

**MINUTES**  
**MEDICAL UNIVERSITY HOSPITAL AUTHORITY**  
**BOARD OF TRUSTEES MEETING**  
**February 12, 2010**

The Board of Trustees of the Medical University Hospital Authority convened Friday, February 12, 2010, with the following members present: Mr. Thomas L. Stephenson, Esquire, Vice Chairman; 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. James E. Wiseman, Jr. Absent: Dr. Charles B. Thomas, Jr., Chairman; Dr. Paula E. Orr.

The following administrative officials were present: Dr. Raymond S. Greenberg, President; 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; Mr. Jim Fisher, Vice President for Development.

The following deans were present: Dr. Jack Sanders, College of Dental Medicine; Dr. Mark Sothmann, College of Health Professions; Dr. Jerry Reves, College of Medicine; Dr. Joseph DiPiro, South Carolina College of Pharmacy; Dr. Gail Stuart, College of Nursing.

**Item 1. Call to Order-Roll Call.**

There being a quorum present, Vice Chairman Stephenson called the meeting to order at 9:00 a.m. 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, April 9, 2010.

**Item 3. Approval of Minutes of the Regular Meeting of the Medical University Hospital Authority of December 11, 2009.**

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 stated that Ms. Peggy Schachte will be retiring from her position at the University as Director of the Office of Research Development. He said that there was no one more responsible for winning as many of the large infrastructure grants this institution has received over the last twenty years or so than Peggy. He called on Dr. Steve Lanier to read a resolution from the Board of Trustees in appreciation for her outstanding service and many contributions for thirty-nine years.

Dean Reves said the College of Medicine appreciated Peggy's outstanding leadership and, as a token of that, the College has established the Peggy Schachte Research Mentor Award. The annual award has a \$50,000 endowment for the purpose of giving a \$1,000 monetary gift each fall to recognize the outstanding mentor in the entire University.

Dr. Greenberg then recognized Dean Reves and stated he had been selected to be designated a Distinguished University Professor. As everyone knows, Dean Reves will be stepping down as Dean in the near future and he was asked to make a presentation to the Board today. Dean Reves reviewed his career including his interest in cardiac anesthesiology research. He talked about his plans for retirement including travel, research and writing. He thanked Dr. Greenberg for the opportunity to serve the University for the past nine years.

Dr. Greenberg asked Dr. Bruce Elliott, who nominated Dean Reves for the Distinguished University Professor Award to say a few words. Dr. Elliott said the Dean's career embodies the essence of a Distinguished University Professor. He has achieved national and international acclaim for his many outstanding accomplishments as an investigator, a teacher, a researcher, a clinician and a leader. His passion for his specialty, anesthesiology, and his untiring service to this community and this institution is indisputable. Dr. Elliot said he was honored to recommend Dean Reves for the award.

Recommendation of Administration: That these reports 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 that the gamma knife was now operational and eleven cases have been completed in the three weeks since its installation. He also stated that the Medical Center activity continues to grow.

He asked for Board approval for a new affiliation with the Georgetown Hospital that would build upon a well-established history of collaboration between Georgetown Hospital System (GHS) and MUSC. The strategic affiliation agreement would expand local access to medical services, expertise and clinical support offered by MUSC.

As a result of the new agreement, patients will benefit from a wide variety of MUSC medical specialty consultation services as a result of a telecommunications system that links the two organizations. Enhanced opportunities for participation in clinical trials and research, as well as training opportunities for MUSC residents and medical students, are other benefits.

Recommendation of Administration: That the affiliation with Georgetown Hospital be approved.

Recommendation of Committee: The affiliation with Georgetown Hospital be approved.

Board Action: A motion was made, seconded and unanimously voted to approve the affiliation with Georgetown Hospital System.

**Item 7. MUSC Medical Center Financial and Statistical Report.**

Statement: Mr. Smith stated the current financial statements for the Medical Center were included in the agenda. Ms. Montgomery reported to committee on the UHC benchmark data. FTEs per adjusted occupied bed for MUHA is at 6.6 which is in the 25<sup>th</sup> percentile of UHC hospitals.

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 8. Report on Quality and Patient Safety.**

Statement: Dr. Baker stated a report by Dr. Patrick Cawley had been given to 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 9. Report of the Vice President for Medical Affairs and Dean, College of Medicine.**

Statement: Dr. Baker stated in lieu of a report to committee, Dean Reves provided a presentation during the Board meeting.

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 10. Report on University Medical Associates.**

Statement: Dr. Baker stated Mr. Valerio had briefed the committee on three outreach activities. The Gynecological Oncology group will provide services in the Beaufort area. The Psychiatric service will assist with a 20 bed unit at Colleton Medical Center and one of the electrophysiologists will handle cases at Trident.

Recommendation of Administration: That these outreach activities be approved.

Recommendation of Committee: That these outreach activities be approved.

Board Action: A motion was made, seconded and unanimously voted to approve the outreach activities.

**Item 11. Legislative Update.**

Statement: Dr. Baker stated Mr. Faulkner had given a legislative update 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 12. Other Committee Business.** None

**Item 13. Special Healthcare Alternative Retirement Plan (SHARP) Amendment (Consent Item).**

Statement: The SHARP Amendment was presented for approval.

Recommendation of Administration: That the Amendment be approved.

Recommendation of Committee: That the Amendment be approved.

Board Action: A motion was made, seconded and unanimously voted to approve the SHARP Amendment.

**Item 14. Revisions to the Medical Staff Bylaws and Rules and Regulations (Consent Item).**

Statement: The Revisions to the Medical Staff Bylaws and Rules and Regulations were presented for approval.

Recommendation of Administration: That the Revisions be approved.

Recommendation of Committee: That the Revisions be approved.

Board Action: A motion was made, seconded and unanimously voted to approve the Revisions to the Medical Staff Bylaws and Rules and Regulations.

**Item 15. Medical University Hospital Authority Appointments, Reappointments and Delineation of Privileges (Consent Item).**

Statement: An updated list of 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 approve.

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

**Item 16. Medical Executive Committee Minutes (Consent Item).**

Statement: Minutes of the Medical Executive Committee for December 16, 2009 were presented for information.

Recommendation of Administration: That this be received as information.

Recommendation of Committee: That this be received as information.

Board Action: The minutes of the Medical Executive Committee for December 16, 2009 were received as information.

**Item 17. 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 18. Update on Projects.**

Statement: Mr. Bingham reported that Mr. Frazier presented an update on Authority projects to the 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 19. Other Committee Business.** None

**Item 20. Facilities Contracts Awarded (Consent Item).**

Statement: Facilities Contracts awarded since the last 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. Federal Audits.**

Statement: Mr. Stephenson stated a report had been received by committee on federal audits.

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 22. Legal Counsel Update.**

Statement: Mr. Stephenson stated a report had been received by committee from legal counsel.

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 23. Report of the Office of Internal Audit.**

Statement: Mr. Stephenson stated a report had been received from the Internal Auditor.

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 24. Other Committee Business.** None

**OTHER BUSINESS FOR THE BOARD OF TRUSTEES:**

**Item 25. 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 26. New Business for the Board of Trustees.** None.

**Item 27. Report from the Chairman.**

There being no further business, the Hospital Authority meeting was adjourned and the University Board of Trustees meeting was convened.

Respectfully submitted,



Hugh B. Faulkner III  
Secretary

**Board of Trustees  
Medical University Hospital Authority  
Operations and Finance Committee  
Minutes  
February 11, 2010**

**Attendees:**

Dr. Stanley C. Baker, Chair  
Mr. Melvyn Berlinsky  
Mr. William H. Bingham, Sr.  
Mr. William B. Hewitt  
Dr. Donald R. Johnson  
Dr. E. Conyers O'Bryan, Jr.  
Dr. Thomas C. Rowland  
Mr. Charles W. Schulze  
Thomas L. Stephenson, Esq.  
Hon. Robin M. Tallon  
Charles B. Thomas  
James E. Wiseman, Jr.  
Dr. Raymond Greenberg  
Mr. Stuart Smith  
Ms. Lisa Montgomery

Dr. J. G. Reves  
Mr. Jim Fisher  
Dr. Pat Cawley  
Dr. Phil Costello  
Joseph Good, Esq.  
Mr. Betts Ellis  
Ms. Susan Barnhart  
Mr. John Cooper  
Dr. Marilyn Schaffner  
Annette Drachman, Esq.  
Mr. Steve Valerio  
Dr. Dennis Frazier  
Mr. Steve Hargett  
Sarah King

The meeting was called to order by Dr. Stanley Baker, Chair.

**Item 6. MUSC Medical Center Status Report**

Gamma Knife – Mr. Smith reported that the gamma knife was now operational, and 11 cases have been completed in the three weeks since its installation. This is above the number of cases we had projected.

Statistical Report – Mr. Smith reported that overall the Medical Center activity continues to grow. Through January, discharges have increased 2.8%, operating room cases are up 4.9%, and outpatient visits are up 5.3%.

Affiliation: Mr. Smith reported in an earlier committee that the board needs to approve an affiliation with Georgetown. This action will take place in the full Board meeting on Friday.

Action: Recommend approval of Georgetown affiliation.



## **Item 7. Financial and Statistical Report**

Lisa Montgomery reported on the 6 months ending December 31, 2009. Net patient revenue is approximately \$500 million.. The cash position has improved significantly and we should meet our projected budget by year end.

She also reported on MUHA benchmark data as compared with other UHC institutions. MUHA ranks in the 25<sup>th</sup> to 50<sup>th</sup> percentile in Average length of stay, FTEs per adjusted occupied bed, and net operating revenue per CMI adjusted discharge. FTEs per adjusted occupied bed is at 6.6 which is in the 25<sup>th</sup> percentile of UHC hospitals. MUHA is also meeting all bond covenants.

Action: Report received as information

## **Item 8. Quality and Patient Safety Report**

Dr. Patrick Cawley presented a sentinel event review. Sentinel events are unexpected occurrences involving death, serious physical or psychological injury, or the risk thereof. Any event determined to be serious is evaluated and requires a 45 day action plan. MUHA's Administrative Review Group makes a determination of whether an event is considered sentinel. The Administrative Review Group reviewed 18 cases and deemed 10 of them as sentinel. Following this review all sentinel events have a root cause analysis done, a facilitator assigned and then are taken to an IMPROVE meeting and eventually to the Hospital Administrators and Quality Council for final action. An event deemed serious but not sentinel has a facilitator assigned, is presented at the IMPROVE meeting and is also taken to Hospital Administrators and Quality Council for final action. MUHA had 25 serious events which were evaluated in 2009. Of the sentinel and serious events in 2009, three were referred to peer review.

Causes for most sentinel events included personnel performance or chain of command issues, lack of policy or standardized procedure, or injury as a result of a fall. Main issues related to the serious events were lack of standardization of policy or procedures, inappropriate coordination of care, and personnel performance issues.

Improvements have been made since last year. We have seen a decrease in cases involving failure to rescue, retained items, and medication errors.

MUHA continues to have a policy of notifying the patient or family of any sentinel event. We also evaluate if any sentinel events are related to staffing issues. Our evaluation indicates that staffing levels played no part in any of our sentinel events.

Dr. Cawley presented a number of actions which have improved patient safety. These actions were the result of event root cause analysis or proactive assessment. Among these actions are an improved counting process in labor and delivery, improved medication security and patient monitoring, a focus on falls, a nursing quality oversight committee similar to peer review for physicians, improved communication among providers, improved retained object tracking, procedures to prevent elopements, and improved identification of donor organs during retrieval. The complete list was reviewed in the presentation.

Action: Report received as information

**Item 9. Report of Vice President for Medical Affairs and Dean, College of Medicine**

Report will be presented in another committee

**Item 10. Report on University Medical Associates**

Steve Valerio briefed the committee on three outreach activities. The Gynecological Oncology group will provide services in the Beaufort area. The Psychiatric service will assist with a 20 bed unit at Colleton Medical Center, and one of our electrophysiologists will handle cases at Trident. These cases should produce referrals to the MUSC Cardiovascular Surgery division.

Action: Recommend approval

**Item 11. Legislative Update**

Mr. Faulkner reported that the Legislature has approved a pilot program to provide bariatric surgery for 100 patients who are covered by the state health plan. Also, he reported that on February 23 the Ways and Means committee will begin hearings on the appropriations bill, and that regulatory relief is on the Senate agenda.

**Item 12. Other Business**

No items

Consent Agenda

**Item 13. Special Healthcare Alternative Retirement Plan (SHARP) amendment**

This amendment allows those in this plan to designate a beneficiary other than a spouse.

Action: Recommend Approval

**Item 14. Revisions to the Medical Staff Bylaws and Rules and Regulations.**

These revisions were presented to the committee and approved.

Action: Recommend Approval.

**Item 15. Medical University Hospital Authority Appointments and Reappointments and Delineation of Privileges.**

Credentialing Rosters from November 28, 2009 and December 28, 2009 were presented to the committee. These have been reviewed and recommended for approval by the Medical Executive Committee.

Action: Recommend approval

**Item 16. Medical Executive Committee Minutes**

The minutes from December 16, 2009 were presented to the committee. They were approved as presented.

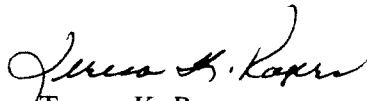
Action: Recommend approval.

**Item 17. Medical Center Contracts and Agreements.**

The contracts and agreements entered into since the last meeting of the Board have been reviewed.

Action: Received as information

There being no further business, the committee adjourned.

  
Teresa K. Rogers

**Medical University Hospital Authority  
Physical Facilities Committee  
February 11, 2010  
Minutes**

**Attendees:**

Mr. William H. Bingham, Sr., Chair	Dr. Phil Costello
Dr. Stanley C. Baker, Jr.	Ms. Annette Drachman
Mr. Melvyn Berlinsky	Mr. Jim Fisher
Dr. Cotesworth P. Fishburne, Jr.	Mr. Dennis Frazier
Mr. William B. Hewitt	Mr. Steve Hargett
Dr. Donald Johnson, II	Ms. Sarah King
Dr. E. Conyers O'Bryan, Jr.	Dr. Steve Lanier
Dr. Thomas C. Rowland, Jr.	Mr. John Malmrose
Mr. Charles W. Schulze	Mr. Stewart Mixon
Thomas L. Stephenson, Esquire	Ms. Lisa Montgomery
The Honorable Robin M. Tallon	Ms. Jennifer Pearce
Dr. Charles B. Thomas, Jr.	Ms. Gina Ramsey
Dr. James E. Wiseman, Jr.	Dr. Jerry Reves
Dr. Raymond S. Greenberg	Mr. Stuart Smith
Ms. Susan H. Barnhart	Mr. Maurice Snook
Dr. Frank Clark	
Mr. John Cooper	

Mr. Bingham called the meeting to order.

**REGULAR Items**

**Item 18. Update on Projects.**

Mr. Frazier reported that Mr. Bingham, Drs. Wiseman and Rowland had interviewed architectural firms to provide design services for the renovation of 6 East in the Main Hospital. The firm selected was Compass 5 Partners, LLC. He also reported on various Authority projects: 7<sup>th</sup> floor renovation of ART, the Cafeteria renovation, the Gamma Knife Center, 7E – Children's Hospital, Infrastructure Upgrades in Rutledge Tower and the Children's Hospital Chiller Replacement.

Recommendation of Committee: Received as information.

**Item 19. Other Committee Business.** None

**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.

Respectfully submitted,



Celeste Jordan

**Medical University Hospital Authority  
Audit Committee  
February 11, 2010  
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 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.  
Dr. Raymond S. Greenberg  
Ms. Susan H. Barnhart

Dr. Phil Costello  
Ms. Annette Drachman  
Ms. Lisa Montgomery  
Ms. Jody O'Donnell  
Ms. Gina Ramsey  
Dr. John Raymond  
Dr. Jerry Reves  
Ms. Darlene Shaw  
Ms. Reece Smith  
Mr. Stuart Smith  
Mr. Maurice Snook  
Dean Mark Sothmann  
Mr. Steve Valerio

Mr. Stephenson called the meeting to order.

**REGULAR Items**

**Item 21. Federal Audits.**

Ms. Reece Smith provided an update on the status of the following audits: RAC, Medicaid, and Office of Inspector General.

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

**Item 22. Legal Counsel Update.**

Ms. Annette Drachman provided an update on the status of various legal matters.

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

**Item 23. Report of the Internal Auditor.**

Mr. Stephenson reported Ms. Susan Barnhart had provided audit information to the Board and if they had any questions, she was available to respond.

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

**Item 24. Other Committee Business.**      None

Respectfully Submitted,

  
Celeste Jordan

## **AMENDMENT NEEDED FOR SPECIAL RETIREMENT PLAN TO COMPLY WITH CHANGE TO IRS REGULATIONS**

### **KEY POINTS**

The Medical University Hospital Authority adopted the Special Healthcare Alternative Retirement Plan (SHARP) in July 2002.

The UMA and Hospital Authority leadership advocated implementation of the SHARP to minimize burden on UMA Ambulatory Care employees who were required to transfer to the Authority payroll in July 2002.

The State Retirement System authorized the Authority to implement the SHARP. Also, State Retirement regulations enable certain categories of employees (such as nursing personnel) to opt not to enroll in the State Retirement Plan and this enables interested new hires to have the option to select the SHARP.

The SHARP, unlike the State Retirement Plan, does not require an employee contribution. The Authority's employer contribution to SHARP for which employees can become vested is the same as the State's Optional Retirement Plan.

A recent change to IRS regulations necessitates an amendment to the SHARP. The amendment is needed to comply with IRS Code Section 415 which sets a minimum threshold for an eligible rollover distribution paid to an eligible retirement plan and allows rollovers by a non-spouse designated beneficiary.

Operationally the SHARP has been in compliance with the IRS regulation change; however, formal approval of an amendment to the plan effective December 28, 2009, is needed by the Board of Trustees.

**AMENDMENT OF  
THE SPECIAL HEALTHCARE ALTERNATIVE RETIREMENT PLAN**

THIS AMENDMENT (this "Amendment"), is made this 12<sup>th</sup> day of February, 2010, amending the Special Healthcare Alternative Retirement Plan (the "Plan"), by the Medical University Hospital Authority (hereinafter referred to as the "Employer").

WITNESSETH:

WHEREAS, the Employer sponsors the Plan, has reserved the authority to amend the Plan, and desires to exercise such authority in connection with Plan amendment required to comply with the final U.S. Treasury Regulations promulgated under Internal Revenue Code Section 415.

NOW, THEREFORE, effective as of December 28, 2009, the Employer does hereby amend the Plan in accordance with "'Good Faith' Amendment regarding the final regulations under Code Section 415 for Defined Contribution Plans" which is incorporated herein by this reference, and does hereby ratify any and all actions taken by each representative of the Employer to amend the Plan.

FURTHER RESOLVED, that each representative of the Employer (acting alone or jointly) is hereby authorized, empowered and directed to execute such document, and take such action, in connection with the preceding resolution, as each such representative deems necessary or appropriate, and the actions of each representative of the Employer taken in connection with the preceding resolution are hereby ratified and approved.

IN WITNESS WHEREOF, the Employer, by its duly authorized representatives, have executed this Amendment effective December 28, 2009.

EMPLOYER:

Medical University Hospital Authority

By: \_\_\_\_\_  
Its Authorized Officer

## **A RESOLUTION**

### **AUTHORIZING AN AMENDMENT TO THE MEDICAL UNIVERSITY HOSPITAL AUTHORITY'S SPECIAL HEALTHCARE ALTERNATIVE RETIREMENT PLAN**

WHEREAS, the Authority sponsors the Special Healthcare Retirement Plan, has reserved authority to amend the Plan, and desires to exercise such authority as required in connection with the Internal Revenue Code of 1986, as amended.

NOW, THEREFORE, BE IT RESOLVED that the Plan amendment is authorized ratified and approved to comply with IRS Code Section 415 which sets a minimum threshold for an eligible rollover distribution paid to an eligible retirement plan and allows rollovers by a non-spouse designated beneficiary.

\_\_\_\_\_  
Secretary, Medical University Hospital Authority

\_\_\_\_\_  
Date





***Medical University of South Carolina  
Medical Center***

***Medical Staff  
Rules and Regulations***

***June, 2008***

## **DEFINITIONS:**

1. **Medical Staff** - all persons who are privileged to engage in the evaluation, diagnosis and treatment of patients admitted to the MUSC Medical Center, and includes medical physicians, osteopathic physicians, oral surgeons and dentists.
2. **Board of Trustees** - the Board of Trustees of the Medical University of South Carolina, which also functions as the Board of Trustees for the MUSC Medical Center.
3. **University Executive Administration** - refers to the President of the Medical University of South Carolina and such Vice Presidents and Administrators as the Board directs to act responsibly for the Hospital.
4. **Dean** - the Dean of the appropriate College of the Medical University of South Carolina.
5. **VP for Clinical Operations/ Executive Director, Medical Center** - the individual who is responsible for the overall management of the Hospital.
6. **Executive Medical Director** - the individual who is responsible for the overall management of medical staff functions.
7. **Practitioner** - an appropriately licensed medical physician, osteopathic physician, oral surgeon, dentist, podiatrist, or any other individual who exercises independent judgment within areas of his professional judgment and applicable state practice.
8. **Executive Committee** - the Executive Committee of the Hospital.
9. **House Staff** - any post graduate physician practitioner in specialty or sub-specialty training.
10. **Affiliated Health Professional** - any health professional who is not a licensed medical physician, osteopathic physician or dentist; subject to licensure requirements or other legal limitations; with delineated clinical privileges; exercises independent judgment within areas of his professional competence and, is qualified to render direct or indirect care.
11. **Medical Record** - any/all information, paper and/or computer (consents, OR notes, path, lab & imaging reports, consultations, D/C summary), concerning a single patient that describes the course of the evaluation, treatment and change in condition during a hospital stay, an ambulatory or emergency visit. It is the legal record of care.
12. **Authenticate** - refers to the date and signature by the author of the entry in the medical record; signature is to include full name and the individual's credentials. The signature may be handwritten, by rubber stamp, or by computer key.
13. Whereas herein the word "**Hospital**" is used it refers to the MUSC Medical Center and its component hospitals and outpatient activities.
14. Since the English language contains no singular pronoun which includes both sexes, wherever the word "**he**" appears in this document, it signifies he/she.

# **MEDICAL STAFF RULES AND REGULATIONS**

## **I INTRODUCTION**

It is the duty and responsibility of each member of the medical staff to abide by the Rules and Regulations set forth here within this document. These rules and regulations shall be made a part of the MUSC Medical Staff Bylaws. Such amendments shall become effective when approved by the Board.

## **II ADMISSIONS**

### **Who May Admit Patients**

A patient may be admitted to the Medical Center only by a medical staff member who has been appointed to the staff and who has privileges to do so. Patients shall be admitted for the treatment of any and all conditions and diseases for which the Medical Center has facilities and personnel. When the Medical Center does not provide the services required by a patient or a person seeking necessary medical care, or for any reason cannot be admitted to the Medical Center, the Medical Center or attending physician, or both, shall assist the patient in making arrangements for care in an alternate facility so as not to jeopardize the health and safety of the patient. Except in an emergency, no patient shall be admitted to the Medical Center unless a provisional diagnosis has been stated. In emergency cases, the provisional diagnosis shall be stated as soon after admission as possible.

### **Admitting Physician Responsibilities**

Each patient shall be the responsibility of a designated attending physician of the medical staff. Such attendings shall be responsible for the

- initial evaluation and assessment of the admitted patient. Such an evaluation must be completed within 24 hours of admission.
- management and coordination of the care, treatment, and services for the patient including direct daily assessment, evaluation and documentation in the medical record by the attending or the designated credentialed provider
- for the prompt completeness and accuracy of the medical record,
- for necessary special instructions, and
- for transmitting reports of the condition of the patient to the referring physician or agency. Whenever these responsibilities are transferred to another medical staff member and service, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

The admitting practitioner shall be responsible for providing the Medical Center with such information concerning the patient as may be necessary to protect the patient, other patients, or Medical Center personnel from infection, disease, or other harm, and to protect the patient from self-harm.

### **Alternate Coverage**

Each medical staff appointee shall provide assurance of immediate availability of adequate professional care for his patients in the Medical Center by being available or having available, an alternate medical staff appointee with whom prior arrangements have been made and who has clinical privileges at the Medical Center sufficient to care for the patient. Residents may provide coverage only under the direct supervision of an attending physician.

### **Emergency Admissions**

The history and physical examination must clearly justify any admission on an emergency basis and must be recorded on the patient's chart no later than 24 hours after admission. In the case of emergency admission, patients who do not already have a personal admitting physician will be assigned to a medical staff appointee with privileges in the clinical department appropriate to the admitting diagnosis.

## **III MEDICAL RECORDS**

### **General Guidelines**

- a. The "legal medical record" consists of all authenticated (signed) documentation, handwritten or electronically generated related to the care of an individual patient regardless of storage site or media. Included are all inpatient records from the Medical Center, IOP, Children's Hospital, and their outpatient, provider-based clinics and associated records of patients participating in research projects.
- b. All records are the property of MUSC and shall not be removed except as pursuant to provision of law. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.
- c. Physicians shall not remove any part of the medical record for any reason. Any physician who purposely removes any document from a medical record will be suspended and/or lose Medical Staff Membership.
- d. The attending Physician shall be held responsible for the preparation of a complete medical record for each patient.
- e. Diagnostic and therapeutic orders given by medical staff members shall be authenticated by the responsible practitioner.
- f. Symbols and abbreviations may be used only when approved by the Medical Staff. The use of unapproved abbreviations as specified in Medical Center Policy #C-21 "Use of Abbreviations" is prohibited.
- g. Progress notes are to be documented daily by the designated attending or his designated credentialed provider for all inpatient and observation patients.
- h. The patient's medical record requires the progress notes, final diagnosis, and discharge summary or final visit note to be completed with authenticated dates and signatures. All final diagnosis, complications, or procedures must be recorded

without abbreviations.

- i. Patient progress note entered into the Medical Record by Medical students must be co-signed by either a resident or an attending physician.
- j. Stat dictation shall be limited to urgent situations such as when a patient transfer is pending.

**History and Physical Requirements**

- a. H&Ps shall be completed no later than twenty-four (24) hours after admission or at the initial visit to an ambulatory clinic.
- b. H&Ps must be completed prior to any operative, invasive, high risk diagnostic or therapeutic procedure, or procedures requiring moderate or deep sedation regardless of setting. For other non- inpatients procedures a focused history and physical may be completed based on the presenting problem.
- c. H&Ps are required in all primary care clinics. On subsequent primary care visits and in specialty clinics, the H&P can be focused, based on the presenting problem(s).
- d. When the H&P examination is not on the chart prior to the surgery or high risk diagnostic or therapeutic procedure, the said procedure shall be delayed until the H&P is completed unless it is an emergency.
- e. When using an H & P that was performed prior to admission or the outpatient procedure, an update to the H&P must be completed within 24 hours for inpatients and prior to the outpatient procedure. This includes intra campus admissions from the Medical Center. (ie, TCU, IOP) For all outpatient surgeries and other procedures requiring an H&P the update may be completed in combination with the preanesthesia assessment.
- f. A completed H&P (except in circumstances allowing a focused H&P as described in paragraph b above) must include (as information is available):
  - chief complaint,
  - details of present illness (history),
  - past history (relevant - includes illnesses, injuries, and operations),
  - social history,
  - allergies and current medications,
  - family history,
  - review of systems pertinent to the diagnosis,
  - physical examination pertinent to the diagnosis,
  - pertinent normal and abnormal findings, and
  - conclusion or a planned course of action.

- g. Dentists are responsible for the part of their patient's H&P that relates to dentistry.
- h. Oral and maxillofacial surgeons may perform a medical H&P examination in order to assess the status and risk of the proposed surgery or procedures.
- i. Podiatrists are responsible for the part of their patient's H&P that relates to podiatry.
- j. Optometrists are responsible for the part of their patient's H&P that relates to optometry.
- k. The attending physician is responsible for the complete H&P.
- l. Residents, advanced nurse practitioners and in some cases physicians assistants, appropriately privileged, may complete the H&P with the attending physician's counter signature. In lieu of a signature the attending physician may complete an additional attestation sheet to confirm or change the initial history and physical.

### **Informed Consent Requirements**

It is the responsibility of the attending physician to assure appropriate informed consent. Is obtained and documented in the medical record and when appropriate, also document the discussion in a progress note. Nursing staff and other personnel may witness patient signature but may not consent the patient.

Informed consent is required for all invasive procedures, for the use of anesthesia including moderate and deep sedation and for the use of blood and blood products.

Appropriate informed consent shall include at a minimum:

- patient identity,
- date,
- procedure or treatment to be performed,
- name of person performing the procedure or treatment,
- authorization for the proposed procedure
- authorization for anesthesia or moderate sedation if indicated.
- indication that alternate means, risk and complications of the planned procedure and recuperation, and anesthesia have been explained,
- authorization for disposition of any tissue or body parts as indicated,
- risks and complications of blood or blood product usage (if appropriate),
- witnessed signature of the patient or other empowered individual authorizing informed consent, and
- signature, name/identity and pager # of the physician who obtained the consent, (verbal consent may be witnessed by the nurse and indicated on the consent form).
- physician documentation of the consent process in a progress note or on the consent form.

Physician documentation of the consent process and discussion may be accomplished with

either an out-patient or in-patient note in the record.

### **Operative and Other Procedure Documentation Requirements**

Immediately after the operation/procedure a progress note will be written and promptly signed by the primary physician/surgeon (this applies to both inpatients and outpatients). This progress note is considered an abbreviated report and will include the pre-operative procedure/diagnosis, the name of the primary physician/surgeon and assistants, findings, procedure performed and a description of the procedure, estimated blood loss, as indicated any specimens/tissues removed, and the postoperative/procedure diagnosis.

For all patients (both inpatient and outpatient) the full operative/procedure report shall be written or dictated and signed by the primary physician/surgeon and entered into the medical record no later than fourteen (14) days from the completion of completion of operation/procedure.

Operative/ procedure reports may be completed by residents with supervision by the attending as evidenced by the attending's counter signature authenticating the report. These documentation requirements apply to all procedures billed as such according to a CPT code.

### **Discharge Summary Requirements**

Discharge summary must include reasons for admission, significant findings, procedures performed, treatment given, condition of the patient upon discharge, specific instructions given to patient and/or patient's family in regard to activity, discharge, medications, diet, and follow-up instructions. Residents may complete the discharge summary with attending supervision as evidenced by the attending's counter signature on the report.

### **Complete Medical Records**

The attending physician is responsible for supervising the preparation of a complete medical record for each patient.

- a. Specific record requirements for physicians shall include:
- identification date, name, address, birth date, next of kin, patient history number, legal status (for behavioral health patients)
  - initial diagnosis
  - history and physical
  - orders
  - clinical observation, progress note, consultations
  - reports of procedures, tests, and results
  - operative reports
  - reports of consultations
  - discharge summary

- all final diagnoses, complications, or procedures

Medical records for patients with diagnosed cancer must include AJCC staging forms completed by the attending physician.

#### **Medical Records Preparation and Completion**

The history and physical, consults, and orders as well as authentications of such will be completed in the time frame specified in these Rules and Regulations. All diagnostic study reports must be dictated and on the medical record within 72 hours of the completion of the study.

The records of all discharged patients (inpatients and ambulatory) not fully completed within fourteen (14) days of discharge will be considered delinquent

- Five days after discharge, if a patient's medical record is not completed the attending physician will receive notification that the chart is incomplete.
- The physician will receive a suspension warning if the chart remains incomplete after ten (10) days post discharge in writing by fax, email, or letter or orally by direct phone call or pager.
- If the record remains incomplete at thirteen (13) days the physician will receive notice one day prior to suspension of privileges orally by direct phone call or pager.
- The suspended physician cannot admit new patients to his or her care.
- The suspended physician can continue to provide care for those patients directly under his/her care prior to the suspension.
- Three (3) such suspensions in a twelve (12) month period will result in a loss of Medical Staff Membership, according to the MUSC Medical Staff Bylaws.

## **IV. ORDERS**

#### **General Requirements**

- All orders must be written clearly, legibly, and completely and must include date, time written, legible authentication, and the ordering practitioner's pager ID. Orders which are illegible or improperly written will not be carried out until they are clarified, rewritten, and are understood. Orders can not be written with abbreviations listed on the prohibited abbreviation list. Scientifically approved chemical symbols for certain drugs are acceptable (i.e., KCL for potassium chloride).
- When a practitioner uses a rubber stamp signature, he/she is the only one who uses it and must sign a statement to that effect. It is the responsibility of each practitioner to forward a copy of this statement to the Medical Staff Office. When a practitioner uses an electronic signature, he/she must ensure it is only used in accordance with



departmental policies and related regulatory guidelines.

- c. When a patient returns to a patient care unit from the OR all orders must be totally rewritten with the exception of minor procedures as defined by a procedure that could also be performed in a non-OR setting. In that case, the pre-procedure orders are adjusted by the physician postoperatively according to patient condition. When the physician review is completed, a note is entered on the order form which states that the orders have been reviewed and all orders are current.

Patients transferred into or out of an intensive care unit from or to a non intensive care area must have all orders rewritten.

- d. Orders will be rewritten when a patient is transferred between levels of care (i.e. from an intensive care unit to the floor or vice versa.) A reorder for medication or treatment is to be written after an automatic stop order has been employed.
- e. Explicit orders must be written for each action to be taken.
- f. Medications should be ordered within the MUSC formulary.
- g. Blanket orders such as resume pre-op medications as outlined above in c or resume home medications are prohibited.
- h. Illegible Orders. Admitting privileges and surgical or procedures privileges can also be suspended for illegible orders. Illegible is defined as orders that three (3) other individuals cannot read. Suspension will occur after the physician has been notified, either orally or in writing, on three (3) separate occasions regarding legibility.
- i. All medication orders must be written according to Medical Center Policy #C-78 "Medication Orders".

#### **Who May Write Orders**

Orders may be written by members of the medical staff and allied health professionals (advanced nurse practitioners, PA's, residents, psychologists) within the scope of their practice, delineated clinical privileges, and approved protocols. All orders must be written clearly, legibly, and completely and must include date, time written, legible authentication, and the ordering practitioner's pager ID. Authenticated electronic signatures for orders are acceptable when available.

#### **Orders for Specific Procedures/Circumstances**

- a. All requests for tests such as imaging and labs, etc shall contain a statement of the reason for the examination.
- b. All orders for therapy shall be entered in the patient's record and signed by the ordering practitioner.
- c. Therapeutic diets shall be prescribed by the attending physician in written orders on

the patient's chart. Orders for diet must be specific as in the case of limited sodium diets where the desired sodium content must be stated in either milligrams or grams.

- d. All orders for *restraints* shall include the type of restraint, the reason for the restraint, the length of time (not to exceed 24 hours), and alternatives attempted. Restraints can be ordered by a physician, or an advanced nurse practitioner or psychologist within the scope of their duties. Such orders must be signed and dated by the ordering practitioner at the time restraints are ordered. Emergency verbal orders must be secured within one hour of the nurse initiating restraints. Verbal orders for restraints must be signed by the ordering practitioner within twenty-four (24) hours. PRN orders are not acceptable.
- e. When restraints are used for behavioral reasons, the patient must be seen by an MD within one hour of initiation.
- f. Do Not Resuscitate (DNR) orders may be accepted as a verbal order only when the patient has executed an advance directive and that directive is included in the patient's record. A no-code (DNR) must be written by the attending physician with the progress notes reflecting the patient's mental status, the reasons for the DNR, diagnosis and prognosis, and a statement of the patient's wishes. Medical staff are to follow Medical Center Policy #C-13 "Resuscitation Orders". In all cases the patient has the right to refuse resuscitation verbally or as by written advanced directive.

### **Verbal Orders**

A verbal order is defined as an urgent or emergent order that has not been written and is relayed verbally from the physician or dentist. The request for and use of verbal orders should be limited to urgent or emergent situations. In all cases a telephone or verbal order will not be considered complete until the individual receiving the order, reads back and verifies the content of the order

- a. The following disciplines may request and accept a verbal order within the scope of their practice when the need for such an order is urgent:
  - Registered Nurse
  - Licensed Practical Nurse (in ambulatory clinics only)
  - Licensed Physicians Assistant
  - Registered Pharmacist
  - Certified Respiratory Care Practitioner
  - Emergency Medical Technician
  - Licensed Physical Therapist
  - Licensed Occupational Therapist
  - Registered Dietician
  - Board Registered or Licensed Nuclear Medicine Technologist
  - Board Registered or Licensed Radiologic Technologist
  - Dental Hygienist

- Licensed speech language pathologist
- b. Verbal orders must be signed with credentials, dated and timed, read back and verified, and flagged for signature by the person accepting the order.
- c. The name and pager ID of the practitioner who dictated the order must be documented.
- d. All verbal orders (with the exception of verbal orders for restraint or seclusion) must be signed, timed, and dated by the practitioner, or designee (a physician member of the service team) who issued the order within forty-eight (48) hours.
- e. Verbal orders for Schedule II Controlled Substances must be signed, timed and dated **only by the practitioner** who issued the order within 48 hours. (SC Code Ann.Reg 61-4.908 and 909)
- f. Unsigned verbal orders for controlled substances must be discontinued after forty-eight (48) hours.
  - The responsible physician or dentist must be notified by a nurse of the discontinuation.
  - Documentation of notification of the physician or dentist must occur in the medical record.
- g. Verbal orders must not be accepted for chemotherapy agents, investigational drugs or Do Not Resuscitate Orders. Immunosuppressants may not be initiated with verbal orders, however a verbal order for subsequent dose modifications may be accepted.
- h. Non-licensed/certified personnel (i.e., unit secretaries, pharmacy technicians) may not give or accept verbal orders from either physicians or dentists under any circumstances.
- i. The above applies to both paper and electronic medical record verbal order entry.
- j. When using the electronic system, the appropriate physician must select the verbal order within the sign tab and then submit the order.

## V CONSULTATIONS

### Who May Give Consultations

Any qualified practitioner with clinical privileges in the Medical Center can be asked for consultation within his area of expertise. In circumstances of grave urgency, or where consultation is required by the rules of the medical staff as stated below, the President of the Medical Staff, or the appropriate department chair, or the designee of either of the above, shall at all times have the right to call in a consultant or consultants.

### Required Consultations

- a. Consultation shall be required in all non-emergency cases whenever requested by the patient or the patient's personal representative if the patient is incompetent. Consultations are also required in all cases in which, in the judgment of the attending physician:
  1. the diagnosis is obscure after ordinary diagnostic procedures have been completed,
  2. there is doubt as to the choice of therapeutic measures to be utilized,
  3. unusually complicated situations are present that may require specific skills of other practitioners,
  4. the patient exhibits severe symptoms of mental illness or psychosis.
- b. The attending practitioner is responsible for requesting consultation when indicated and for calling in a qualified consultant.
- c. It shall be the responsibility of all individuals exercising clinical privileges, to obtain any required consultations, and requests for a consultation shall be entered on an appropriate form in the medical record. If the history and physical are not on the chart and the consultation form has not been completed, it shall be the responsibility of the practitioner requesting the consultation to provide this information to the consultant.
- d. It is the duty of the Credentials Committee, the Department Chair, and the Medical Executive Committee, to make certain that appointees to the staff request consultations when needed.

#### **Contents of Consultation Report**

Consultations will be completed within 24 hours for inpatients. Each consultation report should contain a written opinion and recommendations by the consultant that reflects, when appropriate, an actual examination of the patient and the patient's medical record. This report shall be made a part of the patient's record within 24 hours of completion of the consultation. While the consultant may acknowledge data gathered by a member of the house staff, a limited statement, such as "I concur" alone does not constitute an acceptable consultation report. When operative or invasive procedures are involved, the consultation note shall be recorded prior to the operation, except in emergency situations so verified on the record. The consultation report shall contain the date and time of the consultation and the signature of the consultant.

#### **Emergency Department Consultations**

Specialists who are requested as consultants to the Emergency Department (ED) must respond in a timely fashion. In addition, any specialist who provides a consultation in the ED for a patient with an urgent condition is responsible for providing or arranging follow-up care. It is the policy of the ED that all patients are seen by an attending physician physically present in the ED. House staff evaluating patients in the ED for the purpose of consultation will confer with the responsible attending within their given specialty who is physically present in the ED. When such an attending is not physically present, the attending physician

responsible for overseeing the patient's care will default to the ED attending physician while in the ED.

## **VI SUBSTANCE ABUSE/PSYCHIATRIC PATIENTS**

Any patient known to be suicidal in intent or with a primary diagnosis of substance abuse or psychiatric disorder shall be admitted to the appropriate psychiatric unit. If there are no accommodations available in this area, the patient shall be referred to another institution where suitable facilities are available. In the event that the patient has a non-psychiatric condition which requires treatment at the Medical Center and no accommodations are available in the Institute of Psychiatry, the patient may be admitted to another unit of the Medical Center only after consultation with the Executive Medical Director or his designee and the assigned Medical Director of the relevant service. Explicit orders regarding precautionary measures are required.

Any patient known or suspected to be suicidal or with a primary diagnosis of substance abuse or psychiatric disorder who is admitted to a non-psychiatric unit must have consultation by a Medical Staff member of the psychiatric staff.

All patients admitted to a non-psychiatric unit while awaiting transfer will be medically assessed and stabilized before transfer. The care of such patients will remain with the attending MD until transfer or discharge.

Patients exhibiting symptoms of a psychiatric disorder or substance abuse while hospitalized with a medical/surgical diagnosis will have a consultation by a physician or a member of the Department of Psychiatry.

## **VII MODERATE AND DEEP SEDATION**

Moderate sedation will be administered under the immediate direct supervision of a physician, dentist, or other practitioner who is clinically privileged to perform moderate sedation. Moderate sedation will be administered ONLY in areas of the medical center where trained, qualified staff and appropriate equipment are present, according to Medical Center Policy #C-44 "Moderate Sedation/Analgesia"

Deep sedation/analgesia will be administered only by an anesthesiologist, CRNA or a physician holding appropriate clinical privileges. Deep sedation will be administered ONLY in areas of the medical center where trained, qualified staff and appropriate equipment are present, according to Medical Center Policy #C-44 "Moderate Sedation/ Analgesia".

## **VIII PATIENT DISCHARGE**

### **Who May Discharge**

Patients shall be discharged only on the order of the attending/covering physician. Should a patient leave the Medical Center against the advice of the attending physician or without proper discharge, a notation of the incident shall be made in the patient's medical record and the patient will be asked to sign the Medical Center's hospital release form.

### **Discharge of Minors and Other Incompetent Patients**

Any individual who cannot legally consent to his own care shall be discharged only to the custody of parents, legal guardian, person standing in loco parentis or another responsible party unless otherwise directed by the parent, guardian, or court order. If the parent or guardian directs that discharge be made otherwise, that individual shall so state in writing and the statement shall become a part of the permanent medical record of the patient.

### **Transfer of Patient**

Patients may be transferred to another medical care facility after arrangements for transfer and admission to the facility have been made. Clinical records of sufficient content to ensure continuity of care shall accompany the patient.

### **Death of Patient**

Should a patient die while being treated at the Medical Center, the attending physician should be notified immediately. A practitioner will pronounce the patient dead, notify the family ASAP, and request and document permission to perform an autopsy, when applicable.

### **Methods for Obtaining an Autopsy**

Methods for obtaining an autopsy shall include:

- a. The family requests an autopsy
- b. The death falls within the jurisdiction of the Coroner/Medical Examiner of Charleston County
  - The attending physician requests an autopsy based on the College of American Pathologists criteria and Medical Center #C-16 "Decedent Care Program".
- c. No autopsy shall be performed without written consent of a responsible relative or authorized person unless ordered by the Coroner/Medical Examiner of Charleston County.

### **Duties of the Physician for Obtaining an Autopsy**

- a. Determine whether the death falls within the jurisdiction of the Coroner/Medical Examiner of Charleston County. (Refer to "A Guide to the Autopsy for Physicians and Nurses.")
- b. Obtain permits for organ donation when applicable according to the Organ Procurement, Medical Center Policy #C-17 "Organ/Tissue Donation".
- c. Documentation of request for autopsy must be completed, authenticated, and placed in the medical record.

### **Scope of Autopsy**

- a. The scope of the autopsy should be sufficiently completed in order to answer all questions posed by the attending physician and by the pathologist, upon review of the clinical database.
- b. The autopsy report should include: a summary of the clinical history, diagnoses, gross descriptions, microscopic descriptions, and a final summary that includes a clinicopathologic correlation.
- c. The autopsy findings should be promptly communicated to the attending physician along with all additional information the pathologist considers relevant to the case
- d. The results of autopsies will be monitored as a part of performance improvement.

## **IX MAYDAY PROCEDURE**

In the event that a clinical emergency situation arises within the Medical Center or within any University area designated in the Medical Center Policy #C-14 "Medical Emergency Response". Medical Staff are to follow specific duties as outlined in the policy.

## **IX EMERGENCY MEDICAL SCREENING**

Any individual who presents in the Emergency Department or other department of the Medical Center either by him or herself, or by way of an accompanied party, and requests an examination for treatment of a medical condition must be screened by an appropriate practitioner to determine whether or not an emergency medical condition exists. Individuals qualified to provide this medical screen include attending physicians, house staff, nurse practitioners, and physician assistants.

## **X PATIENT SAFETY INITIATIVES**

All members of the medical staff are required to follow all guidelines/policies related the National Patient Safety Goals and other patient safety initiatives. These policies include but are not limited to:

Patient Safety C-76  
Verbal Orders - C-56  
Notification of Critical Values - C-80  
Time Out-Universal Protocol (Wrong Site, Wrong Procedure, Wrong Person  
Surgery/Procedure) C-25  
Use of Abbreviations C-21  
Sentinel Events C-49  
Patient Identification C-58  
Hand Hygiene IC-27  
Medication Reconciliation C-146

## **XI HOUSE STAFF/RESIDENT PHYSICIANS**

House staff (post graduate physician practitioners in specialty or sub-specialty training) at the MUSC Medical Center shall not be eligible to become appointees of the active medical staff and shall not be eligible to admit patients. They are authorized to carry out those duties and functions normally engaged in by house staff according to their defined job descriptions and/or scope of practice under the supervision of an appointee of the active medical staff. Supervision of residents is required. Supervision includes but is not limited to counter signature in the medical record by the attending, participation by the resident in rounds, one on one conference between the resident and attending, and the attending physician's observation of care being delivered by the resident. Active medical staff members are required to supervise students as specified in Medical Center policy C-74, Resident Supervision.

## **XII PEER REVIEW**

All members of the MUSC Medical Center Medical Staff, House Staff, and Professional Staff will be included in the Medical Staff's peer review process.

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***Medical University of South Carolina  
Medical Center***

***Medical Staff Bylaws***

***February, 2008***

## **ARTICLE I PURPOSE AND RESPONSIBILITIES**

The purpose of the organized Medical Staff of the MUSC Medical Center is to bring the professionals, who practice at the Medical Center together into a self governing cohesive body to:

1. provide oversight of quality of care, treatment and services to patients of the MUSC Medical Center.
2. determine the mechanism for establishing and enforcing criteria and standards for Medical Staff membership
3. determine the mechanism for establishing and enforcing criteria for delegating oversight responsibilities for non-member practitioners with independent privileges.
4. review new and on-going privileges of members and non-member practitioners with independent privileges.
5. approve and amend medical staff bylaws, and rules and regulations.
6. provide a mechanism to create a uniform standard of care, treatment, and service.
7. evaluate and assist in improving the work done by the staff, provide education, and offer advice to the Vice President for Clinical Operations/Executive Director of the MUSC Medical Center.

The organized medical staff is also responsible for:

1. the ongoing evaluation of the competency of practitioners who are privileged,
2. delineating the scope of privileges that will be granted to practitioners
3. providing leadership in performance improvement activities within the organization.
4. assuring that practitioners practice only within the scope of their privileges.

The Medical University Hospital Authority, that includes the Medical University hospitals, clinics, and other health care related facilities, shall hereinafter be referred to in the body of this document as the Medical University of South Carolina Medical Center (MUSC Medical Center).

## **ARTICLE II BILL OF RIGHTS**

### **I Member Staff Rights**

Members of the Medical Staff are afforded the following rights:

- A. Right of Notification- Any matter of performance or conduct that could result in denial, suspension, or reduction of privileges will cause the Department Chairperson to notify the affected member before formal activity commences.
- B. Access to Committees - Members of the Medical Staff are entitled to be present at any committee meeting except during peer review proceedings. Members present for a specific agenda item shall be recognized by the Chairperson as time permits. Members can petition the Medical Executive Committee (MEC) for a specific agenda item or issue.

- C. Right of Information - Activities of the various committees (with the exception of peer review proceedings) may be reviewed by the Medical Staff members in the Medical Staff office. The MEC will provide to the active membership all changes to the Rules & Regulations, Credentials Policy Manual, and the Fair Hearing Document.
- D. Fair Hearing - Members are entitled to a fair hearing as described in the Fair Hearing Document.
- E. Access to Credentials File - Each member shall be afforded an opportunity to review his/her own credentials file before submission for approval. This review will occur at the time of initial appointment and at the time of reappointment as specified in the Credentials Policy Manual.
- F. Physician Health and Well-Being - Any member may call upon the resources of the Medical Staff in personal, professional, and peer matters to seek help and improvement.
- G. Confidentiality - Matters discussed in committee and otherwise undertaken in the performance of Medical Staff duties and privileges are strictly confidential. Violation of this provision is grounds for expulsion from the Medical Staff.

### **ARTICLE III MEDICAL STAFF MEMBERSHIP**

#### **I MEDICAL STAFF APPOINTMENT**

Appointment to the Medical Staff of the MUH is a privilege that shall be extended only to competent professionals, who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and associated policies of the Medical Staff and MUH.

#### **II QUALIFICATIONS FOR MEMBERSHIP**

- A. Only physicians with Doctor of Medicine (MD) or Doctor of Osteopathy (DO) degrees, or Dentists or podiatrists holding a current, valid license to practice in the State of South Carolina shall be qualified for appointment to the Medical Staff. Additional requirements include:
  - documentation of background, experience, training, judgment, individual character and demonstrated competence, and physical and mental capabilities, with sufficient adequacy to assure the Medical Staff and Board that any patient treated by them in the hospitals will be given a high quality of patient care,
  - demonstrated adherence to the ethics of their profession, and ability to work with others

No professional may be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges at the MUSC Medical Center merely by virtue of licensure to practice in this or any other state, or of membership in any professional organization, or of privileges at another Medical Center.

- B. Must be free from government sanctions and bans as outlined by Medicare and the Department of Health and Human Services - Office of the Inspector General (DHHS-OIG).
- C. Must meet appointment requirements as specified in the Credentials Policy Manual.
- D. An MD, DO or Dentist member, appointed after December 11, 1992, shall be eligible for or have obtained board certification and comply with individual board requirements in his/her respective medical or dental specialty board. This Board must have been approved by the American Medical Association, the American Osteopathic Association, or the American Board of Medical Specialties. A five (5) year grace period may be allowed an applicant from the time of completion of his/her residency or fellowship to obtain initial board certification. Newly hired physicians who are not board certified or are more than 5 years out from initial eligibility are required to attain Board Certification within two (2) years, or reappointment will not be granted. In special cases where a need exists, an exception to these qualifications can be made, only after the applicant has demonstrated competency to the satisfaction of the Department Chairperson in the department in which they are assigned and the Department Chairperson has attested either in a written or oral format to the Medical Executive Committee for approval.

Waiver of board certification requirement can be granted when no board specialty exists and the Department Chairperson attests (in written and oral format) to adequacy of training and competency.

Foreign Board Certification may be an appropriate substitute for United States Board approval. The delegated committee (Credentials Committee) may choose to accept or reject such certification. In the event the certification is rejected by the Credentials Committee, the Department Chairperson may petition the Medical Executive Committee for approval.

- E. A member of the Medical Staff must be a member of the faculty of the Medical University of South Carolina.
- F. Maintain malpractice insurance as specified by the MEC, MUH and Board of Trustees.

### **III NON-DISCRIMINATION**

The Medical University Hospital will not discriminate in granting staff appointment and/or clinical privileges on the basis of age, sex, race, creed, color, or nationality.

### **IV CONDITIONS AND DURATION OF APPOINTMENT**

- A. Initial appointments and reappointments to the Medical Staff shall be made by the Board. The Board shall act on appointments and reappointments only after there has been a recommendation from the Credentials Committee and MEC.

- B. All initial appointments shall be for a provisional period of one year.
- C. Appointments to the staff will be for no more than 24 calendar months.
- D. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted by the Board.
- E. Medical Staff membership, clinical privileges and prerogatives will be terminated immediately if the practitioner is under government sanctions as listed by the DHHS – Office of the Inspector General.

## **V PRIVILEGES AND PRACTICE EVALUATION**

The privileging process is described as a series of activities designed to collect verify, and evaluate data relevant to a practitioner's professional performance and focuses on objective, evidence-based decisions regarding appointment and reappointment.

Initial requests for privileges are made simultaneously with the filing of the application for Medical Staff membership. Following procedures stated in the Credentials Policy Manual, and with a recommendation of the appropriate Department Chairperson, the Medical Staff organization will evaluate and make recommendations to the Board. Privileges will only be granted or renewed, after applicant meets the criteria related to current licensure, relevant education, training and experience, demonstrated current competence, physical ability and the clinical ability to perform the requested privileges. For new procedures and at the time of reappointment, members' requests for privileges will be subject again to the procedures outlined in the Credentials Policy Manual.

When considering privileges for a new practitioner, current data should be collected during the provisional time period for those privileges selected by the Department Chairperson

Prior to the granting of a privilege, the Department Chairperson determines the resources needed for each requested privileges and must assure the resources necessary to support the requested privilege are currently available or define the timeframe for availability. These resources include sufficient space, equipment, staffing, and financial. The Chairperson will work with hospital to ensure resources are available

At the time of appointment and reappointment each candidate applying for privileges will be evaluated using the following six areas of general competence as a reference:

- a. Patient Care
- b. Medical/Clinical Knowledge
- c. Practice-based learning and improvement
- d. Interpersonal and communication skills
- e. Professionalism
- f. System-based practices

A Focused Professional Practice Evaluation allows the medical staff to focus on specific aspects of a practitioner's performance. This evaluation is used when:

- a. A practitioner has the credentials to suggest competence, but additional information or a period of evaluation is needed to confirm competence in the organizations' setting.
- b. Questions arise regarding a practitioner's professional practice during the course of the Ongoing Professional Practice Evaluation
- c. For all initially requested privileges (Effective January 2008)

Ongoing Professional Practice is designed to continuously evaluate a practitioner's professional performance. It allows potential problems to be identified and also fosters a more efficient, evidence-based privilege renewal process. The type of data to be collected is approved by the organized medical staff but is determined by individual departments and is uniformly applied to all members within the department. The frequency of data collection is determined by the organized Medical Staff in collaboration with the Executive Medical Director and the Center for Clinical Effectiveness and Patient Safety. Information from ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privileges.

## **VI TEMPORARY and DISASTER PRIVILEGES**

- A. Temporary privileges may be granted by the Executive Director of the Medical Center or his designee for a stated limited time upon the recommendation of the applicable Department Chairperson or the President of the Medical Staff, in all other circumstances, as detailed in the Credentials Policy Manual.
- B. Disaster privileges may be granted by the Executive Director of the Medical Center or the President of the Medical Staff or the Medical Director of the Medical Center, according to Medical Center Policy C-35 "Disaster Privileges for Licensed Independent Practitioners, when the Emergency Management Plan for the Medical Center has been activated and when the Medical Center cannot handle the needs of patients with just the available credentialed staff. The Department Chairperson will be responsible for monitoring the professional performance of volunteer practitioners with disaster privileges. This monitoring will be accomplished through direct observation, staff feedback, and when appropriate, medical record review. The Department Chairperson is responsible for reviewing the continuation of disaster privileges within 72 hours of granting the disaster privileges.

## **VII LEAVE OF ABSENCE**

Any member may apply to the Credentials Committee for a leave of absence not to exceed one (1) year. Reinstatement of privileges may be requested from the Credentials Committee without formal re-application. Absence for a period longer than one (1) year will require formal re-application. In some special cases, (i.e., military service) a Department Chairperson through the Credentials Committee can recommend to the MEC that a leave of absence be extended beyond a year without the necessity for formal reappointment. At no time can a special circumstance leave of absence extend beyond a two year re-appointment cycle.

## **VIII RESPONSIBILITIES OF MEMBERSHIP**

Each staff member will:

- A. Provide timely, appropriate and continuous care/treatment/services for his/her patients and supervise the work of any allied health professional or trainee under his/her direction when appropriate.
- B. Assist the MUH in fulfilling its responsibilities by participating in the on-call coverage of the emergency room and other coverage as determined by the MEC.
- C. Assist other practitioners in the care of their patients when asked.
- D. Act in an ethical and professional manner.
- E. Treat employees, patients, visitors, and other physicians in a dignified and courteous manner.
- F. Actively participate in the measurement, assessment, and improvement of patient care processes.
- G. Participate in peer review as appropriate.
- H. Abide by the bylaws, rules and regulations, department rules, and other policies and procedures of the MUSC Medical Center.
- I. Participate in continuing education as directed by state licensure and the MEC.
- J. Speak as soon as possible with hospitalized patients who wish to contact the attending about their medical care in accordance with the South Carolina Lewis Blackman Hospital Patient Safety Act.
- K. When required as a part of the practitioner well being program, comply with recommended actions.
- L. Manage and coordinate their patients care, treatment, and services.

**ARTICLE IV  
CATEGORIES OF THE MEDICAL STAFF**

**I THE ACTIVE CATEGORY**

A. Qualifications - Appointee to this category must:

1. Be involved on a regular basis in patient care delivery at the Medical University hospitals and clinics annually, providing the majority of their services/activities within the MUSC Medical Center.
2. Have completed at least one (1) year of satisfactory performance on the Medical Staff. (See Provisional Status MUSC Credentials Policy Manual)

B. Prerogatives - Appointees to this category may:

1. Exercise the privileges granted without limitation, except as otherwise provided in the Medical Staff Rules and Regulations, or by specific privilege restriction.
2. Vote on all matters presented at general and special meetings of the Medical Staff, and of the Department and Committees on which he is appointed.
3. Hold office, sit on or be chairperson of any committee, unless otherwise specified elsewhere in these Bylaws.
4. Admit patients to the MUSC Medical Center.

C. Responsibilities: Appointee to this category must:

1. Contribute to the organizational and administrative affairs of the Medical Staff.
2. Actively participate in recognized functions of staff appointment, including performance improvement and other monitoring activities, monitoring initial appointees during their provisional period, and in discharging other staff functions as may be required from time to time.
3. Accept their individual responsibilities in the supervision and training of students and House Staff members as assigned by their respective department, division or section head and according to Medical Center Policy C-74 "Resident Supervision".
4. Participate in the emergency room and other specialty coverage programs as scheduled or as required by the MEC or Department Chairperson.



D. Removal:

Failure to satisfy the requirements for activity for the MUSC Medical Center, as deemed by the Chairperson of the department, during the appointment period will result in automatic transfer to Affiliate Category. The practitioner shall have the rights afforded by Article IX, Section IV.

## **II AFFILIATE CATEGORY**

A. Qualifications - Appointees to this category must:

1. Participate in the clinical affairs of the MUSC Medical Center.
2. Be involved in the care or treatment of at least six (6) patients of the MUSC Medical Center hospitals or clinics during his/her appointment period, or
3. Refer patients to other physicians on staff of the MUSC Medical Center or those who order diagnostic or therapeutic services at the MUSC Medical Center

B. Prerogatives - Appointees to this category may

1. Exercise the privileges granted without limitation, except as otherwise provided in the Medical Staff Rules and Regulations, or by specific privilege restriction.
2. Attend meetings of the Staff and Department to which she is appointed and any staff or MUSC Medical Center education programs.
3. Request admitting privileges.

C. Limitations - Appointees to the Affiliate Category do not have general Medical Staff voting privileges.

## **III HONORARY / ADMINISTRATIVE CATEGORY**

This category is restricted to those individuals the Medical Staff wishes to honor or to those physicians who have only administrative positions and no clinical privileges. Such staff appointees are not eligible to admit patients to the MUSC Medical Center, to vote, or to exercise clinical privileges in the MUSC Medical Center. They may, however, attend Medical Staff and department meetings. This category is exempt from the malpractice insurance requirements and Board Certification requirements, unless required within their position description.

Physicians with the MUSC Medical Center whose duties include both administrative and clinical activities must be members of the Medical Staff, and must obtain clinical privileges in the same manner as any other Medical Staff member. When a contract exists, the contract of the physician who has both administrative and clinical duties shall clearly define the relationship between termination of the contract by the MUSC Medical Center and reduction or termination in privileges.

#### **IV OTHER / NON-MEDICAL STAFF MEMBERS**

House Staff - The House Staff consists of those practitioners, who by virtue of a contract, are in the postgraduate training program at the Medical University of South Carolina. They are not eligible to hold a Medical Staff office and are not eligible to vote unless otherwise indicated in these Bylaws.

Only practitioners who are graduates of an approved, recognized medical, osteopathic or dental school, who are legally licensed to practice in the State of South Carolina and who, continue to perform and develop appropriately in their training are qualified for assignment to the House Staff. The Chairperson of the House Staff member's department and Associate Dean for Graduate Medical Education will be responsible for monitoring performance and will notify the Chairperson of the Executive Committee of any status changes.

Allied (affiliated) Health Professionals - Allied (affiliated) Health Professionals are those health practitioners, not a licensed MD, DO or Dentist, who, although not members of the Medical Staff are credentialed through the Medical Staff process as described in the Credentials Policy Manual.

### **ARTICLE V OFFICERS**

#### **I OFFICERS OF THE MEDICAL STAFF**

The officers of the Medical Staff shall be:

- A. President
- B. Vice President
- C. Secretary

#### **II QUALIFICATIONS OF OFFICERS**

Officers must be members of the Active Medical Staff at the time of nomination and election and must remain members in good standing during their terms of office. Officers should possess some Medical Staff administrative experience. In addition, Medical Staff officers must be committed to put in the required time to assist the functioning of the organized Medical Staff.

### **III SELECTION OF OFFICERS**

- A. A nominating committee shall be appointed by the Medical Staff president at the meeting prior to biennial elections. This committee shall present a slate of officers to the Medical Staff at its annual meeting.
- B. Medical Staff members may submit names for consideration to members of the nominating committee.
- C. Only Active Staff shall be eligible to vote. A plurality vote of those Active Staff present at the annual meeting is required.

### **IV TERM OF OFFICE**

All officers shall take office on the first day of the calendar year and serve a term of two years.

### **V VACANCIES IN OFFICE**

Vacancies in office during the Medical Staff year, except the Office of President, shall be filled by the MEC of the Medical Staff. If there is a vacancy in the Office of the President, the Vice President shall serve the remainder of the term.

### **VI DUTIES OF OFFICERS**

- A. President -The President shall serve as the chief administrative officer of the Medical Staff and will fulfill those duties as specified in the organization and functions manual.
- B. Vice President - In the absence of the President, Vice President shall assume all the duties and have the authority of the President. He shall perform such further duties to assist the President as the President may, from time to time request, including the review and revision of bylaws as necessary, supervision of the Medical Center's quality, patient safety, and resource utilization programs, and the MEC liaison for medical staff peer review activities The Vice President will serve as the President-Elect.
- C. Secretary -The secretary shall ensure that the recording, transcription, and communication processes produce accurate and complete minutes of all Medical Staff meetings.

## **VII REMOVAL FROM OFFICE**

- A. The Medical Staff and/or Board of Trustees may remove any Medical Staff officer for failure to fulfill his responsibilities, conduct detrimental to the interests of the MUSC Medical Center and/or the Medical Staff, physical or mental infirmity to the degree that renders him incapable of fulfilling the duties of the office.
- B. Elected officers may be removed by 2/3 majority vote of the Medical Staff for the reasons stated in **VII A** above.
- C. Removal from elected office shall not entitle the practitioner to procedural rights.
- D. Any Medical Staff member has the right to initiate a recall election of a Medical Staff Officer. A petition to recall must be signed by at least 25% of the members of the active staff and presented to the MEC. Upon presentation, the MEC will schedule a general staff meeting to discuss the issue(s) and, if appropriate, entertain a no confidence note.

## **ARTICLE VI DEPARTMENTS**

### **I ORGANIZATION OF DEPARTMENTS**

- A. The Medical Staff shall be organized into departments, divisions, and or sections, in a manner as to best assure:
  - 1. the supervision of clinical practices within the Hospital;
  - 2. the conduct of teaching and training programs for students and House Staff;
  - 3. the discovery of new knowledge;
  - 4. the dissemination of new knowledge;
  - 5. the appropriate administrative activities of the Medical Staff; and an integrated quality management program to monitor objectively and systematically evaluate the quality and appropriateness of patient care, objectively establish and monitor criteria for the effective utilization of hospital and physician services, and pursue opportunities to improve patient care and resolve identified problems.
  - 6. the active involvement in the measurement, assessment and improvement of patient care processes.

## **II QUALIFICATIONS AND SELECTION OF DEPARTMENT CHAIRPERSON**

- A. Each Chairperson shall be a member of the Active Category of the Medical Staff and be well qualified by training and experience and demonstrated ability for the position. The Chairperson should be certified in an appropriate specialty board.
- B. The appointment and removal of Department Chairpersons shall be the responsibility of the Dean of the appropriate College, in accordance with Article IV of the General Rules and Regulations of the Faculty of the Medical University of South Carolina. Such appointment must then be submitted to the Board of Trustees for approval.

## **III FUNCTIONS OF DEPARTMENT**

**Through the department Chairperson each department shall:**

- A. Recommend to the Medical Staff the objective and evidenced based criteria consistent with the policies of the Medical Staff and the Board of Trustees for the granting and renewal of clinical privileges.
- B. Recommend clinical privileges for each member of the Department
- C. Develop and uniformly apply criteria for a focused time limited professional practice evaluation for all initially requested privileges of independent practitioners within their department.
- D. Develop and uniformly apply criteria for the on-going professional evaluation of all independent practitioners within their department.
- E. Assure the decision to deny a privilege(s) is objective and evidenced based.
- F. Establish policies and procedures and scope of practice for House Staff supervision. The character of supervision will depend upon the level of training and demonstrated competence of each House Staff member.
- G. As required by the Board of Trustees through the Performance Improvement Plan, each department shall participate in a medical care evaluation program and/or quality improvement program as required by accrediting bodies, federal regulations and state statutes. This plan shall include a process that assures active participation in the ongoing measurement, assessment and improvement of the quality of care and treatment and may include quality control processes as appropriate.
- H. Shall establish standards and a recording methodology for the orientation and continuing education of its members. Such continuing education should (1) represent a balance between intra-institutional and outside activities, (2) be based, when applicable, on the findings of the quality improvement effort, (3) be appropriate to the practitioner's privileges and will be considered as part of the reappointment process. Participation in the roles of both students and teachers is recognized as the means of continuously improving the services rendered by the Medical Staff.
- I. Coordinate clinical activities of the department and integrate all patient care and clinical activities with MUSC Medical Center.

- J. Monitor on a continuing basis, departmental activities and compliance with Medical Staff Bylaws or other accrediting bodies.
- K. Define the circumstances and implement the process of focused peer review activities within the department.
- L. Assess and recommend off-site sources for needed patient care, treatment and service when not provided by the department.
- M. Conduct administrative duties of the department when not otherwise provided by the hospital.
- N. Coordinate and integrate all inter and intra departmental services.
- O. Develop and implement department policies and procedures for the provision of safe and quality care, treatment, and services.
- P. Recommend sufficient qualified and competent staff to provide care within the department and with Clinical Services determine the qualifications and competencies of non LIP's within the department.
- Q. Recommend space and resource needs of the department.
- R. Ensure the timely and appropriate completion of MUSC Medical Center administrative responsibilities assigned to departmental physicians.
- S. Supervise the completion of the assigned responsibilities of departmental members who serve as MUSC Medical Center Medical Directors.
- T. With MUSC Medical Center leaders determine the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.

#### **IV ASSIGNMENT TO DEPARTMENTS**

All members of the Medical Staff shall be assigned to a department as part of the appointment process.

### **ARTICLE VII COMMITTEES**

#### **I. MEDICAL EXECUTIVE COMMITTEE**

- A. Composition: The MEC shall include the elected officers of the Medical Staff, Past President of the Medical Staff, the Vice President for Clinical Operations/Executive Director of MUSC Medical Center, Senior Associate Dean for Clinical Affairs, the Medical Director and/ or designee, Administrator of Clinical Services, Department of Medicine Chairperson, Department of Surgery Chairperson, the Director of Quality, Administrator of

Ambulatory Care, the Vice President for Medical Affairs, the CEO of UMA, President of the House Staff (voting), Chairperson of Credentials Committee, Physician Director of Children's Health Services, the Director for Graduate Medical Education, the President of UMA, the Director of Emergency Medicine, and a designee appointed by the Chairpersons of the Departments of Laboratory Medicine & Pathology, Anesthesiology and Peri-operative Medicine, and Radiology, , three (3) elected Medical Staff representatives: one (1) each to represent the Institute of Psychiatry, primary care and surgical specialties to be elected by the Medical Staff members of those represented departments , three elected Medical Directors from service lines, and two ( 2) Department Chairpersons not already assigned . Membership for elected members and unassigned Department Chairpersons will be for a two year period.

- B. The Medical Executive Committee will be chaired by the Vice President for Medical Affairs (or his/her designee) and Co-chaired by the Medical Staff President.
- C. All members will have voting rights.
- D. Duties - The duties of the MEC shall be to:
  - 1. Ensure high quality cost-effective patient care across the continuum of the MUSC Medical Center
  - 2. Represent and to act on behalf of the Medical Staff
  - 3. Coordinate the activities and general policies of the Medical Staff;
  - 4. Determine and monitor committee structure of the Medical Staff;
  - 5. Receive and act upon reports and recommendations from departments, committees, and officers of the Medical Staff;
  - 6. Implement Medical Staff policies not otherwise the responsibility of the departments;
  - 7. Provide a liaison between the Medical Staff and the Executive Director of the MUSC Medical Center;
  - 8. Recommend action to the Executive Director of the MUSC Medical Center on medico-administrative matters;
  - 9. Make recommendations to the Board of Trustees regarding: the Medical Staff structure, membership, delineated clinical privileges, appointments, and reappointments to the Medical Staff, and performance improvement activities;
  - 10. Ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the MUSC Medical Center
  - 11. Fulfill the Medical Staff organization's accountability to the Board for the medical care of patients in the MUSC Medical Center;

12. Take all reasonable steps to ensure professionally ethical conduct and competent clinical performance for all members with clinical privileges;
  13. Conduct such other functions as are necessary for effective operation of the Medical Staff;
  14. Report at each general staff meeting; and
  15. Ensure that Medical Staff is involved in performance improvement and peer review activities.
  16. The organized medical staff delegates the authority to the Medical Executive Committee the ability to act on its behalf in between organized meetings of the medical staff
- E. Meetings - The MEC shall meet at least six (6) times a year or as often as necessary to fulfill its responsibility and maintain a permanent record of its proceedings and actions. Special meetings of the MEC may be called at any time by the Chairperson.

## **II OTHER MEDICAL STAFF FUNCTIONS**

The accomplishment of the following functions may or may not require the existence of separate, established committees. The functions consist of collection of relevant information (monitoring), and presentation to the appropriate Clinical Departments, discussion, and action (evaluation and problem solving). Evidence that these functions are being effectively accomplished at the departmental level is included in departmental reports to the MEC, and in MEC reports to the Board. These functions can be carried out by a Medical Staff Committee, a MUSC Medical Center interdisciplinary committee, a responsible group, or individual. These functions include, but are not limited to:

- A. Conduct or coordinate quality, appropriateness, and improvement activities, including but not limited to operative, invasive, and high risk procedures review, tissue review, blood usage review, drug usage review, medical record review, mortality and morbidity review, autopsy review, sentinel event and other reviews;
- B. Conduct or coordinate utilization activities;
- C. Peer review.
- D. Conduct or coordinate credentials investigations for staff membership and granting of clinical privileges;
- E. Provide continuing education opportunities responsive to quality assessment/improvement activities, new state-of-the-art developments, and other perceived needs;



- F. Develop and maintain surveillance over drug utilization policies and practices;
- G. Investigate and control nosocomial infections and monitor the MUSC Medical Center infection control program;
- H. Plan for response to fire and other disasters;
- I. Direct staff organizational activities, including staff Bylaws, review and revision, Staff officer and committee nominations, liaison with the Board and MUSC Medical Center administration, and review and maintenance of MUSC Medical Center accreditation.

## **ARTICLE VIII MEDICAL STAFF MEETINGS**

### **I REGULAR MEETINGS**

- A. The Medical Staff shall meet at least quarterly or more often, as needed. Appropriate action will be taken as indicated.
- B. An Annual Medical Staff Meeting shall be held during the last quarter of each year. Written notice of the meeting shall be sent to all Medical Staff members and conspicuously posted.
- C. The primary objective of the meetings shall be to report on the activities of the staff, elect officers if necessary, and conduct other business as may be on the agenda. Written minutes of all meetings shall be prepared and recorded.

### **II SPECIAL MEETINGS**

The President of the Medical Staff, the Medical Director, the Dean of the College of Medicine, the Vice President of Academic Affairs or the Medical Executive Committee may call a special meeting after receipt of a written request for same signed by not less than five (5) members of the Active and Affiliate Staff and stating the purpose for such meeting. The President of the Medical Staff shall designate the time and place of any special meeting. Written or printed notice stating the place, day and hour of any special meeting of the Medical Staff shall be delivered, either personally or by mail, including electronic mail, to each member of the Active Category of the Medical Staff not less than 48 hours before the date of such meeting, by or at the direction of the President of the Medical Staff. If mailed, the notice of the meeting shall be deemed delivered when deposited in the Campus Mail addressed to each Staff member at his address as it appears on the records of the Hospital. Notice may also be sent to members in other Medical Staff categories who have so requested. The attendance of a member of the Medical Staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

#### IV QUORUM

The quorum requirements for all meetings shall be those present and voting, unless otherwise indicated in these Bylaws.

#### V ATTENDANCE REQUIREMENTS

- A. Although attendance at regular Medical Staff meetings is encouraged, Medical Staff members are not required to attend general staff meetings. Medical staff meeting attendance will not be used as a reappointment measurement.
- B. Attendance requirements for department meetings are at the discretion of the Department Chairpersons.
- C. Members of the MEC and Credentials Committee are required to attend fifty percent (50%) of the committee meetings during each year unless otherwise excused.

#### VI PEER REVIEW

All members of the MUSC Medical Center Medical Staff, House Staff, and Professional Staff will be included in the Medical Staff's peer review process.

Peer Review is initiated as outlined in the Medical Staff Rules and Regulations and the Medical Center Policy "Peer Review". A peer review committee for the Medical Staff will be maintained by the Medical Executive Committee. This committee will be chaired by the Vice President of the Medical Staff, as will a subcommittee for Professional Staff peer review. A subcommittee for House Staff peer review will be chaired by the Secretary of the Medical Staff. Members of each of these committees will be appointed by the MEC

All peer review activities whether conducted as a part of a department quality plan or as a part of a medical staff committee will be considered medical staff quality activities and fall under the protection of SC Code Section 40-71-10 and 40-71-20.

**Deleted:** are subject to Peer Review as the result of numerous quality review activities.

**Deleted:** at a Medical Staff Committee level, or at a Medical Staff Department level through the Department Chairperson to the MEC

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#### VII PARTICIPATION BY EXECUTIVE DIRECTOR OF THE MUSC MEDICAL CENTER

The Executive Director of the MUSC Medical Center or his/her designee may attend any Committee, Department, or Section meeting of the Medical Staff.

#### VIII ROBERT'S RULES OF ORDER

The latest edition of *ROBERT'S RULES OF ORDER* shall prevail at all meetings of the General Staff, MEC, and Department Meetings unless waived by the Chairperson.

## **IX NOTICE OF MEETINGS**

Written notice stating the place, day, and hour 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 or department not less than three (3) days before the time of such meeting by the person or persons calling the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

## **X ACTION OF COMMITTEE/DEPARTMENT**

The action of a majority of its members present at a meeting at which a quorum is present shall be the action of a committee or department.

## **XI MINUTES**

Minutes of each regular and special meeting of a Committee or Department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes from the Departments and Credentials Committee Meetings shall be signed, electronically or physically, by the presiding officer and copies thereof submitted to the MEC. The minutes from other committee meetings shall be signed by the presiding officer and copies thereof submitted to the appropriate departments.

# **ARTICLE IX TERMINATION, REDUCTION, AND SUSPENSION OF PRIVILEGES**

## **I SUSPENSION**

In the event that an individual practitioner's action may pose a danger to patients, other Medical Staff members, or the Hospital or its personnel, then either the President of the Medical Staff or Medical Director or the Chairperson of the clinical department to which the practitioner is a member, shall each have the authority, as independent action, to suspend all or any portion of the Clinical Privileges of the Medical Staff member in question. Such precautionary suspension does not imply final findings of fact or responsibility for the situation that caused the suspension.

Such precautionary suspension is immediately effective, is immediately reported to all the individuals named above, and the Medical Staff Office, and remains in effect until a remedy is effected following the provision of this Article of the Medical Staff Bylaws. Immediately upon the imposition of a suspension, the appropriate Department Chairperson or the Chief of Staff assigns to another Medical Staff member the responsibility for care of any hospitalized patients of the suspended individual. As soon as practical, but in no event later than three (3) days after a precautionary suspension, the Medical Executive Committee shall convene to review the action. The affected practitioner may request to be present at this meeting, which is not a hearing and is not to

be construed as such. The MEC may continue the suspension, or take another action pursuant to this Article. If the action taken entitles the affected practitioner to a hearing, then the Hearing and Appeals Procedure Fair Hearing Plan shall apply.

## **II EFFECT OF OTHER ACTIONS ON MEDICAL STAFF MEMBERSHIP AND CLINICAL PRIVILEGES**

Failure to Complete Medical Records - All portions of each patient's medical record shall be completed within the time period after the patient's discharge as stated in Medical Staff Rules and Regulations. Failure to do so (unless there are acceptable extenuating circumstances) automatically results in (a) the record being defined as delinquent and (b) notification of the practitioner.

A temporary suspension in the form of withdrawal of admitting privileges, scheduling of clinic appointments, or scheduling of elective surgical cases, effective until the medical records are complete, shall be imposed automatically after warning a member of his/her delinquency and his/her failure to complete such medical records within a seven (7) day period after delivery of such warning to him/her either orally or in writing.

Having three (3) suspensions in one (1) consecutive 12 month period will be reason for removal from the Medical Staff. Re-application for reinstatement to the staff is allowed immediately upon completion of the delinquent record(s).

Failure to complete Education Requirements – The Medical Staff recognizes the need to mandate certain education requirements for all Medical Staff in order to ensure ongoing success of quality improvement.

The MEC will regularly review and approve the education requirements, including time periods, for Medical Staff members. All education requirements for Medical Staff members shall be completed within the time period. Failure to do so (unless there are acceptable extenuating circumstances) automatically results in an education delinquency and notification to the practitioner of temporary suspension.

A temporary suspension in the form of withdrawal of admitting privileges, scheduling of clinic appointments, or scheduling of elective surgical cases, effective until the education requirements are complete, shall be imposed automatically after warning a member of his/her delinquency and his/her failure to complete such education requirement within a seven (&) day period after delivery of such warning to him/her either orally or in writing.

Having three (3) suspensions in one (1) consecutive 12 month period will be reason for removal from the Medical Staff. Re-application for reinstatement to the staff is allowed immediately upon completion of the delinquent education requirements.

Actions Affecting State License to Practice - If a practitioner's state license to practice or DEA registration is revoked, suspended, limited for disciplinary reasons, not renewed by the relevant agency, or voluntarily relinquished by the individual, then staff membership and privileges are automatically revoked, suspended, or limited to at least the same

extent, subject to re-application by the practitioner when or if his/her license or DEA registration is reinstated, or limitations are removed, whatever is the case.

Lapse of Malpractice Coverage - If the MEC and Board have established a requirement for liability coverage for practitioners with clinical privileges, and if a staff member's malpractice coverage lapses without renewal, then the practitioner's clinical privileges are automatically suspended until the effective date of his/her new malpractice coverage, unless otherwise determined by the Board.

Governmental Sanction or Ban - Imposition of governmental sanction or ban as outlined by Medicare and the DHHS -Office of the Inspector General is cause for immediate loss of all clinical privileges.

Felony Conviction - conviction of a felony offense is cause for immediate loss of all clinical privileges.

Loss of Faculty Appointment - Loss of faculty appointment shall result in immediate revocation of clinical privileges and appointment to the Medical Staff.

Failure to Meet Application Requirements - Failure to comply with deadlines or other application requirements will result in loss of appointment and privileges as outlined in the Credentials Policy Manual.

#### **IV HEARING/APPEAL**

Any physician has a right to a hearing/appeal pursuant to the institution's Fair Hearing Plan in the event any of the following actions are taken or recommended:

- A. Denial of initial staff appointment,
- B. Denial of reappointment,
- C. Revocation of staff appointment,
- D. Denial or restriction of requested clinical privileges,
- E. Reduction in clinical privileges,
- F. Revocation of clinical privileges,
- G. Individual application of, or individual changes in, the mandatory consultation requirement, and
- H. Suspension of staff appointment or clinical privileges if such suspension is for more than 14 days.

**ARTICLE X**  
**REVIEW, REVISION, ADOPTION, AND AMENDMENT OF THE BYLAWS**

**I MEDICAL STAFF RESPONSIBILITY**

The Medical Staff shall have the responsibility to formulate, review, adopt, and recommend to the Board, Medical Staff Bylaws and Amendments thereto, which shall be effective when approved by the Board. Such responsibility shall be exercised in good faith and in a reasonable, responsible, and timely manner.

**II METHODS OF ADOPTION AND AMENDMENT**

All proposed amendments, whether originated by the MEC, another standing committee, or by a member of the Active Category of the Medical Staff, must be reviewed and discussed by the MEC prior to a MEC vote. Such amendments may be recommended to the Board:

- A. The Bylaws may be amended or revised after submission of the proposed amendment at any regular or special meeting of the Medical Staff or by email or US mail submission to all Active Medical Staff members. To be adopted, an amendment or revisions shall require a majority vote of the Active members. Voting can be completed either in person at a Medical Staff meeting or by electronic ballot vote of those who are eligible to vote on the Bylaws. Amendments so made shall be effective when approved by the Board of Trustees.
- B. The Executive Committee is authorized to make minor changes/corrections when necessary due to spelling, punctuation and/or grammar.
- C. These Bylaws shall be reviewed at least every two (2) years by the Officers of the Medical Staff. Findings shall be reported at a regular meeting of the Medical Staff or at a special meeting called for such purpose or by email to active Staff members. Any recommended changes shall be amended in accordance with these Bylaws.

**III RULE CHALLENGE**

Any practitioner may raise a challenge to any rule or policy established by the MEC. In the event that a rule, regulation or policy is felt to be inappropriate, any physician may submit a petition signed by 25% of the members of the Active Staff. When such petition has been received by the MEC, it will either:

- A. Provide the petitions with information clarifying the intent of such rule, regulation, or policy and/or
- B. Schedule a meeting with the petitioners to discuss the issue.

#### **IV RELATED PROTOCOLS AND MANUALS**

The MEC will provide to the Board a set of Medical Staff Rules and Regulations, a Credentials Policy Manual, a Fair Hearing Plan, that further defines the general policies contained in these Bylaws. These manuals will be incorporated by reference and become part of these Medical Staff Bylaws.

Approved by the Medical Executive Committee on November 28, 2007, and by majority vote of the Medical Staff on January 28, 2008.

Revisions approved by the Board of Trustees as of this February 8, 2008.

**ROSTER**  
Board of Trustees Credentialing Subcommittee  
November 28, 2009

The Medical Executive Committee reviewed the following applicants  
on November 18, 2009 and recommends approval by the Board of Trustees effective November 28, 2009.

**Medical Staff--Initial Appointment and Privileging**

Albert	Maniscalco	M.D.	Medicine
Braxton	Wannamaker	M.D.	Neurosciences

**Medical Staff--Reappointment and Reprivileging**

Calvert	Alpert	M.D.	Anesthesiology
Ettaleah	Bluestein	M.D.	Ophthalmology
Steve	Chin	M.D.	Psychiatry
Lisa	David	M.D.	Surgery
Jonathan	Donaldson	M.D.	Urology
Samir	Fakhry	M.D.	Surgery
Christopher	Fields	M.D.	Psychiatry
Jennifer	Fogle	D.M.D.	Oral & Maxillofacial Surgery
Gene	Howard	M.D.	Ophthalmology
Matthew	Kornegay	M.D.	Pediatrics
Eric	Lentsch	M.D.	Otolaryngology
Frederick	Moore	D.M.D.	Oral & Maxillofacial Surgery
William	Rambo	M.D.	Surgery
Anita	Ramsetty	M.D.	Medicine
Scott	Reeves	M.D.	Anesthesiology
John	Robinson	M.D.	Surgery
Girish	Shirali	M.B.B.S	Pediatrics
Mark	Siegel	M.D.	Ophthalmology
Michael	Smith	M.D.	Pathology & Lab. Med.
Yalani	Vanzura	M.D.	Medicine
Derick	Vergne	M.D.	Psychiatry
Robert	Warters	M.D.	Anesthesiology
Rodney	Young	M.D.	Surgery

**Medical Staff--Reappointment with a Request for Change in Privileges**

Athena	Beldecos	M.D.	Medicine	Replacement: Refer and Follow
Franklin	Lee	M.D.	Pediatrics	Replacement: Refer and Follow
Philip	McGaha	M.D.	Pediatrics	Replacement: Refer and Follow
Michael	Noone	M.D.	Otolaryngology	Replacement: Refer and Follow
William	Ottinger	M.D.	Obstetrics & Gynecology Services	Replacement: Refer and Follow
Donna	Roberts	M.D.	Radiology	Replacement: Refer and Follow
Rudolph	Rustin	M.D.	Surgery	Replacement: Refer and Follow
Alan	Sechtin	M.D.	Radiology	Replacement: Refer and Follow
Gwendolyn	Todd-Houston	M.D.	Pediatrics	Replacement: Refer and Follow

**Medical Staff--Request for Change in Privileges**

Robert	Adams	M.D.	Neurosciences	Addition: Telemedicine for Stroke
Julio	Chalela	M.D.	Neurosciences	Addition: Telemedicine for Stroke
Marc	Chimowitz	M.B.Ch.B.	Neurosciences	Addition: Telemedicine for Stroke
Evert	Eriksson	M.D.	Surgery	Addition: Moderate Sedation
Kelly	Gajewski	M.D.	Pediatrics	Addition: Pediatric Emergency Privileges
Angela	Hays	M.D.	Neurosciences	Addition: Telemedicine for Stroke
Edward	Jauch	M.D.	Medicine	Addition: Telemedicine for Stroke
Jessica	Kanis	M.D.	Pediatrics	Addition: Moderate Sedation
Christos	Lazaridis	M.D.	Neurosciences	Addition: Telemedicine for Stroke
Nikolaos	Papamitsakis	M.D.	Neurosciences	Addition: Telemedicine for Stroke
Steven	Shapiro	M.D.	Pediatrics	Replacement: Reinstatement due to administrative error
Tanya	Turan	M.D.	Neurosciences	Addition: Telemedicine for Stroke



**Professional Staff--Initial Appointment and Privileging**

Beth	Griffin	P.A.C.	Neurosciences
Jennifer	Lewey	F.N.P.	Pediatrics

**Professional Staff--Reappointment and Reprivileging**

Jeffrey	Acsell	C.C.P.	Surgery
Michele	Ballister	C.R.N.A.	Anesthesiology
Laura	Carpenter	Ph.D.	Pediatrics
Rhiannan	Davis	C.R.N.A.	Anesthesiology
Merriman	Dowdle	P.A.C.	Medicine
Julie	Dukes	P.A.	Surgery
Adam	Fernandez	C.C.P.	Surgery
Barbara	Haase	P.N.P.	Obstetrics & Gynecology Services
Ashley	Hodge	C.C.P.	Surgery
Sharon	Kelly-Brown	P.N.P.	Pediatrics
Catherine	Kelso	P.A.C.	Otolaryngology
Alice	Libet	Ph.D.	Psychiatry
Emily	Munday	C.R.N.A.	Anesthesiology
Crispin	Reeves	P.A.C.	Medicine
Alicia	Sievert	C.C.P.	Surgery
Erika	Stewart	A.N.P.	Surgery

**ROSTER**  
Board of Trustees Credentialing Subcommittee  
December 28, 2009

The Medical Executive Committee reviewed the following applicants  
on December 16, 2009 and recommends approval by the Board of Trustees effective December 28, 2009.

**Medical Staff--Initial Appointment and Privileging**

Jennifer	Fisher	M.D.	Obstetrics & Gynecology Services
Richard	Gentzler	M.D.	Medicine
Constance	Guille	M.D.	Psychiatry
Thomas	Murphy	M.D.	Pediatrics

**Medical Staff--Reappointment and Reprivileging**

Sarah	Book	M.D.	Psychiatry
Jane	Charles	M.D.	Pediatrics
Neal	Christiansen	M.D.	Medicine
Joel	Cochran	D.O.	Pediatrics
Howard	Evert	M.D.	Medicine
John	Feussner	M.D.	Medicine
Mary	Herring	M.D.	Neurosciences
Marc	Judson	M.D.	Medicine
Edward	Kantor	M.D.	Psychiatry
Henry	Kearse	M.D.	Dermatology
Janice	Key	M.D.	Pediatrics
Dana	King	M.D.	Family Medicine
Michelle	Lally	M.D.	Pediatrics
R. Layton	McCurdy	M.D.	Psychiatry
Diana	Mullis	M.D.	Psychiatry
James	Oates	M.D.	Medicine
Christopher	Parsons	M.D.	Medicine
James	Roberts	M.D.	Pediatrics
Sally	Self	M.D.	Pathology & Lab. Med.
Tamas	Szabo	M.D.	Anesthesiology

**Medical Staff--Reappointment with a Request for Change in Privileges**

Laurence	Blumenthal	M.D.	Medicine	Replacement: Refer and Follow
Denise	Devine	M.D.	Obstetrics & Gynecology Services	Replacement: Refer and Follow
Laura	Goetzl	M.D.	Obstetrics & Gynecology Services	Addition: Telemedicine

**Medical Staff--Request for Change in Privileges**

Mark	Alanis	M.D.	Obstetrics & Gynecology Services	Addition: Telemedicine
Eugene	Chang	M.D.	Obstetrics & Gynecology Services	Addition: Telemedicine
Donna	Johnson	M.D.	Obstetrics & Gynecology Services	Addition: Telemedicine
Jami	Lovell	M.D.	Pediatrics	Addition: Moderate Sedation
Jill	Mauldin	M.D.	Obstetrics & Gynecology Services	Addition: Telemedicine
Roger	Newman	M.D.	Obstetrics & Gynecology Services	Addition: Telemedicine
William	Randazzo	M.D.	Pediatrics	Addition: Circumcision
Charles	Rittenberg	M.D.	Obstetrics & Gynecology Services	Addition: Telemedicine
Christopher	Robinson	M.D.	Obstetrics & Gynecology Services	Addition: Telemedicine
Scott	Sullivan	M.D.	Obstetrics & Gynecology Services	Addition: Telemedicine
James	VanDorsten	M.D.	Obstetrics & Gynecology Services	Addition: Telemedicine

**Professional Staff--Initial Appointment and Privileging**

Elizabeth	Jennings	C.R.N.A.	Anesthesiology
Sarah	Kaufman	A.N.P.	Neurosciences
Shannon	Vaillancourt	P.N.P.	Neurosciences

**Professional Staff--Reappointment and Reprivileging**

Carla	Bistrick	C.C.P.	Surgery
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Peter	Dodge	P.A.C.	Family Medicine
Darlene	Fischer	P.A.C.	Medicine
Joanne	Hunter	A.N.P.	Psychiatry
Dean	Kilpatrick	Ph.D.	Psychiatry
Amy	King	C.R.N.A.	Anesthesiology
Mary	McCall	C.C.P.	Surgery
Cameron	Oswald	P.A.C.	Medicine
Malissa	Sandhu	P.A.C.	Ophthalmology
Anthony	Shackelford	C.C.P.	Surgery
Brenda	Toohey	F.N.P.	Surgery

**Professional Staff--Reappointment and Request for Change in Privileges**

Mary	Johnson	P.N.P.	Pediatrics
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Replacement: Change in Division

**Professional Staff--Request for Change in Privileges**

Frederica	Hughes-Joyner	P.N.P.	Pediatrics
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Replacement: Change in Department

Eileen	Palmer	ANP	Medicine
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Replacement: Change in Department