

# General Rules of the Marquette General Health System Medical Staff

## I. PATIENT ADMISSION, ALTERNATE COVERAGE, TRANSFER, DISCHARGE AND DEATH

### 1.1 ADMISSION CRITERIA

- 1.1-1 Who may admit patients. Only a Member with admitting privileges may admit or co-admit a patient to the Hospital. Except as provided for Qualified Oral Surgeons, Podiatrists and Independent Allied Health Professionals in the Medical Staff Bylaws, a physician Member will be responsible for the general medical care and treatment of every patient admitted to the Hospital. Medical care may be provided by a Resident, other specified professional personnel or Allied Health Staff members, Medical Students or Allied Health Students provided they are working under the supervision of a Practitioner with clinical privileges. Medical care will be provided only by Members and Hospital support staff authorized to perform such services.
- 1.1-2 Admission Information. An admitting Practitioner will provide the following information in the patient's medical record, if such information is available to the admitting Practitioner:
- (a) Provisional diagnosis.
  - (b) A valid reason for admitting the patient, including information to support the medical necessity and the appropriateness of the admission.
  - (c) Information needed to properly care for the patient being admitted.
  - (d) Information needed to protect the patient from himself/herself.
  - (e) Information needed to protect Hospital personnel and others from potential problems or dangers presented by the patient.
  - (f) Information deemed necessary by the Hospital.
- 1.1-3 Admission of potentially suicidal or dangerous patients. If an admitting Practitioner reasonably believes a patient admitted for other purposes is potentially suicidal or dangerous to himself/herself or others, the admitting Practitioner will promptly obtain a consultation from a suitable mental health professional. If, in the opinion of the consultant, there is a probability that the patient is suicidal or dangerous to himself/herself or others, appropriate action shall be taken.
- 1.1-4 Medical records responsibilities of admitting Practitioners: In addition to other responsibilities, each practitioner who admits a patient to the Hospital or is the patient's attending Practitioner is also responsible for the prompt completeness and accuracy of all medical records, for necessary special instructions, and for communicating reports of the condition of the

patient to the referring Practitioner.

- 1.1-5 Transfer of patients to another attending Practitioner: Whenever these responsibilities are transferred to another Practitioner, the transferring Practitioner will enter on the order sheet of the patient's medical record a note defining the transfer of responsibility.
- 1.1-6 Members with Courtesy privileges are limited to treatment, consultation or admission of no greater than 12 (twelve) patients per calendar year.
- 1.1-7 Members with Consulting privileges are limited to treatment or consultation of no greater than 12 (twelve) patients per calendar year.

## 1.2 ADMISSION OF EMERGENCY PATIENTS

- 1.2-1 Justification of "emergency" admissions. Practitioners admitting patients on an emergency basis will, as soon as possible after admission, document in the patient's medical record the justification for the emergency admission.
- 1.2-2 Transfer of Member responsibility of patients admitted through the Emergency Room. If a patient to be admitted does not have a personal physician or Qualified Oral Surgeon, then the Active category Member Physician on call in the Department or Service will be assigned to the patient, with patient consent.
- 1.2-3 Emergency Department treatment. An Emergency Department physician will be responsible for the medical treatment of all Emergency Department patients, until the patient is discharged or transferred from the Emergency Department. However, when an Emergency Department Physician reasonably believes that it is necessary, he or she will have the authority to require that a patient be seen by a Physician on-call from the Department to which the patient is to be admitted or any other Department the Emergency Department physician deems necessary. The Emergency Department Physician may be responsible for supervising any Resident, Medical Student or Allied Health Student who may attend the patient in the Emergency Department.
- 1.2-4 Emergency Physician Admitting Privilege. To facilitate the timely transfer of a patient from the Emergency Department to a medical-surgical hospital unit, an Emergency Department physician may submit an order for inpatient admission. After transfer from the Emergency Department, however, the attending physician assumes responsibility for medical evaluation and treatment of the patient.

## 1.3 COMMUNITY RESPONSIBILITY/ALTERNATE COVERAGE

- 1.3-1 Practitioner Absence. The Practitioner is responsible to assure coverage for their patients at all times. In the event an alternate Practitioner(s) is (are) not named or cannot be contacted, any Medical Staff officer or the

Chairperson for the appropriate Department will have the authority to call any Active category Member to provide care and treatment to the patient(s) in question. Failure of an attending Practitioner to meet these requirements will be considered a gross dereliction of duty and can result in summary suspension followed by permanent loss of all Privileges.

1.3-2 Patient Preference. Patient preference should be considered when assigning admitting physicians, transferring care and assigning coverage.

1.3-3 On-call Schedule. Pursuant to the Medical Staff Bylaws regarding categories of the Medical Staff, those Active and Senior Active (whether Provisional or not) category Members will be required to take part in a Departmental on-call schedule. Each Department and subspecialty category within the department will provide its own on-call schedule, assuring continuous, adequate coverage, including exceptions and changes and report in a timely fashion to the Hospital. Senior Active members may not be required to serve on Emergency Department call for unassigned patients, but may participate if the Member so desires or if departmental staffing necessitates taking call.

1.3-4 Admission to special care units. Patients admitted to special care units will be seen, and appropriate treatment orders written, by the attending or consulting Physician in accord with the unit policy. The following exceptions will apply: patients seen and evaluated by the attending physician or consultant in the Emergency Department immediately prior to transfer to special care units, patients seen in the office and then admitted directly to the special care unit, patients transferred from another unit in the hospital following evaluation by a physician, or patients admitted to a special care unit immediately postoperatively.

#### 1.4 CO-ADMISSIONS FOR DENTAL AND PODIATRIC TREATMENT

1.4-1 A patient who is admitted for podiatric or dental treatment will be co-admitted both by a Member who is a Podiatrist or Dentist and a Physician who will be responsible for managing the patient's known medical condition, except Qualified Oral Surgeons and Podiatrists with appropriate privileges may independently admit patients without known medical problems outside the oral cavity or scope of practice for podiatry, respectively. In the event of such co-admission, both the Podiatrist or the Dentist and the Physician will serve as attending Practitioners within their areas of responsibility.

#### 1.5 ADMISSION HISTORY AND PHYSICAL EXAMINATION

1.5-1 History and physical examination required. All patients admitted for inpatient care will have a history taken and physical examination performed and recorded no more than 30 days prior to admission or within 24 hours after admission. However, a history and physical examination will be documented in the medical record prior to the performance of surgery, including ambulatory procedures performed in the operating

room, except in a life-threatening emergency, defined herein as a situation where any delay in treatment caused by performance of administrative functions would be reasonably considered to endanger a patient's life or response to planned intervention. Otherwise, no patient may be taken to surgery unless the patient's history and physical exam report is in the patient's medical record.

- (a) The history will include the major complaint, details of the present illness, including when appropriate, an assessment of the patient's emotional, behavioral and social status, relevant past, social and family histories and an inventory of body systems.
- (b) The physical examination will reflect a comprehensive current physical assessment.
- (c) An updated history and physical examination reflecting any subsequent changes may be used when a patient is readmitted within 30 days for the same or a related problem, provided the original history and physical examination information is readily available.
- (d) Conclusions or impressions drawn from the admission history and physical examinations will be included in the medical record.
- (e) The course of action planned for the patient during the hospital stay will be included in the medical record.

1.5-2 Ambulatory procedures not performed in the operating suite that place the patient at significant risk require a brief history and physical.

- (a) The history & physical will include the reason for the procedure, significant past medical history (illnesses and procedures), current medications, allergies, plan for anesthesia, post-operative plan, recording of vital signs and examination of heart and lungs and part to be invaded.
- (b) Significant risk includes, but is not limited to, procedures with moderate sedation, or select designated procedures without moderate sedation, such as invasive radiology or invasive cardiology procedures as defined by Department policy.

1.5-3 History and physical examinations by oral surgeons, dentists or podiatrists.

- (a) Members who are Qualified Oral Surgeons and Podiatrists with such clinical privileges may, for patients they admit, perform history and physical examinations and assess the medical risk of proposed surgical procedures on patients with no known medical problem. For inpatients they co-admit who require care for their medical condition, Oral Surgeons and Podiatrists are responsible at least for

- the part of the history and physical related to their fields.
- (b) Members who are Dentists are responsible for that part of their patient's history and physical examination related to dentistry.

1.5-4 History and physical examination. Other Hospital professional staff with appropriate Privileges may be designated by an attending Practitioner to perform the history and physical examination; provided that the findings and conclusions of the designee will be confirmed and co-signed by the attending Practitioner.

1.5-5 Validating history and physical examination performed by non-MGH medical staff. MGHS physician may utilize a history and physical examination performed by a physician who is not on the MGHS medical staff for the purposes of preoperative assessment if:

- (a) The history and physical examination was performed within 30 days of the procedure.
- (b) The performing physician is licensed and believed to be in good standing with his/her medical staff.
- (c) The H&P is readily available and has been entered into the relevant preoperative records.
- (d) One of the two following methods is used to establish or redact the history and physical which is provided:
  1. The attending physician completes a stamped template entry on the H&P. That entry must then be signed with a legible signature (printed name or stamped name below the signature as needed), timed, and dated. The entry on the approved stamp for this purpose states "I have reviewed the History and Physical. It is accurate and complete except for \_\_\_\_\_."
  2. The attending physician prints or legibly enters the same information as in (1) in the medical record instead of using the stamped template.

## 1.6 PATIENT TRANSFER

1.6-1 Transfer of inpatients to other hospitals. No inpatient will be transferred to another hospital unless the patient has been seen by the Member ordering the transfer within 24 hours and the Member indicates the reason(s) for the transfer in the patient's medical record. Before making the transfer, arrangements for transfer will be made with the receiving facility to make sure that it has available space and qualified personnel to treat the patient and that it agrees to accept and provide the patient with appropriate care.

1.6-2 Types of situations requiring transfer to other hospitals. Inpatients with specific injuries or illnesses in need of specialized services not offered by the Hospital, will be transferred to an appropriate facility providing the needed specialized services.

## 1.7 PATIENT DISCHARGE

- 1.7-1 Written discharge order. Written discharge order may be written by the attending Member or a dependent AHP under the attending's supervision.
- 1.7-2 Exceptions to discharge by attending Member. No written discharge order is required in the following circumstances:
- (a) When a patient is removed pursuant to a disaster plan.
  - (b) When a patient leaves the Hospital against advice.
  - (c) Patient expiration.
- 1.7-3 Final diagnosis at discharge. At the time of discharge, the attending Member will state the patient's final diagnosis on the medical record, unless the Member is awaiting the pathologist's report, which will be stated in the medical record. When the pathology report is received, the final diagnosis will be promptly placed in the medical record.
- 1.7-4 Discharge Summary at discharge. The attending Member will record a complete narrative discharge summary. The discharge summary will include the condition of the patient on discharge, and any specific instructions given to the patient and/or family, including physical activity, medication, diet and follow-up care.

## 1.8 PATIENT DEPARTURE AGAINST MEDICAL ADVICE

- 1.8-1 Notification in reporting. If a patient threatens to leave or leaves the Hospital against advice without usual discharge, a notation of the event will be made in the patient's medical record. A discharge note will then be properly prepared by the attending Member(s).
- 1.8-2 Limitation on patient's right to discharge against medical advice. A competent patient generally has the right to leave the Hospital against the advice of the patient's attending Member. However, the Member has a responsibility, in the Member's discretion, to disallow a patient's departure under certain circumstances for community safety reasons.

## 1.9 TIME OF PATIENT DISCHARGE

- 1.9-1 It is the responsibility of each attending Member to discharge the attending Member's patients prior to 11:00 a.m. on the day of discharge whenever possible and reasonable.

## 1.10 BRAIN DEATH

- 1.10-1 Pronouncement of death. If a patient dies, the patient will be pronounced dead by the attending Practitioner, or his designee, or the medical examiner within a reasonable time.
- 1.10-2 Brain death protocol. Brain death is defined as the permanent cessation of all centers of the brain as evidenced by neurological assessment and neurodiagnostic tests. Determination of brain death will be made by a neurologist or neurosurgeon or a physician in consultation with the neurologist or neurosurgeon according to medical staff policy.

## 1.11 WITHDRAWING OR WITHHOLDING SERVICES

1.11-1 "Do not resuscitate" (DNR) and other orders limiting treatment modalities will be governed by Hospital policies on these subjects, which policies will be deemed incorporated into these Rules.

## 1.12 OBTAINING AUTOPSIES/AUTOPSY CRITERIA.

1.12-1 It is the duty of all Members to alert the acting Medical Examiner regarding deaths due to unclear or non-natural causes, in accordance with the following criteria:

- (a) Potential County Medical Examiner Cases. (Call Pathologist who is the acting Medical Examiner and inform of death).
  - 1. Permission for autopsy need not be obtained; the Medical Examiner will make the decision on whether investigation/autopsy should be done (based on laws and regulations of the State of Michigan).
    - A. A Member cannot request a "Medical Examiner autopsy".
    - B. If a Member desires an autopsy to be done on a case referred to the Medical Examiner, that physician should determine if the Medical Examiner intends to do an autopsy. If not, an autopsy can still be done as a non-medical examiner case if an appropriate permission is secured.
  - 2. Guidelines for contacting the Medical Examiner:
    - A. Death due to accident, homicide or suicide.
    - B. Death due to medical complications of injuries or other non-natural disease (time frame is irrelevant).
    - C. Death of patient in Hospital less than 24 hours, if the patient does not have documented illness which would explain demise.
    - D. Intra-operative or immediately postoperative death, if not due to obvious and documented natural disease (also applies to procedures).
    - E. Unexplained Sudden death.
    - F. Obstetric (maternal) death.
    - G. Death inpatient under custody.
- (b) Cases with Medical Aspects Making Autopsy Desirable
  - 1. Permission must be obtained, a non-medical examiner case cannot be done without appropriate permission.
  - 2. Guidelines:
    - A. Neonatal or fetal death.
    - B. Pediatric death.
    - C. Death of a patient currently in a protocol involving investigational therapy.
    - D. Obstetrical (maternal) death.
    - E. Unexpected deaths, or deaths in which the cause *is* clearly natural but is poorly understood.

The Attending Practitioner will be notified as to the time of the autopsy by the pathologist. When an autopsy is performed, the pathologist will record the provisional anatomic diagnoses on the medical record within 72 hours, and a final report will ordinarily be made part of the decedent's medical record within 60 days.

## **II. PATIENT MANAGEMENT, CONSULTATION AND UTILIZATION**

### **2.1 DAILY PATIENT VISITS**

2.1-1 A Hospital patient will be visited daily by his/her attending Practitioner(s) and/or the dependent Allied Health Professional (AHP) under that attending's supervision. Evidence of daily visits should be found in the patient's medical record through documentation in progress notes or orders (with the exception of rehabilitation care, which requires notations five days a week).

### **2.2 SPECIAL REQUEST FOR PATIENT VISIT**

2.2-1 If a patient's condition demands the presence and attention of the attending Physician, upon request and as soon as possible, the Practitioner will come to the hospital to attend to the patient, taking into consideration the immediate needs of other patients under the Practitioner's care. If attendance by the attending Practitioner is not possible within a reasonable time, based on the condition of the patient as described by the person communicating the request, then the attending Practitioner will instruct the nursing staff to call the Practitioner's alternate, who will then come to the Hospital as soon as possible to attend to the patient in question. If the attending Practitioner and the alternate Practitioner are both unable to come to the Hospital to attend to the patient within a reasonable time, then the nursing staff will notify the Chairperson of the Department, the COS, or the Vice-COS. The person contacted will then be responsible for arranging the immediate attendance of a Member in order to attend the needs of the patient in question.

### **2.3 SUICIDAL OR DANGEROUS PATIENTS**

2.3-1 For the protection of the patient's visitors and staff when a patient is or suspected to be dangerous to himself/herself or others, the attending Practitioner will request a consultation by a suitable mental health professional on staff at the Hospital, who will promptly examine the patient and make a record of consultation if the patient is suspected to be dangerous to himself/herself or others.

2.3-2 Any patient known or suspected to be suicidal in intent will be transferred to suitable facilities, if available.

### **2.4 PHYSICAL RESTRAINT OF PATIENTS**



2.4-1 The use of restraints will be governed by specific Hospital policies for those areas.

## 2.5 CONSULTATIONS

2.5-1 An attending Practitioner is primarily responsible for, when indicated, requesting consultation and obtaining a qualified consultant. The attending Practitioner will provide a written authorization to permit another Member to examine the patient. The level of consultation and management requested should be specified.

2.5-2 Responsibility of a consultant:

- (a) A consultation will be performed within 24 hours after it is received.
- (b) All consultations will include the performance and recording of a patient examination, as well as recording of the consultant's overall impressions and recommendations into the patient's medical record.

## 2.6 UTILIZATION

2.6-1 An attending Practitioner is required to document in the medical record continued justification and supportive evidence for the patient's continued stay. Documentation should include plans for post-hospitalization care.

# III. ORDERS BY STAFF MEMBERS AND RESIDENTS

## 3.1 WRITTEN ORDERS

3.1-1 Except in an emergency declared by the ordering Practitioner, all orders for medications, treatment or therapy must be:

- (a) Legibly written, or if illegible, rewritten or clarified; and
- (b) Signed, Dated and Timed. Any clarified order must be rewritten and signed in the patient's medical record within 48 hours after the order is clarified.

## 3.2 VERBAL ORDERS

3.2-1 A verbal or telephone order is treated as a written order if dictated to an authorized recipient. All orders for treatment will be in writing and given only by Members of the Medical Staff. An order will be considered to be in writing if dictated to licensed registered nursing personnel on the Nursing Unit, and those other individuals in their particular areas of care/service: licensed practical nurses, respiratory therapist, pharmacist, physical therapist, occupational therapist, speech therapist, dietitian and appropriate others. Orders dictated over the phone will be signed by the individual to whom dictated with the name of the physician per his or her

own name. Verbal orders for treatment and/or diagnostic orders must be signed, dated, and times by the Member within 48 hours or before discharge, whichever comes first. If the Member is unavailable or otherwise unable to attend this, a designated Member who is covering may do so.

### **3.3 AUTOMATIC TERMINATION OF MEDICATIONS**

3.3-1 All medication and treatment orders will be automatically terminated when the patient is transferred to the operating room for purposes of performing inpatient operative or surgical procedures.

## **IV. PATIENT MEDICATIONS/HIV TESTING**

### **4.1 HOSPITAL APPROVED MEDICATIONS**

4.1-1 All medications used in the Hospital, with the exception of medications used for bonafide clinical investigational purposes, will be approved as a Hospital Formulary medication by the Pharmacy and Therapeutics Committee. Medications under study for a bonafide clinical investigation will be approved by the Institutional Review Board. Use of dangerous and toxic medications will be subject to control pursuant to guidelines developed by the Pharmacy and Therapeutics Committee.

### **4.2 GENERIC/TRADE USAGE**

4.2-1 If a Member orders a medication by its trade name, then the pharmacist may dispense the medication by its generic name, unless the attending Member designates on the order next to the name of the medication "Dispense as written" or "DAW." If a Member names a specific manufacturer when ordering a medication, then the manufacturer's medication, if available in the Hospital, will be dispensed.

### **4.3 HOSPITAL FORMULARY**

4.3-1 The Hospital formulary is prepared and revised by the Pharmacy and Therapeutics Committee in conjunction with staff from the department of Pharmacy, and other appropriate departments and committees. No new medication may be admitted into the Hospital Formulary or stocked in the Pharmacy, except for controlled research, until after it has been authorized for marketing by the Federal Food and Drug Administration.

### **4.4 HUMAN IMMUNODEFICIENCY VIRUS (HIV) TESTING POLICY**

4.4-1 Testing for HIV is designed to diagnose current HIV infection in an individual. HIV testing is appropriately performed for the purpose of making a diagnosis, answering a patient's questions whether he or she is infected, conducting follow-up after potential exposure has occurred or

screening blood, organs, or other body substances prior to donation. However, routine testing of patients should not be used as a means of reducing the risk of exposure to HIV. The HIV Policy and procedures of the Hospital apply also to the Medical Staff of the Hospital.

## V. MEDICAL RECORDS

### 5.1 RESPONSIBLE PARTY

5.1-1 The attending Practitioner is responsible for the overall preparation, legibility, and timely completion of the medical record.

### 5.2 GENERAL CONTENT OF THE MEDICAL RECORD

5.2-1 Medical Records will include documentation of at least the following:

- (a) Identification data;
- (b) Medical history, including:
  - 1. The major complaint;
  - 2. Details of the present illness including, when appropriate, assessment of emotional, behavioral, and social status;
  - 3. Relevant past, social, and family histories;
  - 4. Allergies
- (c) Physical examination, reflecting a comprehensive current assessment;
- (d) Clinical reports, if any;
- (e) Diagnostic and therapeutic orders;
- (f) Evidence of appropriate informed consent;
- (g) Clinical observations;
- (h) Consultation reports, if any;
- (i) Operative reports;
- (j) Progress notes;
- (k) Final diagnoses;
- (l) Condition on discharge;
- (m) Discharge summary;
- (n) Autopsy report, if applicable.

### 5.3 HISTORY AND PHYSICAL EXAMINATION

5.3-1 General rule. The patient's history and physical report will include all pertinent findings resulting from an assessment of all body systems, including:

- (a) The necessity for admission and the plan for treatment;
- (b) When appropriate, the patient's emotional, behavioral, and social status, and relevant past social and family history;
- (c) Conclusions or impressions drawn from the history and physical examination; and

- (d) The course of action, including the plan for treatment, planned for the patient during the Hospital stay.

5.3-2 Exceptions. If a history and physical examination has occurred greater than seven (7) days but not more than thirty (30) days prior to admission, then a legible copy of the report may be used in the patient's Hospital medical record, provided, upon re-examination of the patient, there is documentation of no subsequent changes or the changes have been recorded at the time of admission.

Furthermore, if a patient is readmitted within 30 days with the same diagnosis, then a short admission note may be used. The short admission note may be written in the progress notes and must reflect the history and physical examination and any changes since discharge. No review of systems is required.

#### 5.4 ADMISSION NOTE

5.4-1 An admission note will be made by the attending Practitioner(s) or designee on all patients admitted into the Hospital. The note will include a concise summary of the patient's major complaint, conditions, and any changes or additions to the history and physical examination already performed and a provisional diagnosis and plan for evaluation and/or therapy. The note should also provide evidence justifying the need for admitting the patient. If a complete current history and physical examination is available in the medical record upon the patient's admission, then the admission note is not necessary.

#### 5.5 INFORMED CONSENT FOR SPECIAL PROCEDURES OR SURGERY

5.5-1 The Member who performs or supervises a service or procedure is responsible for adequately informing the patient and securing consent for a service or procedure from the patient. However, the process of documenting the informed consent, who may consent, and who must witness the signature on a consent form, will be provided in a Hospital policy addressing this subject.

#### 5.6 OPERATIVE OR PROCEDURE REPORTS

5.6-1 An operative or procedure report must be dictated or written immediately following inpatient or outpatient surgery to provide pertinent information for use by any other health care professional who is required to care for the patient. The operative or procedure report must include but not be limited to: a description of the findings, the technical procedures, the specimens removed (if any), the preoperative and postoperative diagnosis, estimated blood loss, the name of the primary surgeon and any assistants if pertinent.

If the practitioner chooses to write a progress note immediately following inpatient or outpatient surgery, the note must include the above-mentioned elements and be placed in the medical record prior to the patient leaving the treatment area. This progress note may suffice as the final operative report.

If the practitioner chooses to dictate the operative or procedure report immediately following inpatient or outpatient surgery, the practitioner must write a progress note that includes the above mentioned elements and place the note in the medical record prior to the patient leaving the treatment area.

## 5.7 COSIGNATURES OF ENTRIES BY RESIDENTS, ALLIED HEALTH PROFESSIONALS, STUDENTS AND MEDICAL STUDENTS

- 5.7-1 At a minimum, the discharge summary completed or dictated by a Resident and history and physicals completed or dictated by a Resident or Dependent AHP must be authenticated by the Practitioner.
- 5.7-2 Daily progress notes that are provided by the Resident must be authenticated by the supervising Member.
- 5.7-3 Documentation entered by the Medical Student must be authenticated by a supervising Physician, which may include a Resident. Teaching Physicians must follow CMS guidelines.

## 5.8 PROGRESS NOTES/DAILY VISITS

- 5.8-1 Progress notes will be maintained on all patients admitted to the Hospital and will be recorded at the time of observation. The progress notes will contain sufficient detail to permit continuity of care and transferability, to identify current and potential problems, and to reflect changes in conditions as well as results of treatment. Progress notes must reflect the seriousness and progress of the patient's illness and should be recorded as frequently as the condition indicates, but must be recorded at least daily to reflect daily visits by the attending Practitioner.

## 5.9 REPORTS OF TEST RESULTS

- 5.9-1 Reports of therapeutic procedures, including pathology and clinical laboratory examinations, radiology, and nuclear medicine examinations or treatment, and cardiopulmonary tests or treatment should be promptly completed, authenticated, and filed in the patient's medical record within 24 hours of completion, if reasonably possible. For reports from facilities outside of the Hospital, the source facility will be identified on the report.

## 5.10 POST-ANESTHESIA EVALUATION

- 5.10-1 The Physician, Anesthesiologist, or designee, must record post anesthetic visits including at least one note describing the apparent presence or absence of anesthesia-related complications. Each post anesthetic note

must be dated and timed. If a post anesthetic visit and record entry is not feasible because of early patient release from the Hospital, then the name of the Member responsible for the patient will be recorded in the medical record and the patient discharged according to the discharge criteria, as approved by the Medical Staff.

## 5.11 CONSULTATIONS

5.11-1 A consultant must record a summary of the consultant's findings and recommendations as soon as possible following the consultation, but not later than 24 hours after the consultation has taken place. The consultation report will reflect, when appropriate, actual examination of the patient and the patient's medical record. If the consultant recommends surgery, the consultant's recommendation and findings will be recorded in the patient's records prior to surgery, unless an emergency prevents timely recording.

## 5.12 DISCHARGE SUMMARY

5.12-1 A discharge or death summary will be dictated by the responsible Member following the patient's discharge or death. The summary will recapitulate the reason for the patient's hospitalization, any significant findings, procedures performed and treatment rendered, the condition of the patient on discharge, final diagnosis (pending final Pathology diagnosis if applicable) and any specific instructions given to the patient and/or family, including physical activity, medication, diet, and follow up care. The content of the medical record will be sufficient to justify the diagnosis and warrant the treatment and end result.

## 5.13 AUTOPSY REPORT

5.13-1 When an autopsy is performed, the provisional anatomic diagnosis must be recorded in the medical record within three days, and the complete report must be made part of the medical record within 60 days; however, if because of unavoidable delays in obtaining the results of special scientific tests or reliance upon reporting from outside consultants, the final report is not available within the 60-day period, a provisional report will be put in the chart within the 60-day period, the final report will be placed within the medical record within two business days after its receipt.

## 5.14 SYMBOLS AND ABBREVIATIONS

5.14-1 Symbols and abbreviations may be used in the medical record only when they have been approved by the Medical Staff Executive Committee. An approved explanation legend of the approved abbreviations will be distributed and kept on file in the Medical Records Department.

## 5.15 AUTHENTICATION OF ENTRIES

5.15-1 All clinical entries in the patient's medical record will be accurately dated and authenticated. Authentication means to establish authorship by written signature, identifiable initials or electronic signature. The use of a rubber signature stamp is prohibited.

## 5.16 COMPLETION OF THE MEDICAL RECORD

5.16-1 A medical record is considered complete when the required contents are assembled and authenticated.

## 5.17 DELINQUENCY OF MEDICAL RECORD

5.17-1 In accordance with the Medical Staff Bylaws, Members who fail to complete their medical records (including inpatient and outpatient records) within 21 days from the date of discharge or treatment may have their Privileges temporarily suspended until all of their charts are completed. Discharge summaries should be dictated within 7 days. Grace periods may be allowed for those Members who have notified the Medical Records department of a vacation or illness, which is one week in length or longer. Exceptions to this may be made by the COS or his/her designee.

## 5.18 CONFIDENTIALITY AND PRESERVATION OF MEDICAL RECORDS

5.18-1 Medical Records must be kept confidential and may be released only in accordance with Hospital policy. Unauthorized release or removal of medical records from the Hospital is grounds for disciplinary action, including immediate suspension of privileges as defined by the rules for Administrative Action. Unauthorized storage, sequestering or other handling of records that results in records being not immediately available or accessible to Medical Records or other practitioners is likewise in violation of policy and shall be grounds for immediate suspension of privileges through Administrative Action of the CEO, COS or their designees.

## VI. CONFLICT RESOLUTION (Remove Section)

### 6.1 NOTIFICATION OF PATIENT CARE CONCERN

6.1-1 If a Physician or nurse is concerned that a Provider's diagnosis, treatment or care of a patient may be inadequate or inappropriate, the concerned party will notify:

- a. If a Practitioner or AHP, the Department Chairperson or Division Chief of the other Provider; or

- b. If a Resident, the supervising Member to which the Resident is assigned or the training program director.
- c. If a Medical Student, Resident or the supervising Member to which the Medical Student is assigned.
- d. If an Allied Health Student, the supervising Member to which the Allied Health Student is assigned.

## 6.2 MEDICAL STAFF ACTION

6.2-1 The individual so notified in 6.1-1 will, upon reviewing the situation and possibly examining the patient and/or communicating with the patient's attending Member, take one of the following actions, giving telephone notice of such action to the person who notified him:

- a. Recommend to the CEO and the COS, or their designees, that an immediate administrative consultation takes place in accordance with the Medical Staff Bylaws.
- b. Advise the CEO and the COS, or their designees, that an administrative consultation will be considered upon further review and investigation; or
- c. Advise the CEO and the COS, or their designees, that no further administrative action need be initiated.

## 6.3 FURTHER ACTION

6.3-1 The CEO in turn may direct that the COS or others deemed appropriate by the CEO review the situation again or direct another Member to review the situation in question.

## VII. OTHER MISCELLANEOUS POLICIES

### 7.1 PUNCTUALITY AND IDENTIFICATION BADGES

7.1-1 Any Member conducting procedures must be available at the scheduled start of the procedure.

7.1-2 All medical staff members are required to wear system-approved photo identification badges in a place clearly visible to others while present on campus.

### 7.2 AGE SPECIFIC GUIDELINES (*eliminated 10-10-17*)

### 7.3 MEDICAL STAFF HEALTH POLICY

7.3-1 Delegated Authority and Purpose: The Board of Trustees ("Board") and Medical Staff ("Staff") have, consistent with their respective legal obligations respecting quality of care in the Hospital and the Medical Staff Bylaws ("Bylaws"), adopted this policy to resolve doubts concerning possible impairment of a Medical Staff member ("Member") of the Hospital



and to assure appropriate assistance and/or rehabilitation is available to aid a Member in retaining or regaining optimal professional functioning, consistent with protection of patients.

For the purpose of this policy, the Medical Staff delegates its authority to the Chief of Staff, or designee, and the Board delegates its authority to the Chief Executive Officer, or designee.

- 7.3-2 Impairment Definitions: For the purpose of this policy: "Impaired Member" is defined as one who is reasonably suspected to be unable to practice medicine with reasonable skill and safety to patients because of a physical or mental illness, including deterioration through the aging process or loss of motor skills, or excessive use or abuse of drugs including alcohol.

"Reasonably suspected of an impairment" means the subject Member, by his/her statements or his/her conduct as observed and reported by reliable sources, appears to have an impairment. Without limitation, observations by Hospital staff members or other persons with credible information of behavior suggesting the use of intoxicating substances or unusually erratic behavior shall be deemed to be grounds of "reasonably suspected" impairment".

- 7.3-3 Operative Provisions: In the event that a Member, while on Hospital premises or in any other patient care setting, is reasonably suspected of an impairment, the COS and/or CEO or their designee, shall be contacted. The COS and/or CEO shall meet with the subject Member and then, in consultation with the Chairperson of the Health and Well Being Committee (if available), decide what actions, if any, shall be taken. The COS or CEO (or their designee) may direct that the subject Member submit to testing or examinations by a health care professional(s) selected by the COS or CEO with report(s) of such testing and examination(s) submitted to the Medical Staff Executive Committee and the Board of Trustees. The COS or CEO shall be deemed to have "just cause" to suspend all or some of the subject Member's clinical privileges pursuant to the Bylaws if:

- (a) The Member fails to submit in a timely fashion to testing or examination after being directed to do so by the CEO or COS.
- (b) The Member prevents or obstructs the reporting of test or examination results to the COS and CEO, and secondarily to the Medical Staff Executive Committee.
- (c) The Member is, in the opinion of the CEO and COS, under the effects of a continuous impairment which subjects Hospital patients, the subject Member and/or other Hospital staff to danger to their well-being.

In the event of such suspension, the procedure set forth in the Bylaws for follow-up (investigation, corrective action proceedings, hearing and appeal) shall apply to the extent deemed necessary by the Medical Staff Executive Committee or subject Member.

Confidentiality of the Member seeking referral or referred for assistance will be maintained, except as limited by law, ethical obligation, or when the safety of a patient is threatened.

#### 7.4 HEARING AND APPELLATE REVIEW POLICY

##### 7.4-1 Right to a Hearing and Appellate Review.

- (a) When any Member receives notice of a recommendation of the MSEC that, if ratified by decision of the Board, will adversely affect the Member's appointment to or status as a member of the Medical Staff or the Member's exercise of clinical privileges, the Member shall be entitled to a hearing before the Hearing Committee of the Medical Staff. If the recommendation of the MSEC, following such hearing, is still adverse to the affected Member, the Member shall then be entitled to an appellate review by the Board before the Board makes a final decision on the matter.
- (b) When any Member receives notice of a decision by the Board that will affect his appointment to or status as a member of the Medical Staff or exercise of clinical privileges, and such decision is not based on a prior adverse recommendation by the MSEC with respect to which the Member was entitled to a hearing and appellate review, the Member shall be entitled to a hearing by a committee appointed by the Board. If such hearing does not result in a favorable recommendation, the Member shall then be entitled to an appellate review by the Board, before the Board makes a final decision on the matter.
- (c) All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this Policy to assure that the affected Member is accorded all rights to which the Member is entitled.

##### 7.4-2 Request for Hearing

- (a) The Chief Executive Officer shall be responsible for giving prompt written notice of an adverse recommendation or decision to any affected Member by certified mail, return receipt requested.
- (b) The failure of a Member to request a hearing to which the Member is entitled by these Bylaws within sixty (60) days and in the manner herein provided, shall be deemed a waiver of the Member's right to such hearing and to any appellate review to which the Member might otherwise have been entitled on the matter. The failure of a Member to request an appellate review to which the Member is entitled by these Bylaws within the time and in the manner herein provided, shall be deemed a waiver of the Member's right to such appellate review on the matter.

- (c) When the waived hearing or appellate review relates to an adverse recommendation of the MSEC or of a hearing committee appointed by the Board, the same shall thereupon become and remain effective against the Member, pending the Board of Trustee's decision on the matter. When the waived hearing or appellate review relates to an adverse decision by the Board, the same shall thereupon become and remain effective against the Member in the same manner as a final decision of the Board, provided for in 7.4-7. In either of such events, the Chief Executive Officer shall promptly notify the affected Member of his status by certified mail, return receipt requested.

#### 7.4-3 Notice of Hearing

- (a) Hearing date shall be not less than seven (7) days, nor more than thirty (30) days from the date of written receipt of the request for hearing; provided, however, that a hearing for a Member who is under suspension which is then in effect shall be held as soon as arrangements may reasonably be made, but not later than thirty (30) days from the date of receipt of such Member's request for hearing.
- (b) The notice of hearing shall state in concise language the time, date and location of the hearing, the acts or omissions with which the Member is charged, a list of specific or representative charts being questioned, and/or the other reasons or subject matter that was considered in making the adverse recommendation or decision. By 7 (seven) days prior to the scheduled hearing, the Member will furnish the CEO with a written response to the statement and reasons for the hearing as well as a list of the specific individuals the Member intends to call in support of the Member's position. Witness information will include: name, title (if applicable), specialty/degree (if applicable), address and phone number.

#### 7.4-4 Composition of Hearing Committee

- (a) When a hearing relates to an adverse recommendation of the MSEC, such hearing shall be conducted by the Hearing Committee of the Medical Staff. No staff member who has actively participated in the consideration of the adverse recommendation shall sit as a member of the Hearing Committee, unless it is otherwise impossible to select a representative group due to the size of the Medical Staff.
- (b) When a hearing relates to an adverse decision of the Board that is contrary to the recommendation of the MSEC the Board shall appoint a hearing committee to conduct such hearing, and shall designate one of the members of this committee as chairman. At least one representative from the Medical Staff shall be included on this committee when feasible.

- (c) A member or other person appointed to serve on the Hearing Committee shall not be disqualified from serving on the Hearing Committee merely because of prior participation in the investigation of the underlying matter and issue because of knowledge of the facts involved, or because of participation in an earlier disciplinary hearing involving the Member. However, if after receipt of notice of the proposed Hearing Committee, the Member shall have 7 (seven) days to submit written objections, if any, to the Hearing Committee members which the Member believes are in direct economic competition with the Member or are so biased against him/her as to prevent a fair hearing if they serve as a Hearing Committee Member. Such objections, if any, will be submitted to and reviewed by the CEO who shall determine in the CEO's good faith discretion as to whether or not the objections are meritorious.

#### 7.4-5 Conduct of Hearing

- (a) There shall be at least a majority of the members of the Hearing Committee present when the hearing takes place and no members may vote by proxy.
- (b) An accurate record of the hearing must be kept. The hearing shall be recorded by minutes prepared by a recording secretary selected by the CEO. Hearing Committee minutes shall be subject to approval and amendment by the Hearing Committee. Additional means of recording (e.g., electronic tape or court stenographer) shall be used only at the request, or with the consent, of the Hearing Committee.
- (c) The personal presence of the Member for whom the hearing has been scheduled shall be required. A Member who fails without good cause to appear and proceed at such hearing shall be deemed to have waived their rights in the same manner as provided in Subsection 2 of this Section 8 and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect as provided in said Subsection 2.
- (d) Postponement of hearings beyond the time set forth in these bylaws shall be made only with the approval of the Hearing Committee. Granting of such postponement shall only be for good cause shown in the sole discretion of the Hearing Committee.
- (e) The affected Member shall be entitled to be accompanied by and/or represented at the hearing by a member of the Medical Staff in good standing, by a member of their local professional society, or by legal counsel. The Hearing Committee may also, in its discretion, retain legal counsel.
- (f) The chairman of the Hearing Committee or 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 relevant oral and documentary evidence, and to maintain decorum.

- (g) The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule, which might make evidence inadmissible or objectionable in civil or criminal action. The Member for whom the hearing is being held shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become a part of the hearing record.
- (h) The MSEC, when its action has prompted the hearing, may appoint one of its members or some other Medical Staff members, or may retain legal counsel, to represent it at the hearing, to present the facts in support of its adverse recommendation, and to examine witnesses. The Board, when its action has prompted the hearing, may appoint one of its members or may retain legal counsel to represent it at the hearing, to present the facts in support of its adverse decision, and to examine witnesses. It shall be the obligation of such representative to present appropriate evidence in support of the adverse recommendation or decision, but the affected Member shall thereafter be responsible for supporting their challenge to the adverse recommendation or decision by an appropriate showing that the charges or grounds involved lack of any factual basis, or that such basis or any action based thereon is either arbitrary, unreasonable, or capricious.
- (i) The affected Member shall have the following rights; to call and examine witnesses called by either party, to introduce exhibits or written evidence, to cross examine any witness on any matter relevant to the issue of the hearing, and to rebut any evidence. If the Member does not testify, the Member may be called and examined as if under cross-examination.
- (j) The Hearing Committee may order that oral evidence be taken only on oath or affirmation administered by any person entitled to notarize documents in the State of Michigan.
- (k) The Hearing Committee may, without special notice, recess the hearing and reconvene the same 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 shall be closed. The Hearing Committee may thereupon, at a time convenient to itself, conduct its deliberation outside the presence of the Member for whom the hearing was convened.
- (l) Within seven (7) days after final adjournment of the hearing, the Hearing Committee shall make a written report with specific findings, and shall make a written recommendation based upon the evidence and findings. The report and the recommendation shall be forwarded, together with the hearing record and all other documentation, to the MSEC when its action has prompted the hearing. The report may recommend confirmation, modification, or

rejection of the original adverse recommendation of the MSEC or decision of the Board.

#### 7.4-6 Appeal to the Board

- (a) Within sixty (60) days after receipt of a notice by an affected Member of an adverse recommendation or decision made or adhered to after a hearing as above provided, the Member may, by written notice to the Board delivered through the Chief Executive Officer by certified mail, return receipt requested, request an appellate review by the Board. Such notice may request that the appellate review be held only on the record on which the adverse recommendation or decision is based, as supported by the Member's written statement provided for below, or may also request that oral argument be permitted as part of the appellate review.
- (b) If such appellate review is not requested within sixty (60) days, the affected Member shall be deemed to have waived his right to the same, and to have accepted such adverse recommendation or decision, and the same shall become effective immediately as provided in Subsection 2 of this Section 8.
- (c) Within seven (7) days after receipt of such notice of request for appellate review, the Board shall schedule a date for such review, including a time and place for oral argument, if such has been requested, and shall, through the Chief Executive Officer, by written notice sent by certified mail, return receipt requested, notify the affected Member of the same. The date of the appellate review shall not be less than seven (7) days nor more than sixty (60) days from the date of receipt of the notice of request for appellate review, except that when the Member requesting the review is under a suspension, which is then in effect. Such review shall be scheduled as soon as the arrangements for it may reasonably be made, but not more than thirty (30) days from the date of receipt of such notice.
- (d) The appellate review shall be conducted by the Board or by a duly appointed appellate review committee of the Board of not less than seven (7) members. The affected Member may be assisted and/or represented at any stage of the appellate review, by a member of the Medical Staff in good standing, by a member of his local professional society, or by legal counsel. The MSEC, the Board, and the appellate review committee, if any, may also be assisted by legal counsel.
- (e) The affected Member, or representative, shall have access to the report and record (and transcription, if any) of the hearing committee and all other material, favorable, that was considered in making the adverse recommendation or decision against the Member. The Member shall have thirty (30) days to submit a written statement in the Member's own behalf, in which these factual and procedural matters with which the Member disagrees,

and the reason for such disagreement, shall be specified. This written statement may cover any matters raised at any step, in the procedure to which the appeal is related. Such written statement shall be submitted to the Board through the Chief Executive Officer by certified mail, return receipt requested, at least seven (7) days prior to the scheduled date for the appellate review. A similar statement may be submitted by the MSEC or by the chairman of the Hearing Committee appointed by the Board. If submitted, the Chief Executive Officer shall provide a copy thereof to the Member at least seven (7) days prior to the date of such appellate review by certified mail, return receipt requested.

- (f) The Board or its appointed review committee shall act as an appellate body. It shall review the record created in the proceedings, and shall consider the written statements submitted pursuant to subparagraph (e) in this Subsection 6, for the purpose of determining whether the adverse recommendation against the affected Member was justified and was not arbitrary or capricious. If oral argument is requested as part of the review procedure, the affected Member shall be present at such appellate review and shall answer questions put to the Member by any member of the appellate review body. The Member, or their representative, shall be permitted to speak to whether the adverse action against the affected Member was justified and was not arbitrary or capricious. The MSEC or the Board, whichever is appropriate, shall also be represented by an individual who shall be permitted to speak in favor of the adverse recommendation or decision and who shall answer questions put to the Member by any member of the appellate review body.
- (g) New or additional matters not raised during the original hearing or in the hearing committee report, nor otherwise reflected in the record, shall only be introduced at the appellate review under unusual circumstances, and the Board or the committee thereof appointed to conduct the appellate review shall in its sole discretion determine whether such new matters shall be accepted.
- (h) If the appellate review is conducted by the Board, it may affirm, modify or reverse its prior decision, or, in its discretion, refer the matter back to the MSEC for further review and recommendation within thirty (30) days. Such referral may include a request that the MSEC arrange for a further hearing to resolve disputed issues. Within thirty (30) days after receipt of such recommendation after referral, the Committee shall make its recommendation to the Board as provided above.
- (i) The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Subsection 6 have been completed or waived. All action required of the Board may be taken by a committee of the Board duly authorized to act.

#### 7.4-7 Final Decision of Board

- (a) Within fourteen (14) days after the conclusion of the appellate review, the Board shall make its final decision in the matter and shall send notice thereof to the MSEC and, through the Chief Executive Officer, to the affected Member, by certified mail, return receipt requested. This decision shall be immediately effective and final, and shall not be subject to further hearing or appellate review.
- (b) Notwithstanding any other provisions of these bylaws, no Member shall be entitled as a right to more than one hearing and one appellate review on any matter which shall have been the subject of action by the MSEC, or by the Board, or by a duly authorized committee of the Board, or by both.

7.4-8 Health Care Quality Improvement Act of 1986: Those actions or recommendations which entitle a Member to a hearing pursuant to this Policy, are those matters the Hospital and Medical Staff reasonably believe represent “professional review action” and “professional review activity” which may “adversely affect” a “physician” pursuant to the Health Care Quality Improvement Act of 1986. In this respect, it is the intent and purpose of this Policy that the initiation and conduct of professional review actions hereunder comply with all material respects with the provisions of the Act.

## 7.5 MEDICAL STAFF DUES

7.5-1 All members of the Active and Provisional Active Staff shall pay such yearly dues as determined by the staff at its annual December meeting. Members of the other staff categories shall not be required to, but may, pay staff dues. Members of the staff on an approved Leave of Absence shall not be required to pay dues. *Certain Active Staff Members who exercise privileges only occasionally, such as locum tenens physicians, may have all or some medical staff dues waived by a majority vote of the MSEC.* New Medical Staff Members shall be required to pay the total Medical Staff dues. If the Medical Staff determines, at their Annual December Meeting, that additional Medical Staff assessments will be imposed (e.g. Medical Library contribution) the following prorated calculation will be utilized: Members joining the Staff between January 1 and March 30 will pay 100% of the assessment, Members joining the Staff between April 1 and June 30 will pay 50% of the assessment and Members joining after June 30 will not be required to pay the assessment.

## 7.6 RESIDENTS

- 7.6-1 (a) Residents shall, at all times, abide by the Bylaws and Rules and Regulations of the Medical Staff of Marquette General Health System and the policies of Marquette General Health System.
- (b) Residents will at all times have a designated attending, or supervisory, physician who is on the staff of Marquette General Health System.



- (c) All clinical activities of a Resident are to be supervised and directed by a qualified Member of the UPHS-Marquette Medical Staff who has the appropriate privileges for the activity being performed.
- (d) Residents may seek other patient care situations in the Hospital, but will first obtain the physician's agreement for supervision. Other circumstances where Resident involvement in emergent situations occur, the Resident may be involved as defined by the Rapid Response, Code 5 or Code Stroke policies
- (e) Medical Records:
  1. History and physicals, operative/procedure notes and discharge summaries must be co-signed by the attending physician and appropriate attestation statement applied, in accordance with the Bylaws.
  2. Specialty consults, other than to Family Medicine, Pediatrics or the Hospitalist Service, must be dictated by the attending physician. For Residents in other specialties, consults may be dictated only in their specialty.
  3. Timely dictation and completion of the Medical Record is the responsibility of the Resident and his/her attending physician and is subject to the restriction of privileges identical to that of the general medical staff.

## 7.7 MEDICAL STUDENTS

- 7.7-1
- (a) Medical Students shall comply with all the medical Staff Bylaws, Medical Staff Rules and Regulations and policies of the Hospital.
  - (b) At all times a Medical Student will have a designated attending physician.
  - (c) All clinical activities of a Medical Student are to be supervised and directed by a qualified member of the UPHS-Marquette Medical Staff who has the appropriate privileges for the activity being performed.
  - (d) Medical Records:
    - (1) Medical Students may document in the medical record (history & physicals, progress notes, discharge summaries, and procedure notes) provided they and their supervising physician follow CMS Teaching Physician Rules. If a student note is not for the medical record, but for educational purposes only, the document should be identified as such.
    - (2) In dictation, students should identify themselves by medical school, year and attending physician.
    - (3) All orders entered by Medical Students must be countersigned by the Resident or attending physician before the order is implemented. It is the responsibility of the student to obtain the signature.
    - (4) No Medical Student will give telephone or verbal orders.
    - (5) Under no circumstances will a Medical Student dictate or write operative notes or consultation notes. They may

- dictate a procedural note.
- (6) Legal restriction precludes certain activities by Medical Students. Students may not:
  - (A) Sign birth certificates;
  - (B) Sign death certificates;
  - (C) Complete any document requiring a physician's signature unless the document is countersigned by the responsible physician.

#### 7.7-2 ALLIED HEALTH PROFESSIONAL STUDENTS – Physician Assistant (PA)/ Nurse Practitioner (NP) Student

- (a) At all times a PA/NP Student, hereafter 'Student(s)', will have a designated attending Physician(s) and a PA or NP supervisor/s, both of whom are members of the medical staff in good standing.
- (b) Students shall comply with all of the Medical Staff Bylaws and Rules and Regulations and policies of the Hospital.
- (c) Students may participate in patient care activities under the direction of a member of the UPHSM Medical Staff noted in (a). The designated attending physician and supervising PA/NP must have the appropriate privileges for the student activity being performed.
- (d) The supervising PA/NP must have a "Physician – Mid-level Supervision Plan" in force, authenticated, and on file in the respective PA/NP's professional file.
- (e) Medical Records:
  - (1) In dictation, students should identify themselves by their program school, year and supervising PA/NP.
  - (2) All orders written by Students must be countersigned by the supervising PA/NP and/or one of the PA/NP's supervising attending physicians. It is the joint responsibility of the student and the supervising PA/NP to obtain required signatures.
  - (3) A student may write orders in the supervising PA/NP's absence, but the orders must be confirmed by that PA/NP or the attending physician by telephone, with a nurse on the line with both the student and PA/NP or attending physician before the orders may be carried out. The orders should be countersigned by the respective PA/NP physician within 24 hours. No student will give telephone orders.
  - (4) Under no circumstances will a student dictate or write operative notes or consultation notes.
    - (i) Legal restriction precludes certain activities by Medical Students. Students may not:
      - (ii) Sign birth certificates;
      - (iii) Sign death certificates;
      - (iv) Complete any document requiring a physician's signature unless the document is countersigned

## 7.8 Qualified Medical Person or Personnel

7.8-1 A Qualified Medical Person or Personnel, or "QMP", means an individual

other than a licensed physician, Allied Health professional (AHP), Resident physician, or Medical Student who has demonstrated current competency in the performance of Medical Screening Examinations (MSE) and has been approved by the Health System Advisory Board as qualified to administer one or more types of MSE/s and complete/sign a certification for transfer or disposition of a patient in consultation with a physician. The categories of non-physician practitioners who may be designated QMPs is set forth in the Medical Staff Bylaws or Rules & Regs and are approved by the Advisory Board. Ad hoc QMP designations of other categories of non-practitioners are not permissible.

*Amendments to General Rules & Regulations Approved by Board of Trustees:*

*Section 3.2-1 amended 1-24-2005*

*Section 7.5-1 amended 1-24-2005*

*Section 7.6-1 (e) amended 7-24-2006*

*Section 5.18-1 amended 5-21-2007*

*Section 5.17-1 was amended and 7.1-2 added 7-28-08*

*Section 1.12-1 amended 12-21-09*

*Section 3.2-1 amended 12-21-09*

*Section 1.5-1 amended 07-10-12*

*Section 3.2-1 amended 12-10-13*

*Section 1.5.5 added 01-27-14*

*Section 1.7-1 amended 03-24-14*

*Section 2.1-1 amended 04-28-14*

*Section 7.6-1(e) amended 08-21-14*

*Section 1.2-4 added 11-17-14*

*Section 5.17-1 amended 07-27-15*

*Section 7.8-1 added 07-27-15*

*Section 7.7-2 added 6-27-16*

*Section 7.2 Age Specific Guidelines eliminated; replaced with MS Policy 10-10-17*

*Sections 1.1, 1.2-3, 5.7, 6.1-1, 7.6-1, 7.7- amended 12-11-18*