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The Medical Executive Committee shall adopt Rules and Regulations and Policies and Procedures, as it deems appropriate for the proper conduct of the Medical Staff. Such rules and regulations and/or policies and procedures shall be considered part of the Bylaws, except that they may be amended at any regular meeting of the Medical Executive Committee without previous notice, by a two-thirds vote of a quorum of the Medical Executive Committee. Amendments shall become effective when approved by the Board of Trustees.

I. **ADMISSION AND DISCHARGE OF PATIENTS:**

A patient may be treated only by staff members who have submitted proper credentials and have been duly appointed to membership on the Medical Staff and hold clinical privileges except as otherwise provided by these Bylaws.

Only qualified practitioners (MD, DO, DPM, DDS, DMD) holding a current and valid license to practice in the State of New Jersey, may provide referrals and orders for physical, speech and/or occupational therapy.

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

In any emergency case in which it appears the patient will have to be admitted to a hospital, the practitioner shall, when possible, first contact the Admitting Department to ascertain whether there is an available bed.

Practitioners admitting emergency cases shall be prepared to justify to the Medical Executive Committee of the Medical Staff and the Administration of the Hospital that the said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient’s chart as soon as possible after admission.

Consult requests designated as “emergent” indicate that the requesting clinical provider wishes to present a patient to the appropriate on-call physician to the Emergency Department and that the patient’s condition requires the on-call physician’s prompt response. The on-call physician to the Emergency Department shall respond by telephone within twenty (20) minutes of receiving a call from hospital clinical staff. In addition, the treating physician present in the hospital and the on-call physician shall discuss and agree upon an appropriate in-person response time for the on-call physician. If the physicians are unable to reach an agreement as to an appropriate in-person response time for the on-call physician, the opinion of the treating physician present in the hospital shall govern. With regard to patients aged 18 or under, the in-person response time shall not be longer than sixty (60) minutes after the initial call to the on-call physician.
Physicians may admit a patient to the service of another practitioner when there is a prior agreement and approval of both physicians (e.g. coverage groups). The physician issuing the order to admit remains responsible for all care rendered to the patient until the covering physician physically attends the patient or issues a verbal or telephone order acknowledging his/her responsibility for the patient's care.

Patients may be transferred to the service (responsibility) of another physician only when the physician receiving the patient in transfer acknowledges and agrees to the transfer by written or verbal acknowledgement as stated above.

Each member of the staff shall name a member of the Medical Staff who may be called to attend his patients in an emergency or until he arrives. If an attending physician or his/her call coverage is not available, the President of the Medical Staff, or Chairman of the Department concerned, or VPMA/CE shall have authority to call any member of the active staff in such an event.

A patient to be admitted on an emergency basis who does not have a private practitioner may select any practitioner in the applicable department or service to attend him. Where no such selection is made, a member of the active staff on duty in the department or service will be assigned to the patient on a rotation basis where possible. The chairman of each department shall provide a schedule for such assignments.

The Medical Staff shall define the categories of medical conditions and criteria to be used in order to implement patient admission priorities and the proper review thereof. These shall be developed by each clinical department and approved by the Executive Committee.

**Patient Transfers:**

**Transfer within Ocean:**
- a. Emergency Room to appropriate patient bed.
- b. From critical care units to general care area.
- c. From temporary placement in an inappropriate geographic or a clinical service area to the appropriate area for that patient.
- d. No patient will be transferred without such transfer being approved by the responsible practitioner.

**Transfer from Ocean to another facility:**

This institution shall arrange safe transfer of patients to another facility when the patient’s medical condition exceeds the capacity and/or scope of services normally available at this institution or if patient requests a transfer.

The patient, or person acting on the patient’s behalf, must be informed of Ocean Medical Center’s obligation to treat and admit all patient’s requiring (Emergency Care) under COBRA/EMTALA laws and regulations, as well as the risks and benefits of a transfer. The patient must then be asked to consent to the transfer.
Documentation of compliance shall be documented in (EMTALA) Patient Transfer Record.

The admitting practitioner shall be held responsible for giving such information as may be necessary to assure the protection of others whenever his patients might be a source of danger from any cause whatever.

Qualified Medical Personnel under EMTALA

The following providers are approved and authorized to act as “qualified medical personnel” capable of performing medical screening examinations in the Emergency Department pursuant to the EMTALA regulations:

1. Physicians duly authorized by the Board of Trustees to provide clinical services in the Department of Emergency Medicine;

2. Physicians duly authorized by the Board of Trustees to provide clinical services at the Medical Center and treating their own patients in the Department of Emergency Medicine;

3. Mid level practitioners (such as physician assistants, advance nurse practitioners and certified nurse midwives for obstetrical patients only) who are duly authorized by the Board of Trustees to provide clinical services in the Department of Emergency Medicine and residents under the supervision of a physician.

For the protection of patients, the medical and nursing staffs and the hospital, certain principles are to be met in the care of the potentially suicidal patient:

Any patient known or suspected to be suicidal MUST have a consultation by a member of the psychiatric staff. After consultation, patients considered to be suicidal shall be admitted to a psychiatric unit with the consent of the attending physician. If there are no accommodations available in this area, the patient shall be referred, if possible, to another institution where suitable facilities are available. When transfer is not possible, the patient may be admitted to a general area of the hospital and as a temporary measure, special companionship provided.

Discharges

Patients shall be discharged only on a order of the attending physician. Should a patient leave the hospital 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.

Deaths

In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner or his designee within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the
Medical Staff. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease where-in the patient's course has been adequately documented to within a few hours of death. Policies with respect to release of dead bodies shall conform to local law.

Autopsy Procedure: Refer to Administrative Policy MHC-ADMIN-02-1034

II. MEDICAL RECORDS

A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Hospital and shall promptly and accurately complete the medical record for each patient. The responsible physician shall also provide the necessary special instructions and reports of the condition of the patient to the referring practitioner and to members of the patient’s immediate family. Whenever these responsibilities are transferred to another member of the Medical Staff, a notation referring to the transfer of responsibility shall be entered on the order sheet of the patient’s medical record.

Inpatients:

The attending physician shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. The physician's responsibility shall include an admission history and physical examination, an admitting note on emergency or urgent admissions, progress notes, operative reports when indicated, and a discharge summary.

Each patient admitted to the hospital shall have a medical history and physical examination that includes a provisional diagnosis performed by a physician, or other qualified practitioner granted privileges, within thirty days prior to admission or within twenty-four (24) hours after admission or registration or prior to surgery or a procedure requiring anesthesia services which ever comes first. Physicians admitting patients for less than twenty-four (24) hours or receiving only local anesthesia may use the “short stay” H&P form if, in their judgment, use of this form will accurately describe the patient’s medical condition and includes the information outlined below. All patients admitted for more than twenty-four (24) hours shall have a full H&P completed as outlined below. If the history and physical were performed within thirty (30) days prior to admission, the patient’s history and physical examination record completed by the practitioner shall be included in the medical record with any subsequent changes recorded at the time of admission or registration or prior to surgery or a procedure requiring anesthesia services. This report should include all pertinent findings resulting from an assessment of all the systems of the body. If a complete history has been recorded and a physical examination performed prior to the patient’s admission to the hospital, a reasonably durable, legible copy of these reports may be used in the patient’s hospital medical record in lieu of the admission history and report of the physical examination, provided these reports were recorded by a member of the Medical Staff. In such instances, an interval admission note that included all additions to the history and any subsequent changes in the physical findings must always be recorded.
For those patients readmitted for the same condition within thirty (30) days, a legible copy of the previous history and physical examination may be used in the patient’s medical record, provided any changes that may have occurred are recorded in the medical record at the time of admission.

A complete history and physical shall include: (refer to HIM –OMC Policy: Medical Record Content)

- Chief Complaint
- History of Present Illness
- Past Medical History, Past Surgical History, Family History and Social History
- Medications
- Allergies
- Review of Systems
- Physical examination by body systems
- Impression
- Treatment plan

A complete history and physical is not required for patients expected to have a length of stay of less than 24 hours, or for patients receiving only local anesthesia. A brief history and physical that includes the following elements is required:

- Reason for the procedure
- Significant past medical history
- Current medications
- Allergies
- Plan for anesthesia
- Postoperative plan
- Recording of vital signs, examination of heart, lungs and part to be invaded

Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Every acute care patient shall receive a visit by the attending physician or covering physician and that visit shall be reflected in the daily progress notes.

Operative reports shall include a detailed account of the findings at surgery as well as the details of the surgical technique. Operative reports shall be dictated by the operating surgeon or proceduralist immediately following surgery. If the operative report is not dictated, then a postoperative note should be written in the chart immediately following surgery and a full dictated operative report shall be dictated within 24 hours of the procedure.

The operative or other high risk procedure report shall include:

- The name of the member of the medical staff performing the procedure and his/her assistant;
- Preoperative Diagnosis
- The postoperative diagnosis
d. The name of the anesthesiologist and anesthetic administered

e. The name(s) of the procedure(s) performed;

f. A description of the procedure;

g. Findings of the Procedure(s);

h. Any estimated blood loss; and

i. Any specimen removed.

Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record.

All clinical entries in the patient's medical record shall be accurately dated, timed and authenticated. Signatures shall include the practitioner’s name in block lettering.

Documentation in the medical record may not include unacceptable abbreviations as defined in the medical staff policy on unacceptable abbreviations.

The records of a discharged patient including a discharge summary will be completed within a period of time that in no event exceeds thirty days following discharge on all medical records of patients hospitalized over 48 hours or any patient that has expired except for normal obstetrical deliveries, normal newborn infants and certain selected patients with problems of a minor nature. For these exceptions, a final summation-type progress note shall be sufficient. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. Medical Records should be completed prior to the time of discharge by the attending physician or designee. For all Medicare admissions, the admission order must be countersigned or validated by the admitting physician prior to discharge from the hospital, including telephone admitting orders.

Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records are the property of the hospital and shall not otherwise be taken away without permission of an Administrator. In case of readmission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient is attended by the same practitioner or by another. Unauthorized removal of charts from the hospital is grounds for disciplinary action of the practitioner to be determined by the Medical Executive Committee.

Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual. All such projects shall be approved by the Medical Executive Committee before records can be studied. Subject to the discretion of the administrator, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.
The patient's medical record shall be complete in accordance with the Medical Record Completion Policy.

Signatures:

a. All entries in the medical record shall be written legibly in ink or via CPOE, timed, dated and authenticated; Signatures shall include the practitioner’s name in block lettering.

b. The use of signature stamps and pencils is not permitted;

c. Covering physicians and/or associates may countersign verbal orders and other entries to the medical record when appropriate;

d. Users of electronic signatures shall comply with the NJ Hospital Licensing Standards (NJAC 8:43 G15.2b) and OMC administrative policies concerning such signatures.

The practitioner’s orders must be written clearly, legibly and completely. Orders that are illegible or improperly written will not be carried out until re-written or understood by the nurse. The use of “Renew”, “Repeat”, and “Continue Orders” are not acceptable.

The Medical Record Department will notify each practitioner one-week in advance of the number of charts that are incomplete along with a pre-scheduled suspension date.

The Medical Record Department shall notify each practitioner by phone forty-eight (48) hours prior to the suspension of his/her admitting privileges. The Medical Record Department shall notify the President of the Medical Staff by phone twenty-four (24) hours prior to the suspension of the practitioner’s admitting privileges. Any practitioner who receives two (2) such suspensions shall be notified prior to a third suspension by registered mail.

Three (3) such suspensions of his/her admitting privileges within any twelve (12) month period shall be sufficient cause for the physician involved to be referred to the Executive Committee for explanation of his failure to comply with the above requirements and for possible disciplinary action or reported to the NJ State Board of Medical Examiners.

Medical Record Suspension shall be enforced per HIM Medical Record Completion and Suspension policy.

Day Stay Patients:

For ambulatory procedures that require informed consent, the physician must complete a short stay H&P form. When an H&P is completed within 30 days prior to the procedure, an update is required after admission and prior to the procedure.

The medical record for same day procedures shall include at least:

The patient’s written informed consent
A pre-procedure assessment by the physician, with appropriate additions by dentists, or podiatrists, where indicated. This includes the procedure plan. A preoperative anesthesia note by the anesthesiologist, if applicable. Documentation of the history and physical examination performed by a physician within thirty days prior to the procedure or registration or prior to surgery or a procedure requiring anesthesia services whichever comes first. Preadmission testing results. Physician orders. A post procedure note by the performing physician. The physician’s discharge note, written prior to discharge from the hospital, which describes the disposition of the patient and discharge instructions.

III. GENERAL CONDUCT OF CARE:

The “attending physician” means the individual who is responsible for those requirements outlined in the Medical Staff Rules and Regulations, including the preparation of complete and legible medical record entries related to the specific care/service he/she provides and the prompt and accurate completion of the discharge summary. The admitting physician shall be the attending physician unless there is a transfer of care to another member of the Medical Staff.

At all times during a patient’s hospitalization, the identity of the attending physician shall be clearly documented in the medical record. Whenever the responsibilities of the attending physician are transferred to another physician, an order covering the transfer of responsibility will be entered in the orders of the patient’s medical record. The attending physician will be responsible for verifying the other physician’s acceptance of the transfer.

The attending physician shall provide continuous medical care and treatment of each patient in the hospital and shall document such care on a daily basis. Consultants shall document, at a minimum, at least once weekly until such consultative care is no longer required.

All clinical entries in the patient’s medical record shall be accurately timed and dated with signature authentication via block letters in the practitioner’s name under the signature.

The attending physician will provide the hospital with any information concerning the patient that is necessary to protect the patient, other patients, or hospital personnel from infection, disease or other harm, and to protect the patient from self-harm.

A general consent form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission. Access Services should obtain the form. When so notified, it shall, except in emergency situations, be the practitioner’s obligation to obtain proper consent before the patient is treated in the hospital. In addition, for special procedures, specific consent should be obtained.

Any credentialed licensed independent practitioner may give oral orders when the patient’s circumstances require. Acceptance of an oral order is limited to the following personnel functioning within his/her sphere of competence and with restrictions where noted:
a. A physician, dentist, or podiatrist with clinical privileges at this hospital;
b. A registered nurse
c. A pharmacist who may transcribe oral orders pertaining only to medications
d. A physical therapist, occupational therapist, speech therapist, recreational therapist, or dietician may transcribe oral orders pertaining only to their respective disciplines; and
e. A respiratory therapist may transcribe oral orders pertaining only to respiratory therapy treatments.
f. A physician assistant or nurse practitioner may transcribe oral orders received from his/her employer except in the intensive care units where the physician must speak directly with a hospital staff nurse.
g. A Licensed Radiology Technologist may receive orders classified as “add on” as reflex orders.

All oral orders shall be authenticated, date and time verbal orders as soon as possible or within 48 hours.

All telephone orders/verbal orders will be completed with the timeframe of Medical Record Completion (30 days).

All residents or fellows participating in a professional graduate education program shall be supervised by a licensed physician with appropriate clinical privileges. All portions of the medical record in which a resident or fellow has documented shall be reviewed by the supervising medical staff member. All residents and fellows shall hold either a permit issued by the New Jersey State Board of Medical Examiners or New Jersey license and therefore, no countersignatures are required. All prescriptions written by permit holders that are to be filled in an outpatient pharmacy shall be cosigned by a licensed physician as necessary.

The practitioner’s orders which are illegible or improperly written will not be carried out until rewritten or appropriate clarification is obtained consistent with the pharmacy policy.

All previous orders are cancelled following admission to or transfer from the intensive care units, and when patients go to surgery.

All orders for treatment and medication shall be in writing or into the electronic data processing system. The medication order must specify the name of the drug, dose, frequency and route of administration and be signed and dated by the prescriber.

Any qualified practitioner with clinical privileges in this hospital may be called for consultation within his/her area of expertise.

The attending physician is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. He/She will provide written authorization to permit another attending physician to attend or examine his/her patient except in an emergency.

Routine and emergency cases shall be disposed as follows:
a. Consult requests designated as “routine” indicate that the requesting physician wishes to present a patient to a specialist but the patient’s condition does not require emergency consultation and requires physician to physician communication. Physician consultation shall be performed and documented within 24 hours of the initial consultation request.

b. Consult requests designated as “stat” indicate that the requesting physician wishes to present a patient to a specialist and the patient’s condition requires the physicians prompt response. The treating physician and the consulting physician shall discuss and agree upon an appropriate in-person response time for the consultation.

The medical staff member shall be required to provide Medical Staff Services with their office, home, cell phone numbers and personal e-mail and any changes of such information. Home telephone numbers may be made available to the Administrator on call in the event of an unforeseen emergency.

Medical staff member’s e-mail addresses will not be distributed and shall not be used to promote private practice social events, announcements, or other non hospital related information. Any information distributed via e-mail, with the exception of clinical department or section information initiated by the Department Chair or Section Chief, shall require the approval/permission of the Medical Executive Committee or Medical Staff President.

IV. CONDUCT WITHIN THE HOSPITAL:

It is the policy of Ocean Medical Center’s medical staff and the Hospital that all individuals within the facilities be treated courteously, respectfully, and with dignity. To that end, the Hospital and Medical Staff require that all licensed independent practitioners conduct themselves in a professional and cooperative manner in the hospital. All such individuals shall refrain from disruptive, abusive, or otherwise inappropriate conduct toward hospital patients, employees, physicians, visitors, and other persons conducting business with the hospital.

If a licensed independent practitioner on the medical staff fails to conduct themselves appropriately, the matter shall be addressed in accordance with the Code of Conduct Policy.

Members of the Medical Staff should not treat themselves or members of their immediate family. In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. Except in emergencies, it is not appropriate for physician to write prescriptions for controlled substances for themselves or immediate family members.

V. EMERGENCY SERVICES:

The Medical Staff shall adopt a method of providing medical coverage in the emergency services department. This shall be in accord with the hospital’s basic plan for the delivery of such services, including the delineation of clinical privileges for all physicians who render
emergency care. A medical screening will be provided by qualified medical personnel as defined in the Medical Staff Bylaws.

The duties and responsibilities of all personnel serving patients within the emergency area shall be defined in a procedure manual relating specifically to this outpatient facility. The contents of such a manual shall be developed by the Emergency Department. When there may be an impression of conflict of interest, i.e. a practitioner or HPA employed in private practice or by a hospital outside the MeridianHealth Corporation, the practitioner or HPA shall not be permitted application to provide services within the emergency department or vice versa.

An appropriate medical record shall be kept for every patient receiving emergency service and shall be incorporated in the patient’s hospital record. The record shall include:

a. Adequate patient identification;

b. Information concerning the time of the patient’s arrival, means of arrival and by whom transported;

c. Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his arrival at the hospital;

d. Description of significant clinical, laboratory, and roentgenologic findings;

e. Diagnosis;

f. Treatment given;

g. Condition of the patient on discharge or transfer, and

h. Final disposition, including instruction given to the patient and/or family, relative to necessary follow up care;

i. Whether the patient left the hospital against medical advice or eloped.

Each patient’s medical record shall be signed by the practitioner in attendance who is responsible for its clinical accuracy.

There shall be a plan for the care of mass casualties at the time of any major disaster based upon the hospital’s capabilities in conjunction with other emergency facilities in the community. It shall be developed by a Disaster Planning Committee which includes members of the Medical Staff, the director of nursing services or designee, and a representative from hospital administration. The plan shall be approved by the Medical Executive Committee and the Board of Trustees.

Disaster Credentialing Plan – see the Medical Staff Disaster Credentialing Policy.

On Call day is 7:00 a.m. to 7:00 a.m. The responsibility for being on call shall take effect at 7:00 a.m. on the date listed on the schedule and end at 7:00 a.m. the following morning.

VI. CONTINUING AMBULATORY CARE SERVICES:

For patients receiving continuing ambulatory care services, the medical record contains a summary list. The summary list is initiated of the patient by the third visit and maintained thereafter. The summary list contains:
a. Known significant diagnosis and conditions;
b. Known significant operative and invasive procedures
c. Known adverse and allergic drug reactions
d. Known long term medications, including current medications, over the counter drugs, and herbal preparations.

VII. OPERATING ROOM:

It shall be the policy of the surgical units that except in severe emergencies, the preoperative diagnosis and required laboratory tests must be recorded on the patient’s medical record prior to any surgical procedure. If not recorded, the procedure outlined in Section II of the Rules & Regulations shall be enforced. In any emergency, the practitioner shall make at least a comprehensive note regarding the patient’s condition prior to induction of anesthesia and start of surgery.

A patient admitted for care by a dentist or podiatrist shall be the dual responsibility of the dentist or podiatrist and a physician member of the Medical Staff.

a. Dentist or Podiatrist Responsibilities:
   i. A detailed specialty oriented history justifying hospital admission;
   ii. A detailed specialty oriented examination and a preoperative diagnosis;
   iii. A complete operative report describing the findings and technique. All tissue removed shall be sent to the hospital pathologist for examination.
   iv. Progress notes as are pertinent to the specialty involved
   v. Clinical resume (or summary statement)

b. Physician’s Responsibilities:
   i. Medical history pertinent to the patient’s general health and a physical examination to determine the patient’s condition prior to anesthesia and surgery which shall be the admission history and physical examination.
   ii. Supervision of the patient’s general health status while hospitalized.

c. The discharge of the patient shall be on written order of the Dentist or Podiatrist.

Written, signed, informed surgical consent shall be obtained prior to the operative procedure except in those situations wherein the patient’s life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian, or next of kin, these circumstances should be fully explained on the patient’s medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken if time permits.

The anesthesiologist shall maintain a complete anesthesia record to include evidence of preanesthetic evaluation and postanesthetic follow up of the patient’s condition.

VIII. MEDICAL EXECUTIVE COMMITTEE
The Medical Executive Committee shall be composed of the President of the Medical Staff as its Chair, the other Officers of the Medical Staff, the Chairman of each of the clinical departments, the President of the hospital or his duly appointed designee, the Vice President of Medical Affairs or his equivalent (without vote) and two (2) members at large with one (1) alternate member at large. Active staff members holding the rank of Associate Attending, Full Attending, or Senior Attending are eligible for at large positions. Term of office shall be for two years.

Two members at large shall be elected by the voting members of the medical staff for two year terms. A minimum of three (3) nominees for member at large shall be recommended by the Nominating Committee. Elections shall be conducted in accordance with the Bylaws. Those nominees with the two highest numbers of votes shall be standing members at large. The nominee with the third highest number of votes shall serve as the alternate.

In order to be eligible for office, candidates must have done the majority of their hospital work at Ocean Medical Center in the two (2) years prior to their nomination and election.

The President of the Medical Staff appoints the chairs and members of the following committees:

- Blood Utilization
- Credentials Committee
- Critical Care
- Infection Control
- Medical Education
- Operating Room
- Patient Rights & BioEthics
- Pharmacy & Therapeutics
- Physician Computer Advisory
- Quality Improvement & Outcomes
- Strategic Planning
- Emergency Department Oversight

It is the policy of the Medical Staff to require its members who serve in a leadership position, either as a Medical Staff Officer, or as member of the Medical Executive Committee, or Chairmen of a Department, to discharge their duties in good faith. On an annual basis, each member of the Medical Executive Committee shall complete a disclosure statement in such form as established by the Board of Trustees. Each member of the Committee has an obligation to advise the President of the Medical Staff promptly of any change in the information contained in the disclosure statement.

Any member of the Medical Executive Committee having an interest in a contract or other transaction presented to the Committee for authorization, approval, or modification shall recuse themselves from the discussion, other than to present factual information or to respond to questions, and shall not vote

**IX. SPECIAL COMMITTEES**
The Medical Executive Committee and/or President of the Medical/Dental Staff shall have the authority to establish special committees or task forces as needed. These Committees or Task Forces shall remain in effect until the issue has been resolved or may be a permanently established committee. The Chair of the committee shall be appointed by the President of the Medical/Dental Staff who shall establish the committee’s purpose and timeframe. The Clinical Care Committee shall be a standing Special Committee.

**Clinical Care Committee:** The Clinical Care Committee is a subcommittee of the QI&O Committee and shall be composed of the Chair of the QI&O Committee as the subcommittee Chair, the President of the Medical Staff, the Vice President of the Medical Staff, and the Vice President of Medical Affairs/Clinical Effectiveness. The purpose of this committee shall be to investigate clinical areas of concern involving members of the medical staff and make recommendations to the Medical Executive Committees for action, which may be areas for improvement, correction or disciplinary action. Investigations resulting in the need for corrective action which impact the practitioner’s clinical privileges will follow the procedure as outlined in Article IX of the Medical/Dental Staff Bylaws.

If any member of the CCC has an economic or other conflict of interest with the LIP being investigated that member may self recuse or be recused by the President of the Medical Staff. If the President of the Medical Staff is being investigated, the immediate Past President of the Medical Staff shall function as the President for the investigation. Any interview with the LIP being investigated must be attended by at least two (2) members of the IC.

**X. CLINICAL DEPARTMENTS DESIGNATION**

The current Departments are:
1. Anesthesiology
2. Emergency Medicine
3. Medicine (including Cardiology, Family Practice, Gastroenterology, Geriatrics, Hematology/Oncology, Internal Medicine, Nephrology, Neurology, Pulmonary, Psychiatry, Psychology and other such medical specialties)
4. Obstetrics and Gynecology
5. Orthopedics (including Physical Medicine & Rehabilitation, Podiatry)
6. Pathology
7. Pediatrics
8. Radiation Oncology
9. Radiology

Each Department and special care unit must establish its own regulations and procedural rules. These must not conflict with the Medical Staff Bylaws and Rules and Regulations. Both the Executive Committee of the Medical Staff and the governing must approve them.

**XI. DUES AND SPECIAL ASSESSMENTS**
The amount of dues shall be determined by the Medical Executive Committee at their regular meeting in December of each year for the following year. The establishment of a special assessment may be made by the Medical Executive Committee which shall set the amount and designated use.

All members of the medical staff shall be required to pay annual dues except for consultant, honorary and emeritus staff.

Payment notices for dues shall be mailed to each practitioner in January of each year. Payment is due in full within 30 days of notification. If dues payments are not received in full within 30 days, a second certified notice will be mailed allowing 10 additional business days for receipt.

Failure to pay assessed dues or special assessments within 30 days of the due date will result in automatic suspension from the medical staff. Should the payment of dues not be received by the time of the practitioner’s scheduled reappointment, membership and privileges will automatically lapse with no right for review or appeal.

XII. MEDICAL STAFF FUNDS

Deposits will be made through Medical Staff Services to the Medical Staff Account(s). The Medical Staff Account(s) will be maintained at an FDIC approved bank and reconciled by Medical Staff Services.

Authorization to sign checks:
   a. Medical Staff President;
   b. Medical Staff Treasurer.

The Medical Staff Office will maintain receipts for all purchases/payments made utilizing the Medical Staff Account(s).

Authorized Expenditures:
   a. Expenses related to credentialing as invoiced;
   b. Medical Staff Stipends, quarterly;
   c. Charitable donations as approved by the Medical Executive Committee;
   d. Gifts or donation for the death or birth in the immediate family of a Medical Staff member or Ocean Medical Center staff member, not to exceed $500.00;
   e. Flowers for the hospitalization of a Medical Staff member or a member of their immediate family or Ocean Medical Center staff member, not to exceed $100.00;
   f. Daily newspaper(s) for the Medical Staff lounge;
   g. Expenses related to recognition events or holidays, i.e. Annual Physician’s Outing, National Doctor’s Day, holiday party/recognition gifts, etc.
   h. Expenditures not listed above, shall require approval by the Medical Executive Committee. Expenditures over $5000.00 shall require approval by the voting members of the Medical Staff.
If the funds are exhausted, no disbursements shall be made until such funds are available.

XIII. OBSERVERS

Observers in the hospital may be permitted on an individualized basis with the permission of the VPMA/CE upon written request from the supervising physician.

Under no circumstances will an observer be allowed to perform procedures or have access to patient records.

All such individuals are to follow proper behavior and conform to relevant hospital policies.

XIV. HEALTH PROFESSIONAL AFFILIATES

Health Professional Affiliates, credentialed through the medical staff process, shall be assigned to an appropriate clinical department or service as it relates to their supervising/collaborating physician, and will carry out activities subject to the department policies and procedures and in conformity with the applicable provisions of the Medical Staff Bylaws, Rules and Regulations, Department/Section Rules and Regulations, and Health Professional Affiliate Scope of Practice and Rules and Regulations.

At no time shall the HPA assume the responsibilities of the physician member. An HPA is not eligible to provide sole consultation and may only perform a preliminary review of the patient. The collaborating/supervising physician may not abdicate his role in providing medical care to the patient and must continue to provide daily visits to all patients of which he is the attending physician of record, or weekly visits to those patients for whom he is consulted.

XV. IMPAIRED PHYSICIANS OR NON EMPLOYED HEALTH PROFESSIONAL AFFILIATES – An impaired practitioner is defined as a “practitioner whose professional performance has been impaired as a consequence of alcohol abuse, the abuse of drugs other than alcohol, mental or emotional illness, dementia or a physical disability severe enough to impact on professional performance”. A physician or non employed Health Professional Affiliate with a suspected impairment shall be addressed in accordance with the Licensed Independent Practitioners – Health Policy.