

# **ORGANIZATIONAL MANUAL OF THE MEDICAL STAFF**

## **MEMORIAL HOSPITAL OF SOUTH BEND, INC. SOUTH BEND, INDIANA**

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## PART ONE. RESPONSIBILITIES AND AUTHORITY OF OFFICERS

### 1.1 **RESPONSIBILITIES AND AUTHORITY OF THE MEDICAL STAFF PRESIDENT**

The Medical Staff President, as the primary Medical Staff officer, the chief administrative officer of the Medical Staff, and the Medical Staff's representative in its relationships to others, has the following responsibilities and authority:

#### 1.1-1 **AS THE MEDICALSTAFF'S REPRESENTATIVE TO OTHERS**

- A. Transmit to the Board or the appropriate Committee(s) and to the Hospital President the views and recommendations of the Medical Staff and the Medical Executive Committee (MEC) on matters of Hospital policy, planning, operations, governance, and relations with external agencies; and transmit the views and decisions of the Board and Hospital President to the MEC and the Medical Staff Membership.
- B. Communicate and represent the opinions and concerns of the Medical Staff and its individual Members on organizational and individual matters affecting Hospital operations to the Board and the Hospital President.
- C. Oversee compliance on the part of the Medical Staff with the procedural safeguards and rights of individual Staff Members in all stages of the Medical Staff credentialing process.

#### 1.1-2 **AS THE CHIEF ADMINISTRATIVE OFFICER**

- A. Direct the efficient operation and organization of the administrative policy-making and representative aspects of the Medical Staff organization; work with the Hospital President to coordinate Medical Staff activities and policies with administration, nursing, support and other personnel and services; enforce compliance with the provisions of the Bylaws, Rules and Regulations, Policies, and Procedures of the Staff and the Hospital; enforce compliance with regulatory and accrediting agencies' requirements, and periodically evaluate the effectiveness of the Medical Staff organization.
- B. Be responsible for the agenda of and preside at all General and Special Meetings of the Medical Staff and of the MEC.
- C. Appoint, subject to MEC approval, Medical Staff Members to Committees formed to accomplish Staff administrative, environmental, or representation functions; unless otherwise provided in the Medical Staff Bylaws or this Manual,
- D. Review and enforce compliance with standards of ethical conduct and professional demeanor among the Members of the Medical Staff in their relations with each other, the Board, Hospital management, other professional and support staff, and the community.

#### 1.1-3 **AS THE CHIEF CLINICAL OFFICER**

- A. Supervise the clinical organization of the Staff, coordinate the delivery of services among the clinical services, and work with the Hospital President in coordinating activities of administration, nursing, support and other personnel and services with Medical Staff clinical units.
- B. Advise the Board, the Hospital President and the MEC on matters impacting patient and clinical services, including the need for new or modified programs and services, the need for recruitment and training of professional and support staff personnel, and the need for specific staffing patterns.

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## 1.2 **RESPONSIBILITIES AND AUTHORITY OF THE VICE PRESIDENT**

As the second ranking Medical Staff officer, the Vice President has the following responsibilities and authority:

- A. Assume all of the duties and responsibilities and exercise all of the authority of the Medical Staff President when the Medical Staff President is unable--temporarily or permanently--to accomplish the same by reason of illness, absence, other incapacity or unavailability, or refusal.
- B. Serve as a member of the MEC and Medical Staff Peer Review Committee (PRC).
- C. Perform such additional duties as may be assigned by the Medical Staff President, the MEC, or the Board.

## 1.3 **RESPONSIBILITIES AND AUTHORITY OF THE SECRETARY-TREASURER**

The Secretary-Treasurer has the following responsibilities and authority:

- A. Serve as a member of the MEC.
- B. Report on meetings of the Medical Staff and the MEC.
- C. Give proper Notice of all Medical Staff and MEC meetings.
- D. Supervise the collection of and account for any funds that may be collected in the form of dues, assessments, or otherwise.
- E. Prepare an annual financial report for transmittal to the Medical Staff at its Annual Meeting and to the Board and Hospital President, and prepare any other interim reports that may be requested by the Medical Staff President or the MEC.
- F. Perform such additional duties as may be assigned by the Medical Staff President, the MEC, or the Board.

## 1.4 **ROLES AND RESPONSIBILITIES OF DEPARTMENT CHIEF AND VICE-CHIEF**

The roles and responsibilities of Department Chief and Vice-Chief are delineated in the Bylaws.

## 1.5 **SPECIAL STAFF OFFICERS**

### 1.5-1 **DESIGNATION**

A Special Staff Officer is a Medical Staff Member serving full or part-time under contract or other working arrangement with the Hospital to perform medico-administrative or education functions. The current Special Staff Officer positions include: Director of Medical Education, Departmental Education Directors, Family Medicine Residency Program Director, and the Vice President of Medical Affairs.

### 1.5-2 **QUALIFICATIONS, SELECTION AND TERM**

#### A. **Vice President of Medical Affairs**

The Vice President of Medical Affairs will:

1. Report to the Hospital President and Chief Executive Officer and is charged with the duties of promoting, stimulating, and cultivating a climate that is supportive of the highest level of quality patient care and medical education.

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2. Be responsible for overseeing all of the professional and medical activities at the Hospital and acting as an advocate for quality care.
3. These activities will be carried out in conjunction with Medical Staff Officers and Department Chiefs.

When a Vice President of Medical Affairs is to be selected, an ad hoc Search Committee will be constituted for the purpose of recommending one or more qualified nominees for the office. It is recommended that the Search Committee include Members of the Active Staff in Good Standing, appointed by the President of the Medical Staff, the Hospital President, and the Chairman of the Board.

## **B. Director of Medical Education**

The Director of Medical Education must:

1. Be a Member of the Active Medical Staff and recognized for superior clinical and teaching abilities.
2. Have demonstrated executive and administrative ability in order to effectively supervise and organize various types of continuing medical education and medical student training activities.
3. Willingly and faithfully discharge the duties of office and work cooperatively with Medical Staff Officers, Hospital Administration, and the Board.

The Director is appointed by the Hospital President with the approval of the Medical Executive Committee. The term of office is continuous until resignation, retirement, or removal from office.

## **C. Departmental Education Director**

A Departmental Education Director must:

1. Be a Member of the Active Medical Staff and a member of the applicable Department.
2. Be recognized for superior clinical and teaching abilities.
3. Willingly and faithfully discharge the duties of office and work cooperatively with Medical Staff Officers, Hospital Administration, and the Board.

A Departmental Education Director is appointed to a two year term by the Director of Medical Education, subject to the approval of the Medical Executive Committee.

## **D. Family Medicine Residency Program Director**

The Program Director must:

1. Be a member of the Active Medical Staff and a member of the Department of Family Medicine.
2. Be board certified in Family Medicine.
3. Be recognized for superior clinical and teaching abilities.

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4. Have demonstrated executive and administrative ability.
5. Willingly and faithfully discharge the duties of office and work cooperatively with Medical Staff Officers, Hospital Administration, and the Board.

When a Program Director for the Family Medicine Residency is to be selected, an ad hoc Search Committee will be constituted for the purpose of recommending one or more qualified nominees for the office. The Search Committee will include at least three Members of the Active Staff in good standing appointed by the Medical Staff President, the Hospital President, and the Chairman of the Board. The Search Committee transmits its written report and nominations, together with supporting documentation, to the MEC. After review, the MEC transmits its written report and recommendation to the Board for action. Any minority views are also to be reported. If the Board does not approve the nomination, the nomination process will be repeated by the same or a newly designated Search Committee as the Board may direct. The Program Director's term of office will be as specified in any contract with the Hospital.

## 1.5-3

### **RESIGNATION AND REMOVAL**

#### **A. Resignation**

Any Special Staff Officer may resign from office at any time by giving written notice to the authority designated below. Such resignation, which may or may not be made contingent on formal acceptance, takes effect on the date of receipt or at any later time specified therein.

1. Director of Medical Education to the Hospital President
2. Departmental Education Directors to Director of Medical Education
3. Family Medicine Residency Program Director to the Hospital President
4. Vice President for Medical Affairs to the Hospital President

#### **B. Removal**

Removal of a Special Staff Officer will be governed by the terms of the Special Staff Officer's employment contract. The MEC may make recommendations for removal of a Special Staff Officer to the Hospital President, the Board, or others to whom the Special Staff Officer is responsible. A Departmental Education Director may be removed by the Director of Medical Education with the approval of the MEC. Grounds for removal of a Special Staff Officer include:

1. Failure to perform the duties of the position in a timely and appropriate manner.
2. Failure to continuously satisfy the position's specific qualifications.

## 1.5-4

### **RESPONSIBILITY AND AUTHORITY**

The Director of Medical Education is responsible to the Hospital President and the MEC and is charged with developing and supervising the policies and programs of the Department of Medical Education, providing overall direction and coordination for the Hospital's continuing Medical Education program and its medical student training activities, and performing such other duties as any employment contract delineates. The Departmental Education Directors are responsible for the coordination and planning of the continuing education needs and activities of their respective Departments and are responsible for participating in and supervising the teaching of medical students. The Family Medicine Residency Program Director is responsible to the Hospital President and the MEC and is charged with the overall direction and administration of the Family Medicine Residency Program and other responsibilities and authority as are delineated in any employment contract.

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## PART TWO. MEDICAL STAFF COMMITTEES AND DEPARTMENTS

### 2.1 **DESIGNATION**

There will be a Medical Executive Committee (MEC) and other Standing Committees as delineated in this Part which are responsible to the MEC.

### 2.2 **MEDICAL EXECUTIVE COMMITTEE**

#### 2.2-1 **PURPOSE**

The purpose, composition, functions, and reporting mechanisms for the MEC are delineated in the Bylaws.

#### A. **Circulation of Agenda**

The agenda will be provided to members of the Committee at least one week in advance of each Regular MEC Meeting.

#### B. **Request to Participate**

At least three (3) working days prior to a Regular MEC Meeting, any Staff Member or Privilege holder who does not hold a position on the Committee may, by written notice to the Medical Staff President, request to participate at the Meeting in the discussion of specific agenda items. Each such notice must make reference to the agenda items involved and must be supported by reasons for the request. The request to appear may be denied if the Medical Staff President believes that the request is not substantiated or that a denial is in the best interests of the efficient functioning of the MEC. The MEC must be informed of the request and of the action. The MEC may over-ride the Medical Staff President and postpone consideration of the item in question or otherwise allow participation by the requesting individual.

### 2.3 **AIR MEDICAL TRANSPORT COMMITTEE**

#### 2.3-1 **PURPOSE AND MEETINGS**

The purpose of the Air Medical Transport Committee is to oversee the operation of and address issues related to Memorial's Air Medical transport program, Memorial MedFlight, and Memorial's transfer system, TransferDirect. The Committee meets at least quarterly and reports to the MEC.

#### 2.3-2 **COMPOSITION**

The Air/Medical Transport Committee includes at least ten (10) Members of the Medical Staff representing as many as possible of the following specialties: emergency medicine, cardiothoracic surgery, obstetrics/gynecology, pediatrics (PICU), orthopaedic surgery, general surgery/trauma, cardiology, neurosurgery, medicine, and critical care medicine. Additional non-voting members may include the MedFlight Program Manager, Trauma Services Director, Outreach Transport Coordinator, Transfer Coordinator, Administrative Vice President, and other healthcare professionals who can contribute specialized or unique knowledge and skills

#### 2.3-3 **FUNCTION**

1. Review and revision of standing medical orders and other protocols for Memorial MedFlight helicopter personnel.
2. Development and oversight of transfer coordination procedures, including review of transfer conversations, between referral sources and Memorial Hospital.
3. Ongoing review of care provided to patients transported by Memorial MedFlight.

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## 2.4 **BYLAWS COMMITTEE**

### 2.4-1 **PURPOSE AND MEETINGS**

The Bylaws Committee fulfills Medical Staff responsibilities related to review and revision of the Medical Staff Bylaws, the Related Manuals, the Rules and Regulations, the Policy Manuals, and any forms promulgated in connection with these documents. It also assumes the responsibility for investigating and providing recommendations on such Administrative policy-making and planning matters and activities of concern to the Staff as are referred by the MEC. It also supervises overall Medical Staff compliance with accreditation and other regulatory requirements applicable to the Medical Staff or any of its clinical units. The Committee meets annually or as needed and reports to the MEC.

### 2.4-2 **COMPOSITION**

The Bylaws Committee includes at least five (5) Members of the Medical Staff. A representative of Administration serves without a vote.

### 2.4-3 **FUNCTION**

The Bylaws Committee conducts, on a periodic basis, a review and revision of the Medical Staff Bylaws, the Related Manuals, the Rules and Regulations, the Policy Manuals, and any forms promulgated in connection with these documents. These review activities are undertaken both as a good governance practice and in order to assist the MEC in fulfilling the document review responsibilities that are established in the Bylaws.

## 2.5 **CREDENTIALS COMMITTEE**

### 2.5-1 **PURPOSE AND MEETINGS**

The Credentials Committee coordinates the credentialing function of the Medical Staff by receiving and analyzing applications and issuing recommendations for appointment, reappointment, and Clinical Privileges. It also supervises the process and procedure for credentialing Allied Health Professionals. The Committee meets as often as necessary and reports to the MEC.

### 2.5-2 **COMPOSITION**

The Credentials Committee will be composed of at least five (5) Members of the Medical Staff. A representative of Administration serves without vote.

### 2.5-4 **CREDENTIALS REVIEW**

- A. Review, evaluate, and transmit written reports as required by the Bylaws or Credentialing Procedures Manual on the qualifications of each applicant, Member, or Privilege holder for appointment, reappointment or modification of appointment or grant or modification of Clinical Privileges.
- B. Review, evaluate, and transmit written reports on the qualifications of each Allied Health Professional and AHP applicant for the performance of specified services.
- C. Assist the MEC on the initiation, investigation, reviewing, and reporting of Corrective Action matters and any other matters involving the clinical, ethical, or professional conduct of any Member or Privilege holder assigned or referred by the MEC, the Board of Trustees, any Medical Staff Officer, the Hospital President, or any Department Chief or Committee Chair.
- D. Submit written reports monthly to the MEC and the Board on the status of pending applications or other credentialing matters including the specific reasons for any inordinate delay in the processing of any application.



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- E. Maintain, in conjunction with the Medical Staff office, a credentials file for each Medical Staff Member and Privilege holder including records of participation in Staff activities and results of Quality Assessment monitoring and utilization activities.

## **2.6 INFECTION CONTROL COMMITTEE**

### **2.6-1 PURPOSE AND MEETINGS**

The Infection Control Committee reviews infection reports and investigates causes of Hospital infections and makes recommendations concerning the prevention and proper isolation of infectious diseases. The Committee submits any findings of significant variances to the MEC and, where appropriate, to the Quality Assessment Committee. The Committee meets at least quarterly.

### **2.6-2 COMPOSITION**

Suggested membership includes at least five (5) Members of the Medical Staff from the Departments of Surgery, Medicine, Orthopaedics, Family Medicine, Obstetrics-Gynecology, Pediatrics, and Pathology. Representatives from Nursing Services, Administration, and other appropriate Hospital departments may serve without vote.

### **2.6-3 FUNCTION**

- A. Maintain surveillance over the Hospital Infection Control Program.
- B. Develop a system for reporting, identifying, and analyzing the incidence and cause of infections.
- C. Develop and implement a preventive and corrective program that is designed to minimize infection hazards, including establishing, reviewing, and evaluating aseptic isolation and sanitation techniques.
- D. Develop, evaluate, and review preventive, surveillance, and control policies and procedures relating to all phases of the Hospital's activities, including:
  - 1. Operating Rooms
  - 2. Delivery Rooms
  - 3. Special Care Units
  - 4. Central Sterile Processing
  - 5. Isolation procedures
  - 6. Prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment
  - 7. Testing of Hospital personnel for carrier status
  - 8. Disposal of infectious materials
  - 9. Environmental Services and Laundry sterilization and disinfection procedures by heat, chemicals, or otherwise
  - 10. Food sanitation and waste management
  - 11. Other situations as required.
- E. Coordinate activities with the Pharmacy and Therapeutics Committee.
- F. Conduct on a periodic basis, statistical studies of antibiotic usage and susceptibility/resistance trend studies in conjunction with the Pharmacy and Therapeutics Committee.

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## **2.7 LEADERSHIP AND SUCCESSION COMMITTEE**

### **2.7-1 PURPOSE AND MEETINGS**

The purpose of the Leadership and Succession Committee is to identify Medical Staff Members who have leadership capabilities and are willing to serve in leadership positions in the Medical Staff Organizational structure.

### **2.7-2 COMPOSITION**

Membership is as delineated in the Bylaws.

### **2.7-3 FUNCTION**

The Committee is to convene and offer nominees for Medical Staff Officers as delineated in the Bylaws, and is to verify the qualifications of other nominees for Staff Officers as described in the Bylaws.

## **2.8 MEDICAL STAFF PEER REVIEW COMMITTEE**

### **2.8-1 PURPOSE AND MEETINGS**

The Medical Staff Peer Review Committee (PRC) coordinates and monitors the Medical Staff data gathering and analysis components of the Medical Staff's Peer Review Program. It meets at least quarterly and as necessary. Oversight of the Peer Review Process is delegated by the MEC to the PRC

### **2.8-2 COMPOSITION**

The Medical Staff Peer Review Committee (PRC) includes at least 5 Practitioners appointed by the Medical Staff President representing the diverse medical specialties contained within the Memorial Hospital Medical Staff. The current elected Vice President of the Medical Staff is also a standing member of the Committee. The Vice President for Medical Affairs, acting as an Administrative representative, and Quality Management personnel also attend without vote. Refer to the Medical Staff Peer Review Policy for further information regarding the function of the Committee.

### **2.8-3 FUNCTION**

The Peer Review Committee transmits its findings to the MEC for informational purposes or for its recommendations. The Committee may, subject to MEC approval, designate Departmental Peer Review Bodies for those departments which request such designation. Departmental Peer Review Bodies shall establish themselves as Peer Review Bodies for purposes of confidentiality, shall be responsible only for peer review involving medical care provided by members of their department, and shall report to the Medical Staff Peer Review Committee.

## **2.9 ONCOLOGY CARE COMMITTEE**

### **2.9-1 PURPOSE AND MEETINGS**

The purpose of the Oncology Care Committee is to provide advice, consultation, and direction for the Oncology Unit, to establish and review policies and procedures for the provision of cancer care, to engender a holistic approach to patient care by the establishment of a multi-disciplinary team, and to determine needs for educational programs which will enable the provision of comprehensive care to the patient. The Committee meets at least quarterly and reports directly to the MEC on policies and procedures that affect Medical Staff Members or Privilege holders.

### **2.9-2 COMPOSITION**

Suggested membership for the Oncology Care Committee includes at least six (6) Members of the Medical Staff, including a radiation oncologist, medical oncologist, diagnostic radiologist, general surgeon, pathologist, and a cancer liaison physician. The cancer liaison

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may also fulfill the role of one of the suggested physician specialties. The Committee may also include without vote, the Cancer Program Administrator and representatives from the following: Radiation Oncology, Breast Care Center, Pain Center, Lymphedema program, Pediatric Oncology, Clinical Research, Oncology Nursing, Social Services, Quality Management, community representation, and a Certified Tumor Registrar (CTR).

## **2.10 OPERATING ROOM COMMITTEE**

### **2.10-1 PURPOSE AND MEETINGS**

The purpose of the Operating Room Committee is to address issues regarding operating room policies and procedures and to provide guidance on clinical, technological, and quality issues, and to provide input on new program development. The Committee meets every other month and reports to the MEC.

### **2.10-2 COMPOSITION**

Membership may include representation from the following specialties: anesthesiology, obstetrics-gynecology, ophthalmology, orthopaedic surgery, otolaryngology, pathology, radiology, general surgery, neurosurgery, plastic surgery, cardiothoracic surgery, and urology. Additional non-voting members include the Executive Director of Surgical Services, Director of Outpatient Surgery, and the Directors of Major Surgery.

### **2.10-3 FUNCTION**

- A. Review operating room policies and procedures.
- B. Review OR time allocations/blocks.
- C. Make recommendations regarding OR performance and efficiencies.
- D. Provide guidance on clinical, technological, quality issues, and new program development.
- E. Provide a forum for physician input and feedback.
- F. Address issues related to interpersonal conflict and disruptive behavior.

## **2.11 PHARMACY AND THERAPEUTICS COMMITTEE**

### **2.11-1 PURPOSE AND MEETINGS**

The purpose of the Pharmacy and Therapeutics Committee is to promote and maximize rational drug use within the Hospital. This purpose is both advisory and educational in nature. In an advisory capacity, the Committee recommends the adoption of, or assists in the formulation of, policies regarding the evaluation, selection, and therapeutic use of drugs in the Hospital. In an educational capacity, the Committee recommends or assists in the formulation of programs designed to meet the needs of the professional staff (physicians, nurses, pharmacists, and other healthcare practitioners) for complete and current knowledge on matters related to drugs and drug use. The Committee meets at least quarterly and reports to the MEC.

### **2.11-2 COMPOSITION**

The Committee is comprised of at least five (5) Members of the Medical Staff representing various Departments. Additional non-voting members may include the Director of Pharmacy, Director of Nursing, Administrative Vice President, and other healthcare professionals who can contribute specialized or unique knowledge and skills.

### **2.11-3 FUNCTION**

- A. Advise the Medical Staff and Hospital administration in matters pertaining to the use of drugs.

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- B. Advise pharmacy on the implementation of effective drug distribution and control procedures.
- C. Maintain a formulary system, whereby a formulary of drugs accepted for use in the Hospital is compiled and continually revised. The Committee will define operating policies and procedures for the formulary system including those governing generic substitution, therapeutic interchange, and investigational drugs. These policies and procedures will be made available to, and observed by all Staff Members.
- D. Establish programs and procedures which help ensure cost effective drug therapy.
- E. Participate in performance improvement activities related to the prescription, distribution, and administration of drugs.
- F. Direct drug usage evaluation studies, review the results of such activities, and initiate any necessary follow-up action.
- G. Establish educational programs for the Hospital's professional staff on matters related to drug therapy.
- H. Review adverse drug reactions occurring in the Hospital.
- I. Make recommendations concerning drugs to be stocked in Hospital patient care areas.

## **2.12 PHYSICIAN ASSISTANCE COMMITTEE**

### **2.12-1 PURPOSE AND MEETINGS**

The purpose of the Physician Assistance Committee is:

- A. To provide a service that can be performed for Practitioners by their colleagues, by recognizing and encouraging Practitioners who may be impaired and unfit for duty as a result of physical, psychiatric, or emotional illness, or as the result of alcohol or drug use, to submit themselves voluntarily to a peer review committee thereby negating the requirement of direct reporting to the Medical Licensing Board.
- B. To define the process for times when the situation ultimately deteriorates to the point of becoming a threat to patient care, and formal reporting to the Hospital Board is required, as well as the initiation of Corrective Action under the Medical Staff Bylaws, and, in the case of a Practitioner who is an employee of the Hospital, the Hospital's employee disciplinary action policies.
- C. To assist an individual Practitioner in active medical practice who had previously functioned in a competent and productive fashion and who has demonstrated behaviors that suggest impairment and inadequacy in his function as a Practitioner.
- D. To identify and manage matters of individual physician health which are separate from the medical staff disciplinary function.
- E. To provide education about Practitioner health, as well as the prevention of physical, psychiatric, or emotional illness and facilitate confidential diagnosis,

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treatment and rehabilitation of Practitioners who suffer from a potentially impairing condition.

- F. To assist and rehabilitate rather than discipline.
- G. To aid a Practitioner in retaining or regaining optimal professional functioning, consistent with protection of patients.

The Committee meets as needed and reports to the Medical Executive Committee.

## **2.12-2 COMPOSITION**

The Committee is comprised of at least five (5) Members of the Medical Staff representing various Medical Staff Departments. Additional non-voting members may include the Vice President for Medical Affairs and other healthcare professionals who can contribute specialized or unique knowledge and skills.

## **2.12-3 PROCEDURE:**

Impairment exists when a Practitioner exhibits a change in behavior which might compromise their ability to maintain the professional standards of practice established in this community and those mandated by law in the State of Indiana. Changes in behavior that demonstrate a failure to maintain such standards express themselves in many ways and to varying degrees. When a Practitioner is in this state, they are “impaired” and requires intervention. Until appropriate initial treatment and continuing care programs are completed, the Practitioner is still considered impaired.

If at any time during the diagnosis, treatment, or rehabilitation phase of the process, it is determined that a Practitioner is unable to safely perform the Privileges he or she has been granted, the matter will be forwarded to Medical Staff Leadership for appropriate Corrective Action that includes strict adherence to any state or federally mandated reporting requirements.

- A. Identifying the impaired Practitioner is the beginning of his/her recovery. The impairment may be self-reported by the Practitioner or it may be reported by colleagues or staff members. Prompt intervention and treatment are the next steps. Continuing care and monitored re-entry into professional, social, and family responsibilities represent the next phase in recovery. At this point, the Practitioner is not impaired, but recovering. As long as they exhibit satisfactory progress in a monitored program of assistance, they becomes more “recovered” and less “impaired.” After two years, the “repaired” state can be expected to become “fixed” in the chemically dependent Practitioner.
- B. Once a potential impairment has been identified, it falls to medical peers or hospital administrative staffs to initiate an immediate investigation, as the possibility of risk to the general public or patients from the potentially impaired Practitioner exists. Such assessment may lead to temporary Suspension of Privileges or other efforts to protect the individual patient. Once this has been achieved, the focus should be shifted to the Practitioner individually. The Practitioner should be confronted in a gentle and supportive way. The Practitioner may deny all difficulties or minimize problems, in which case, consistent efforts should be continued to provide help and guidance toward treatment and rehabilitation. It may be necessary to force further treatment as a requirement for resumption of Medical Staff Privileges, etc. Whenever possible, the goal should be to return the Practitioner, in a rehabilitated state, to competent

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practice, but with ongoing scrutiny through an identified and personalized monitoring system.

- C. When impairment is identified within the Hospital, the Physician Assistance Committee must be immediately available to act. Usually this involves meeting the Practitioner with at least two members of the Committee or the Medical Staff Officers; they never act alone.
- D. Practitioner impairment may be in the obvious areas of alcohol or other drug abuse, physical impairment, or in psychiatric disturbances, such as progressive depression or manic-depressive illness. Significant stress leading to impairment can also occur from sexual misbehavior, or severe financial and business problems leading to anxiety, etc.
- E. It is not the intention of the Physician Assistance Committee to address the issue of incompetence where lack of adequate training or skills is a problem unto itself and there pre-exists a particular complaint suggesting impairment.
- F. The Committee will meet on an as needed basis to review the treatment progress of Practitioners for whom they are advocating, and if necessary, interview these Practitioners personally. Special meetings should be held promptly when a new complaint of impairment arises against a Practitioner or a Practitioner in recovery relapses. The Director of Risk Management and the Vice President of Medical Affairs will serve as the coordinators of this program.
- G. The Medical Licensing Board of Indiana at 844 IAC 5-1-2(g) (2) requires a Practitioner who has personal knowledge, based upon a reasonable belief that another Practitioner has engaged in illegal, unlawful, incompetent, or fraudulent conduct in the practice of medicine, to promptly report such conduct to a peer review committee. This provision does not prohibit a Practitioner from promptly reporting the conduct directly to the Medical Licensing Board, ~~if he so chooses.~~

The regulation further provides that a practitioner who voluntarily submits himself to a peer review committee, or who is otherwise undergoing a course of treatment for addiction, severe dependency upon alcohol or other drugs or controlled substances, or for psychiatric impairment, where such treatment is sponsored or supervised by an impaired physician committee, is exempt from reporting to the Medical Licensing Board so long as the practitioner is complying with the course of treatment and so long as the practitioner is making satisfactory progress.

If a practitioner fails to comply with the peer review committee, or is not benefited by the course of treatment outlined by the peer review committee, then the chief administrative officer of the peer review committee, ~~or his~~ designee, or any member of the impaired physician committee is required to promptly report the facts and circumstances of the case to the Medical Licensing Board.

- H. Indiana's Peer Review Immunity Statutes provide immunity for any Practitioner serving on the Physician Assistance Committee as long as the actions are taken in good faith. Confidentiality of Committee proceedings and communications are protected. This legal framework empowers the Committee to advocate and monitor impaired Practitioners without interference from outside peer review organizations or fear of litigation.

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## **2.12-4 Guidelines for Dealing with Impaired Practitioners:**

- A. When Hospital personnel, a patient, or a patient's family expresses concern over the behavior of a Practitioner to a Hospital employee, then that Hospital employee must contact the Unit Director, Department Director, or the Nursing Supervisor immediately.
- B. The Unit Director, Department Director, or Nursing Supervisor will first confirm the Practitioner's behavior is inappropriate, and then will inform the Practitioner that it is necessary to contact the Chief of the Medical Staff Department.
- C. The Chief of the Department will talk with the Practitioner regarding their behavior. As a result of the conversation, if the Chief believes the Practitioner is unable to provide care to patients, then the Chief of the Department will arrange for appropriate transition of patient care and the incident will be documented for review.
- D. In the case where the Chief is not available, then the following people will be contacted in the following order:
  - 1. The Vice President for Medical Affairs.
  - 2. The President of the Medical Staff
  - 3. The President of the Hospital
- E. The Chief of the Department should contact a member of the Physician Assistance Committee or Risk Management and the Vice President of Medical Affairs for assistance in dealing with a Practitioner who may be impaired.
- F. The Practitioner may be requested to submit to drug screening as well as a blood/breath alcohol test. Failure to consent to such a request may be grounds for disciplinary action under the Medical Staff Bylaws and/or the Hospital's personnel policies in the case of an employed Practitioner.

With any type of drug/alcohol testing, i.e., breath, blood, or urine, the physician must sign a consent form. If the Practitioner refuses the testing, they should sign a form indicating refusal to submit to drug/alcohol testing.

If the Practitioner agrees to the test and is found to have a positive drug/alcohol level, the Chief of the Department or designee will inform the Practitioner they are to leave the Hospital. If the Practitioner refuses to leave the Hospital, then the Chief of the Department will contact either the President of the Medical Staff or President of the Hospital to Summarily Suspend their Clinical Privileges. Upon refusing to leave the Hospital, the Chief of the Department will arrange to have security escort the Practitioner off of Hospital premises. If the Practitioner is deemed impaired, transportation for the Practitioner should be arranged. In both situations, the Chief of the Department will assume immediate responsibility for the care of the Practitioner's patient(s), or will arrange for immediate care of the patient(s), if necessary.

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- G. A report of the incident will be given to the Physician Assistance Committee for further evaluation, if necessary. A report will also be given to the Chief of the Department for evaluation and may be placed in the Practitioner's quality assurance file. Information placed in a Practitioner's quality assurance file will be used to assess the credentials of that Practitioner for Clinical Privileges at Memorial Hospital.
- H. All actions taken in implementing these guidelines for dealing with impaired Practitioners shall be confidential and will constitute peer review activity.
- I. Information relating to the Physician Assistance Committee involvement with a Practitioner will be maintained in a file separate from quality assurance and credential files

## **2.13 SPECIAL CARE COMMITTEE**

### **2.13-1 PURPOSE AND MEETINGS**

The Special Care Committee is responsible for developing and enforcing policies and procedures for the activities of the Special Care Units: ICU, CCU, OHR, and medical and cardiac step down units. The Committee establishes guidelines for the use of special techniques and therapeutic agents, establishes criteria and guidelines for admission and discharge of patients in these units, and establishes guidelines concerning quality of care. This Committee is involved in special training, protocols, equipment needs of the units, and establishes guidelines for the activities of health care personnel. The Committee reports to the MEC and meets at least quarterly.

### **2.13-2 COMPOSITION**

Suggested membership for the Special Care Committee includes at least nine (9) Members of the Medical Staff including a pulmonologist, cardiologist, neurologist, CV surgeon, neurosurgeon, anesthesiologist, family medicine practitioner, and internist. A representative from Administration, Quality Management, and applicable hospital departments may serve without vote.

## **2.14 TRAUMA COMMITTEE**

### **2.14-1 PURPOSE AND MEETINGS**

The purpose of the Trauma Committee is to monitor and evaluate the quality, timeliness, and appropriateness of trauma care and to resolve any identified problems. The Committee meets at least quarterly and reports to the MEC.

### **2.14-2 COMPOSITION**

Suggested membership includes at least eight (8) Members of the Medical Staff from the Departments of Surgery, Anesthesia, Radiology, Emergency Medicine, Family Medicine, Otolaryngology, Orthopedics, Pathology, and Pediatrics. Also suggested is a thoracic surgeon and a neurosurgeon. Non-voting members may include the Emergency Department Nursing Director, the Trauma Clinical Nurse Specialist, and representatives from Quality Management and Administration.

### **2.14-3 FUNCTION**

- A. Review trauma cases according to quality care criteria.
- B. Coordinate the functions of the multidisciplinary response team.
- C. Review and evaluate pre-hospital trauma care.
- D. Make recommendations regarding hospital support services including Radiology,



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Laboratory, Blood Bank, and Central Sterile Processing.

- E. Collect and evaluate trauma data and make recommendations for changes in trauma care as appropriate.
- F. Report findings to the appropriate Department and/or Quality Assessment Committee.

## **2.15 CURRENT CLINICAL DEPARTMENTS**

The clinical Departments are Anesthesiology, Cardiac Services, Emergency Medicine, Family Medicine, Hospitalist Medicine, Medicine, Obstetrics/Gynecology, Ophthalmology, Oral/Dental Surgery, Orthopedics, Otolaryngology/Head and Neck Surgery, Pathology, Pediatrics, Psychiatry, Radiology, and Surgery.

## **PART THREE. MEETING PROCEDURES**

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### **3.1 NOTICE OF MEETINGS**

A schedule of Regular General Staff, Department, and Committee Meetings will be distributed to all Medical Staff Members at the beginning of each Medical Staff year. Notice of any Special Meeting of the Medical Staff, or any special Meeting of a Department, or a Committee will be distributed to the appropriate Medical Staff Members. Personal attendance at a Meeting constitutes a waiver of Notice of such Meeting, except when a person attends a Meeting for the express purpose of objecting, at the beginning of the Meeting, to the transaction of any business because the Meeting was not duly called or convened. No business shall be transacted at any Special Meeting except that stated in the Meeting Notice.

### **3.2 QUORUM**

The quorum requirement for the MEC, Credentials Committee, and the MSQA Committee shall be 30 percent. All other Medical Staff Department and Committee Meetings shall be those present and voting.

### **3.3 ORDER OF BUSINESS AT REGULAR MEETINGS OF THE MEDICAL STAFF**

The order of business at a Regular General Staff Meeting is determined by the Medical Staff President. The agenda includes as least:

- A. Review and acceptance of the minutes of the last Regular Meeting and any Special Meeting held since the last Regular Meeting.
- B. Administrative reports from the Medical Staff President and the Hospital President.
- C. The election of Officers and of representatives to Staff and Hospital Committees, if any such election is required by the Medical Staff Bylaws.
- D. Reports by responsible Officers, Departments, and Committees, and discussion on the overall results of the Staff's performance improvement activities and on the fulfillment of the other required Staff functions.
- E. New business.
- F. Optional education program.

### **3.4 MANNER OF ACTION**

Except as otherwise specified, the action of a majority of the members present and voting at a Meeting is the action of the group. Action may be taken by a Department or Committee without a Meeting by unanimous consent in writing setting forth the action taken and signed by each member entitled to vote.

### **3.5 MINUTES**

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Minutes of all Meetings shall be prepared including the vote taken on each matter. Copies of said minutes must be approved by the attendees, forwarded to the MEC, or the parent Committee in the case of a subcommittee, and made available to any Member of the Medical Staff upon request. A permanent file of the minutes of each Meeting shall be maintained.

## **3.6 PROCEDURAL RULES**

Meetings of the Staff, Departments, and Committees will be conducted according to the then current edition of Robert's Rules of Order. In the event of conflict between said Rules and any provision of the Medical Staff Bylaws or any of its Related Manuals, the latter shall prevail

<b>PART FOUR. AMENDMENT</b>
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## **4.1 AMENDMENT**

This Organizational Manual may be amended or repealed, in whole or in part, by following the procedures outlined in the Medical Staff Bylaws.

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## *CERTIFICATION OF ADOPTION AND APPROVAL*

*Adopted by the Medical Staff*

6/6/2011  
Date

*Approved by the Board of Trustees*

6/23/2011  
Date