

MINUTES
MEDICAL UNIVERSITY HOSPITAL AUTHORITY
BOARD OF TRUSTEES MEETING
February 11, 2011

The Board of Trustees of the Medical University Hospital Authority convened Friday, February 11, 2011, with the following members present: Thomas L. Stephenson, Esquire, Chairman; Dr. James E. Wiseman, Jr., Vice Chairman; Dr. Stanley C. Baker, Jr.; Mr. Melvyn Berlinsky; Mr. William H. Bingham, Sr.; Mr. William B. Hewitt; Dr. E. Conyers O'Bryan, Jr.; Dr. Thomas C. Rowland, Jr; and Dr. Charles B. Thomas, Jr. Emeritus: Mr. Allan E. Stalvey. Absent: Dr. Cotesworth P. Fishburne, Jr.; Dr. Donald R. Johnson II; Dr. Paula E. Orr; Mr. Charles W. Schulze; The Honorable Robin M. Tallon.

The following administrative officials were present: Dr. Raymond S. Greenberg, President; Dr. Mark Sothmann, Interim Vice President for Academic Affairs and Provost; Dr. Etta Pisano, Vice President for Medical Affairs, and Dean, College of Medicine; Ms. Lisa Montgomery, Vice President for Finance and Administration; Mr. Stuart Smith, Vice President for Clinical Operations and Executive Director, MUHA; 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. Lisa Saladin, College of Health Professions; Dr. Etta Pisano, College of Medicine; Dr. Philip Hall, College of Pharmacy; 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, 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 8, 2011.

Item 3. Approval of Minutes of the Regular Meeting of the Medical University Hospital Authority of December 10, 2010.

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

RECOMMENDATIONS AND INFORMATIONAL REPORTS OF THE PRESIDENT

OLD BUSINESS: None.

NEW BUSINESS:

Item 4. General Informational Report of the President.

Dr. Greenberg asked Dr. Feussner to introduce the speaker. Dr. Feussner introduced Dr. Dee Ford who is currently an Assistant Professor in Pulmonary, Critical Care, Allergy & Sleep Medicine. Dr. Ford graduated Phi Beta Kappa from the University of South Carolina and went to Medical School at Johns Hopkins where

she was elected to Alpha Omega Alpha. She did her internal medicine training at Johns Hopkins and came to MUSC to complete her fellowship training in pulmonary and critical care medicine and joined the MUSC faculty in 2005. Dr. Ford will present information on Critical Care Excellence in Sepsis and Trauma (CREST). It is an innovative research activity which is a more integrated approach into how we manage complex, critically ill patients.

Dr. Ford discussed CREST and ideas for future direction of the program. She also discussed the concept of telecritical care in South Carolina.

At the conclusion of the presentation, Dr. Greenberg commented that Dr. Ford's work has the potential of being a transformative opportunity to manage patients, not just in MUSC's physical facility; but also allow MUSC doctors to become fundamentally on-site managers where there are no intensivists available. Dr. Greenberg thanked Dr. Ford for the work she is doing.

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

Board Action: Received as information.

Item 5. Other Business. None.

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

OLD BUSINESS: None.

NEW BUSINESS:

Item 6. MUSC Medical Center Status Report.

Statement: Mr. Stuart Smith stated the Hospital's financial situation had been reviewed in detail at the committee meeting. Ms. Montgomery reported that through the first six months the Medical Center is approximately \$1 million under budget partly due to the failure of the Guardian Insurance Company and the subsequent write off of claims. The cash position was also reviewed and Ms. Montgomery stated that situation should be remedied by June 30. There was also an extensive discussion about the Medicaid situation.

Recommendation of Administration: Received as information.

Recommendation of Committee: Received as information.

Board Action: Received as information.

Item 7. MUSC Medical Center Financial and Statistical Report.

Statement: Financial report given at part of Item 6.

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 Safety Report.

Statement: Dr. Baker stated Dr. Cawley had given a report on Quality and Patient Safety including sentinel events, value based purchasing and clinical system goals.

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. Outreach Activity Report, University Medical Associates.

Statement: No Report.

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

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

Board Action: Received as information.

Item 10. Legislative Update.

Statement: Dr. Baker stated Bo Faulkner had given an update on several legislative issues.

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 11. Other Committee Business. None

Item 12. 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: A motion was made, seconded and unanimously voted to approve the list of appointments, reappointments and delineation of privileges to the medical staff.

Item 13. Amendment and Resolution – Special Healthcare Alternative Retirement Plan (Consent Item).

Statement: An Amendment and Resolution with regard to Special Healthcare Alternative Retirement Plan (SHARP) were presented for approval.

Recommendation of Administration: That the Amendment and Resolution be approved.

Recommendation of Committee: That the Amendment and Resolution be approved.

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

Item 14. Revisions to Medical Staff Bylaws, Rules and Regulations and Credentials (Consent Item).

Statement: Revisions to Medical Staff Bylaws, Rules and Regulations and Credentials were presented for approval.

Recommendation of Administration: That the revisions to Medical Staff Bylaws, Rules and Regulations and Credentials be approved.

Recommendation of Committee: That the Medical Staff Bylaws, Rules and Regulations and Credentials be approve.

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

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

Statement: Minutes of the Medical Executive Committee for November 2010, December 2010 and January 2011 meetings were presented to the Board.

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 were received as information.

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

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

Recommendation of Administration: That this be received as information.

Recommendation of Committee: That this be received as information.

Board Action: Received as information.

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

OLD BUSINESS: None.

NEW BUSINESS:

Item 17. Update on Projects.

Statement: Mr. Bingham reported the report had been deferred until the next meeting.

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 18. Other Committee Business. None

Item 19. 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: MR. WILLIAM B. HEWITT. (Detailed committee minutes are attached to these minutes).

OLD BUSINESS: None.

NEW BUSINESS:

Item 20. MUHA Compliance Update.

Statement: Mr. Hewitt stated Ms. Reece Smith presented the MUHA Compliance update to committee and she thanked a number of people for helping get claims overturned.

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 21. Report of the Office of Internal Audit.

Statement: Mr. Hewitt stated the committee had received a report from the Director of Internal Audit and the report was received as information.

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. Other Committee Business. None.

OTHER BUSINESS FOR THE BOARD OF TRUSTEES:

Item 23. 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 24. New Business for the Board of Trustees.

None.

Item 25. **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,

A handwritten signature in black ink, appearing to read "H.B. Faulkner III". The signature is written in a cursive style with a horizontal line at the end.

Hugh B. Faulkner III
Secretary

/wcj
Attachments

**Medical University Hospital Authority
Authority Operations and Finance Committee
Board of Trustees
Minutes
February 10, 2011**

Attendees:

Dr. Stanley Baker, Chair	Dr. Mark Sothmann
Mr. Melvyn Berlinsky	Mr. James Fisher
Mr. William Bingham	Mr. Tom Anderson
Dr. Cotesworth Fishburne	Dr. Sabra Slaughter
Mr. William Hewitt	Dr. Phil Costello
Dr. Donald Johnson	Dr. Patrick Cawley
Dr. E. Conyers O'Bryan	Dr. Marilyn Schaffner
Mr. Charles Schulze	Joseph Good, Esq
Thomas Stephenson, Esq.	Annette Drachman, Esq
Dr. Charles Thomas	Mr. Casey Liddy
Dr. Raymond Greenberg	Mr. Steve Hargett
Mr. Stuart Smith	Mr. Betts Ellis
Dr. Etta Pisano	Mr. H. B. Faulkner
Ms. Lisa Montgomery	Mr. Mark Sweatman
Dr. Frank Clark	

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

Item 6.MUSC Medical Center Status Report

Mr. Smith and Ms. Montgomery presented a detailed report of the status of the MUSC Medical Center in relation to the current state Medicaid situation.

Ms. Montgomery reported that through the first 6 months the Medical Center was ahead of last year in net patient services revenue but was slightly behind budget. This is related to the increasing number of observation patients seen by the Medical Center. Our change in net assets is approximately \$1 million under budget; partly attributable to the failure of the Guardian Insurance Company and the subsequent write off of claims.

Our cash situation has declined since October. November and December have had a number of additional expenditures which have had a direct impact on this cash situation. These included an additional biweekly payroll in December, PTO cash in for employees, Medicaid match payment which had to be paid early, and a bank note which

came due during this time. Our projected cash analysis thru June 2011 estimates a steady increase of cash to approximately \$40 million by fiscal year end.

She also reported that the Medical Center had a number of items which will not have to be paid in FY12 such as the Medicaid settlement, HUD mortgage reserve funds, and a Paid Time Off cash-in. This amounts to approximately \$25.7 million which will not have to be paid, and should help to build our cash.

Ms. Montgomery reported that the Health and Human Services shortfall for this fiscal year is \$225 million, \$100 million of which the Budget and Control Board has agreed to recognize. This leaves a shortage of \$125 million this year and an expected \$660 million next fiscal year. The Medical Center is anticipating a budget cut this fiscal year of 5% and an additional cut for next fiscal year of possibly 10%. The S.C. Hospital Association is lobbying for alternatives to additional hospital rate cuts in the form of an increased hospital contribution in order to maximize Federal match dollars as well as increased scrutiny on managed care programs.

Mr. Schulze noted that \$660 million in Medicaid cuts could easily equate to the closing of many rural hospitals, thus causing loss of jobs and a potential loss of revenue for the state of as much as \$250 million.

Mr. Smith presented the Medical Center's plan to deal with the anticipated Medicaid cuts. These measures include a continued focus on reducing overtime, re-evaluation of premium pay and staffing ratios, use of ANSOS and e-Shift which are programs designed to electronically manage staffing in order to reduce overtime and premium pay, and a continued emphasis on limited hiring for all areas unless there is a direct impact on safety or revenue enhancement. The 5&5 plans which Mr. Smith discussed at the last Board meeting are continuing to evaluate ways for the medical Center to save 10% over the next two years by evaluating all expenditures and re-engineering our methods of providing patient care in an more efficient and cost effective manner. These plans are being developed by our administrative teams as well as our physician leaders.

Mr. Smith also reported that supplies are being managed through increased vendor negotiations as well as detailed analysis of our supply purchases in all areas. Capital projects are being delayed if not yet underway, and only emergency capital equipment will be purchased.

Action: Report received as information

Item 7. Financial and Statistical Report

Report given as part of Item 6 above

Item 8. Report on Quality and Patient Safety

Dr. Patrick Cawley presented the report on Quality and Patient Safety. He reported on three major areas:

Sentinel Event Review:

Sentinel events are unexpected occurrences involving death, serious physical or psychological injury, or the risk thereof. Any event determined to be sentinel 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 27 cases and deemed 17 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.

Causes for most sentinel events included retained items, patient elopement, and issues dealing with coordination of care. Main issues related to the serious events were lack of standardized practice, and issues dealing with psychiatric patients.

Improvements have been made since last year. We have seen a decrease in cases involving patient falls and events related to personal performance. Areas which present opportunities for future improvement include improved security for wandering patients and increased focus on retained OR items.

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 improved process for distributing blood from the blood bank, improved multiple processes regarding information system outages, improved process for monitoring patients on unfractionated heparin infusions, standardizing OR counting procedures, and improved process for approving changes in enteral formulas.

Dr. Cawley also reported on the Peer Review Process. There is a peer review process for physicians, residents and mid-level providers. In 2010, 78 cases were referred to peer review. The peer review process involves extensive investigation as well as counseling and possible suspension or termination. The goal of the process is to rehabilitate the provider and this is handled through the Professional Peer Program which is administered through the Institute of Psychiatry. Approximately 30 physicians have been referred to this program and it has proved successful. One provider has left the institution as a result of the peer review process.

Value Based Purchasing

Value Based Purchasing is a Federal program to evaluate care given in hospitals which accept Medicare patients. Reimbursement is tied to the ranking received by

hospitals for care of those patients. CMS and HCAHPS measures are evaluated for each hospital and funding is decreased if those measures are not appropriate. MUHA currently ranks well in those measures, but there will be continued focus on this area, and these rankings continue to be a high priority for the Medical Center.

Clinical System Goals

In the past, MUSC has used a mortality measurement as one of our major clinical goals. In the future we will transition to a harm avoidance goal. This is a measurement of patient harm metrics including hospital acquired infections, patient safety indicators, and CMS measures to name a few. The goal of this system is to provide “ideal care” for a patient. This goal has three components: harm avoidance, measurement process and outcomes measurement. Harm metrics are in the process of being developed nationally and we will see an increased focus in this area in the future.

Action: Report received as information

Item 9. Outreach Activity Report, University Medical Associates

No report

Item 10. Legislative Update

Mr. Faulkner stated that Ms. Montgomery had covered most of the issues related to the budget discussions and Medicaid cuts in an earlier discussion. He mentioned recent legislation which would have deleted a portion of “other funds” from the agencies. This would have had an impact on grants, tuition, parking fees and other items. At the present time this legislation has been delayed. He will keep the Board posted on this item. He also reported that Dr. Pisano has had several meetings with our delegation in Washington regarding NIH funding. She will continue to stay in touch with members of our delegation.

Action: Received as information

Item 11. Other committee business

None

Consent Agenda

Item 12. Medical University Hospital Authority Appointments, Reappointments and Delineation of Privileges

The appointments, reappointments, and delineation of privileges were presented to the committee. They have been recommended for approval by the respective chair, the credentials committee and the Medical Executive Committee.

Action: Recommend approval

Item 13. Amendment and Resolution – Special Health Alternative Retirement Plan (SHARP)

The restated SHARP plan was presented as required to the Internal Revenue Service. This was reviewed by the committee and recommended for approval.

Action: Recommend approval

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

These documents were submitted to the committee and have been reviewed by all appropriate groups. The committee has reviewed and recommended approval.

Action: Recommend approval

Item 15. Medical Executive Committee Minutes

The Medical Executive Committee Minutes for November 2010, December 2010, and January 2011 have been presented and reviewed by the committee.

Action: Received as information

Item 16. Medical Center Contracts and Agreements

The contracts and agreements entered into since the last meeting of the board were reviewed.

Action: Received as information

There being no further business, the committee adjourned at 11:10 a.m.

Respectfully submitted,

Teresa K. Rogers

**Medical University Hospital Authority
Physical Facilities Committee
February 10, 2011
Minutes**

Attendees:

Mr. William H. Bingham, Sr., Chair	Mr. Jim Fisher
Dr. Stanley C. Baker	Mr. Joe God
Mr. Melvyn Berlinsky	Dr. Stephen Lanier
Dr. Cotesworth P. Fishburne, Jr.	Mr. John Malmrose
Mr. William B. Hewitt	Ms. Lisa Montgomery
Dr. Donald R. Johnson II	Ms. Jennifer Pearce
Dr. E. Conyers O'Bryan, Jr.	Dr. Etta Pisano
Mr. Charles W. Schulze	Mr. Stuart Smith
Thomas L. Stephenson, Esquire	Dr. Mark Sothmann
Dr. Charles B. Thomas, Jr.	Mr. Mark Sweatmann
Dr. James E. Wiseman, Jr.	Mr. Patrick Wamsley
Dr. Raymond S. Greenberg	
Ms. Susan Barnhart	

Mr. Bingham called the meeting to order.

REGULAR Items

Item 17 Update on Projects

No Report.

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

Item 18 Other Committee Business None

CONSENT Items for Information:

Item 19 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 10, 2011
Minutes**

Attendees:

Mr. William B. Hewitt, Chair
Dr. Stanley C. Baker
Mr. Melvyn Berlinsky
Mr. William H. Bingham, Sr.
Dr. Cotesworth P. Fishburne, Jr.
Dr. Donald R. Johnson II
Dr. E. Conyers O'Bryan, Jr.
Mr. Charles W. Schulze
Thomas L. Stephenson, Esquire
Dr. Charles B. Thomas, Jr.
Dr. James E. Wiseman, Jr.
Mr. Hugh B. Faulkner
Dr. Raymond S. Greenberg
Ms. Susan H. Barnhart

Ms. Annette Drachman
Mr. Jim Fisher
Mr. Joe Good
Dr. Stephen Lanier
Ms. Lisa Montgomery
Dr. Etta Pisano
Dr. Mark Sothmann
Mr. Mark Sweatmann
Mr. Patrick Wamsley

Mr. Hewitt called the meeting to order.

REGULAR Items

Item 20 MUHA Compliance Update.

Ms. Reece Smith provided an MUHA Compliance update. She reported on the SCDHHS Audits and thanked the doctors, Annette Drachman and the SCHA for their help in getting most of the denied claims overturned.

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

Item 21 Report of the Internal Auditor.

Ms. Susan Barnhart provided a report on the activities of the office of Internal Audit.

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

Item 22 Other Committee Business. None

Respectfully Submitted,

Celeste Jordan

Board of Trustees Credentialing Subcommittee

The Medical Executive Committee reviewed the following applicants on December 15, 2010 and recommends approval by the Board of Trustees Credentialing Subcommittee effective December 28, 2010

Medical Staff Initial Appointment and Privileges

<u>Practitioner Name</u>	<u>Degree</u>	<u>Status</u>	<u>Dept</u>
Caplan, Michael	MD	Initial	Path
Medina, Ana	MD	Initial	Path

Medical Staff Reappointment and Privileges

Aaronson, Ian	MBChB	Active	Urol
Anton, Raymond	MD	Active	Psych
Bowman, Charles	MD	Active	Peds
Brilliant, Howard	MD	Affil RF	OrthoSurg
Brown, Grace	MD	Affil	Anes
Burges, Gene	MD	Active	Derm
Bush, Jeffrey	MD	Active	Medi
Carter, James	MD	Active	ObGyn
Chaudry, Mohammad	MD	Active	Radio
Chessman, Alexander	MD	Active	FamMed
Davidson, Andrew	MD	Affil RF	Peds
Davis, Kimberly	MD	Active	Medi
Diaz-Gonzalez, Victor	MD	Affil	Medi
Gentzler, Richard	MD	Active Prov	Medi
George, Mark	MD	Active	Psych
Gilkeson, Gary	MD	Active	Medi
Gold, Michael	MD	Active	Medi
Guille, Constance	MD	Active Prov	Psych
Guimaraes, Marcelo	MD	Active	Radio
Hannegan, Christopher	MD	Active	Radio
Henshaw, Melissa	MD	Active	Peds
Hoffman, Brenda	MD	Active	Medi
Jenkins, Dorothea	MD	Active	Peds
Kinsman, Stephen	MD	Active	Neuro
Kraveka, Jacqueline	DO	Active	Peds
Kruesi, Markus	MD	Active	Psych
Krywko, Diann	MD	Active	Medi
Leman, Robert	MD	Active	Medi
Lopes-Virella, Maria	MD	Active	Medi
Losek, Joseph	MD	Active	Peds
Macias, Michelle	MD	Active	Peds
Peysen, Robert	MD	Affil RF	Ophth
Schabel, Stephen	MD	Active	Radio
Stapleton, Sarah	MD	Affil CFCRF	Medi
Vasko, Todd	MD	Affil RF	Peds

Medical Staff Reappointment and Change in Privileges

Farr, Kenneth	MD	Affil	Ophth	Switching to Refer and Follow Privileges
Ikonomidis, John	MD	Active	Surg	Addition: Lung Transplantation

Professional Staff Initial Appointment and Privileges

Mack, Kate	FNP	Initial	Urol
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Professional Staff Reappointment and Privileges

Bieganousky, Karen	CRNA	AHP	Anes
Byrd, Elizabeth	CRNA	Prov AHP	Anes
Caldwell, Jennifer	CRNA	AHP	Anes
Carlson, Cheryl	NNP	AHP	Peds
Comley, James	CRNA	AHP	Anes
Cooper, Annette	CRNA	AHP	Anes
Danielson, Carla	PhD	AHP	Psych
Denham, Sarah	ANP	Prov AHP	Neuro
Dooley, Carmen	NNP	AHP	Peds
Dufour, Diane	PNP	AHP	Peds
Ernst, Linda	NNP	AHP	Peds
French, Pamela	APRN	AHP	Psych
Grannell, Timothy	CRNA	Prov AHP	Anes
Harper, Amanda	CRNA	AHP	Anes
Highland, Heather	CRNA	AHP	Anes
Jennings, Elizabeth	CRNA	Prov AHP	Anes
Keegan, Nina	FNP	Prov AHP	Peds
Killeen, Therese	APRN	AHP	Psych
LaRowe, Steven	PhD	Prov AHP	Psych
Licht, Janna	FNP	AHP	Psych
Long, Patti	NNP	AHP	Peds
Lynn, Rachel	CRNA	AHP	Anes
Madan, Alok	PhD	AHP	Psych
Porcher, Frances	PNP	AHP	Peds
Rheingold, Alyssa	PhD	AHP	Psych
Rubinstein, Catherine	FNP	AHP	Surg
Saladin, Michael	PhD	AHP	Psych
Salak, Vicky	FNP	AHP	Neuro
Schaub, Christine	APRN	AHP	Medi
Steadman, E. Elizabeth	ACNP	AHP	Surg
Wedin, Sharlene	PsyD	AHP	Psych
Zinko, Frances	CRNA	AHP	Anes

Professional Staff Change in Privileges

Veitch, Joyce	FNP	AHP	Neuro	Switching from Department of FAM MED to Department of NSC
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Board of Trustees Credentialing Subcommittee

The Medical Executive Committee reviewed the following applications on November 17, 2010 and recommends approval by the Board of Trustees Credentialing Subcommittee, effective November 28, 2010

Medical Staff Initial Appointment and Privileges

<u>Practitioner Name</u>	<u>Degree</u>	<u>Status</u>	<u>Dept</u>
Dwyer, Richard	MD	Initial	Psych
Lal, Chitra	MD	Initial	Medi
Evans, Melissa	MD	Initial	Peds
Mauriello, Joseph	MD	Initial	Ophth

Medical Staff Reappointment and Privileges

Akhtar, Jeffrey	DO	Affil RF	Medi
Bach, Durwood	DDS	Active	OralMax
Beischel, Charles	MD	Affil	Ophth
Brady, Kathleen	MD	Active	Psych
Byrne, Thomas	MD	Active	Surg
Castell, Donald	MD	Active	Medi
Creasman, William	MD	Active	ObGyn
Elliott, Bruce	MD	Active	Surg
Everman, Paul	MD	Affil	Psych
Glenn, James	MD	Active	Medi
Hay, J. Michael	MD	Active	Anes
Herpel, Laura	MD	Active	Medi
Javed, Tariq	DMD	Affil RF	OralMax
Katikaneni, Lakshmi	MD	Active	Peds
Klauber, Carol	MD	Affil RF	Peds
Lewin, David	MD	Active	Path
Luttrell, Louis	MD	Active	Medi
Maize, John Sr.	MD	Affil	Derm
Maize, John Jr.	MD	Affil	Derm
Mallin, Kimberly	MD	Active	FamMed
Mauldin, Jill	MD	Active	ObGyn
McDonald, John	MD	Affil RF	Medi
Morris, Pamela	MD	Active	Medi
Murphy, Thomas	MD	Affil RF	Affil Prov
Othersen, H. Biemann	MD	Active	Surg
Pollack, Ross	MD	Active	Derm
Poletti, Steven	MD	Affil RF	OrthoSurg
Pope, Thomas	MD	Active	Radio
Ravenel, Michele	DMD	Affil RF	OralMax
Reuben, Adrian	MBBS	Active	Medi
Robison, Jacob	MD	Active	Surg
Saul, J. Philip	MD	Active	Peds
Shealy, Gerald	MD	Active	OrthoSurg
Spratt, Eve	MD	Active	Peds
Stafford, Sam	MD	Affil	Derm

Stelter, Taryn	MD	Affil RF	Peds
Thiers, Bruce	MD	Active	Derm
Tsai, Nancey	MD	Active	Neuro
Turk, Aquilla	DO	Active	Radio
Turner, Robert	MD	Active	Neuro
Wagner, Mark	MD	Active	Psych
Wilson, Marion Edward	MD	Active	Ophth

Medical Staff Reappointment and Change in Privileges

Canivan, Christine	MD	Affil	Peds	Switching to Refer and Follow Privileges
Eagerton, Donlad	MD	Affil	Medi	Switching to Refer and Follow Privileges

Medical Staff Change in Privileges

Yarbrough, William	MD	Active	Surg	Addition: General Surgery Core Privileges/Procedures
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Professional Staff Initial Appointment and Privileges

Bowman, Tamara	ANP	Initial	Medi
Fabrizio, Katherine	APRN	Initial	Peds
Freilich, Carly	PAC	Initial	Neuro
Mund, Angela	CRNA	Initial	Anes
Neumann, Jill	PAC	Initial	Surg

Professional Staff Reappointment and Privileges

Barreira, Jeanne	CNM	AHP	ObGyn
Bissinger, Robin	NNP	AHP	Peds
Black, Robert	OD	AHP	Ophth
Bond, Sharon	PhD	AHP	ObGyn
Brand, Elizabeth	CNM	AHP	ObGyn
Burbage, Gloria	CRNA	AHP	Anes
Chalk, Mary	FNP	AHP	Otol
Cushman, Rona	NNP	AHP	Peds
Forbus, Amanda	FNP	AHP	Medi
Gamble, Laura	PNP	AHP	Peds
Gottshalk, Tammy	FNP	AHP	Medi
Haynes, Hwajoo	ANP	AHP	Medi
Hogg, Cameron	FNP	AHP	OrthoSurg
Kibler, Annette	NNP	AHP	Peds
Palmer, Eileen	ANP	AHP	Medi
Ridgeway, Jennifer	PAC	AHP	Surg
Swing, Jane	CRNA	AHP	Anes
Vaillancourt, Shannon	PNP	Prov AHP	Neuro
Veitch, Joyce	FNP	AHP	FamMed
Wolfman, Michael	CRNA	AHP	Anes
Wymer, Joy	PhD	AHP	Neuro

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

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.

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 SHARP amendment and restatement is required, as indicated in the attached, for Internal Revenue Code compliance purposes. These changes should have little or no financial impact on the cost of benefits under the plan.

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

SECRETARY'S CERTIFICATE

MEDICAL UNIVERSITY HOSPITAL AUTHORITY

The undersigned, as the duly appointed and acting Secretary of the Board of Trustees of the Medical University Hospital Authority (the "Company"), does hereby certify the following, as of December 28, 2010:

1. The undersigned is the duly appointed and acting Secretary of the Company.
2. The following are true and complete excerpts of resolutions adopted by the Board of Trustees of the Company at a meeting of the Board of Trustees duly convened and such resolutions continue to be in full force and effect:

WHEREAS, the Company sponsors the Special Healthcare Alternative Retirement Plan (the "Plan"), has reserved the authority to amend the Plan, and desires to exercise such authority; and

WHEREAS, the Company desires to amend the Plan, among other amendments, to comply with the applicable requirements of EGTRRA (defined below).

NOW, THEREFORE, BE IT RESOLVED, that the Company does hereby amend and restate the Plan in accordance with a final draft amended and restated Plan document which was presented at the meeting of the Board of Trustees of the Company, effective as of the Effective Date as defined in such final draft Plan document, except as otherwise provided in the following resolution.

FURTHER RESOLVED, (i) that, notwithstanding anything in the Plan (as amended and restated pursuant to one or more of the resolutions set forth in this writing (collectively and singularly, the "Plan's Current Restatement")) to the contrary, the retroactive effective dates required by the General Agreement on Tariffs and Trade, Uniform Services Employment and Reemployment Rights Act of 1994, Small Business Job Protection Act, Taxpayer Relief Act of 1997, Internal Revenue Service Restructuring and Reform Act of 1998, the Community Renewal Tax Relief Act of 2000, the Economic Growth and Tax Relief Reconciliation Act of 2001, the most recent legislative and regulatory changes applicable in relation to Internal Revenue Code of 1986, as amended ("Code"), Section 401(a)(9), and the most recent legislative and regulatory changes applicable in relation to Code Section 401(a)(31)(B), the most recent legislative and regulatory changes applicable in relation to Code Sections 415 and 436, the Pension Protection Act of 2006, the HEART Act and WRERA (each hereinafter referred to as "Component Legislation or Regulation" and collectively as "EGTRRA") and any other final Treasury Regulations published and effective since the effective date of the most recent amendment and restatement of the Plan (which precedes the Plan's Current Restatement), shall apply as the Effective Date (under the Plan's Current Restatement) with respect to the applicable provisions of the Plan as necessary for the Plan to qualify under Code Section 401(a) and for the Plan's related trust to be exempt under Code Section 501(a) (collectively, "Code Qualification"); provided, however, that, to the extent the Plan was operated in accordance with the provisions of the Plan's Current Restatement as of an effective date earlier than that required by EGTRRA, a provision of any Component Legislation or Regulation or any such Treasury Regulations, such date shall be the Effective Date (under the Plan's Current Restatement) with respect to such applicable provisions of the Plan's Current

Restatement; provided, further, that, to the extent the Effective Date (under the Plan's Current Restatement), without regard to this resolution, is sufficient to obtain retroactive effective date-related Code Qualification, then to such extent, this resolution shall not be applicable or operative under the Plan's Current Restatement; and (ii) that, to the extent this resolution is operative or applicable under the Plan, this resolution shall be considered to be part of and included in all applicable Plan provisions.

FURTHER RESOLVED, that each officer of the Company, acting alone or jointly, is hereby authorized, empowered and directed to execute such documents and other writings, and take such other action, on behalf of the Company, as may be necessary or appropriate in connection with the preceding resolution.

IN WITNESS WHEREOF, the undersigned, being the Secretary of the Board of Trustees of the Company, has executed this writing as of the date first above-written.

X _____

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 as indicated in the attached Secretary's Certificate.

Secretary, Medical University Hospital Authority

Date



*Medical University of South Carolina
Medical Center*

Medical Staff Bylaws

January 2011

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**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.
5. [selecting and removing medical staff officers.](#)

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 & STRUCTURE

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 unrestricted 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 of Trustees 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

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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. Should the practitioner become eligible for board certification, s/he will be required to attain Board Certification within two (2) years, or reappointment will not be granted. 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.

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- F. Maintain malpractice insurance as specified by the MEC, MUH and Board of Trustees.
- G. [Follow the associated details for qualifications for Medical Staff membership outlined in the Credentials Manual.](#)

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 of Trustees. The [Board of Trustees](#) shall act on appointments and reappointments only after there has been a recommendation from the Credentials Committee and MEC [as outlined with associated details in the Credentials Manual.](#)
- 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. [Only those practitioners assigned to the Active Medical Staff have general Medical Staff voting privileges.](#)
- F. 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.

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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 [and the associated details](#) 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 and associated details](#) outlined in the Credentials Policy Manual.

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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

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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

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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.

V CONTRACT SERVICES

The clinical privileges of any practitioner who has a contractual relationship with an entity that has a contractual relationship with MUSC Medical Center to provide professional services to patients shall be subject to those provisions contained in said contract with regard to the termination of Medical Staff membership and privileges upon the expiration, lapse, cancellation, or termination of the contract. If no provisions for termination of membership or privileges are contained in the contract, the affected practitioners' membership and clinical privileges will be terminated at the time of the contract termination, lapse, expiration or cancellation date. The affected practitioners shall have no right to a hearing regarding termination of Medical Staff membership or privileges.

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**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.

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- 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 vote.

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**ARTICLE VI
DEPARTMENTS**

I ORGANIZATION OF DEPARTMENTS

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- 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 must be certified in an appropriate specialty board, or have comparable competence that has been affirmatively established through the credentialing process.
- B. The appointment and removal of Department Chairpersons shall be the responsibility of the Dean of the appropriate College, in accordance with the Board of Trustees approved Rules and Regulations of the Faculty of the Medical University of South Carolina (Faculty Handbook). Such appointment must then be submitted to the Board of Trustees for approval.

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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 related to patient care provided within the department
- 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.

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- G. 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 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 that guide and support the provision of safe quality care, treatment, and services.
- P. Recommend sufficient qualified and competent staff to provide care within the department and with Clinical Services and MUSC Medical Center leaders determine the qualifications and competencies of non LIP's within the department who provide patient care, treatment, and services.
- 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.

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Assess and improve on a continuing basis the quality of care, treatment, and services provided in the department.

Comment [pjc1]: This phrase is redundant

IV ASSIGNMENT TO DEPARTMENTS

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

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ARTICLE VII COMMITTEES AND FUNCTIONS

I. MEDICAL EXECUTIVE COMMITTEE

A. Composition: The Medical Executive Committee (MEC) is the executive committee of the organized Medical

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Staff. The majority of members are physicians. Other hospital and University leaders shall have membership in order to allow the committee to have an integrated leadership role within MUSC Medical Center. 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 Executive Medical Director, Associate Executive Medical Directors, Administrator of Clinical Services, Department of Medicine Chairperson, Department of Surgery Chairperson, the Director of Quality, the Director of Strategic Planning, the Director of Pharmacy, 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 Senior Associate Dean for Medical Education, 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.

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- 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 of Trustees 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;

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14. Report at each general staff meeting; and
15. Ensure that Medical Staff is involved in performance improvement and peer review activities.

E. Delegated Authority-

1. The 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.
2. The Medical Staff delegates authority to the MEC to make amendments and submit directly to the Board of Trustees for adoption those associated details of processes defined in these bylaws that reside in the Credentials Manual of the Medical Staff, the Rules and Regulations of the Medical Staff, and the Fair Hearing Plan of the Medical Staff or other Medical Staff policies. Such detail changes/amendments shall not require Medical Staff approval prior to submission to the Board. The MEC shall however notify the Medical Staff of said changes prior to Board of Trustees submission. The associated details are defined as those details for the processes of qualifications of the Medical Staff, appointment and re-appointment to the Medical Staff, credentialing/privileging and re-credentialing/ re-privileging of licensed independent practitioners and other practitioners credentialed by the Medical Staff, the processes and indications for automatic and or summary suspension of medical staff membership or privileges, the processes or indications for recommending termination or suspension of a medical staff membership and/or termination, suspension or reduction of clinical privileges and other processes contained in these bylaws where the details reside either in The Rules and Regulations of the Medical Staff, the Credentials Manual of the Medical Staff, the Fair Hearing Plan, or other Medical staff policies. The Medical Staff, after notification to the MEC and the Board, by a two thirds vote of voting members shall have the ability to remove this delegated authority of the MEC.
3. The authority to amend these bylaws cannot be delegated.

Deleted: <#>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.¶

F. 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.

G. Removal from MEC- The Medical Staff and/or the Board of Trustees may remove any member of the MEC 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 committee. Any Medical Staff member has the right to initiate a recall of a Medical Executive Committee member. A petition to recall must be signed by at least 25% of the members of the Active staff and presented to the MEC or to the Board of Trustees if the recall is for the majority or all of the MEC members. Upon presentation, the MEC or Board of Trustees will schedule a general staff meeting to discuss the issue(s) and, if appropriate, entertain a no confidence vote. Removal of an MEC member shall require a 2/3 majority vote of voting members. Removal from the MEC shall not entitle the practitioner to procedural rights.

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II OTHER MEDICAL STAFF FUNCTIONS

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 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.

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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.

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. Conduct or coordinate credentials investigations for staff membership and granting of clinical privileges;
- D. Provide continuing education opportunities responsive to quality assessment/improvement activities, new state-of-the-art developments, and other perceived needs;
- E. Develop and maintain surveillance over drug utilization policies and practices;
- F. Investigate and control nosocomial infections and monitor the MUSC Medical Center infection control program;
- G. Plan for response to fire and other disasters;
- H. Direct staff organizational activities, including staff Bylaws, review and revision, Staff officer and committee nominations, liaison with the Board of Trustees and MUSC Medical Center administration, and review and maintenance of MUSC Medical Center accreditation

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ARTICLE VIII HISTORY AND PHYSICAL REQUIREMENTS

Comment [pjc2]: This section is moved from Rules & Regulations

A. A Comprehensive History and Physical (H&Ps) shall be completed no later than twenty-four (24) hours after admission (includes inpatient or observation status) or at the initial visit to an ambulatory clinic, or prior to any operative, invasive, high risk

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diagnostic or therapeutic procedure, or procedures requiring moderate or deep sedation or anesthesia regardless of setting. A complete H&P (except in circumstances allowing a focused H&P) 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.

B. For other non- inpatients procedures a focused history and physical may be completed

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based on the presenting problem. A focused H&P must include at a minimum:

- present illness
- past medical/surgical history
- medications
- allergies
- focused physical exam to include the presenting problem and heart and lungs,
- impression and plan including the reason for the procedure.

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). The focused H&P must meet the requirements for a focused H&P.

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 within 30 days prior to admission or a procedure, and that H&P is in the patient's medical record, an update to the H&P must be completed within 24 hours for inpatients or prior to the procedure whichever comes first . This includes intra campus admissions from the Medical Center. (i.e., TCU, IOP) For all surgeries and other procedures requiring an H&P this update may be completed in combination with the preanesthesia assessment.

F. Dentists are responsible for the part of their patient's H&P that relates to dentistry.

G. 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.

H. Podiatrists are responsible for the part of their patient's H&P that relates to podiatry.

I. Optometrists are responsible for the part of their patient's H&P that relates to optometry.

J. The attending physician is responsible for the complete H&P.

K. 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. The co-signature by the attending or the attestation must be completed by the attending within 48 hours of admission or prior to any procedure requiring H&P's.

ARTICLE IX MEDICAL STAFF MEETINGS

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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.

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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

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 X 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.

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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

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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 (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 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 of Trustees](#) 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.

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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.

III. **FAIR HEARING PLAN**

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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.

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Comment [pjc3]: This was previously separate from Bylaws – now it will be inserted.

A. DEFINITIONS

1. The term “professional review action” means an action or recommendation of the professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual practitioner which affects (or could affect) adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges of the practitioner or the practitioner’s membership. Such term includes a formal decision of the professional review body not to take an action or make a recommendation described in the previous sentence and also includes professional review activities relating to professional review action.

An action not considered to be based on the competence or professional conduct of a practitioner if the action taken is primarily based on:

- a. The practitioner’s association or lack of association with a professional society or association;
- b. The practitioner’s fees or the practitioner’s advertising or engaging in other competition acts intended to solicit or retain business;
- c. The practitioner’s participation in prepaid group health plans, salaried employment, or any other manner of delivering health services whether on a fee-for-service or other basis;
- d. A practitioner’s association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with a member of members of a particular class of health care practitioner or professional; or
- e. Any other matter that does not related to the competence or professional conduct of a practitioner.

2. The term “professional review activity” means an activity of the Hospital with respect to an individual practitioner.

- a. To determine whether the practitioner may have clinical privileges with respect to or membership;
- b. To determine the scope or conditions of such clinical privileges or membership;
- c. To change or modify such clinical privileges or membership.

3. The term “Professional Review Body” means the Hospital and the Hospital’s governing body or the committee of the Hospital which conducts the professional review activity and includes any committee of the Medical Staff of the Hospital when assisting the governing body of the Hospital in a professional review activity.

4. The term “adversely affecting” includes reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership.

5. The term “Board of Medical Examiners”, “Board of Dental Examiners”, and Board of Nursing are those bodies established by law with the responsibility for the licensing of physicians, dentists, and Affiliated Health Care Professionals respectively.

6. The term “clinical privileges” includes privileges, membership, and the other circumstances pertaining to the furnishing of medical care under which a practitioner is permitted to furnish such care in the Hospital.

7. The term “medical malpractice action or claim” means a written claim of demand for payment based on a health care provider’s furnishing (or failure to furnish) health care services including the filing of a cause of action, based on the law of tort, brought in any court of the State or the United States seeking monetary damages.

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B. STANDARDS FOR PROFESSIONAL REVIEW ACTIONS

1. For the purposes of the protection provided by Section 411(a) of the Health Care Quality Improvement Act of 1986 and in order to improve the quality of medical care, a professional review action shall be taken:
 - a. In the reasonable belief that the action was in the furtherance of quality health care;
 - b. After a reasonable effort to obtain the facts of the matter;
 - c. After adequate notice and hearing procedures are afforded to the practitioner involved or after such other procedures are fair to the practitioner under the circumstances; and
 - d. In the belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after adequate notice and hearing procedures are afforded.
2. A professional review action shall be presumed to have met the preceding standards unless the presumption is rebutted by a preponderance of evidence.
3. Impaired Practitioners: The MUSC Medical Center subscribes to and supports the South Carolina Medical association's policies and procedures on impaired practitioners. The staff will support and follow procedures of the South Carolina Medical Association Impaired Physician Committee in dealing with any practitioner who has an addiction to drugs and/or alcohol which impairs his ability to function or otherwise disables him from the practice of medicine.

C. ADEQUATE NOTICE AND RIGHT TO HEARING

1. Notice of Proposed Action – the practitioner shall be given a notice stating:
 - a. [1] that a professional review action has been proposed to be taken against the practitioner;
[2] the reasons for the proposed action; and
 - b. [1] that the practitioner has a right to request a hearing on the proposed action;
[2] that the practitioner has thirty (30) days within which to request such hearing; and
2. The Notice of Right to Hearing to the practitioner shall also state that the request for hearing shall be delivered to the Chair of the Executive Committee personally or by certified, registered mail, restricted delivery.
3. The Notice of Right to Hearing shall additionally state that a failure on the part of the practitioner to make a written request for hearing within the thirty (30) day time period shall constitute a waiver of the practitioner's right to hearing and to any further appellate review on the issue.
4. The Executive Medical Director shall be responsible for giving the prompt written notice to the practitioner or any affected party who shall be entitled to participate in the hearing.
5. The Notice shall also state that, upon the receipt of Request for Hearing, the practitioner shall be notified of the date, time, and place and shall be provided with written charges against him or the grounds upon which the proposed adverse action is based.

D. NOTICE AND REQUEST FOR HEARING

1. If a hearing is requested on a timely basis, the practitioner involved shall be given additional notice state:
 - a. The time, place and date of a pre-hearing conference in order to review or clarify procedures that will be utilized;
 - b. The place, time and date of hearing, which date shall not be less than thirty (30) days after the date of the notice;
 - c. A list of witnesses (if any) expected to testify at the hearing on behalf of the Professional Review Body;
 - d. A statement of the time, place and nature of the hearing;

- e. A statement of the authority under which the hearing is to be held;
- f. Reference to any rules, regulations or statutes in issue; and
- g. A short and plain statement of the charges involved and the matters to be asserted.

E. CONDUCT OF HEARING AND NOTICE

- 1. If a hearing is requested on a timely basis, the hearing shall be held as determined by the Executive Medical Director of the Hospital:
 - a. Before an Arbitrator mutually acceptable to the practitioner and the Hospital;
 - b. Before a Hearing Officer who is appointed by the Executive Medical Director of the Hospital and who is not in direct economic competition with the practitioner involved; or
 - c. Before an ad hoc Hearing Committee of not less than five (5) MEMBERS OF THE Medical Staff appointed by the Chair of the Hospital Executive Committee. One of the members so appointed shall be designated as chair. No Medical Staff member who has actively participated in the consideration of any adverse recommendation or action shall be appointed a member of this committee.
- 2. The Hearing Committee, the Arbitrator, or the Hearing Office may issue subpoenas for the attendance and testimony of witnesses and the production and examination of books, papers, and records on its own behalf or upon the request of any other party to the case. Failure to honor an authorized subpoena may be grounds for disciplinary action against the subpoenaed party including, but not limited to, a written reprimand, suspension, or termination.
- 3. The personal presence of the affected party shall be required by the Arbitrator, Hearing Officer, or Committee. Any party who fails, without good cause, to appear and proceed at the hearing shall be deemed to have waived his rights to the hearing and to have accepted the adverse action, recommendations, or decision or matter in issue, which shall then remain in full force and effect.
- 4. Postponement of hearing shall be made only with the approval of the Arbitrator, Hearing Officer, or ad hoc Hearing Committee. Granting of such postponement shall be only for good cause shown and shall be at the sole discretion of the decision maker.
- 5. The right to the hearing shall be forfeited if the practitioner fails, without good cause, to appear.

F. RIGHTS OF THE PARTIES

- 1. In the hearing, the practitioner involved has the right:
 - a. To representation by an attorney or any other person of the practitioner's choice;
 - b. To have a record made of the proceedings, copies of which may be obtained by the practitioner upon payment of any reasonable charges associated with the preparation thereof;
 - c. To call, examine, and cross-examine witnesses;
 - d. To present evidence determined to be relevant by the Arbitrator, Hearing Officer, or Committee regardless of its admissibility in a court of law;
 - e. To submit a written statement at the closing of the hearing.
 - f. The hearing and all proceedings shall be considered confidential and all proceedings shall be in closed session unless requested otherwise by the affected practitioner. Witnesses and parties to the hearing shall not discuss the case except with the designated parties' attorneys or other authorized individuals and shall not discuss the issue outside of the proceedings.

G. COMPLETION OF HEARING

- 1. Upon completion of the hearing, the practitioner involved shall the right:
 - a. To receive the written recommendations of the Arbitrator, Officer or ad hoc Hearing Committee, including a statement of the basis for the recommendation, including findings of the fact and conclusions of law; and

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- b. To receive a written decision of the Hospital, including a statement of the basis for that decision.

H. CONDUCT OF HEARING

1. If the Hospital, in its sole discretion, chooses to utilize an ad hoc Hearing Committee, a majority of the Hearing Committee must be present throughout the hearing and deliberations. If a Committee member is absent from any part of the proceedings, he shall not be permitted to participate in the deliberations or the decision.
2. The Chair of the Hearing Committee, or his designee, shall preside over the hearing to determine the order of procedure during the hearing to assure that all participants in the hearing have a reasonable opportunity to present and respond to relevant oral and documentary evidence and to present arguments on all issues involved.
3. The Hearing Committee may recess the hearing and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the Hearing Committee shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties.
4. A record of the hearing shall be kept that is of sufficient accuracy to permit an informed and valid judgment to be made by any group that may later be called upon to review the record and render a recommendation or decision in the matter. The Hearing Committee may select the method to be used for making the record, such as the court reporter, electronic recording unit, detailed transcription or minutes of the proceedings. The minutes shall be transcribed at the request of any party.
5. All oral evidence shall be taken only after an Oath of Affirmation.

I. EVIDENTIARY MATTERS IN CONTESTED CASES

1. Evidence determined to be relevant by the Hearing Officer, Arbitrator, or ad hoc Hearing Committee, regardless of its admissibility in a court of law, shall not be excluded.
2. Documentary evidence may be received in the form of copies or excerpts, if the original is not readily available. Upon request, parties shall be given an opportunity to compare the copy with the original.
3. Notice may be taken of judicially cognizable facts. In addition, the Hearing Officer, Arbitrator or ad hoc Hearing Committee may taken notice of generally recognized technical or scientific facts within the Committee's specialized knowledge. Parties shall be notified either before or during the hearing of the material noticed, including any staff memoranda or data, and they shall be afforded an opportunity to contest the material noticed. The Committee's experience, technical competence and specialized knowledge shall be utilized in the evaluation of the evidence.

J. BURDEN OF PROOF

1. When a hearing relates to the following:
 - a. Denial of staff appointment;
 - b. Denial of requested advancement in staff category;
 - c. Denial of department, service, or section affiliation; or
 - d. Denial of requested clinical privileges.

The practitioner who requested the hearing shall have the burden of proving, by clear and convincing evidence, that the adverse recommendation or action lacks any substantial factual basis or that such basis or the conclusions drawn therefore are either arbitrary, unreasonable, or capricious.

K. REPORT AND FURTHER ACTION

1. At the conclusion of the final hearing, the Arbitrator, Hearing Officer or the ad hoc Hearing Committee shall:
 - a. Make a written report of the conclusions and recommendations in the matter and shall forward the same, together with the hearing record and all other documentation considered by it, to the Chair of the Executive Committee. All findings and recommendations by the Arbitrator, Hearing Officer or ad hoc Hearing Committee shall be supported by reference to the hearing record and the other documentation considered by it; and
 - b. After receipt of the report, conclusions and recommendations of the Arbitrator, Hearing Officer or ad hoc Hearing Committee, the Executive Committee shall consider the report, conclusions and recommendations and shall issue a decision affirming, modifying or reversing those recommendations received.

L. NOTICE OF DECISION

1. The Chair of the Executive Committee shall promptly send a copy of the decision by written notice to the practitioner, the practitioner's chair, the Vice President for Academic Affairs, the Vice President for Medical Affairs, the Vice President for Clinical Operations and CEO and the President of the University.
2. This notice shall inform the practitioner of his right to request an appellate review by the Board of Trustees.

M. NOTICE OF APPEAL

1. Within ten (10) days after receipt of notice by a practitioner or an affected party of an adverse decision, the practitioner or affected party may, by written notice to the Executive Medical Director (by personal service or certified mail, return receipt requested), request an appellate review by the Board of Trustees. The Notice of Appeal and Request for Review, with or without consent, shall be presented to the Board of Trustees at its next regular meeting. Such notices requesting an appellate review shall be based only on documented record unless the Board of Trustees, within its sole discretion, decides to permit oral arguments.
2. If such appellate reviews not requested within ten (10) days, the affected practitioner shall have deemed to have waived his right to appellate review and the decision an issue shall become final.

N. APPELLATE REVIEW PROCEDURE

1. Within five (5) days after receipt of Notice of Appeal and Request for Appellate Review, the Board of Trustees shall, through the Executive Committee, notify the practitioner, and other affected parties in writing by certified mail, return receipt requested, or by personal service, of the date of such review, and shall also notify them whether oral arguments will be permitted.
2. The Board of Trustees, or its appointed Review Committee, shall act as an appellate body. It shall review the records created in the proceedings.
 - a. If an oral argument is utilized as part of the review procedure, the affected party shall be present at such appellate review, shall be permitted to speak against the adverse recommendation or decision, and shall answer questions put to him by any member of the Appellate Review Body.
 - b. If oral argument is utilized, the Executive Committee and other affected parties shall also be represented and shall be permitted to speak concerning the recommendation or decision and shall answer questions put to them by any member of the Appellate Review Body.

3. New or additional matters not raised during the original hearings and/or reports and not otherwise reflected in the record shall only be considered during the appellate review upon satisfactory showing by the affected practitioner or party that substantial justice cannot be done without consideration of these new issues and further giving satisfactory reasons why the issues were not previously raised. The Appellate Review Body shall be the sole determinant as to whether such new information shall be accepted.
 4. The Board of Trustees may affirm, modify, or reverse the decision in issue or, in its discretion, may refer the matter back to the Executive Committee for further review or consideration of additional evidence. Such referral may include a request that the Executive Committee arrange for further hearing to resolve specified disputed issues.
 5. If the appellate review is conducted by a committee of the Board of Trustees, such committee shall:
 - a. Make a written report recommending that the Board of Trustees affirm, modify, or reverse the Decision in issue, or
 - b. Refer the matter back to the Executive Committee for further review and recommendations. Such referral may include a request for a hearing to resolve the disputed issues.
- O. FINAL DECISION BY THE BOARD OF TRUSTEES
1. After the Board of Trustees makes its final decision, it shall send notice to the President of the Medical University, the Executive Committee, the Executive Medical Director, and to the affected practitioner and other affected parties, by personal service or by certified mail, return receipt requested. This decision shall be immediately effective and final.
- P. ADEQUATE PROCEDURES IN INVESTIGATIONS OR HEALTH EMERGENCIES
1. Nothing in this section shall be construed as:
 - a. Requiring the procedures under this section where there is no adverse professional review action taken;
 - b. In the case of a suspension or restriction of clinical privileges for a period of not longer than fourteen (14) days during which an investigation is being conducted to determine the need for professional review action; or
 - c. Precluding an immediate suspension or restriction of clinical privileges, subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any individual.
- Q. REPORTING OF CERTAIN PROFESSIONAL REVIEW ACTIONS TAKEN BY HOSPITALS
1. In the event the Hospital:
 - a. Takes a professional review action that adversely affects the clinical privileges of a practitioner for a period of longer than thirty (30) days;
 - b. Accepts the surrender of clinical privileges of a practitioner:
 1. While the practitioner is under investigation by the Hospital relating to possible incompetence or improper professional conduct; or
 2. In return for not conducting such an investigation or proceeding; or
 - c. In the case where action is taken by the Hospital adversely affecting the membership of the practitioner, it is agreed and understood that the Hospital shall report to the appropriate State Board the following information:
 1. The name of the practitioner involved;
 2. A description of the acts or omissions or other reasons for the action or, if known, for the surrender of the privileges; and
 3. Such other information respecting the circumstances of the action or surrender as deemed appropriate.

Pursuant to Federal and State Statutes such reports to the State Boards will be reported to the National Practitioner Data Bank.

**ARTICLE XI
CONFLICT MANAGEMENT AND RESOLUTION**

I MEC and Medical Staff-

If a conflict arises between the Medical Executive Committee and the voting members of the Medical Staff regarding issues pertaining to the Medical Staff including but not limited to proposals for adoption or amendment of bylaws, rules and regulations, or medical staff policies and when MUSC Medical Center Policy A-115 Conflict Management does not apply, the voting members of the medical staff by a 2/3rds vote may appoint a Conflict Management Team consisting of six (6) Active members of the staff who are not on the MEC. In such an event, the action or recommendation of the MEC at issue shall not go into effect until thirty (30) days after the appointment of the Conflict Management Team, during which time the MEC and the Conflict Management Team shall use their best efforts to resolve or manage the conflict. If the conflict is not resolved, the Medical Staff, by a two-thirds (2/3) vote of the Active members may make a recommendation directly to the Board of Trustees for action.

II MEC and BOARD of TRUSTEES

If a conflict arises between the MEC and the Board of Trustees regarding a matter pertaining to the quality or safety of care or to the adoption or amendment of Medical Staff Bylaws, Rules and Regulations, or Medical Staff Policies and when MUSC Medical Center Policy A-115 Conflict Management does not apply, the Executive Director may convene an ad-hoc committee of MUSC Medical Center, Board of Trustees and Medical Staff leadership to manage or resolve the conflict. This committee shall meet as early as possible and within 30 days of its appointment shall report its work and report to the MEC and the Board of Trustees its recommendations for resolution or management of the conflict.

**ARTICLE XII
OFFICIAL MEDICAL STAFF DOCUMENTS**

The official governing documents of the Medical Staff shall be these bylaws, the Rules and Regulations of the Medical Staff, the Medical Staff Credentials Manual, the Fair Hearing Plan, and other Medical Staff policies pursuant to these bylaws. Adoption and Amendment of these documents shall be as provided below:

I BYLAWS

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. Neither the Medical Staff nor the Board of Trustees may unilaterally amend these bylaws and the authority to adopt or amend them may not be delegated to any group. If a conflict exists between the Bylaws and other documents as outlined in this section, the Bylaws will supercede.

A. Methods Of Adoption And Amendment- Amendments to these bylaws may be on recommendation from the MEC approved by the voting members of the Medical Staff or after notification to the MEC on a proposal directly from a two thirds (2/3) majority of voting Medical Staff to the Board of Trustees, 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 only when approved by the Board of Trustees.

A.

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Deleted: 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:

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Deleted: The Bylaws may be amended or revised after submission of the proposed amendment

Deleted: 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.

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- 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.

II Rules and Regulations and Other Related Documents- The MEC will provide to the Board of Trustees 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.

A. These manuals will be incorporated by reference and become part of these Medical Staff Bylaws. The MEC has the delegated authority to make amendments to the Rules and Regulations of the Medical Staff, the Credentials Manual of the Medical Staff, the Fair Hearing Plan and other Medical Staff policies as outlined in Article VII

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B. Alternatively the Medical Staff may propose an amendment to the Rules and Regulations and other afore mentioned associated documents directly to the Board of Trustees. Such a proposal shall require a two-thirds (2/3) majority vote of the Active Medical Staff and shall require notification to the MEC.

C. When there is a documented need for an urgent amendment to rules and regulations to comply with the a law or regulation, the voting members of the organized medical staff delegate the authority to the MEC to by a majority vote of the MEC members provisionally adopt such amendments and seek provisional Board of Trustees approval without prior notification to the medical staff. The MEC will immediately notify the Medical Staff of such provisional approval by the Board. The Medical Staff at its next meeting, or at a called meeting or through electronic communication will retrospectively review the provisional amendment. If there is no conflict between the organized medical staff and the MEC regarding the amendment, the provisional amendment stands. If there is a conflict over the provisional amendment(s) the Conflict Management process as outlined in Article X of these bylaws will be implemented. If necessary a revised amendment is then submitted to the Board of Trustees for action.

D. The Rules and Regulations of the Medical Staff, the Credentials Manual, the Fair Hearing Plan and the Policies of the Medical Staff are intended to provide the associated details necessary to implement these Bylaws of the MUSC Medical Staff.

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.

Approved by the Medical Executive Committee on, and by majority vote of the Medical Staff on

Revisions approved by the Board of Trustees as of this _____

Deleted: IV. RELATED PROTOCOLS AND MANUALS¶

Deleted: 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. ¶

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

***Medical Staff
Rules and Regulations***

January 2011

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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.

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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 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 seventy two (72) hours from the completion of operation/procedure. The signature of the primary physician/surgeon is required within 7 days of the procedure.

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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

For all inpatient and observation stays, a discharge summary must be completed within 72 hours of discharge with signature within 7 days of discharge. The discharge summary must include reasons for hospitalization, 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.

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For inpatient and observation stays less than 24 hours, in order to facilitate continuity and patient safety, an abbreviated discharge summary may be completed, but it must include the same elements as the previous paragraph.

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.

- a. Five days after discharge, if a patient's medical record is not completed the attending physician will receive notification that the chart is incomplete.

- b. 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.
- c. 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.
- d. The suspended physician cannot admit new patients to his or her care.
- e. The suspended physician can continue to provide care for those patients directly under his/her care prior to the suspension.
- f. 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

- a. 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).
- b. 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.