Smith
Dr. Frank Clarke
Dr. J. G. Reves
Dr. John Raymond
Ms. Lisa Montgomery
Dr. Sabra Slaughter
Dean Mark Sothmann

Dr. Patrick Cawley
Dr. John Feussner
Dr. Howard Evert
Ms. Joan Herbert
Dr. Marilyn Schaffner
Mr. John Cooper
Mr. Steve Hargett
Mr. Betts Ellis
Mr. Dennis Frazier
Annette Drachman, Esq.
Ms. Susan Barnhart
Joseph Good, Esq.
Mr. Mark Sweatman
Mr. H. B. Faulkner
Mr. Maurice Snook

The meeting was called to order at 9:30 a.m. by Dr. Stanley Baker, Chair.

Item 6: MUSC Medical Center Status Report

Statistical Update

Ms. Smith briefed the committee on statistical data for the MUSC Medical Center. MRI and CT procedures have continued to increase. Operating Room Cases have increased 4.3% through October and outpatient visits have increased 9%. Admissions have increased 1.9% which is a reflection of the capacity issues the current hospital faces.

MUSC Excellence Update

Mr. Smith also briefed the committee on progress with the MUSC Excellence Program. The Medical Center leadership has just completed its eighth management training session and the College of Medicine has completed its fourth session. Mr. Smith explained the structure of the MUSC Excellence Program and briefed the committee on

methods to achieve improved patient and employee satisfaction as well as increased leader accountability.

Joan Herbert, Administrator for the Institute of Psychiatry, explained the process for aligning individual leader goals with the overall organizational goals. This process has led to increased leader accountability and has shown an expected change in leader evaluations. As expected, the range of scores reflects a normal bell curve, which is more reflective of actual performance than scores received prior to implementation of the MUSC Excellence program.

Every Patient Counts Program

Mr. Smith reported that the S.C. Hospital Association is focusing on the Every Patient Counts Program. MUSC is supportive of this program and has been proactive in providing quality care and reporting its results.

Action: Report received as information

Item 7: MUSC Medical Center Financial and Statistical Report

Ms. Montgomery briefed the committee on the financial status of the Medical Center. The change in net assets is ahead of budget and is \$6.6 million and cash on hand is 26.8 days or \$56 million. Increase in revenue is currently less than budget.

Ms. Montgomery asked for approval of a resolution which allows MUHA to enter into an interest rate swap on the MUSC Central Energy Plant LLC bond financing.

Action: Financial report received as information and resolution approved.

Item 8: MUSC Medical Center Policies

Dr. Cawley briefed the committee on changes to MUHA Policy C-13 Resuscitation Orders and Policy C-23, Withholding/Withdrawing Life sustaining Treatment.

Action: Recommend approval of revised policies

Item 9: Report on Quality and Patient Safety

Dr. Patrick Cawley briefed the committee on MUSC's recent award by the University Healthcare Consortium. MUSC received the Quality and Accountability Performance Award for Significant Improvement. This award is based on safety, effectiveness, efficiency, equitable care, patient centered care, and timeliness of care.

Action: Report received as information

Item 10: Report of Vice President for Medical Affairs and Dean, College of Medicine

Dean Reves briefed the committee on the College of Medicine and UMA efforts toward MUSC Excellence. Overall Goals have been set for the College and UMA. People goals include: Improving employee and faculty satisfaction and monitor turnover patterns to establish trends.

Service goals include: Improving customer satisfaction, improving student satisfaction and improving administrative performance ratings on service to faculty.

Quality goals include: Decreasing patient mortality, improving USMLE pass rates, residing in upper quartile of peer group in NIH, having faculty in the NAS and IOM, improving diversity of staff, students and faculty, and maintaining interdisciplinary programs.

Growth goals include increasing the number of MUSC graduates, adopting patient growth goals, increasing MUSC market share, and improving ranking of NIH funding. Finance goals include improving the hospital operating margin, attaining an annual energy reduction in college occupied space, maintaining a balanced budget, and increasing research return on investment. The college has made improvements in many of these areas and continues to work closely with the hospital in the MUSC Excellence Program.

Action: Report received as information

Item 11: Report on University Medical Associates

Dr. Feussner briefed the committee on UMA outreach activities. He requested that additional equipment be authorized for neurosciences in the East Cooper Area. This equipment is estimated at \$8600. He requested approval of the telemedicine Stroke project as well as development of outreach efforts for the Department of Orthopedics in Georgetown and Walterboro. This will require approval of two leases. He also presented a need for additional equipment for urology in the Mt. Pleasant clinic (\$6800), and for a Cynosure Cynergy laser for Dermatology. This laser is estimated at \$84,400.

Dr. Feussner reported that UMA's recommendation is to abandon the plan for a large facility in the East Cooper and concentrate on expanding in two smaller facilities in the area. He also briefed the committee on the plan to acquire land for future development.

Dr. Feussner also briefed the committee on the North Area outreach activities. Annette Drachman will prepare a resolution dealing with a CON issue which will be presented at the full Board of Trustees meeting on Friday.

Action: Recommend approval of neurosciences equipment, urology equipment, dermatology equipment, approval of two leases, purchase of two facilities in Mt.

Pleasant, and that the UMA leadership continue discussion of land for future development at a future meeting.

Item 12: Legislative Update

No Report

Consent Agenda:

Item 14: Medical University Hospital Authority Appointments, Reappointments and Delineation of Privileges

The appointments, reappointments, and delineation of privileges were approved as presented. Due to the change in dates of the December Board meeting, the reappointments were approved on December 7 by expedited credentialing process. This was ratified by the committee.

Action: Recommend approval

Item 15: Medical Executive Committee Minutes of September and October were presented for information.

Action: Received as information

Item 16: Medical Center Contracts and Agreements:

The contracts and agreements signed since the last meeting were presented for information.

Action: Received as information

There being no further business, the committee adjourned at 11:30 a.m.

Teresa K. Rogers

**Medical University Hospital Authority
Physical Facilities Committee
December 13, 2007
Minutes**

Attendees:

Mr. William H. Bingham, Sr., Chair
Dr. Stanley C. Baker, Jr.
Mr. Melvyn Berlinsky
Dr. Cotesworth P. Fishburne, Jr.
Mr. William B. Hewitt
Dr. E. Conyers O'Bryan, Jr.
Dr. Thomas C. Rowland, Jr.
Mr. Charles W. Schulze
Thomas L. Stephenson, Esquire
The Honorable Robin M. Tallon
Dr. Charles B. Thomas, Jr.
Dr. James E. Wiseman, Jr.
Mr. Hugh B. Faulkner
Dr. Raymond Greenberg
Mr. Tom Anderson
Dr. Pat Cawley

Mr. John Cooper
Ms. Annette Drachman
Dr. Jack Feussner
Mr. Dennis Frazier
Mr. Steve Hargett
Mr. Chip Hood
Mr. Mike Keels
Mr. John Malmrose
Mr. Stewart Mixon
Ms. Lisa Montgomery
Ms. Jennifer Pearce
Dr. John Raymond
Dr. Jerry Reves
Dr. Sabra Slaughter
Mr. Stuart Smith
Mr. Maurice Snook
Mr. Patrick Wamsley

Mr. Bingham called the meeting to order.

REGULAR Items

Item 17. Facilities Procurements/Contracts Proposed

Mr. Dennis Frazier presented the following for approval:

- Replacement of Children's Hospital Air Handling Unit #4: Total project cost: \$3,300,000.
- Lease of 2,100 square feet of clinical space at 200 Rutledge Avenue: 5 year lease totaling \$277,914.

Recommendation of Committee: That the replacement of the Children's Hospital Air Handling project be approved as presented. The lease at 200 Rutledge Avenue was originally approved; however, subsequently Mr. Berlinsky made a motion to withdraw the approval which was seconded and unanimously voted. The committee recommended further review of space on campus to accommodate Forensic Psychiatry's space needs.

Item 18. Update on Projects

Mr. Dennis Frazier presented an update on the new hospital – Ashley River Tower.

Recommendation of Committee: That the report be received as information.

Item 19. Other Committee Business

Mr. Stuart Smith provided an update on the Children's Hospital Addition and the Adult

Emergency Department Renovation.

Recommendation of Committee: That the report be received as information.

CONSENT Items for Information:

Item 20 Facilities Contracts Awarded

The facilities contracts since the last board meeting were presented for information.

Recommendation of Committee: That this report be received as information.

With no further business, the meeting was adjourned.

A handwritten signature in black ink, appearing to read "Christy Jordan". The signature is fluid and cursive, with a large initial "C" and a long, sweeping underline.

Medical University Hospital Authority Audit Committee
December 13, 2007
Minutes

Attendees:

Thomas L. Stephenson, Esquire, Chair
Dr. Stanley C. Baker, Jr.
Mr. Melvyn Berlinsky
Mr. William H. Bingham, Sr.
Dr. Cotesworth P. Fishburne, Jr.
Mr. William B. Hewitt
Dr. Donald R. Johnson, II
Dr. E. Conyers O'Bryan, Jr.
Dr. Thomas C. Rowland, Jr.
Mr. Charles W. Schulze
The Honorable Robin M. Tallon
Dr. Charles B. Thomas, Jr.
Dr. James E. Wiseman, Jr.
Mr. Hugh B. Faulkner III

Dr. Raymond S. Greenberg
Ms. Susan Barnhart
Mr. John Cooper
Ms. Annette Drachman
Dr. Howard Evert
Dr. Jack Feussner
Mr. Joe Good
Mr. Steve Hargett
Ms. Lisa Montgomery
Dr. John Raymond
Dr. Jerry Reves
Mr. Stuart Smith
Mr. Maurice Snook
Mr. Patrick Wamsley

Mr. Stephenson called the meeting to order.

REGULAR Items

Item 21. MUHA External Audit Report.

Mr. Brad R. Benton and Mr. Milford W. McGuirt, Partners in the firm of KPMG, presented a joint report on the University and Authority annual external audits. They confirmed that KPMG acted as independent accountants with respect to the Institutions. As such, KPMG issued unqualified opinions on both MUHA and MUSC.

They reviewed internal controls as required to express opinions on financial statement audits and reported no material weaknesses. Being conservative, they noted significant deficiencies as follows: MUSC – in the area of grants accounting and related deferred revenue recognition and MUHA in the area of accounting for capital assets.

They noted significant accounting estimates for MUSC as follows: allowances for receivables; depreciable lives for capital assets; accrued liabilities. They noted significant accounting estimates for MUHA as follows: allowances for doubtful accounts and contractual adjustments; third-party payor accounting; self-insurance reserves.

They reported no "significant or unusual" transactions for either entity.

Recommendation of Committee: That the report be received as information.

Item 22. Report of Internal Auditor.

Ms. Susan Barnhart provided a report on the MUHA Petty Cash Review.

Recommendation of Committee: That the report be received as information.

Item 23 Other Committee Business

None.

There being no further business, the meeting was adjourned.

Respectfully submitted,


Celeste Jordan

**RESOLUTIONS OF THE
BOARD OF TRUSTEES OF
THE MEDICAL UNIVERSITY HOSPITAL AUTHORITY**

December __, 2007

At a regularly scheduled meeting of the Board of Trustees of the Medical University Hospital Authority (the "Board") held on October 12, 2007, the Board discussed and adopted various resolutions (the "October Resolutions") concerning the proposal from Banc of America Securities LLC to effect a restructuring of the MUFC Central Energy Plant, LLC bond financing entitled "Medical University Facilities Corporation Conversion of Series 2004 MUFC Central Energy Plant LLC Bonds to Index Floating Rate Bonds, Master Plan of Finance as of October 4, 2007" (together with all amendments and modifications thereto to the date hereof and such other amendments and modifications as may be approved by any of the Authorized Officers identified herein, referred to herein collectively as the "Proposal") and the proposed remarketing, and amendment and conversion to an Index Floating Rate Mode, of the \$61,000,000 original principal amount of the South Carolina Jobs-Economic Development Authority Economic Development Revenue Bonds (MUFC Central Energy Plant Project), Series 2004 (the "Original Bonds"). In furtherance of the foregoing, the Board has adopted the following resolutions on the date first set forth above:

RESOLVED, that the Board hereby confirms, ratifies and reaffirms the October Resolutions and, without limiting the October Resolutions but in furtherance thereof, the Medical University Hospital Authority ("MUHA") is authorized to enter into all agreements, instruments, documents and other papers as are referred to in the October Resolutions or as may otherwise be deemed necessary or desirable in connection with the transactions referred to in the October Resolutions, the Proposal or these resolutions (collectively with those applicable to any Swap Transaction referred to below, the "Amendment Documents"), in such form and together with such changes, modifications and revisions thereto as the Authorized Officers of MUHA (or any of them) identified below shall determine to make, and such Amendment Documents and the transactions contemplated thereby are hereby approved; and

FURTHER RESOLVED, that the Board hereby approves the entering into by MUFC Central Energy Plant, LLC, a South Carolina limited liability company (the "Company") of one or more arrangements for the purpose of managing the variable interest rate feature of the Original Bonds in whatever variable rate mode, which arrangement may take the form of an "interest rate swap" or any other type of arrangement designed to hedge all or a portion of the risk presented by such variable interest rate feature of the Original Bonds in whatever applicable mode, including without limitation any options related thereto if applicable, and which arrangement may (but need not) take the form of the "ISDA Master Agreement" (1992 Local Currency – Single Jurisdiction) version and any applicable schedules, credit support annexes and confirmations to be delivered in connection therewith, including the termination, restructuring or other modification of any interest rate

cap or other hedging agreements presently in place (all of the foregoing, collectively, the "Swap Transaction", the documents with respect to which being included within the meaning of the term "Amendment Documents" for purposes of these resolutions), it being acknowledged that the payments that may be owing by the Company under any Swap Transaction are included among the scope of payments required to be covered by MUHA to the extent provided in the Energy Services Agreement between MUHA and the Company and other applicable arrangements pertaining to the Original Bonds; and

FURTHER RESOLVED, that the President, Executive Director and Administrator of Finance and Support Services of MUHA (each an "Authorized Officer"), or any of them acting alone, are hereby authorized to execute and deliver any and all of the Amendment Documents, together with such changes, modifications or revisions as may be approved by any such Authorized Officer, such Authorized Officer's signature being conclusive evidence of his or her approval thereof; and

FURTHER RESOLVED that the Authorized Officers of MUHA, and the other duly appointed officers of MUHA as may be designated by the Authorized Officers, or any of such persons acting alone, are hereby authorized to negotiate, execute and deliver such other documents, agreements or certificates, and take such other action as may be necessary or desirable in connection with the matters referred to in the October Resolutions, the Proposal, these resolutions and the Amendment Documents, the execution and delivery by MUHA of the Amendment Documents, and the actions and matters contemplated in connection herewith and therewith.

I Certify that these Resolutions were duly made by the members of the Board of Trustees of the Medical University Hospital Authority on the date first set forth above.

Secretary



Medical Center Policy Manual

Number & Title: C-13 – Resuscitation Orders
Owner: Quality Department
Location/File name: I:\EllisT\Data\Word\MUH
Clinical Policies\C-13.Resuscitation Orders

Dates:
Originated: 06/97
Reviewed: 08/02, 10/06
Legal Review: 10/07
Revised: 08/00, 10/07

Definitions:

Cardiopulmonary Arrest - Acute cardiovascular or respiratory collapse that would result in the patient's death or anoxic encephalopathy within several minutes unless cardiopulmonary resuscitation was started.

Cardiopulmonary Resuscitation (CPR) - The emergency application of electrical cardioversion, intubation, chest compression, or other advanced life support interventions to manage cardiopulmonary arrest.

Attending Physician - Physicians who have gone through the hospital credentialing process to obtain hospital privileges; physician of record or his designee.

Physician-in-Training - Residents and Fellows who have not gone through the hospital credentialing process to obtain hospital privileges.

Physician - Attending Physician or Physician-in-Training.

Purpose:

To provide practitioners with guidelines and requirements for issuing Allow Natural Death/Limited Resuscitation Orders.

Cardiopulmonary resuscitation (CPR), an emergency medical treatment for sudden cardiopulmonary arrest, shall be instituted by trained staff on any patient who suffers a cardiac or respiratory arrest unless an Allow Natural Death/Limited Resuscitation Order has been entered in the patient's medical record. If no such order is present, resuscitation efforts should be aggressive and complete according to the guidelines on Advanced Cardiac Life Support and the American Heart Association.

Patients with an Allow Natural Death/Limited Resuscitation order may still receive therapeutic interventions for acute, potentially life-threatening problems that do not constitute a full cardiopulmonary arrest. Exclusion of all life-sustaining interventions for any potentially life-threatening condition requires a specific written order and progress note that describe these exclusions in addition to the resuscitation order. Medical and ethical concerns with CPR focus on selecting patients who are likely to benefit from this intervention while maintaining a meaningful role in patient autonomy in the decision making process.

An order to Allow Natural Death or for specific resuscitation measures does not represent abandonment of the patient, nor is it an indication for less than optimal care. The order to Allow Natural Death simply means that the patient will not receive CPR. The Allow Natural Death/Limited resuscitation order should prompt a review of management to ensure that the patient is receiving all care from which he or she can benefit, including palliative efforts. These include basic nursing care (including bodily cleanliness and mouth care), adequate analgesia (even if it may hasten death), symptom control, suctioning, oxygen as required for comfort, intake for comfort, and facilitated access to family, clergy, and social and psychological personnel.

REASONS FOR CONSIDERING AN ORDER TO ALLOW NATURAL DEATH OR LIMIT RESUSCITATION:

A. Competent Adult Patient Refusal of Resuscitation:

Competent adult patients have the legal right to refuse any medical interventions, including life-saving interventions. Any patient, who understands the nature of his/her illness and can make informed, reasoned choices about treatment, can refuse resuscitation for medical or non-medical reasons. The attending physician makes determination of a patient's capacity for decision making. The patient may refuse resuscitation verbally or through a written advance directive.

Any physician who will not honor the capable patient's refusal of resuscitation should consider withdrawal from the case by making a reasonable effort to transfer the patient's care to another physician or by making a referral to the Ethics Consultation Service.

B. Medically Ineffective Resuscitation:

Treatment that would be medically ineffective should not be recommended or imposed upon a patient. Therefore, physicians have no obligation nor is it good practice to recommend resuscitation or offer it as a treatment option for a patient for whom it would not be medically beneficial. Any treatment, including resuscitation, which cannot reasonably be expected to be effective can be omitted.

If a patient, either directly or through an advance directive, or the patient's surrogate requests resuscitation which the attending physician determines would be medically ineffective and/or outside the standard of care, the attending physician shall discuss fully with the patient or surrogate the medical reasons why resuscitation is inappropriate and the overall goals of the patient's care.

If the patient or surrogate continues to request inappropriate resuscitation, the attending physician must request a consultation with a second attending to confirm the assessment of medically ineffective resuscitation. If disagreement regarding an Allow Natural Death/Limited Resuscitation order still exists, the attending must also request assistance with family mediation from the Ethics Consultation Service of the Ethics Committee, Social Work, the Department of Psychiatry, or Pastoral Care Services.

If all efforts to resolve the dispute have been unsuccessful, the physician must make a reasonable effort to transfer the patient to another physician or medical institution willing to abide by the patient or surrogate's request.

C. Refusal of Resuscitation through an Advance Directive - Living Will or Durable Power of Attorney for Health care:

A competent, capable adult patient may explicitly refuse resuscitation by presenting a ***Living Will*** document to the attending physician or designee. A Living Will instructs the physician to withhold or withdraw resuscitative interventions when the patient is in a terminal condition or a persistent vegetative state. Incapacitated patients, who made clear, explicit statements of their treatment wishes, including resuscitation, while still a capable decision maker, shall have those statements given priority over any conflicting opinions or desires of family members and must be honored.

An adult patient with a ***Durable Power of Attorney for Health care*** has legally named an adult as his/her agent for making health care decisions in the event the patient is no longer a capable decision maker. The agent has the legal authority to refuse resuscitative measures. If the surrogate's decision conflicts with the patient's previously expressed wishes, the physician can contact the Ethics Consultation Service for assistance.

D. Refusal of Resuscitation by a Surrogate Decision Maker:

ADULTS

According to the South Carolina Adult Health Care Consent Act, a patient's inability to consent must be certified by two licensed physicians, each of whom has examined the patient and documented the assessment in the medical record.

If the patient is unable to understand the nature and consequences of his/her illness or is incapable of making informed choices about treatment, the physician must consult with the patient's surrogate, in the presence of at least one witness, to arrive at a **substituted judgment** for the patient about resuscitation measures.

The surrogate should make a good faith effort to determine the religious beliefs and basic values of the patient and to inform the patient, to the extent possible, of the proposed treatment and that the surrogate is authorized to make a decision regarding that treatment.

The surrogate should base his/her decision on the patient's religious beliefs, basic values, and any preferences previously expressed regarding treatment to the extent they are known, and if unknown or unclear, on the patient's **best interests**.

According to the South Carolina Adult Health Care Consent Act, the following persons may serve as surrogates, in order of priority:

1. A legally appointed guardian or committee
2. A person appointed under a *Durable Power of Attorney for Health Care*, or designated in the patient's written living will to make health care decisions for the patient
3. The patient's spouse
4. A parent or adult child
5. An adult sibling, grandparent, or adult grandchild
6. Any other relative by blood or marriage

ADULTS WITH NO SURROGATE

If the patient is incapacitated and has no appropriate surrogate, including next of kin, the attending physician must request an assessment by a second attending physician to confirm the assessment of medically ineffective resuscitation. **Refer to Item B – Medically Ineffective Resuscitation**

MINORS

If the patient is an unemancipated minor, the parent or legal guardian must be consulted in working toward a decision in the **best interests** of the child. The minor should be involved in these decisions to the extent of his/her capacity and the wishes of the minor, particularly mature minors, should be given great weight in determining what is in the minor's best interests.

If the minor is emancipated (married, enlisted in the armed services, or has a valid declaration of emancipation), he or she has the authority to make a decision about resuscitation.

E. Honoring Patient Directives:

If there is evidence of an Advance Directive (e.g. a copy of a written living will or a Healthcare Power of Attorney), documentation of that directive should be in the medical record. An oral declaration by a patient must be made in the presence of a physician and one witness and shall be noted in the medical record.

F. Staff Involvement:

Communication about a resuscitation order should occur with all healthcare team members involved in care of the patient. Disagreements among clinicians about the appropriateness of a resuscitation order should be resolved, or at least addressed, prior to the writing of that order.

If there are conflicts among the health care team, the Ethics Consultation Service is available to provide help. Any member of the health care team can call for an ethics consult.

G. Discussing Resuscitation:

Physicians are not required to offer a therapy believed to be medically ineffective or inhumane.

When CPR is considered a medically effective option falling within the standard of care, the physician must provide enough information for patients or surrogates to make an informed choice and to set reasonable goals.

The physician must explain the nature of resuscitation, the possible outcomes (including survival, persistent unconsciousness, ventilator dependency, neurological compromise, or death), the likelihood of the outcomes, and the therapeutic alternatives.

The physician should offer explicit recommendations, including the reasons for those recommendations, while giving the patient or surrogate appropriate choices. Explicit agreement must be reached concerning the use of any resuscitation measures, such as cardiac massage, countershock, artificial ventilation, and pharmacological agents. Decisions regarding a resuscitation order should be made only after a thorough discussion of the therapeutic options.

When multiple attending physicians are participants in a patient's care, good clinical practice dictates that an attending physician be designated to discuss end of life decisions with patients and families and to initiate resuscitation orders, as well as, discuss decision making among the involved physicians.

H. Documenting the Decision:

Documentation in the progress notes of the medical record should record the discussion with the patient or surrogate or others and the views of the patient or surrogate concerning resuscitation measures. The progress notes should include any evidence of advance directives, explanation of the patient's capacity, reflect the reasons for the order, and any efforts made to resolve ethical or communication problems regarding the order.

I. Mandatory Reassessment of Allow Natural Death/Limited Resuscitation Order Before Anesthesia, Surgery, or Other Invasive Procedures:

1. Patients with an Allow Natural Death/Limited Resuscitation Order may be candidates for anesthesia, surgery, or other procedures intended to facilitate care, or to provide for the relief of pain. These procedures may create life-threatening situations, including cardiopulmonary arrest, which may be readily reversible by measures, such as cardiac massage, countershock, and artificial ventilation.

2. As cardiopulmonary arrest is more likely to be reversible when it occurs during anesthesia, surgery, or certain other procedures will often mean that it may be in the patient's best interest to have the Allow Natural Death/Limited Resuscitation Order suspended during the intraoperative and immediate postoperative period or during the procedure.
 - (a) It is the responsibility of the involved physician, in conjunction with the patient's attending physician, to discuss with the patient, surrogate, or legal guardian as to whether the Allow Natural Death/Limited Resuscitation Order should be suspended or modified.
 - (b) If the patient is unable for any reason to participate in this discussion, or surrogate decision makers are not available, including the parent or legal guardian of a pediatric patient, the involved physician shall use his or her discretion about participating in the administration of an anesthetic or performance of a procedure which is not an emergency.
 - (c) If a decision is made to suspend or modify the Allow Natural Death/ Limited Resuscitation Order, the involved physician should inform the patient's attending physician, document the decision in the medical record, and convey the decision to those who will be involved in the patient's care during the intra-operative and post-operative period.

The physician performing the procedure should inform the patient of interventions that will be undertaken in the event of a cardiopulmonary arrest and document both the discussion and the specific interventions in the medical record. Explicit agreement must be reached concerning resuscitation measures, such as cardiac massage, countershock, artificial ventilation, and pharmacological agents.

- (d) The involved physician must coordinate with the patient's attending physician when the Allow Natural Death/Limited Resuscitation Order is to be reinstated.
 - (e) If the patient elects to have the Allow Natural Death/Limited Resuscitation Order remain in effect, the anesthesiologist, or any other care provider, has the option of declining to participate in that facet of care of the patient. The physician must make every reasonable effort to find a physician with similar training and expertise who is willing to treat the patient. An ethics consultation must be requested if this situation is not able to be resolved.

Procedure:

A. An Attending Physician, Following an Assessment of the Patient's Desires, Condition, and Prognosis, May Issue Resuscitation Orders:

1. Physicians-in-training may enter resuscitation orders with the concurrence of an attending physician.
2. The order will be discussed with an attending physician before entered into the medical record.
3. The order must be co-signed by an attending physician within 24 hours.
4. The order must be documented on the preprinted order entitled "Allow Natural Death/Limited Resuscitation Order" form.

B. Before Resuscitation Orders Are Entered in the Chart, the Following Information must Be Included in the Progress Notes in the Medical Record:

1. A brief statement of the patient's physical and mental condition, including diagnosis and prognosis.
2. Reasons for an Allow Natural Death/Limited Resuscitation Order.
3. A description of the patient's mental status at the time the decision was made and identification of the surrogate, if the patient is incapable of making such decisions.
4. A description of the discussion with the patient or surrogate about specific resuscitation measures or forgoing resuscitation. A patient's inability to consent must be certified by two licensed physicians who have examined the patient.
5. A statement of the patient's wishes (when known) or the surrogate's wishes (if the patient lacks the capacity to make decisions) and/or documentation of the patient's advance directives regarding resuscitation.
6. This narrative must be documented on the preprinted progress note entitled "Allow Natural Death/Limited Resuscitation Progress Note".

C. Orders for Allow Natural Death/Limited Resuscitation Will Not Be Enacted until:

1. The physician documents the discussion with the patient and/or applicable others in the medical record
2. The physician enters a ALLOW NATURAL DEATH/ LIMITED RESUSCITATION ORDER in the patient's medical record. The order will not be enacted unless the Physician-in-Training has discussed and obtained approval from the Attending Physician.
3. The physician is present with the patient at the time of cardiopulmonary arrest and personally directs that specific resuscitation measures not be used.

D. Review of Orders for Allow Natural Death/Limited Resuscitation:

An Allow Natural Death/Limited Resuscitation Order must be reviewed by the physician whenever the patient's condition changes significantly and at appropriate intervals, but at least once every seven (7) days with the review documented in the progress notes of the medical record.

Review also needed prior to anesthesia, surgery, or other invasive procedures or prior to transfer of patient from one treatment setting or treatment level to another. The review must ensure that the Allow Natural Death/Limited Resuscitation Order continues to reflect the current evaluation of the patient's medical status, the physician's recommendations, and the preferences of the patient or patient's surrogate.

The attending physician should record results of these reviews on the form entitled "Allow Natural Death/Limited Resuscitation Order Review."

- E. An Allow Natural Death/Limited Resuscitation Order may be reconsidered at any time at the request of the patient, the patient's surrogate, or the physician. The patient or patient's surrogate may revoke the Allow Natural Death/Limited Resuscitation Order at any time. A description of the discussion between the patient or surrogate and the physician regarding revocation of the Allow Natural Death/Limited Resuscitation Order should be documented in the medical record and an order must be written to rescind the Allow Natural Death/Limited Resuscitation Order. The attending physician must cosign the order within 24 hours.
- F. A written Allow Natural Death/Limited Resuscitation Order uses the terms **ALLOW NATURAL DEATH**. Terms such as "Stat Page Only" may not be written.
- G. The Ethics Consultation Service is available 24 hours a day to help clarify ethical issues in clinical situations and resolve conflicts and disagreements (e.g., among family, among staff, or between patients and their family/surrogates and staff) regarding decisions about resuscitation.

Related Policies:

C-2 Informed Consent/Refusal
C-8 Ethics Consultation
C-12 Advance Directive
C-23 Withholding/Withdrawing Life-Sustaining Treatment
C-50 Care at the End of Life

Appendices:

Links to Physician Order Forms

<p><u>MUSC</u> MEDICAL UNIVERSITY OF SOUTH CAROLINA</p> <p><u>BARCODE</u></p> <p>*PHYSORDER* ALLOW NATURAL DEATH or LIMITED RESUSCITATION ORDER</p> <p>Page 1 of 1</p>	<p>STAMP PLATE AREA</p> <p>Patient Name _____</p> <p>MRN _____</p>
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Maintain patient's comfort and hygiene, and check one:

	<input type="checkbox"/> Limited Resuscitation	<input type="checkbox"/> Allow natural death	<input type="checkbox"/> Allow Natural Death & NO NEW medical interventions
Situation	Cardiac or pulmonary arrest * (no pulse, not breathing)	Cardiac or pulmonary arrest * (no pulse, not breathing)	Any clinical event, including cardiac or pulmonary arrest*
Responses	Initiate resuscitative measures with following exclusions (check all that apply) <input type="checkbox"/> No external pacing <input type="checkbox"/> No cardioversion <input type="checkbox"/> No chest compressions <input type="checkbox"/> No endotracheal intubation <input type="checkbox"/> No bolus epinephrine or vasopressors	<u>Do not</u> provide resuscitative measures* (continue appropriate medical treatment)	<u>Do not</u> provide resuscitative measures* and do not start any new medical interventions

- 1) The attending physician must be consulted prior to writing this order. This order must be co-signed by an attending physician within 24 hours.
- 2) This order must be reviewed prior to anesthesia, surgery, or other invasive procedures.
- 3) This order must be reviewed every 7 days.
- 4) Refer to LifePoint if death imminent (see Policy C-17, "Organ and Tissue Donation")
- 5) The Allow Natural Death Progress Note outlining rationale must be written prior to writing an Allow Natural Death order.

Attending/Resident Signature _____ Pager ID _____ Date _____ Time _____ AM/PM

Attending Signature _____ Pager ID _____ Date _____ Time _____ AM/PM

Definitions:

Cardiac or pulmonary arrest: acute cardiovascular or respiratory collapse that would result in patient's death or anoxic encephalopathy within several minutes unless cardiopulmonary resuscitation was started. *Does not* apply to other potentially life-threatening clinical events.

Resuscitative measures: mechanical ventilation, endotracheal intubation, chest compression, electrical cardioversion, external pacemakers, emergency medications, and/or rapid fluid infusions.

Related forms & policies:

Adult Palliative Care Orders , Allow Natural Death/Limited Resuscitation Progress Note, Care at the End of Life, Ethics Consultations, Organ and Tissue Donation , Withholding and Withdrawing Life-Sustaining Treatment .

<p>MUSC MEDICAL UNIVERSITY OF SOUTH CAROLINA</p> <p><u>BARCODE</u></p> <p>*PRGRECRD* ALLOW NATURAL DEATH or LIMITED RESUSCITATION ORDER REVIEW</p> <p>Page 1 of 1</p>	<p>STAMP PLATE AREA</p> <p>Patient Name _____</p> <p>MRN _____</p>
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Allow Natural Death/Limited Resuscitation Order forms must be reviewed at least every 7 days or if:

- prior to anesthesia, surgery, or other invasive procedures
- transfer of patient from one treatment setting or treatment level to another
- substantial change in health status of patient
- patient or surrogate changes treatment preference.

How to review Allow Natural Death/Limited Resuscitation forms:

- 1) Review the "Allow Natural Death/Limited Resuscitation Progress Note" on patient healthcare preferences, then review the "Allow Natural Death /Limited Resuscitation Order" form.
- 2) Record the review on this "Allow Natural Death Order/Limited Resuscitation" form.
- 3) If the "Allow Natural Death/Limited Resuscitation Order" is to be voided, draw line through the form and/ or write "VOID" in large letters, then sign or initial the form.
After voiding an Allow Natural Death/Limited Resuscitation Order, a new form may be completed. If no new form is completed, full treatment and resuscitation may be provided.

Review Date	Attending Reviewer	Review location	Review outcomes
			<ul style="list-style-type: none"> •No Change •Form voided •New form done
			<ul style="list-style-type: none"> •No Change •Form voided •New form done
			<ul style="list-style-type: none"> •No Change •Form voided •New form done
			<ul style="list-style-type: none"> •No Change •Form voided •New form done
			<ul style="list-style-type: none"> •No Change •Form voided •New form done
			<ul style="list-style-type: none"> •No Change •Form voided •New form done
			<ul style="list-style-type: none"> •No Change •Form voided

			<ul style="list-style-type: none"> •New form done
			<ul style="list-style-type: none"> •No Change •Form voided •New form done



Medical Center Policy Manual

Number & Title: C-23 - Withholding/Withdrawing
Life-Sustaining Treatment
Owner: Quality Department
Location/File name: I:\EllisT\Data\Word\MUH
Clinical Policies\C-23.Withdraw Life Support

Dates:
Originated: 06/97
Reviewed: 08/02, 10/06
Legal Review: 10/07
Revised: 08/00, 10/07

Policy:

To provide practitioners with guidelines and requirements for withholding and withdrawing lifesustaining treatments. The patient's medical care should be proportional to the desired outcome, in accordance with the patient's wishes, and should not violate the ethical or philosophical position of practitioners and the hospital. Life-sustaining treatment should be provided in conformity with current medical, ethical, and legal norms. Decisions to initiate life-sustaining treatments should be based on their anticipated benefits rather than their availability. In providing or withdrawing life-sustaining treatment, clinicians should consider potential harm to patients. Harm includes physical problems, such as pain, in addition to psychological, social, and economic consequences for the patient. The benefits of organ donation and the option to donate should be included in all discussions of withholding and withdrawing life-sustaining treatments in patient who could become eligible for organ donation. [42CFR482.45 (a)(1)]

Definitions:

Cardiopulmonary Resuscitation - The emergency application of electrical cardioversion, intubation, chest compression, or other advanced life support interventions to manage cardiopulmonary arrest.

Decisional Capacity - The patient's ability, based on reasonable medical judgment, to:

- Understand the risks, benefits, and alternatives to treatment
- Relate such information to personal values and preference
- Communicate personal preferences to caregivers and surrogate decision-makers.

Futile Treatment - (Medically Ineffective and Without Benefit) - Medical futility may be identified when further therapeutic interventions do not offer meaningful opportunities to fulfill patient's life values and goals.

Life-sustaining Treatment - Any medical intervention, technology, procedure, or medication that forestalls impending death, whether or not the treatment affects the underlying disease process. This includes but is not limited to:

- Mechanical ventilation
- Vasopressors
- Transfusions
- Nutrition and hydration provided by invasive means
- Dialysis
- Antibiotics
- Cardiopulmonary resuscitation
- Laboratory procedures
- Invasive and noninvasive monitoring

Potential Organ Donor - Patient who:

- has severe, acute brain injury,
- is being mechanically ventilated, and
- is located in an intensive care unit or emergency department)

Terminal Illness - An incurable or irreversible condition which would predictably result in death, within a relatively short time, without application of life-sustaining treatment; a condition in which the prospects for recovery of a quality of life acceptable to the patient/family are so minimal that the goal of patient care shifts from prolongation of life to palliative care as death approaches.

Treatment of a Co-existing Illness - Treatment of a co-existing reversible medical condition, unrelated to the terminal illness, may also be withheld or withdrawn whether or not this is a complication of the patient's primary disease.

REASONS FOR CONSIDERING WITHHOLDING/WITHDRAWING LIFE-SUSTAINING TREATMENT

Refusal of Life-Sustaining Treatment by Competent Adult Patient or Emancipated Minors

Competent adult patients or emancipated minors (married, enlisted in the armed services, or has a valid declaration of emancipation) have the legal right to refuse any medical interventions, including life-saving interventions. Any patient, who understands the nature of his/her illness and can make informed, reasoned choices about treatment has the right to refuse life-sustaining treatment for medical or non-medical reasons.

Refusal of Life-Sustaining Treatment Through an Advance Directive (Living Will or Durable Power of Attorney for Health Care)

A competent, capable adult patient may explicitly refuse life-sustaining treatment by presenting a living will document (Declaration of a Desire for a Natural Death, S.C. CODE ANN. 44-77-10, or similar document). A living will instructs the physician in the patient's wishes regarding withholding life-sustaining treatment when the patient is in a terminal condition or a persistent vegetative state.

Incapacitated patients, who made credible and explicit statements of their treatment wishes while still capable decision makers, should have those statements honored over any conflicting opinions or desires of family members. Patients' wishes should be honored.

An adult patient with a Health Care Power of Attorney (S.C. CODE ANN. 62-5-504) has legally named an adult as his/her agent for making health care decisions in the event the patient is no longer a capable decision maker. The agent has the legal authority to refuse life-sustaining treatment unless contradicted by a living will. If the agent's decision conflicts with the patient's expressed wishes or if there is reason to believe that the agent inadequately represents the patient, the physician can contact the Ethics Consultation Service or the Office of Legal Affairs for assistance.

Refusal of Life-Sustaining Treatment by a Surrogate Decision Maker

ADULTS

If the patient is unable to understand the nature and consequences of his/her illness or is incapable of making informed choices about treatment, the physician should consult with the patient's surrogate decision maker, in the presence of at least one witness, to arrive at a substituted judgment about withholding/ withdrawing life-sustaining treatment.

According to the South Carolina Adult Health Care Consent Act (S.C. CODE ANN 44-66-10), the following persons may serve as surrogates, in order of priority:

1. A legally appointed guardian or committee
2. A person appointed under a Medical Power of Attorney or designated in the patient's written living will to make health care decisions for the patient
3. The patient's spouse
4. A parent or adult child
5. An adult sibling, grandparent, or adult grandchild
6. Any other relative by blood or marriage

The surrogate should base his/her decision on the patient's basic values and beliefs and any preferences regarding treatment previously expressed to the extent they are known, and if unknown or unclear, on the patient's best interests.

MINORS

If the patient is an unemancipated minor, the parent or legal guardian must be consulted in working toward a decision in the best interests of the child. A minor should be involved in these decisions to the extent of his/her developmental capacity and the wishes of the minor, particularly mature minors, should be given great weight in determining what is in the minor's best interests.

If a minor is married, enlisted in the armed services, or has a valid declaration of emancipation, he or she has the authority to make decisions about life-sustaining treatment.

Treatment is Futile (Medically Ineffective and Without Benefit)

Treatment that would be medically ineffective in achieving the patient's goals should not be recommended or imposed upon a patient. Moreover, physicians have no obligation nor is it good practice to carry out or maintain such treatment.

Terminal Condition

If a medical judgment is made that intervention will only prolong suffering and the dying process or will fail to reverse or ameliorate the underlying illness, treatment should not be offered or imposed or maintained.

GUIDELINES FOR DECISION MAKING

Every adult with decisional capacity is legally and ethically entitled to make health care decisions for themselves. The attending physician, or designee, is responsible for providing the patient or surrogate with adequate information about applicable therapeutic and diagnostic options. This information should include the risks, side effects, potential benefits, and likelihood, if known, of whether treatment will succeed as well as estimated financial and other costs of treatment and alternatives.

The physician should provide advice about the treatment choices and should recommend the medically best option for the patient under the circumstances and should give reasons, based on medical, experiential, or ethical factors, for such judgment. The physician should remind patients and other decision-makers that they could accept or reject the physician's recommendations.

In the case of potential organ donors, the option of organ donation should be offered during discussion of withholding/withdrawal of life-sustaining treatment. It is strongly recommended that a designated requestor be present to discuss that option. See Policy C-17 (<http://www.musc.edu/medcenter/policy/Med/C17.pdf>).

The physician should elicit questions, provide truthful and complete answers to such questions, attempt to ascertain whether or not the decision maker understands the information and advice provided, and attempt to enhance understanding as needed.

PHYSICIAN-PATIENT OR PHYSICIAN-SURROGATE DISAGREEMENTS

A physician or other clinician is not compelled by the demand of a patient or surrogate to provide treatment that, in the professional judgment of that physician or clinician, is unlikely to benefit the patient (that would be medically ineffective and/or outside the standard of care). However, physicians should not take such a position merely as a justification for circumventing possibly difficult discussions with patients.

If the patient or surrogate requests care that the physician cannot, in good conscience, provide, refer to Clinical Policy C-13 B. Medically Ineffective Resuscitation.

LIFEPOINT PROCEDURE:

The following procedures are in chronological order.

The primary care nurse or designee should notify the LifePoint Communication Center (LCC) (1-800-269-9777). Call LCC when the attending physician has determined that a patient has a severe, irreversible acute brain injury, is being mechanically ventilated, is located in an intensive care unit or emergency department, and withholding/withdrawing of life support is being contemplated.

If LCC (1-800-269-9777) determines that the patient is a potential organ donor, a plan must be developed to offer the family the option of organ/tissue donation as part of the discussion of the potential course of action. (See Policy C-17.)

In all cases in which this policy applies, an Allow Natural Death / Limited Resuscitation Progress Note will be entered in the patient's medical record documenting the process by which the decision to withhold/ withdraw life sustaining treatment was arrived. This note should include:

- In the case of potential organ donors, referral to the LCC (1-800-269-9777) and the outcome of the referral
- The patient's diagnosis and prognosis
- Identification of the decision maker(s) with whom the issue of withdrawing or withholding life-sustaining treatment was discussed
- A description of the discussion including specific reasons for withholding or withdrawing life-sustaining treatment
- A description of the treatments to be withheld or withdrawn
- Signature of the attending physician

A written Allow Natural Death / Limited Resuscitation Order should precede written orders to withhold or withdraw life-sustaining treatment, except under certain circumstances (e.g. withholding of blood products in a Jehovah Witness patient).

Once the decision is made to withhold/withdraw life-sustaining treatment, a plan of palliative care only should be established. Palliative care should have pain management and relief of suffering as a major objective.

The patient's condition should be reassessed to ensure the order(s) to withhold/ withdraw life-sustaining treatment continue to reflect the patient's current medical status, the physician's recommendations, and the preferences of the patient or patient's surrogate.

Refer to Clinical policy C-13, Procedure D. Review of Orders for Allow Natural Death / Limited Resuscitation.

The Ethics Consultation Service is available 24 hours a day to help clarify ethical issues in clinical situations and to help resolve conflicts and disagreements (e.g., among families, among staff, or between patients and their family/surrogates and staff) regarding decisions about withholding/ withdrawing life-sustaining treatment.

Related Policies:

C-1 Patients Rights and Responsibilities (<http://www.musc.edu/medcenter/policy/Med/C01.pdf>)

C-12 Advance Directives (<http://www.musc.edu/medcenter/policy/Med/C12.pdf>)

C-13 Resuscitation Orders (<http://www.musc.edu/medcenter/policy/Med/C13.pdf>)

C-15 Guidelines for the Determination of Death (<http://www.musc.edu/medcenter/policy/Med/C15.pdf>)

C-16 Decedent Care Program (<http://www.musc.edu/medcenter/policy/Med/C16.pdf>)

C-17 Organ/Tissue Donation (<http://www.musc.edu/medcenter/policy/Med/C17.pdf>)

C-50 Care at the End of Life (<http://www.musc.edu/medcenter/policy/Med/C50.pdf>)

Board of Trustees

Credentials Committee Report

MUSC-MC BOARD OF TRUSTEES

Credentials Report

December 14, 2007

The Medical Executive Committee has reviewed the following applicants for appointment / reappointment / change in privileges and recommend approval by the Board.

Status Legend: AC=Active; PA=Prov. Active; AF=Affiliate; PF=Prov. Affiliate; AFC=Affiliate [CFC]; PAFC=Prov. Affiliate [CFC];
AH=Allied Health; PH=Prov. Allied Health; HE=Allied Health [External]; PE= Prov. Allied Health [External]
SB=Sabbatical; AD=Administrative

APPLICANTS FOR APPOINTMENT

<u>Practitioner Name</u>	<u>Degree</u>	<u>Status</u>	<u>Dept</u>	<u>Div</u>	<u>CC</u>	<u>MEC</u>	<u>BOT</u>
Buck, Blair	PA-C	PH	NEUR	NSUR	10/10/2007	10/17/2007	12/14/2007
Dushanko, Michael	CRNA	PH	ANES	---	10/10/2007	10/17/2007	12/14/2007
Fitzgerald, Monica	PhD	PH	PSYC	CRVC	10/10/2007	10/17/2007	12/14/2007
Gamble, Laura	PNP	PH	PEDS	PGCD	10/10/2007	10/17/2007	12/14/2007
Hansen, Ellen	CRNA	PH	ANES	---	10/10/2007	10/17/2007	12/14/2007
Herpel, Laura	MD	PA	MEDI	PULM	10/10/2007	10/17/2007	12/14/2007
Roper, Paige	CRNA	PH	ANES	---	10/10/2007	10/17/2007	12/14/2007
Rumboldt, Tihana	MD	PA	PATH	---	10/10/2007	10/17/2007	12/14/2007
Thelan, Elizabeth	MSN	PH	PEDS	GAST	10/10/2007	10/17/2007	12/14/2007
Tsai, Nancey	MD	PA	NEUR	PHYS	10/10/2007	10/17/2007	12/14/2007
Turk, Aquilla III	MD	PA	RADI	---	10/10/2007	10/17/2007	12/14/2007
Washburn, Amanda	FNP	PH	MEDI	CARD	10/10/2007	10/17/2007	12/14/2007
Bearden, Pam	APRN	PH	MEDI	CARD	11/14/2007	11/28/2007	12/14/2007
Brown, Joshua	PhD	PH	PSYC	WMCT	11/14/2007	11/28/2007	12/14/2007
Campbell, Stephen	MD	PF	ANES	---	11/14/2007	11/28/2007	12/14/2007
Carie, Carissa	PNP	PH	PEDS	GAST	11/14/2007	11/28/2007	12/14/2007
Craig, Mary Hart	MD	PA	PSYCH	---	11/14/2007	11/28/2007	12/14/2007
Glaser, Anthony	MD	PA	FAMP	---	11/14/2007	11/28/2007	12/14/2007
Hay, John	MD	PA	ANES	---	11/14/2007	11/28/2007	12/14/2007
Hood, Jeffrey	OD	PA	OPHT	---	11/14/2007	11/28/2007	12/14/2007
Ivester, Julius	MD	PF	ANES	---	11/14/2007	11/28/2007	12/14/2007
Paglia, Jennifer M.	ANP	PH	MEDI	CARD	11/14/2007	11/28/2007	12/14/2007
Rosecrans, Michelle	CRNA	PH	ANES	---	11/14/2007	11/28/2007	12/14/2007
Satterfield, Teresa	CRNA	PH	ANES	---	11/14/2007	11/28/2007	12/14/2007
Stelter, Taryn	MD	PF	PEDS	---	11/14/2007	11/28/2007	12/14/2007
Singh, G. Rick	DMD	PF	ORAL	---	11/14/2007	11/28/2007	12/14/2007
Weiss, Mark S.	MD	PF	ANES	---	11/14/2007	11/28/2007	12/14/2007
White, Raymon M.	CRNA	PH	ANES	---	11/14/2007	11/28/2007	12/14/2007
Wolfman, Michael	CRNA	PH	ANES	---	11/14/2007	11/28/2007	12/14/2007
Wymer, Joy	PhD	PH	NSUR	NEUR	11/14/2007	11/28/2007	12/14/2007

APPLICANTS FOR REAPPOINTMENT

<u>Practitioner Name</u>	<u>Degree</u>	<u>Status</u>	<u>Dept</u>	<u>Div</u>	<u>CC</u>	<u>MEC</u>	<u>BOT Expedite</u>
Alpert, Calvert C.	MD		ANES		11/14/2007	11/28/2007	12/7/2007
Baron, Paul L.	MD		SURG	SONC	11/14/2007	11/28/2007	12/7/2007
Besenski, Nada	MD, PhD		RADI		11/14/2007	11/28/2007	12/7/2007
Bluestein, Ettaleah	MD		OPHT		11/14/2007	11/28/2007	12/7/2007
Carpenter, Laura A.	PhD		PEDI	PGEN	11/14/2007	11/28/2007	12/7/2007
Coakley, Kimberlyn B.	FNP		MEDI	ENDO	11/14/2007	11/28/2007	12/7/2007
Cotton, Peter B.	MB,BCh		MEDI	GAST	11/14/2007	11/28/2007	12/7/2007
Davis, Debra L.	FNP		PSYC		11/14/2007	11/28/2007	12/7/2007
DeMarco, James R.	MD		ORTH		11/14/2007	11/28/2007	12/7/2007
Donaldson, Jonathan T.	MD		UROL		11/14/2007	11/28/2007	12/7/2007
Dowdle, Merriman L.	PA-C		MEDI	GAST	11/14/2007	11/28/2007	12/7/2007
Dukes, Julie Kate M.	PA-C		SURG	PLAS	11/14/2007	11/28/2007	12/7/2007

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<u>Practitioner Name</u>	<u>Degree</u>	<u>Status</u>	<u>Dept</u>	<u>Div</u>	<u>CC</u>	<u>MEC</u>	<u>BOT</u>
Ernst, John M.	MD		ORTH		11/14/2007	11/28/2007	12/7/2007
Fogle, Jennifer G.	DMD		PEDI	PEDD	11/14/2007	11/28/2007	12/7/2007
Friedman, Richard J.	MD		ORTH		11/14/2007	11/28/2007	12/7/2007
Grush, Owen C.	MD		PSYC		11/14/2007	11/28/2007	12/7/2007
Gwynette, McLeod F.	MD		PSYC		11/14/2007	11/28/2007	12/7/2007
Haase, Barbara A.	PNP		OBGY		11/14/2007	11/28/2007	12/7/2007
Hardesty, Susan J.	MD		PSYC		11/14/2007	11/28/2007	12/7/2007
Harvey, Tracy S.	MD		SURG	PLAS	11/14/2007	11/28/2007	12/7/2007
Havig-Lipke, Kelly C.	MD		PEDI	PEDI	11/14/2007	11/28/2007	12/7/2007
Hebbar, Latha	MBBS		ANES		11/14/2007	11/28/2007	12/7/2007
Howard, Gene R.	MD		OPHT		11/14/2007	11/28/2007	12/7/2007
Kelly-Brown, Sharon M.	PNP		PEDI	ENDO	11/14/2007	11/28/2007	12/7/2007
Kolehman, Kerri A.	MD		NSCI	NSUR	11/14/2007	11/28/2007	12/7/2007
Kraft, Andrew S.	MD		MEDI	HEMA	11/14/2007	11/28/2007	12/7/2007
Lee, Franklin C.	MD		PEDI	PEDI	11/14/2007	11/28/2007	12/7/2007
Lentsch, Eric J.	MD		OTOL		11/14/2007	11/28/2007	12/7/2007
Libet, Alice Q.	PhD		PSYC		11/14/2007	11/28/2007	12/7/2007
McGaha, Philip J.	MD		PEDI	PEDI	11/14/2007	11/28/2007	12/7/2007
Noone, Michael C.	MD		OTOL		11/14/2007	11/28/2007	12/7/2007
Orak, John K.	MD		PEDI	PNEP	11/14/2007	11/28/2007	12/7/2007
Ottinger, William S.	MD		OBGY		11/14/2007	11/28/2007	12/7/2007
Papamitsakis, Nikolaos I.	MD		NSCI	NEUR	11/14/2007	11/28/2007	12/7/2007
Rambo Sr., William M.	MD		SURG	GSUR	11/14/2007	11/28/2007	12/7/2007
Ramsetty, Anita N.	MD		MEDI	ENDO	11/14/2007	11/28/2007	12/7/2007
Reeves, Crispin F.	PA-C		MEDI	EMER	11/14/2007	11/28/2007	12/7/2007
Reeves, Scott T.	MD		ANES	CRIT	11/14/2007	11/28/2007	12/7/2007
Roberts, Donna R.	MD		RADI		11/14/2007	11/28/2007	12/7/2007
Robinson, John H.	MD		SURG	PLAS	11/14/2007	11/28/2007	12/7/2007
Rustin, Rudolph B.	MD		SURG	GSUR	11/14/2007	11/28/2007	12/7/2007
Sharma, Neeraj K.	MD		MEDI	IMED	11/14/2007	11/28/2007	12/7/2007
Shirali, Girish S.	MBBS		PEDI	PCAR	11/14/2007	11/28/2007	12/7/2007
Siegel, Mark S.	MD		OPHT		11/14/2007	11/28/2007	12/7/2007
Smith, Michael T.	MD		PATH	APAT	11/14/2007	11/28/2007	12/7/2007
Stewart, Erika S.	ANP		SURG	GSTS	11/14/2007	11/28/2007	12/7/2007
Todd-Houston, Gwendolyn F.	MD		PEDI	PEDI	11/14/2007	11/28/2007	12/7/2007
Vanzura, Yalani L.	MD		MEDI	EMER	11/14/2007	11/28/2007	12/7/2007
Warters, Robert D.	MD		ANES		11/14/2007	11/28/2007	12/7/2007
Wong, Jeffrey G.	MD		MEDI	IMED	11/14/2007	11/28/2007	12/7/2007
Young, Rodney B.	MD		SURG	PLAS	11/14/2007	11/28/2007	12/7/2007

MEDICAL STAFF/ALLIED HEALTH PROFESSIONALS - Increase/Decrease/Change in Privileges

<u>Practitioner Name</u>	<u>Degree</u>	<u>Status</u>	<u>Dept</u>	<u>Div</u>	<u>CC</u>	<u>MEC</u>	<u>BOT</u>
McElheny, Jill Additional privilege of Moderation Sedation	PNP	PH	PEDI	PEMG	10/10/2007	10/17/2007	12/14/2007
McElheny, Jill Additional privilege of prescriptive authority for Schedules III, IV, & V	PNP	PH	PEDI	PEMG	10/10/2007	10/17/2007	12/14/2007
Amlicke, James Addition of surgical privileges on "First Assist" basis only	MD	AC	ORTH	---	10/10/2007	10/17/2007	12/14/2007
Charles, Jacqueline Additional privilege of prescriptive authority for Schedules III, IV, & V	ANP	PH	MEDI	CARD	10/10/2007	10/17/2007	12/14/2007
Gordon, Leonie Additional privilege of reading P.E.T./C.T. scans	MD	AC	RADI	---	10/10/2007	10/17/2007	12/14/2007

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<u>Practitioner Name</u>	<u>Degree</u>	<u>Status</u>	<u>Dept</u>	<u>Div</u>	<u>CC</u>	<u>MEC</u>	<u>BOT</u>
Costello, Philip Additional privilege of reading P.E.T./C.T. scans	MD	AC	RADI	---	10/10/2007	10/17/2007	12/14/2007
Spicer, Kenneth Additional privilege of reading P.E.T./C.T. scans	MD	AC	RADI	---	10/10/2007	10/17/2007	12/14/2007
Panzegrau, Beata Additional privilege of reading P.E.T./C.T. scans	MD	AC	RADI	---	10/10/2007	10/17/2007	12/14/2007
Rumpp, Laurie Change in Protocol owing to change in back-up Supervising Physician	FNP-C	AH	SURG	SONC	11/14/2007	11/28/2007	12/14/2007
Ruth, Natasha Addition of Medicine privileges, owing to dual appointment	MD	AC	PEDS		11/14/2007	11/28/2007	12/14/2007
Borg, Keith Extension of current privileges to Pediatric ER	MD	AC	MEDI	EMER	11/14/2007	11/28/2007	12/14/2007
Meekins, Paula Extension of current privileges to Pediatric ER	MD	PA	MEDI	EMER	11/14/2007	11/28/2007	12/14/2007
Robins, Amy Extension of current privileges to Pediatric ER	MD	AC	MEDI	EMER	11/14/2007	11/28/2007	12/14/2007
Bush, Jeffrey Extension of current privileges to Pediatric ER	MD	AC	MEDI	EMER	11/14/2007	11/28/2007	12/14/2007
Larson, Eric Extension of current privileges to Pediatric ER	MD	AC	MEDI	EMER	11/14/2007	11/28/2007	12/14/2007
Shapshak, Dag Extension of current privileges to Pediatric ER	MD	PA	MEDI	EMER	11/14/2007	11/28/2007	12/14/2007
Axiotis, Diana Change in Scope of Practice owing to departmental transfer	PA-C	PH	RADI		11/14/2007	11/28/2007	12/14/2007
Williams, Amy Change in Protocol owing to divisional transfer	C-PNP	PH	PEDS	PULM	11/14/2007	11/28/2007	12/14/2007
Turk, Aquilla Additional privilege of Carotid Artery Stent procedures	MD	PA	RADI		11/14/2007	11/28/2007	12/14/2007
Pappolla, Miguel Addition of three surgical privileges	MD	PA	NSUR	NEUR	11/14/2007	11/28/2007	12/14/2007
Dukes, Julie Kate Request for addition of Prescriptive Authority	PA-C	PH	SURG	PLAS	11/14/2007	11/28/2007	12/14/2007
Scott, Lancer Additional privileges of Moderate Sedation, Ltd Emergency Ultrasound, & ext. of current privileges to Pediatric ER	MD	PA	MEDI	EMER	11/14/2007	11/28/2007	12/14/2007

**FACILITIES
HOSPITAL AUTHORITY
CONSTRUCTION PROJECT FOR APPROVAL
DECEMBER 14, 2007**

Project Title: Replacement AHU #4

Project Budget Approval Request:
FY08 \$1,150,000

Source of Funds: Hospital Generated Revenue

Project Request: The replacement project will replace the existing conditioned air handling unit on the second floor in the Children's Hospital with a larger unit to provide redundancy for planned and unexpected air handler shutdowns. The project will be budget neutral for FY 08.

FY08	\$ 1,150,000	Design and order equipment
FY09	\$ 2,150,000	Installation
Total project cost	\$ 3,300,000	

Project Scope: This project will keep the existing Air Handler in operation while a new one is installed in another location of the hospital. As OR volumes continue to grow, we are looking ahead to provide capacity for the present 18 OR's served and added capacity for future needs. When the new AH 4 is installed, the present one will be removed.

The new unit will have two air handlers, each with the capacity to carry the OR load. This design allows for planned maintenance and dealing with unexpected AH repairs without interruption to OR schedules.

The project spans two fiscal years and is expected to be completed by December 2008.

Justification: This project provides a new redundant system to provide Air Handler capacity for 18 OR's in the Medical Center. It also adds capacity for future needs. The present system was installed in the 1980's. Age and maintenance of the present unit make maintenance and emergency repairs difficult and can lead to OR down time during busy surgery schedules.

**FACILITIES
HOSPITAL AUTHORITY
NEW LEASE
FOR APPROVAL**

DECEMBER 14, 2007

DESCRIPTION OF NEW LEASE: This lease is for 2,100 square feet of clinical space located at 200 Rutledge Avenue, and will be occupied by Forensic Psychiatry. The Department's move from the Psychiatry Annex on campus is necessary to vacate space for residency education purposes. The rate per square foot for this lease is \$25.29. This includes the base rent, some operating costs and \$26,670.00 in renovations (amortized throughout the lease term). The monthly rental rate will be \$4,425.75, resulting in an annual rate of \$53,109.00. The base rent (\$19.04) will increase 3% annually.

NEW LEASE AGREEMENT X
RENEWAL LEASE AGREEMENT

LANDLORD: A. Bert Pruitt

LANDLORD CONTACT: John Hassell, Broker, 224-1239

TENANT NAME AND CONTACT: Forensic Psychiatry, Joan Herbert, 792-7274

SOURCE OF FUNDS: Hospital General Operating Funds

LEASE TERMS:

RENEWAL TERM: Five (5) Years

AMOUNT PER SQUARE FOOT: \$25.29

ANNUALIZED RENT:

YEAR 1 \$53,109.00

YEAR 2 \$54,306.00

YEAR 3 \$55,545.00

YEAR 4 \$56,826.00

YEAR 5 \$58,128.00

TOTAL RENT OF TERM: \$277,914.00

EXTENDED TERM(S): To be negotiated

OPERATING COSTS:

FULL SERVICE

NET X