ELKHART
GENERAL HOSPITAL

MEDICAL STAFF RULES AND REGULATIONS
EMERGENCY MEDICINE DEPARTMENT

Revised 2002, 2007; 8/11, 11/11, 01/12, 9/15
Reviews 2/96, 10/98, 3/99, 11/01, 4/02, 4/04, 3/10, 1/13, 4/20, 8/24

I. NAME. The name of the clinical department shall be: The Emergency Medicine Department of the Medical Staff of Elkhart General Hospital.

II. PURPOSE. The purpose of this clinical department shall be:

- **A.** To provide competent and quality medical care.
- **B.** To maintain a high level of professional performance with delineation of clinical privileges and continuing review of physicians' ethical conduct and professional performance.
- **C.** To provide an educational setting where appropriate.
- **D.** To formulate standard procedures for implementation of principles found within the general Medical Staff Bylaws and Rules and Regulations.
- **E.** It shall be incumbent upon the Emergency Department physicians to act in the best interest of the patients and shall secondly conduct themselves in a manner to promote the best interest of the hospital.
- **F.** To provide a medical screening examination to all patients who present to the Emergency Department. Any emergency medical condition identified during this examination will be treated promptly using all available resources.

III. DEPARTMENTAL MEMBERSHIP

- **A.** Membership obligations. A member of the Emergency Medicine Department is obligated
  1. To abide by the Medical Staff Bylaws, department and committee Rules and Regulations, and Policies.
  2. To accept and faithfully discharge Department assignments.
  3. To participate in fulfilling the requirements for providing emergency care.
  4. To serve in any capacity assigned in the disaster plan.
  5. To make a diligent effort to comply with legal requirements for incident reporting.
- **B.** Qualifications for membership. Physicians and APPs who have been appointed to membership on the Medical Staff as provided by the Bylaws, and who meet the following additional requirements:
  1. All newly appointed physicians will be residency trained in Emergency Medicine, and will be Board certified by either the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine within the established timeframe outlined in the Medical Staff Bylaws.
  2. All newly appointment APPs will have completed an accredited master's level nursing program and be certified by an APN/PA certifying body within the established timeframe outlined in the Medical Staff Bylaws.
- **C.** Appointment procedure. Initial appointment will be processed in accordance with the Medical Staff Bylaws.
- **D.** Reappointment process. Reappointment will be processed in accordance with the Medical Staff Bylaws.

IV. CLINICAL PRIVILEGES

A. Scope of privileges. Clinical privileges will be delineated on the approved Emergency Medicine Department core privileges form.

B. Granting of privileges. The granting of clinical privileges will be in accordance with the Medical Staff Bylaws.

C. Criteria for granting of privileges. Privileges are based upon education, clinical training, demonstrated skills and capacity to manage procedurally related complications.

1. Medical Staff. Physicians who are residency trained in Emergency Medicine, and will be Board certified by either the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine.

2. Advanced Practice Professionals working in the Emergency Department must be employed by the contracted Emergency Physician group, have completed an accredited master's level nursing program, be certified by an APN/PA certifying body, have a valid Indiana license as an Advanced Practice Nurse/Physician Assistant and carry malpractice coverage according to Indiana Statute including the Medical Malpractice Act.

3. All members of the Medical Staff are expected to intervene in the case of a life- or limb-threatening patient condition.

D. Provisional status. All newly appointed staff members shall be governed during their provisional status in accordance with policy 110.

E. Monitoring.

1. Monitoring of the quality of patient care provided by members will be done in accordance with the Medical Staff Bylaws, and the Performance Improvement Plan.

2. Monitoring will include the routine collection of patient care information based on approved objective criteria, assessment of the information to identify opportunities to improve care and to identify important problems in patient care, actions to improve patient care, monitoring to determine the effectiveness of the action, and documentation and reporting of the monitoring to the appropriate areas.

F. Additional privileges. Additional privileges may be requested, in writing, and will be processed in the same manner as listed above in IV.B. "Granting of privileges".

V. OFFICERS AND DUTIES

A. The officers shall be a Chairperson and a Vice Chairperson. Qualifications and duties are as outlined in the Medical Staff Bylaws. The Vice Chairperson shall assume all duties of the Chairperson during the Chairperson's absence.

B. Method of election for department officers. Department officers shall be elected by a majority of members present at a meeting at which a quorum is present.

VI. CONSULTATION

. Emergency Department physicians have the right and duty to call in consultants for matters beyond their ken. It is the responsibility of those consultants, when called, to respond when so requested, and to properly evaluate and make disposition of these patients as though they were their own private patients.

VII. DEPARTMENT MEETINGS

. Department meetings shall be held in accordance with the Medical Staff Bylaws.

A. Frequency of meetings. The Department shall meet at least on a quarterly basis. Additional meetings may be called by the Chairperson.

B. Purpose of meetings. The purpose of the meetings shall be to review and evaluate the quality and appropriateness of care provided to patients by the department and to discuss

any other matters concerning the department.

C. Quorum. A quorum shall be established by the presence of two physicians and a chairperson for any regular or special meeting.

D. Manner of action. The action of a majority of members present at a meeting at which a quorum is present shall constitute proper authorization.

E. Attendance at Department meetings. Active Staff physicians are required to attend at least 50% of the Department meetings and Medical Staff Business meetings. Advanced Practice Professionals with clinical privileges shall be invited (requested) to attend Department meetings and to take part in the Department activities but will not be eligible to vote. Administration and other hospital staffs shall also be invited to attend meetings.

VIII. DEPARTMENTAL COMMITTEES

A. Emergency Department Quality Improvement Committee (EDQIC).

1. Purpose. The Committee has the ongoing responsibility for Emergency Department quality assurance and peer review which will be done in accordance with Medical Staff Bylaws; and the Elkhart General Healthcare System Performance Improvement Plan.

2. Policy. The EDQIC functions according to established policy and criteria approved by the Emergency Department in accordance with monitoring guidelines established in the Medical Staff Bylaws, the Emergency Department Rules and Regulations, and policies. Based on their evaluations and proposed action plans, the EDQIC will make recommendations to the Emergency Department.

3. Meetings. The EDQIC will meet as needed, or as set by the Emergency Department chairman.

4. Composition. The Committee chairman and members are appointed by the Emergency Department chairman. Ex officio members will be the President and Director of Nursing and Medical Staff Professional Practice Evaluation Coordinator. Other standing members of the Committee are Radiology Department Chairman and a Hospitalist, or their designee. Ad hoc members of the Committee are Pediatric Department Chairman and Surgical Services Department Chairman, or their designee.

5. Quorum. The presence of two physicians and a chairperson shall constitute a quorum for all actions.

B. The Chairman may appoint special committees as are deemed necessary and appropriate.

IX. THE RULES OF ORDER. Any parliamentary questions not specifically resolved by the provisions set forth in the Medical Staff Bylaws or these Rules shall be subject to the latest edition of Robert's Rules of Order.

X. AMENDMENTS TO DEPARTMENT RULES AND REGULATIONS. These Emergency Medicine Department Rules may be amended, changed or repealed by a majority vote of the entire Department at any regular or special meetings through procedure established in the Bylaws.

XI. POLICIES AND PROCEDURES. Policies and procedures will be developed to manage the day to day functioning and the monitoring of quality of care of the Emergency Medicine Department. Policies and procedures will be developed and approved by this Department, and the Medical Executive Committee, and will be reviewed and revised every three (3) years.

XII. ADOPTION. These Rules and Regulations are hereby adopted, superseding and replacing any and

all previous Emergency Medicine Department Rules and Regulations, pursuant until such time as they are amended in accordance with the terms of the Medical Staff Bylaws.

ELKHART
GENERAL HOSPITAL

MEDICAL STAFF RULES AND REGULATIONS
FAMILY MEDICINE DEPARTMENT

Revised 2001, 2005, 2009, 2011, 2012, 2014, 2015
Reviews 3/96, 12/98, 4/99, 1/00, 12/01, 3/04, 12/05, 11/06, 2/07, 08/07, 04/10, 07/10, 08/10, 7/20

1. **NAME**. The name of the clinical department shall be: The Family Medicine Department of the Medical Staff of Elkhart General Hospital.

2. **PURPOSE**. The purpose of this clinical department shall be:
    1. To provide competent and quality medical care.
    2. To maintain a high level of professional performance with delineation of clinical privileges and continuing review of the ethical conduct and professional performance of physicians.
    3. To provide an educational setting where appropriate.
    4. To formulate standard procedures for implementation of principles found within the general Medical Staff Bylaws and Rules and Regulations.

3. DEPARTMENTAL MEMBERSHIP

1. Membership obligations. A member of the Family Medicine Department is obligated
    1. To abide by the Medical Staff Bylaws and Rules and Regulations, and department and committee Policies.
    2. To accept and faithfully discharge Department assignments.
    3. To participate in fulfilling the requirements for providing emergency care.
2. Qualifications for membership. Physicians, who have been appointed to membership on the Medical Staff as provided by the Bylaws, shall be qualified for appointment to the Family Medicine Department.
3. Appointment procedure. Initial appointment will be processed in accordance with the Medical Staff Bylaws. The Chairman will review all applicants.
4. Reappointment process. Reappointment will be processed in accordance with the Medical Staff Bylaws. The Chairman will review all reappointment applications.
5. All Family Medicine Physicians must be Board Certified and maintain their Board certification. Physicians who are Board Eligible must become Board certified within the two years in accordance with the American Academy of Family Physicians (AAFP) and the American College of Osteopathic Family Physicians (ACOFP).
6. Required certification.
    1. Physicians who are Board Eligible will need to have proof of compliance regarding life support certification until they become Board Certified. (Medical Staff Policy #910)
    2. For Board Certified Members, Basic Life Support (BLS) certification and/or Advanced Life support Certification(s) (ACLS, ATLS, PALS, NRP) is needed only if required by privileges.

4. CLINICAL PRIVILEGES

1. Scope of privileges. Clinical privileges will be delineated on the approved Family Medicine Department clinical privileges form. Effective 11/15/05, board certification in the specialty in which privileges are being requested is required for all new applicants in accordance with the Bylaws.

2. Granting of privileges. The granting of clinical privileges will be in accordance with the Medical Staff Bylaws.
3. Criteria for granting of privileges. Privileges are based upon education, clinical training, a demonstrated skills and capacity to manage procedurally related complications. An applicant must have completed an accredited residency in Family Medicine or documentation of appropriate education and/or experience.
4. Core privileges are defined as those privileges basic to Family Medicine and will be granted by the Family Medicine Department directly reportable to the Medical Executive Committee.
5. Some members of the Family Medicine Department, by virtue of special training, experience or documented competency, may desire more extensive privileges. These should be requested on the "Special Non-Core Privileges" portions of the privilege form and will be recommended with the joint approval of the Family Medicine Department and the specialty department involved.
6. Provisional status. All newly appointed staff members shall be governed during their provisional status in accordance with the Medical Staff Bylaws. The Family Medicine Department Quality Improvement Committee will review all newly appointed staff members at the end of their provisional year. During their provisional year, new physicians with privileges in the Family Medicine Department will have 20 cases retrospectively reviewed.
7. Monitoring.
    1. Monitoring of the quality of patient care provided by members will be done in accordance with the Medical Staff Bylaws, and the Quality Review Program.
    2. Monitoring will include the routine collection of patient care information based on approved objective criteria, assessment of the information to identify opportunities to improve care and to identify important problems in patient care, actions to improve patient care, monitoring to determine the effectiveness of the action, and documentation and reporting of the monitoring to the appropriate areas.
8. Additional privileges. Additional privileges may be requested, in writing, and will be processed in the same manner as listed above in IV.B. "Granting of privileges."
9. Request for privileges by non-department members. Privileges may be requested by non-department members in writing and will be processed in the same manner as listed above in IV.B. "Granting of privileges."

5. **SPECIFIED PROFESSIONAL PERSONNEL.** There are no specified professional personnel in the Family Medicine Department.

6. OFFICERS AND DUTIES

1. The officers shall be a Chairman and a Vice Chairman. Qualifications and duties are as outlined in the Medical Staff Bylaws. The Chairman and Vice Chairman will serve a period of two (2) years, with no limit on the numbers of terms. The Vice Chairman shall assume all duties of the Chairman during the Chairman's absence.
2. Method of election for department officers.
    1. The Vice Chairman shall be elected by a majority of members present at a meeting at which a quorum is present.
    2. The current Vice Chairman shall become Chairman when his/her term as Vice Chairman is over, and s/he shall serve until a new Vice Chairman is appointed.
3. Representatives to the other clinical departments
    1. Members of the Family Medicine Department will be appointed by the Family

Medicine Department chairman-elect as representatives to each department except for Anesthesia, Emergency Medicine, Medicine, Pathology, Psychiatry & Addictions, Radiology and Surgery.

2. Representatives will serve a period of one year from January 1 through December 31, with no limit on the number of terms.

7. **CONSULTATION**. Consultations are to be obtained within the guidelines of sound medical practice. Specific indications may vary and Medical Staff Bylaws and Departmental Policies and Procedures dictate specifically many instances where consultation is standard practice.

8. **DEPARTMENT MEETINGS**. Meetings of the Department shall be held in accordance with the Medical Staff Bylaws.
   1. Frequency of meetings. The Department will meet as needed.
   2. Purpose of meetings. The purpose of the meetings shall be to review and evaluate the quality and appropriateness of care provided to patients by the department and to discuss any other matters concerning the department.
   3. Quorum. The presence of one-fourth (1/4) of the members eligible to vote shall constitute a quorum for any regular or special meeting. Once a quorum has been found, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.
   4. Manner of action. The action of a majority of members present at a meeting at which quorum was established shall constitute proper authorization.
   5. Attendance at Department meetings. Attendance requirements are outlined in the Medical Staff Bylaws. The Medical Associates with clinical privileges shall be invited (requested) to attend Department meetings and to take part in the Department activities but will not be eligible to vote since they are not members of the Medical Staff. Administration and other hospital staffs shall also be invited to attend meetings.

9. **DEPARTMENTAL COMMITTEES.** The Family Medicine Quality Improvement Committee is a standing committee of the Family Medicine Department. The Chairman may appoint special committees as are deemed necessary and appropriate from time to time.
   1. Family Medicine Quality Improvement Committee.
      1. Purpose. The purpose of the Family Medicine Quality Improvement Committee is to evaluate the care provided by physicians in the Family Medicine Department and ascertain that the quality of care provided is satisfactory. The Committee makes recommendations based on this evaluation to the Family Medicine Department.
      2. Meetings. The Family Medicine Quality Improvement Committee will meet as needed, or as set by the Department chairman. The Department Vice Chairman will serve as the Chairman of the Family Medicine Quality Improvement Committee.
      3. Composition. The Committee will be composed of the Family Medicine Department Chairman, Vice Chairman and the immediate past Department Chairman, along with three additional members appointed by the Family Medicine chairman. Ex officio members will be the President or designee and Medical Staff Quality Improvement Coordinator and are not eligible to vote. Every effort should be made to select the additional members using the following selection criteria: One (1) Private Practice Family Medicine Physician, one (1) EGH employed Family Medicine Physician, and one (1) Family Medicine Physician from a Multi-Specialty group.

4. Policy. The Family Medicine Quality Improvement Committee functions according to established policy and criteria approved by the Family Medicine Department in accordance with monitoring guidelines established in the Medical Staff Bylaws, the Family Medicine Department Rules and Regulations, and policies.
5. Quorum. The presence of one-third (1/3) of the total membership eligible to vote at any regular or special meeting shall constitute a quorum for all actions. Once a quorum has been found, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

10. **THE RULES OF ORDER**. Any parliamentary questions not specifically resolved by the provisions set forth in the Medical Staff Bylaws or these Rules shall be subject to the latest edition of Robert's Rules of Order.

11. **AMENDMENTS TO DEPARTMENT RULES AND REGULATIONS**. The Family Medicine Department Rules may be amended, changed or repealed by a majority vote of the entire Department at any regular or special meetings through procedure established in the Bylaws.

12. **POLICIES AND PROCEDURES.** Policies and procedures will be developed to manage the day to day functioning and the monitoring of quality of care of the Family Medicine Department. Policies and procedures will be developed by the Family Medicine Department, will be approved by the Family Medicine Department and the Medical Staff Executive Committee, and will be reviewed and revised-every three (3) years.

13. **ADOPTION**. These Rules and Regulations are hereby adopted, superseding and replacing any and all previous Family Medicine Department Rules and Regulations, pursuant until such time as they are amended in accordance with the terms of the Medical Staff Bylaws.

MEDICAL STAFF RULES AND REGULATIONS
MEDICINE DEPARTMENT

Revised 1999, 3/2007, 8/2007, 9/2009, 9/2010, 4/2011, 9/2011, 5/2014, 9/2014, 2/2017, 5/2020
Reviews: 12/95, 12/98, 2/99, 4/04, 3/07, 9/09, 9/12, 9/15, 5/16

I. NAME. The name of the clinical department shall be: The Medicine Department of the Medical Staff of Elkhart General Hospital. All subdivisions of Internal Medicine (*Allergy/Immunology, Cardiology, Dermatology, Endocrinology, Gastroenterology, Hematology/Oncology, Infectious Disease, Nephrology, Neurology, Physical Medicine and Rehabilitation, Pulmonology, and Rheumatology*) are considered within the scope of these rules and regulations.

II. PURPOSE. The purpose of this clinical department shall be to:

A. provide competent and quality medical care.

B. maintain a high level of professional performance with delineation of clinical privileges and continuing review of physicians' ethical conduct and professional performance.

C. conduct appropriate CME activities.

D. formulate standard procedures for implementation of principles found within the general Medical Staff Bylaws and Rules and Regulations.

III. DEPARTMENTAL MEMBERSHIP

A. Membership obligations. A member of the Medicine Department is obligated to

1. abide by the Medical Staff Bylaws, department and committee Rules and Regulations, and Policies.

2. accept and faithfully discharge Department assignments.

3. participate in fulfilling the requirements for providing emergency care.

4. Internal Medicine Physicians must provide patient care to patient's age of 18 and above. Requests to provide care to patients below that age is at the discretion of the Internal Medicine Physician.

5. Current members of the Medicine Department who are neither board certified nor board eligible, or grandfathered by their specialty board, will be grandfathered by the Medicine Department effective September 19, 2006. Physicians who are grandfathered will be required to provide proof of one hundred (100) CME hours in his/her subspecialty every two (2) calendar years.

B. Qualifications for membership. Physicians who have been appointed to membership on the Medical Staff as provided by the Bylaws shall be qualified for appointment to the Medicine Department. In addition, physicians must have completed an approved residency in internal medicine or in one of its recognized subspecialties, such as neurology and dermatology.

C. Appointment procedure. Initial appointment will be processed in accordance with the Medical Staff Bylaws.

D. Reappointment process. Reappointment will be processed in accordance with the Medical Staff Bylaws.

E. Required Certifications.

1. Physicians who are Board Eligible will need to have proof of compliance regarding life support certification until they become Board Certified. (Medical Staff Policy #910)

2. For Board Certified Members, Basic Life Support (BLS) certification and/or Advanced Life support Certification(s) (ACLS, ATLS, PALS, NRP) is needed only if required by privileges.

IV. CLINICAL PRIVILEGES

A. Scope of privileges. Clinical privileges will be delineated on the approved Medicine Department clinical privileges form. Effective 11/15/05, board certification in the specialty in which privileges are being requested is required for all new applicants.

B. Granting of privileges. The granting of clinical privileges will be in accordance with the Medical Staff Bylaws.

C. Criteria for granting of privileges. Privileges are based upon education, clinical training, demonstrated skills and capacity to manage procedurally related complications.

1. Privileges are divided into the following three categories:

a. Category #1 allows the physician to care for a wide range of medical problems requiring a general knowledge of organ systems and diseases. This category covers uncomplicated illnesses. Physicians with these privileges are required to request consultation in all cases in which doubt exists as to the diagnosis or in cases in which response to treatment is not soon apparent. Requirements are graduation from an approved medical/osteopathic school and proper licensing.

b. Category #2 covers diagnostic problems and complicated illnesses requiring specialized knowledge or skills. Such physicians could act as consultants to other specialists, general practitioners, etc., such as medical management of surgical patients or pre-operative medical evaluation. Physicians in this category would be expected to request consultation when hazardous treatment procedures are contemplated or in cases in which treatment response seems unduly delayed. Requirements are a residency which includes training in areas for which the privileges are requested.

c. Category #3 has the highest level of competence within a given field, on a par with that considered appropriate for a sub-specialist. These physicians are qualified to act as consultants and should, in turn, request consultation from within or from outside the hospital staff whenever needed. Requirements are a residency or additional specialty training as approved by the department chairman in the specific area for which the privileges are requested.

d. One of the following required for procedures:

(1) Evidence of satisfactory instruction during residency.

(2) Completion of an approved course with demonstration of competency documented by an approved credentialing society; a specified number of cases done under the supervision of a colleague who is credentialed in and currently doing the procedure may be required.

(3) Evidence of satisfactory knowledge with a specified number of cases done under the supervision of a colleague who is credentialed in and currently doing the procedure.

2. For coronary angioplasty procedures

a. For those practitioners just out of training, a letter is required from the Fellowship Program Director stating that the applicant is trained in the procedure.

b. For those practitioners already in practice, current privileges for these procedures at another JCAHO or HFAP – accredited hospital together with being a member of that staff in good standing at that hospital is required.

c. ACC/AHA guidelines for training in coronary angioplasty services must be met.

3. For Interventional Cardiology

a. Board Certification in Interventional Cardiology or board certification within five (5) years of completion of fellowship training in Interventional Cardiology is required per the Medical Staff Bylaws. Board certification in cardiology alone will not be acceptable. The ACC criteria for Board Certification in Interventional Cardiology will be adopted. Members on staff 7/14/09 will be grandfathered.

D. Provisional status. All newly appointed staff members shall be governed during their provisional status in accordance with the Medical Staff Bylaws. New physicians requesting privileges in the Medicine Department will have their first twenty cases admitted with an internal medicine diagnosis reviewed. At the end of the provisional year, appropriate recommendations will be made.

E. Monitoring.

1. Monitoring of the quality of patient care provided by members will be done in accordance with the Medical Staff Bylaws, and the Performance Improvement Program.

2. Monitoring will include the routine collection of patient care information based on approved objective criteria, assessment of the information to identify opportunities to improve care and to identify important problems in patient care, actions to improve patient care, monitoring to determine the effectiveness of the action, and documentation and reporting of the monitoring to the appropriate areas.

F. Additional privileges. Additional privileges may be requested, in writing, and will be processed in the same manner as listed in IV.B. "Granting of privileges."

G. Request for privileges by non-department members. Privileges may be requested by non-department members in writing and will be processed in the same manner as listed in IV.B. "Granting of privileges."

V. SPECIFIED PROFESSIONAL PERSONNEL

There are no specified professional personnel in the Medicine Department.

VI. OFFICERS AND DUTIES

A. The officers shall be a Chairman and a Vice Chairman. Qualifications and duties are as outlined in the Medical Staff Bylaws. The Vice Chairman shall assume all duties of the Chairman during the Chairman's absence.

B. Method of election for department officers. Department officers shall be elected by a majority of members present at a meeting at which a quorum is present. The Chairman shall be a member qualified by training and experience to serve in that capacity and shall have three years active service in the Department.

VII. CONSULTATION

A. Consultation requirements. Consultations are to be obtained within the guidelines of sound medical practice. Specific indications may vary and Medical Staff Bylaws and Departmental Policies and Procedures dictate specifically many instances where consultation is standard practice.

B. Consultations will be suggested on all CCC or ICU whose primary diagnosis falls within the accepted limits of Internal Medicine, and whose attending physician is not a member of the Medicine Department.

C. Consultations shall be urged on critically ill patients, and on cases presenting difficult diagnosis or those requiring dangerous or unfamiliar therapeutic measures or diagnostic procedures.

VIII. DEPARTMENT MEETINGS. Meetings of the Department shall be held in accordance with the Medical Staff Bylaws Article.

A. Frequency of meetings. The Department will meet bi-annually or as needed, as determined by the Chairman.

B. Purpose of meetings. The purpose of the meetings shall be to review and evaluate the quality and appropriateness of care provided to patients by, and any other matters concerning, the department.

C. Quorum. The presence of one-fourth (1/4) of the members eligible to vote shall constitute a quorum for any regular or special meeting. Once a quorum has been found, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

D. Manner of action. The action of a majority of members present at a meeting at which a quorum is present shall constitute proper authorization.

E. Attendance at Department meetings. Attendance requirements are outlined in the Medical Staff Bylaws. The Medical Associates with clinical privileges shall be invited (requested) to attend Department meetings and to take part in the Department activities but will not be eligible to vote since they are not members of the Medical Staff. Administration and other hospital staffs shall also be invited to attend meetings.

F. Portions or all of some meetings may be designated as closed to all who are not members of the Medicine Department at the discretion of the Department chairman.

IX. DEPARTMENTAL COMMITTEES. The Medicine Department Quality Improvement Committee is a standing committee of the Medicine Department. The Chairman may appoint special committees as are deemed necessary and appropriate from time to time.

A. Medicine Department Quality Improvement Committee.

1. Purpose. The purpose of the Medicine Department Quality Improvement Committee is to evaluate the care provided by physicians in the Medicine Department and ascertain that the quality of care provided is satisfactory. The Committee makes recommendations based on this evaluation to the Medicine Department.

2. Meetings. The Medicine Department Quality Improvement Committee will meet as needed, or as set by the Department chairman. The Department Vice Chairman will serve as the Chairman of the Medicine Department Quality Improvement Committee.

3. Composition. The Committee will be composed of the Medicine Department Chairman, Vice Chairman and the immediate past Department Chairman, along with additional members appointed by the Medicine Department chairman that will include the following specialties: ICU physician, Hospitalist, Non-Hospitalist Internal Medicine, Cardiology, Neurology, Oncology, Nephrology and when possible, Endocrinology. Ex officio members will be the President or designee and Medical Staff Quality Improvement Coordinator and are not eligible to vote. Every effort should be made to select the additional members using the following selection criteria: One (1) Private Practice Medicine Physician, one (1) EGH employed Medicine Physician, and one (1) Medicine Physician from a Multi-Specialty group.

4. Policy. The Medicine Department Quality Improvement Committee functions according to established policy and criteria approved by the Medicine Department in accordance with monitoring guidelines established in the Medical Staff Bylaws, the Medicine Department Rules and Regulations, and policies.

5. Quorum. The presence of one-third (1/3) of the total membership eligible to vote at any regular or special meeting shall constitute a quorum for all actions. Once a quorum has been found, the business of the meeting may continue and all actions

taken shall be binding even though less than a quorum exists at a later time in the meeting.

B. Cardiovascular Services Quality Improvement Committee.

1. Purpose. The purpose of the Cardiovascular Services Quality Improvement Committee is to evaluate the care provided by physicians in the Cardiology specialty and ascertain that the quality of care provided is satisfactory. The Committee makes recommendations based on this evaluation to the Medicine Department and/or Administration for final action.

2. Meetings. The Cardiovascular Services Quality Improvement Committee will meet as needed, or as set by the Medicine Department chairman.

3. Composition.

a. The Committee will be composed of all active cardiology physicians and cardiovascular physicians along with any additional members appointed by the Medicine Department chairman.

b. Ex officio members will be the President and/or Vice President of Medical Affairs and Medical Staff Quality Improvement Coordinator and are not eligible to vote.

c. Every effort should be made to select the additional members using the following selection criteria: One (1) Anesthesia Department representative, one (1) General Surgery or General & Vascular Surgery physician, one (1) Diagnostic Radiology physician and one (1) Emergency Department physician.

4. Policy. The Cardiovascular Services Quality Improvement Committee functions according to established policy and criteria approved by the Medicine Department in accordance with monitoring guidelines established in the Medical Staff Bylaws, the Medicine Department Rules and Regulations, and policies.

5. Quorum. The presence of one-third (1/3) of the total membership eligible to vote at any regular or special meeting shall constitute a quorum for all actions. Once a quorum has been found, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

C. Sleep Medicine Committee.

1. Purpose. The purpose of the Sleep Medicine Committee is to evaluate the care provided by physicians in the Sleep Medicine specialty and ascertain that the quality of care provided is satisfactory. The Committee makes recommendations based on this evaluation to the Medicine Department and/or Administration for final action.

2. Meetings. The Sleep Medicine Committee will meet as needed, or as set by the Medicine Department chairman.

3. Composition.

a. The Committee will be composed of all active Sleep Medicine physicians along with any additional members appointed by the Medicine Department chairman.

b. Ex officio members will be the President and/or Vice President of Medical Affairs and are not eligible to vote.

4. Policy. The Sleep Medicine Committee functions according to established policy and criteria approved by the Medicine Department in accordance with monitoring guidelines established in the Medical Staff Bylaws, the Medicine Department Rules and Regulations, and policies.

5. Quorum. The presence of one-half (1/2) of the total membership eligible to vote at any regular or special meeting shall constitute a quorum for all actions. Once a quorum has been found, the business of the meeting may continue and all actions

taken shall be binding even though less than a quorum exists at a later time in the meeting.

X. THE RULES OF ORDER. Any parliamentary questions not specifically resolved by the provisions set forth in the Medical Staff Bylaws or these Rules shall be subject to the latest edition of Robert's Rules of Order.

XI. AMENDMENTS TO DEPARTMENT RULES. The Medicine Department Rules may be amended, changed or repealed by a majority vote of the entire Department at any regular or special meetings through procedure established in the Bylaws.

XII. POLICIES AND PROCEDURES. Policies and procedures will be developed to manage the day to day functioning and the monitoring of quality of care of the Medicine Department. Policies and procedures will be developed by the Medicine Department, will be approved by the Medicine Department and the Medical Executive Committee, and will be reviewed and revised every three years.

XIII. ADOPTION. These Rules and Regulations are hereby adopted, superseding and replacing any and all previous Medicine Department Rules and Regulations, pursuant until such time as they are amended in accordance with the terms of the Medical Staff Bylaws.

ELKHART
GENERAL HOSPITAL

MEDICAL STAFF RULES AND REGULATIONS
PAIN MEDICINE COMMITTEE OF THE ANESTHESIA DEPARTMENT

Established March 2005; Reviewed 3/12/10; 09/14/12; 6/12/15, 3/21
Revised 7/13/07, 9/10/10, 12/16, 2/17

I. NAME. The name shall be: The Pain Medicine Committee of the Anesthesia Department of the Medical Staff of Elkhart General Hospital.

II. COMMITTEE MEMBERSHIP

A. Membership obligations. A member of the Pain Management Committee is obligated

1. To abide by the Medical Staff Bylaws, Committee and Committee Rules and Regulations, and Policies.
    a) Pain Management will not be listed on the ER call schedule and Pain Management physicians will not be required to take call for unassigned patients.
2. To accept and faithfully discharge Committee assignments.
3. To serve for one year or until their successors have been duly appointed.

B. Qualifications for membership. Physicians who have been appointed to membership on the Active Medical Staff as provided by the Bylaws, and who perform pain medicine as a specialty or as a part of general practice, shall be qualified for appointment to the Pain Management Committee.

1. Practitioners who request privileges in pain management must have completed an accredited fellowship in Pain Management, or have documentation of appropriate education and/or experience for the privileges requested.
2. Have successfully earned a MD or DO degree and completed a fellowship in Pain Medicine.
3. Have current certification or active participation in the examination process (with achievement of certification within (5) years) leading to subspecialty certification in Pain Medicine by the American Board of Anesthesiology or the American Board of Physical Medicine and Rehabilitation.

C. Appointment procedure. Appointment of a Chairman and members will be processed in accordance with the Medical Staff Bylaws.

D. Composition. The Chairman of Anesthesia shall appoint a committee of

1. All physicians who have Pain Medicine privileges as their primary specialty.
2. Administration and members of other Hospital Staffs shall be invited to attend meetings but will not be eligible to vote since they are not members of the Medical Staff.

III. COMMITTEE DUTIES

A. To promote competent and quality medical care by developing policies regarding the use of the Pain Clinic Unit.

B. To continually monitor, review and analyze the ethical conduct and professional performance of the providers of patient care in the for chronic pain service and in the Pain Clinic Unit.

C. To provide an educational setting where appropriate.

D. To make recommendations regarding the use of clinical privileges to the Chairman of the concerned departments, and to Administration.

IV. CONSULTATION. No specific consultations are recommended.

V. COMMITTEE MEETINGS. Meetings of the Committee shall be held in accordance with Medical Staff Bylaws.

A. Frequency of meetings. Meetings will be held at least quarterly.

B. Purpose of meetings. The purpose of the meetings shall be to review and evaluate the quality and appropriateness of care provided to patients in the Pain Center and by any physician given chronic pain privileges; and, to discuss any other matters concerning the Committee.

C. Quorum. The presence of one-fourth (1/4) of the members eligible to vote shall constitute a quorum for any regular or special meeting. Once a quorum has been found, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

D. Manner of action. The action of a majority of members present at a meeting at which a quorum is present shall constitute proper authorization.

E. Attendance at Committee meetings. Attendance requirements are outlined in the Medical Staff Bylaws and in the Anesthesia Department Rules and Regulations. Administration and other hospital staffs shall also be invited to attend meetings, but shall not vote.

F. There shall also be an Anesthesiologist Liaison position.

1. The duties are to review all matters pertaining to anesthesia, and to make recommendations pertaining to them, to the Pain Medicine Committee Chairman.
2. This position will be appointed by the Department Chairman annually.
3. Requirements are to have privileges in and to be a member of the Anesthesia Department.

VI. RULES OF ORDER. Any parliamentary questions not specifically resolved by the provisions set forth in the Medical Staff Bylaws or these Rules shall be subject to the latest edition of Robert's Rules of Order.

VII. AMENDMENTS TO RULES. Recommendations to amend change or repeal the Pain Medicine Committee Rules may be made by a majority vote of the entire Committee at any regular or special meetings through procedure established in the Medical Staff Bylaws. The recommendation will then be forwarded to the Anesthesia Department for final action.

VIII. ADOPTION. These Rules and Regulations are hereby adopted, superseding and replacing any and all previous Committee Rules and Regulations, pursuant until such time as they are amended in accordance with the terms of the Medical Staff Bylaw.

ELKHART
GENERAL HOSPITAL

MEDICAL STAFF RULES AND REGULATIONS
PATHOLOGY DEPARTMENT

Revised 1999; Reviews: 2/00, 4/04, 4/09, 09/11, 1/16

I. NAME. The name of the clinical department shall be: The Pathology Department of the Medical Staff of Elkhart General Hospital.

II. PURPOSE. The purpose of this clinical department shall be:

A. To provide competent and quality laboratory care.

B. To maintain a high level of professional performance with delineation of clinical privileges and continuing review of physicians' ethical conduct and professional performance.

C. To provide an educational setting where appropriate.

D. To formulate standard procedures for implementation of principles found within the general Medical Staff Bylaws and Rules and Regulations.

III. DEPARTMENTAL MEMBERSHIP.

A. Membership obligations. A member of the Pathology Department is obligated

1. To abide by the Medical Staff Bylaws, department and committee Rules and Regulations, and Policies.

2. To accept and faithfully discharge Department assignments.

3. To participate in fulfilling the requirements for providing emergency care.

4. Call schedules. The pathologist is supposed to participate in rotations for the performance of autopsies, gross surgicals and other assignments as needed. Whenever problems arise which require the attention of the pathologist during working hours, the employee aware of the problem should contact the pathologist in charge of the hospital. If s/he is not available or if during nonworking hours, then s/he should contact the pathologist on clinical pathology call.

5. The pathologist in charge of the hospital will attend the various committee meetings to which he has been assigned by the Medical Staff Executive Committee.

6. All members of the Pathology Staff are expected to take care of Surgical Pathology, Cytology, Autopsy Pathology and Clinical Pathology.

7. The pathologist will serve as consultant to other members of the Medical Staff interested in obtaining laboratory test interpretation and usage in their patients.

8. The pathologists are expected to take active participation in educational activities for the benefit of the members of the Medical Staff and for the technologists working in the laboratory.

9. The pathologist will participate in conferences and lectures to other personnel of the hospital on request.

B. Qualifications for membership. Physicians who are Board-eligible or Board-certified in pathology and who have been appointed to membership on the Medical Staff as provided by the Bylaws, shall be qualified for appointment to the Pathology Department.

C. Appointment procedure. Initial appointment will be processed in accordance with the Medical Staff Bylaws.

D. Reappointment process. Reappointment will be processed in accordance with the Medical Staff Bylaws.

E. Required certification. All Active members of the medical staff are required to obtain and maintain Basic Life Support (BLS) certification (Medical Staff Policy #910). Individual medical staff departments may require advanced life support certification(s) as well.

IV. CLINICAL PRIVILEGES

A. Scope of privileges. Clinical privileges will be delineated on the approved Pathology Department clinical privileges form.

B. Granting of privileges. The granting of clinical privileges will be in accordance with the Medical Staff Bylaws.

C. Criteria for granting of privileges. Privileges are based upon education, clinical training, a demonstrated skills and capacity to manage procedurally related complications. An applicant must have completed an accredited residency in pathology or have documentation of appropriate education and/or experiences.

D. Provisional status. All newly appointed staff members shall be governed during their provisional status in accordance with the Medical Staff Bylaws, and will be monitored by other staff pathologists.

E. Monitoring. The pathologist should expect his/her work to be submitted for review by other pathologists on the staff. All cases having a malignant diagnosis and every tenth case, regardless of diagnosis, will be reviewed by a second pathologist. It is also the responsibility of the pathologist to submit for the review by other pathologists those cases that are difficult or unusual.

F. Additional privileges. Additional privileges may be requested, in writing, and will be processed in the same manner as listed above in IV.B. "Granting of privileges."

G. Request for privileges by non-department members. Privileges may be requested by non-department members in writing and will be processed in the same manner as listed above in IV./B. "Granting of privileges."

V. SPECIFIED PROFESSIONAL PERSONNEL

A. Qualifications for appointment. All specialized pathology paramedical professional personnel will be under the direction of the pathologists. They will be licenses and/or credentialed in their area of specialization and be credentialed at Elkhart General hospital through the usual channels.

B. Privileges. Each pathology paramedical professional will be limited to certain specific privileges commensurate with his/her training and licensing. Appointment of specified professional personnel shall be in accordance with the Medical Staff Bylaws.

C. Monitoring. Each pathology paramedical professional will be under the direction of a pathologist and will be directly monitored by them.

VI. OFFICERS AND DUTIES

A. The officers shall be a Chairman and a Vice Chairman. Qualifications and duties are as outlined in the Medical Staff Bylaws. The Vice Chairman shall assume all duties of the Chairman during the Chairman's absence.

1. While in charge of the Hospital, the pathologist will assume responsibilities for the direction and adequate performance of the hospital laboratory. The hospital department manager is directly responsible to the pathologist in charge.

2. The pathologist will oversee and advise the functioning of the Blood Bank, making sure it meets current regulations and medical standards.

B. Method of election for department officers. Department officers shall be elected by a majority of members present at a meeting at which a quorum is present.

VII. CONSULTATION

A. Unusual or difficult surgical pathology cases may be sent for outside expert consultation at the discretion of either the pathologists or Medical Staff clinicians.

B. South Bend Medical Foundation pathologists will review in consultation those cases coming in to Elkhart General Hospital at the request of staff clinicians.

C. South Bend Medical Foundation will given consultation on clinical laboratory problems upon request.

VIII. DEPARTMENT MEETINGS.

Meetings of the Department shall be held in accordance with the Medical Staff Bylaws.

A. Frequency of meetings. The Department will usually meet monthly as set by the Chairman.

B. Purpose of meetings. The purpose of the meetings shall be to review and evaluate the quality and appropriateness of care provided to patients by the department and to discuss any other matters concerning the department.

C. Quorum. The presence of one-fourth (1/4) of the members eligible to vote shall constitute a quorum for any regular or special meeting. Once a quorum has been found, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

D. Manner of action. The action of a majority of members present at a meeting at which a quorum is present shall constitute proper authorization.

E. Attendance at Department meetings. Attendance requirements are outlined in the Medical Staff Bylaws. The Medical Associates with clinical privileges shall be invited (requested) to attend Department meetings and to take part in the Department activities but will not be eligible to vote since they are not members of the Medical Staff. Administration and other hospital staffs shall also be invited to attend meetings.

IX. DEPARTMENTAL COMMITTEES

A. There are no standing committees.

B. The Chairman may appoint special committees as are deemed necessary and appropriate from time to time.

X. THE RULES OF ORDER.

Any parliamentary questions not specifically resolved by the provisions set forth in the Medical Staff Bylaws or these Rules shall be subject to the latest edition of Robert's Rules of Order.

XI. AMENDMENTS TO DEPARTMENT RULES.

The Pathology Department Rules may be amended, changed or repealed by a majority vote of the entire Department at any regular or special meetings through procedure established in the Bylaws.

XII. POLICIES AND PROCEDURES.

Policies and procedures will be developed to manage the day to day functioning and the monitoring of quality of care of the Pathology Department. Policies and procedures will be developed by the Pathology Department, will be approved by the Psychiatry Department and the Medical Executive Committee, and will be reviewed and revised at least annually.

XIII. ADOPTION. These Rules and Regulations are hereby adopted, superseding and replacing any and all previous Pathology Department Rules and Regulations, pursuant until such time as they are amended in accordance with the terms of the Medical Staff Bylaws.

ELKHART
GENERAL HOSPITAL

MEDICAL STAFF RULES AND REGULATIONS
PEDIATRIC DEPARTMENT

Reviews: 2/96; 11/98; 4/99; 6/02, 6/03, 4/04, 1/07
Revision: 9/08, 12/09, 6/10, 9/11, 10/12, 6/17, 3/19

I. NAME. The name of the clinical department shall be: The Pediatric Department of the Medical Staff of Elkhart General Hospital.

II. PURPOSE. The purpose of this clinical department shall be

- **A.** To provide competent and quality medical care.
- **B.** To maintain a high level of professional performance with delineation of clinical privileges and continuing review of physicians' ethical conduct and professional performance.
- **C.** To provide an educational setting where appropriate.
- **D.** To formulate standard procedures for implementation of principles found within the general Medical Staff Bylaws and Rules and Regulations.

III. DEPARTMENTAL MEMBERSHIP

- **A. Membership obligations**. A member of the Pediatric Department is obligated
  1. To abide by the Medical Staff Bylaws, department and committee Rules and Regulations, and Policies.
  2. To accept and faithfully discharge Department assignments.
  3. To participate in fulfilling the requirements for providing emergency care.
  4. Current members of the Pediatric Department who are currently neither board certified nor board eligible, or grandfathered by their specialty board, will be grandfathered by the Pediatric Department and required to provide proof of one hundred (100) CME hours every two (2) years at reappointment effective January 26, 2006.
- **B. Qualifications for membership**. Physicians who have completed a residency in a pediatric specialty and who have been appointed to membership on the Active Medical Staff as provided by the Bylaws shall be qualified for appointment to the Pediatric Department. The applicant must be a physician board certified or board eligible by the appropriate specialty board and subspecialty board.
- **C. Appointment procedure**. Initial appointment will be processed in accordance with the Medical Staff Bylaws.
- **D. Reappointment process**. Reappointment will be processed in accordance with the Medical Staff Bylaws.

IV. CLINICAL PRIVILEGES

- **A. Scope of privileges**. Clinical privileges will be delineated on the approved Pediatric Department clinical privileges form.
- **B. Granting of privileges**. The granting of clinical privileges will be in accordance with the Medical Staff Bylaws.
- **C. Provisional status**. All newly appointed staff members shall be governed during their provisional status in accordance with the Medical Staff Bylaws.
- **D. Criteria for granting of privileges**. Privileges are based upon education, clinical training, a

demonstrated skills and capacity to manage procedurally related complications.

E. **Pediatric privileges** are divided into four categories:

1. Category one privileges designates a degree of patient care in which the disease process or usual therapy poses a minimal risk to the life of the patient. Requirements are demonstrated significant experience or a minimum of three months structured graduate training in Pediatrics in addition to demonstrated competence.

2. Category two privileges designate a degree of patient care in which there is a major disease process or more complicated therapy that presents increased risk to the life of the patient. Requirements are successful completion of formal residency training and demonstrated competence in Pediatrics.

3. Category three privileges designate a degree of patient care in which there is a major disease process or more complicated therapy that presents a serious threat to the life of the patient. Requirements are successful completion of formal residency and additional special training with demonstrated competence in Pediatrics.

4. Category four privileges are core surgical privileges, which are defined as those privileges basic to Pediatrics and which will be granted by the Pediatric Department directly reportable to the Medical Staff Executive Committee. Requirements are demonstrated significant experience or a minimum of three months structured graduate training in Pediatrics in addition to demonstrated competence.

F. **Neonatology privileges** are divided into four categories:

1. **Category one** privileges designates a degree of patient care in which the disease process or usual therapy poses a minimal risk to the life of the patient. Requirements are demonstrated significant experience or a minimum of three months structured graduate training in Neonatology in addition to demonstrated competence.

2. **Category two** privileges designate a degree of patient care in which there is a major disease process or more complicated therapy that presents increased risk to the life of the patient. Requirements are successful completion of formal residency training and demonstrated competence in Neonatology.

3. **Category three** privileges designate a degree of patient care in which there is a major disease process or more complicated therapy that presents a serious threat to the life of the patient. Requirements are successful completion of formal residency and additional special training with demonstrated competence in Neonatology.

4. **Category four** privileges are core surgical privileges, which are defined as those privileges basic to Neonatology and which will be granted by the Pediatric Department directly reportable to the Medical Staff Executive Committee. Requirements are demonstrated significant experience or a minimum of three months structured graduate training in Neonatology in addition to demonstrated competence.

G. **Monitoring**.

1. Monitoring of the quality of patient care provided by members will be done in accordance with the Medical Staff Bylaws; and, the Elkhart General Healthcare System Performance Improvement Plan.

2. Monitoring will include the routine collection of patient care information based on approved objective criteria, assessment of the information to identify opportunities to improve care and to identify important problems in patient care, actions to improve patient care, monitoring to determine the effectiveness of the action, and documentation and reporting of the monitoring to the appropriate areas.

H. **Additional privileges**. Additional privileges may be requested, in writing, and will be processed in the same manner as listed in IV.B. "Granting of privileges."

I. **Request for privileges by non-department members**. Privileges may be requested by non-department members in writing and will be processed in the same manner as listed in IV.B.

"Granting of privileges."

J. Required certification.

1. Any Provider who cares for or delivers neonates needs to be NRP (Neonatal Resuscitation Program) certified, effective beginning July 1, 2004. Beginning December 31, 2007, Pediatricians recommend any credentialed provider caring for newborns be NRP certified and recertify every two (2) years.

2. All Pediatricians are required to be PALS certified and the pediatricians recommend any credentialed provider caring for children be PALS certified, effective beginning July 1, 2004.

V. SPECIFIED PROFESSIONAL PERSONNEL

SPECIFIED PROFESSIONAL PERSONNEL. There are no specified professional personnel in the Pediatric Department.

VI. OFFICERS AND DUTIES

A. The officers shall be a Chairman and a Vice Chairman. Qualifications and duties are as outlined in the Medical Staff Bylaws. The Vice Chairman shall assume all duties of the Chairman during the Chairman's absence.

B. Method of election for department officers. Department officers shall be elected by a majority of members present at a meeting at which a quorum is present.

C. The Chairman shall serve a term of two consecutive years, with no limit on the number of terms.

VII. CONSULTATION

A. Consultation requirements. Consultations are to be obtained within the guidelines of sound medical practice. Specific indications may vary and Medical Staff Bylaws and Departmental Policies and Procedures dictate specifically many instances where consultation is standard practice.

B. Consultations with a qualified consultant in the field relating to the patient's need shall be either required or recommended.

C. Required pediatric consultations.

1. A written consultation with a qualified consultant shall be required on critically ill patients, such as but not limited to, respiratory distress or failure, from asthma, bronchiolitis, or pneumonia; special procedures such as ventilator support and ribavirin administration; pediatric patients in a special care unit (ICU, CCU, or NICU); and, any patient admitted with suspected abuse or neglect.

2. Any qualified physician in the field of the patient's need shall serve as consultant. Non-members of the Medical Staff of known qualifications and reputation may serve as consultants, as provided in the Bylaws.

3. All consultations shall be documented in the medical record on the special forms provided by the hospital. The physician requiring consultation shall write all the elements of consultation such as history, physical findings, laboratory workup, and shall specifically indicate what is requested in the consultation. The consultant shall put in writing his findings, diagnosis and recommendations.

D. Neonatal consultations not required: Consultation is not required on circumcision, normal newborn care, phototherapy treatment of physiological jaundice, or uncomplicated feeding problems.

E. Neonatal consultation is recommended for the following.

1. All infants of inappropriate gestational size

2. All infants born to mothers with prematurely ruptured membranes of twenty-four (24) hours or more, or where there is evidence of amnionitis

3. Congenital anomalies other than simple cosmetic problems
4. Ambiguous genitalia
5. All newborns that "appear ill"
6. All newborns who have persistent hypoglycemia
7. Infants on continuous monitoring for apnea, bradycardia, or desaturations
8. Infants receiving IV fluids or medications
9. Infants requiring isolation
10. Uncomplicated growing preemies requiring nursing interventions at least every 4 hr
11. Stable infants on IV antibiotics
12. Any infant needing closer observation as ordered by a physician
13. Infants requiring NG or OG feedings
14. Newborns requiring extra day observation after mother leaves. Baby would have been cared for on Mother-Baby if mother had stayed. Examples: poor feeder, unstable temperature, IM antibiotics.
15. Stable infants on continuous monitoring for potential drug withdrawal
16. Any infant who weighs less than five (5) pounds should be admitted (initially) to the intermediate care nursery. Any "newborn call" infant that weighs less than five (5) pounds will go directly to a Neonatologist.

F. Neonatal consultation is required for (Neonatologist should be contacted by the attending physician.)

1. All infants with evidence of intrapartum asphyxia; i.e., ominous fetal heart rate tracing or scalp ph less than 7.20
2. All neonates at or below thirty-four (34) weeks gestation
3. Any infant that, at birth, required vigorous resuscitation and that has a 10 minute APGAR score of less than 6.
4. Any situation that is threatening to the life of the neonate
5. Severe hemolytic disease of the newborn
6. All neonates requiring mechanical ventilation or excessive or extended oxygen therapy
7. Any infant with an umbilical catheter
8. Any infant receiving Parental Nutrition
9. Any infant who is under the care of a family or pediatric physician who displays a medical problem that necessitates placement of the infant in Intensive Care must have a Neonatology consultation. If the infant is found to require intensive medical care, the consulting Neonatologist will assume care of the infant.

VIII. DEPARTMENT MEETINGS. Meetings of the Department shall be held in accordance with Medical Staff Bylaws.

A. Frequency of meetings. The Department will meet as needed to conduct department business or as set by the Chairman.

B. Purpose of meetings. The purpose of the meetings shall be to review and evaluate the quality and appropriateness of care provided to patients by the department and to discuss any other matters concerning the department.

C. Quorum. The presence of one-fourth (1/4) of the members eligible to vote shall constitute a quorum for any regular or special meeting. Once a quorum has been found, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

D. Manner of action. The action of a majority of members present at a meeting at which a quorum was established shall constitute proper authorization.

E. Attendance at Department meetings. Attendance requirements are outlined in the Medical Staff Bylaws. The Medical Associates with clinical privileges shall be invited (requested) to

attend Department meetings and to take part in the Department activities but will not be eligible to vote since they are not members of the Medical Staff. Administration and other hospital staffs shall also be invited to attend meetings.

IX. DEPARTMENTAL COMMITTEES

A. There are no standing committees.

B. The Chairman may appoint special committees as are deemed necessary and appropriate from time to time.

X. RULES OF ORDER. Any parliamentary questions not specifically resolved by the provisions set forth in the Medical Staff Bylaws or these Rules shall be subject to the latest edition of Robert's Rules of Order.

XI. AMENDMENTS TO RULES. The Pediatric Department Rules may be amended, changed or repealed by a majority vote of the entire Committee at any regular or special meetings through procedure established in the Medical Staff Bylaws.

XII. POLICIES AND PROCEDURES. Policies and procedures will be developed to manage the day to day functioning and the monitoring of quality of care of the Pediatric Department. Policies and procedures will be developed by the Pediatric Department, will be approved by the Pediatric Department and the Medical Staff Executive Committee, and will be reviewed and revised every three years.

XIII. ADOPTION. These Rules and Regulations are hereby adopted, superseding and replacing any and all previous Department Rules and Regulations, pursuant until such time as they are amended in accordance with the terms of the Medical Staff Bylaw.

ELKHART
GENERAL HOSPITAL

MEDICAL STAFF RULES AND REGULATIONS
PERINATOLOGY COMMITTEE OF THE SURGERY DEPARTMENT

Reviews: 3/91, 4/92, 11/93, 7/94, 3/96; 12/2001; 03/2005; 08/2005; 04/2008; 09/2008; 3/2011, 5/2017, 8/2020
Revision 8/2/2011, 11/6/2012, 9/15/2014

I. NAME. The name shall be: The Perinatology Committee of the Surgery Department of the Medical Staff of Elkhart General Hospital.

II. COMMITTEE MEMBERSHIP

A. Membership obligations. A member of the Perinatology Committee is obligated
1. To abide by the Medical Staff Bylaws, Committee and Committee Rules and Regulations, and Policies.
2. To accept and faithfully discharge Committee assignments.
3. To serve for one year or until their successors have been duly appointed.

B. Qualifications for membership. Physicians who have been appointed to membership on the Active Medical Staff as provided by the Bylaws, and who do perinatal service as a specialty or as a part of general practice, shall be qualified for appointment to the Perinatology Committee.

C. Appointment procedure. Appointment of a Chairman and members will be processed in accordance with the Medical Staff Bylaws.

D. Composition. The Chief of Staff shall appoint a committee of
1. all OB/GYN specialists actively practicing obstetrics,
2. all Certified Nurse Midwives actively practicing with an OB/GYN member who is actively practicing obstetrics,
3. at least one (1) representative from the Pediatric Department, and
4. at least two (2) representatives from the Family Practice Department.
5. Administration and members of other Hospital Staffs shall be invited to attend meetings but will not be eligible to vote since they are not members of the Medical Staff.

III. COMMITTEE DUTIES

A. To promote competent and quality medical care by developing policies regarding the use of the Obstetric and Neonatal Units.

B. To continually monitor, review and analyze the ethical conduct and professional performance of the providers of patient care in the Obstetric and Neonatal Units.

C. To provide an educational setting where appropriate.

D. To make recommendations regarding the use of clinical privileges to the Chairman of the concerned departments, and to Administration.

IV. CONSULTATION.

A. The following consultations are recommended:
1. Induction of labor if less than thirty-nine (39) weeks without medical indication, and if the Bishop's score is less than or equal to seven (7)
2. Breech presentation
3. Multiple births
4. Obstetrical complications such as
   - **a.** pre-eclampsia/eclampsia
   - **b.** abruptio placenta
   - **c.** placenta previa, marginal or partial
   - **d.** ongoing post partum hemorrhage greater than 1000 cc
   - **e.** prolonged labor over twenty-four (24) hours
5. Management of parturient patients upon whom previous cutting operations on the uterus have been done, such as Cesarean section, hysterotomy or myomectomy, VBAC (vaginal birth after Cesarean section)
6. Any use of intravenous tocolytic therapy

7. Any situation in which the life of the mother and/or the fetus is in jeopardy
8. Destructive operations
9. Interruption of pregnancy before thirty-six (36) weeks
10. Medical complications of pregnancy such as, but not limited to,
  a. major heart disease
  b. pulmonary tuberculosis
  c. Nephritis
  d. cardiovascular renal disease
  e. herpes gestationalis
11. Complete placenta previa
12. Premature labor less than thirty-four (34) weeks gestation
13. Forceps rotation

B. The following consultations are required:
1. Management of non-reactive Non-stress test and/or positive or suspicious Contraction Stress Test
2. Twin Gestations in labor

V. CLINICAL PRIVILEGES

A. Required certification.
1. Anyone who cares for or delivers neonates needs to be NRP (Neonatal Resuscitation Program) certified and remain certified, effective beginning December 31, 2007.
2. In compliance with Medical Staff Policy #910, effective 8/1/2011 all members of the Active Staff category, are required to obtain and maintain a life support certification.

B. **Allied Health Professional Nurse Midwife Criteria**
1. Licensed RN in the State of Indiana;
2. Graduate of an approved midwifery program;
3. Certified in a midwifery and maintain certification;
4. Supervision under a practicing OB/GYN physician with current admitting and cesarean section privileges at EGH

C. **Qualified Medical Personnel approved for performing Medical Screening Exam**. For patients arriving in OB triage, a Medical Screening Exam (MSE) is expected to determine if the patient is in an emergency medical condition in compliance with EMTALA laws. In Labor and Delivery (L & D), Qualified Medical Personnel for OB Triage are physicians credentialed by the Medical Staff at Elkhart General Hospital and/or specially trained RN's who may conduct the MSE on patients over 20 weeks gestation with sole pregnancy related complaints, with 24 hour/day backup from on-call obstetricians. Depending upon the individual's presenting symptoms, this screening examination may range from a relatively simple examination to a complex one which requires substantial use of ancillary services available at the hospital and on-call physicians. (See the algorithm in the ACEP EMTALA book.)

VI. COMMITTEE MEETINGS

COMMITTEE MEETINGS. Meetings of the Committee shall be held in accordance with Medical Staff Bylaws.

A. **Frequency of meetings**. Meetings will be held at least quarterly.
B. **Purpose of meetings**. The purpose of the meetings shall be to review and evaluate the quality and appropriateness of care provided to patients in the Obstetric and Neonatal Units, and to discuss any other matters concerning the Committee.
C. **Quorum**. The presence of one-fourth (1/4) of the members eligible to vote shall constitute a quorum for any regular or special meeting. Once a quorum has been found, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.
D. **Manner of action**. The action of a majority of members present at a meeting at which a quorum was established shall constitute proper authorization.
E. **Attendance at Committee meetings**. Attendance requirements are outlined in the Medical Staff Bylaws. Attendance requirements for Certified Nurse Midwives will be equal to those outlined in the Medical Staff Bylaws for Active members of the Medical Staff. Nurse Midwives may not vote. Administration and other hospital staffs shall also be invited to attend meetings, but shall not vote.

VII. Perinatology QI Committee

A. Purpose. The purpose of the Perinatology QI Committee is to evaluate the hospital's obstetric activity and ascertain that the procedure performed is justified and that the quality of care provided is satisfactory. The Committee makes recommendations based on this evaluation to the Surgery Department.

B. Meetings. The Perinatology QI Committee will meet as needed, or as set by the Committee chairman.

C. Composition. The Committee chairman and members representative of the Perinatology QI Committee are appointed by the Surgery Department chairman and will include: Minimum of 2 (two) OB/GYN physicians, including the chairman, a Pediatrician, a Family Practitioner with OB privileges, a Midwife, an Anesthesiologist and a Neonatal NP. Ex officio members will include an Administrative representative, OB Manager and Medical Staff Quality Improvement Coordinator. An Emergency Department physician, the Surgical Review Committee Chairman and Surgery Department Chairman will be invited to be ad hoc members of the Committee.

D. Policy. The Perinatology QI Committee functions according to established policy and criteria approved by the Surgery Department in accordance with monitoring guidelines established in the Medical Staff Bylaws and the Perinatology Rules and Regulations and Surgery Department policies.

E. Quorum. The presence of the Committee Chairman and 2 (two) additional committee members eligible to vote at any regular or special meeting shall constitute a quorum for all actions. Once a quorum has been found, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

VIII. RULES OF ORDER. Any parliamentary questions not specifically resolved by the provisions set forth in the Medical Staff Bylaws or these Rules shall be subject to the latest edition of Robert's Rules of Order.

IX. AMENDMENTS TO RULES. The Perinatology Committee Rules may be amended, changed or repealed by a majority vote of the entire Committee at any regular or special meetings through procedure established in the Medical Staff Bylaws.

X. ADOPTION. These Rules and Regulations are hereby adopted, superseding and replacing any and all previous Committee Rules and Regulations, pursuant until such time as they are amended in accordance with the terms of the Medical Staff Bylaw.

MEDICAL STAFF RULES AND REGULATIONS
PSYCHIATRY DEPARTMENT

Reviews: 3/96; 12/98; 4/99; 10/00; 6/02; 4/04, 2/07, 02/10, 09/12
Revised: 9/11, 9/15, 12/15, 7/21

I. NAME. The name of the clinical department shall be: The Psychiatry Department of the Medical Staff of Elkhart General Hospital.

II. PURPOSE. The purpose of this clinical department shall be:

- **A.** To provide competent and quality psychiatric, addiction, and medical care.
- **B.** To maintain a high level of professional performance with delineation of clinical privileges and continuing review of physicians' ethical conduct and professional performance.
- **C.** To provide an educational setting where appropriate.
- **D.** To formulate standard procedures for implementation of principles found within the general Medical Staff Bylaws and Rules and Regulations.

III. DEPARTMENTAL MEMBERSHIP.

- **A.** Membership obligations. A member of the Psychiatry Department is obligated:
  - **1.** To abide by the Medical Staff Bylaws, department and committee Rules and Regulations, and Policies.
  - **2.** To accept and faithfully discharge Department assignments.
  - **3.** To participate in fulfilling the requirements for providing emergency care.
- **B.** Qualifications for membership. Physicians who have completed a residency in a psychiatric specialty or certification by the American Society of Addictions Medicine, and who have been appointed to membership on the Active Medical Staff as provided by the Bylaws, shall be qualified for appointment to the Psychiatry Department. Psychiatrist members will be Board-eligible or Board-certified. If Board-eligible, the physician must become certified within five (5) years of completion of training.
- **C.** Appointment procedure. Initial appointment will be processed in accordance with the Medical Staff Bylaws.
- **D.** Reappointment process. Reappointment will be processed in accordance with the Medical Staff Bylaws.
- **E.** Required certification.
  - **1.** All Active members of the medical staff are required to obtain and maintain Basic Life Support (BLS) certification (Medical Staff Policy #910). Individual medical staff departments may require advanced life support certification(s) as well.

IV. CLINICAL PRIVILEGES

- **A.** Scope of privileges. Clinical privileges will be delineated on the approved Psychiatry Department clinical privileges form.
- **B.** Granting of privileges. The granting of clinical privileges will be in accordance with the Medical Staff Bylaws.
- **C.** Criteria for granting of privileges. Privileges are based upon education, clinical training, a demonstrated skills and capacity to manage procedurally related complications.
  - **1.** Physicians:
    - **a.** Psychiatry privileges require American Medical Association or American Osteopathic Association psychiatric training which includes adequate residency, an approved residency in psychiatry, and eligibility for Board

certification.

b. Privileges in addictions require a physician with a residency in psychiatry or addictions, or certification by the American Society of Addictions Medicine.

c. Privileges for ECT requires evidence of satisfactory completion of an approved residency in psychiatry, and proof of current training in ECT.

2. Non-physicians: Privileges for non-physicians in psychiatry or addictions require a professional within the boundaries of his/her license under the supervision of a psychiatrist or addiction psychiatrist/addictions.

D. Provisional status. All newly appointed staff members shall be governed during their provisional status in accordance with the Medical Staff Bylaws.

E. Monitoring.

1. Monitoring of the quality of patient care provided by members will be done in accordance with the Medical Staff Bylaws and the Quality Review Program.

2. Monitoring will include the routine collection of patient care information based on approved objective criteria, assessment of the information to identify opportunities to improve care and to identify important problems in patient care, actions to improve patient care, monitoring to determine the effectiveness of the action, and documentation and reporting of the monitoring to the appropriate areas.

F. Additional privileges. Additional privileges may be requested, in writing, and will be processed in the same manner as listed above in IV.B "Granting of privileges."

G. Request for privileges by non-department members. Privileges may be requested by non-department members in writing and will be processed in the same manner as listed above in IV.B "Granting of privileges."

V. SPECIFIED PROFESSIONAL PERSONNEL

A. Qualifications for appointment. Appointment of specified professional personnel such as clinical psychologists shall be in accordance with the Medical Staff Bylaws.

B. Privileges. Granting of clinical privileges shall be in accordance with the Medical Staff Bylaws.

C. Monitoring. The Department chairman shall monitor the therapeutic activities of non-psychiatrist personnel.

VI. OFFICERS AND DUTIES

A. The officers shall be a Chairman and a Vice Chairman. Qualifications and duties are as outlined in the Medical Staff Bylaws. The Chairman and Vice Chairman shall serve a term of two (2) years consecutively, with no limit on the number of terms. The Vice Chairman shall assume all duties of the Chairman during the Chairman's absence.

B. Method of election for department officers. Department officers shall be elected by a majority of members present at a meeting at which a quorum is present.

VII. CONSULTATION

A. Consultation Requirements. Consultations are to be obtained within the guidelines of sound medical practice. Specific indications may vary and Medical Staff Bylaws and Departmental Policies and Procedures dictate specifically many instances where consultation is standard practice.

B. Psychiatric and addiction consultation is available throughout the hospital.

VIII. DEPARTMENT MEETINGS. Meetings of the Department shall be held in accordance with the Medical Staff Bylaws.

A. Frequency of meetings. The Department will meet twice a year or on an as needed basis as set by the Chairman.

B. Purpose of meetings. The purpose of the meetings shall be to review and evaluate the quality and appropriateness of care provided to patients by the department and to discuss any other matters concerning the department.

C. Quorum. The presence of one-fourth (1/4) or greater than one of the members eligible to vote shall constitute a quorum for any regular or special meeting. Once a quorum has been found, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

D. Manner of action. The action of a majority of members present at a meeting at which a quorum is present shall constitute proper authorization.

E. Attendance at Department meetings. Attendance requirements are outlined in the Medical Staff. The Medical Associates with clinical privileges shall be invited (requested) to attend Department meetings and to take part in the Department activities but will not be eligible to vote since they are not members of the Medical Staff. Administration and other hospital staffs shall also be invited to attend meetings.

IX. DEPARTMENTAL COMMITTEES. The Psychiatry Quality Improvement Committee is a standing committee of the Psychiatry Department. The Chairman may appoint special committees as are deemed necessary and appropriate from time to time.

A. Psychiatry Quality Improvement Committee.

1. Purpose. The purpose of the Psychiatry Quality Improvement Committee is to evaluate the care provided by physicians in the Psychiatry Department and ascertain that the quality of care provided is satisfactory. The Committee makes recommendations based on this evaluation to the Psychiatry Department.

2. Meetings. The Psychiatry Quality Improvement Committee will meet as needed, or as set by the Department chairman. The Department Chairman will serve as the Chairman of the Psychiatry Quality Improvement Committee.

3. Composition. The Committee will be composed of the Psychiatry Department Chairman, Vice Chairman and the immediate past Department Chairman, along with three additional members appointed by the Psychiatry and Addictions chairman. Ex officio members will be the Vice President of Medical Affairs, Nursing Executive Director and Medical Staff Quality Improvement Coordinator and are not eligible to vote. Every effort should be made to select the additional members using the following selection criteria: One (1) Hospitalist Physician, one (1) Emergency Department Physician, and one (1) Family Medicine Physician.

4. Policy. The Psychiatry Quality Improvement Committee functions according to established policy and criteria approved by the Psychiatry Department in accordance with monitoring guidelines established in the Medical Staff Bylaws, the Psychiatry Department Rules and Regulations, and policies.

5. Quorum. The presence of one-third (1/3) of the total membership eligible to vote at any regular or special meeting shall constitute a quorum for all actions. Once a quorum has been found, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

X. **THE RULES OF ORDER**. Any parliamentary questions not specifically resolved by the provisions set forth in the Medical Staff Bylaws or these Rules shall be subject to the latest edition of

Robert's Rules of Order.

XI. AMENDMENTS TO DEPARTMENT RULES. The Psychiatry Department Rules may be amended, changed or repealed by a majority vote of the entire Department at any regular or special meetings through procedure established in the Medical Staff Bylaws.

XII. POLICIES AND PROCEDURES. Policies and procedures will be developed to manage the day to day functioning and the monitoring of quality of care of the Psychiatry Department. Policies and procedures will be developed by the Psychiatry Department, will be approved by the Psychiatry Department and the Medical Executive Committee, and will be reviewed and revised at least annually.

XIII. ADOPTION. These Rules and Regulations are hereby adopted, superseding and replacing any and all previous Psychiatry Department Rules and Regulations, pursuant until such time as they are amended in accordance with the terms of the Medical Staff Bylaws.

ELKHART
GENERAL HOSPITAL

MEDICAL STAFF RULES AND REGULATIONS
RADIOLOGY DEPARTMENT

Reviews: 12/98; 2/99, 4/01, 4/04, 3/07, 12/12, 12/16
Revised: 4/01, 8/07, 8/09, 3/10, 3/17, 9/19, 3/20

I. NAME. The name of the clinical department shall be: The Radiology Department of the Medical Staff of Elkhart General Hospital.

II. PURPOSE. The purpose of this clinical department shall be to

- **A.** insure that all patients admitted to the hospital or treated in the Outpatient Department receive the best possible diagnostic radiology and radiation oncology.
- **B.** provide a chairman who will be responsive to the problems of a medical/administrative nature involving the Medical Staff, Governing Body, and Hospital Administration.
- **C.** initiate and maintain rules and regulations for proper and efficient function of the Radiology Department.
- **D.** promote and maintain educational standards.
- **E.** maintain a high level of professional performance with delineation of clinical privileges and continuing review of physicians' ethical conduct and professional performance.
- **F.** embrace the professional supervision and interpretation of the diagnostic radiology and radiation oncology procedures conducted in the hospital or other satellite imaging facilities governed by the hospital.

III. DEPARTMENTAL MEMBERSHIP

- **A.** Membership obligations.
  - **1.** Each member of the Radiology Department will be expected to perform the duties assigned by the Chairman in accordance with the Medical Staff Bylaws and Rules, the Radiology Department Rules and Regulations, and the Radiology Department policies and procedures.
  - **2.** Each member shall be expected to help perform the general services and teaching duties of the Department. These duties and responsibilities shall be outlined and assigned by the Department Chairman.
- **B.** Qualifications for membership. The Radiology Department shall consist of those physicians appointed to the Medical Staff whose practice is limited to diagnostic radiology, interventional radiology and radiation oncology.
  - **1.** Physicians who have been appointed to membership on the Medical Staff as provided by the Bylaws, shall be qualified for appointment to the Radiology Department.
  - **2.** A member shall be certified by the American Board of Radiology (ABR) or its Canadian equivalent; Radiation Oncologists must have successfully completed an AMA approved residency and must be ABR certified (or its Canadian equivalent) within the first two (2) years of Radiology Department membership.
  - **3.** Consultants used for physics shall be certified by the American Board of Radiology or document equivalent competence in radiologic physics.
  - **4.** It is recommended that the radiologist be a member of an Indiana County Medical Society, Indiana State Medical Society, Indiana Chapter of the American College of Radiology, a member or fellow of the American College of Radiology, or have said application pending.
- **C.** Appointment procedure. Initial appointment will be processed in accordance with the

Medical Staff Bylaws.

D. Reappointment process. Reappointment will be processed in accordance with the Medical Staff Bylaws.

E. Definitions of terms.

1. Diagnostic radiology practice is a consultative physician service rendered by qualified specialists who have completed an accredited residency program in diagnostic radiology or one of its branches, which include the utilization of all modalities of imaging, portrayal of human morphology and physiologic processes in medical diagnosis.

2. Radiation oncology is that branch of radiology which deals with the therapeutic application of ionizing radiation as well as particulate radiation from whatever source including artificially produced and naturally occurring radioactive materials as well and x-ray generators and particulate accelerators.

3. A radiologist is a physician certified by the American Board of Radiology (ABR) or its Canadian equivalent; Radiation Oncologists must have successfully completed an ACGME, AMA, or AOA approved residency and must be ABR certified (or its Canadian equivalent) within the first two (2) years of Radiology Department membership.

4. An Interventional radiologists is a diagnostic radiologist with additional subspecialty training in image guided diagnostic and therapeutic invasive procedures related to the vascular and nonvascular organ systems.

F. Required certification.

1. All Active members of the medical staff are required to obtain and maintain Basic Life Support (BLS) certification (Medical Staff Policy #910). Individual medical staff departments may require advanced life support certification(s) as well.

IV. CLINICAL PRIVILEGES

A. Scope of privileges. Clinical privileges will be delineated on the approved Radiology Department clinical privileges form.

B. Granting of privileges.

1. The granting of clinical privileges will be in accordance with the Medical Staff Bylaws.

2. The Chairman will review all requests and make recommendations for privileges.

3. The exercise of departmental privileges shall be contingent upon satisfactory completion of requirements for continuing education to maintain Board certification.

4. The granting of clinical privileges will be in accordance to the American College of Radiology Standards. Exceptions will be made by majority vote of the Radiology Department.

C. Criteria for granting of privileges.

1. All privileges. Privileges are granted based upon the applicant's education, clinical training, demonstrated skills, and capacity to manage procedurally related complications.

2. Physicians shall be certified by the American Board of Radiology (ABR) or its Canadian equivalent; Radiation Oncologists must have successfully completed an AMA approved residency and must be ABR certified (or its Canadian equivalent) within the first two (2) years of Radiology Department membership.

3. Vertebroplasty and Kyphoplasty.

a) Vertebroplasty. Vertebroplasty is a radiologically guided procedure in which a needle is placed into a fractured vertebral body and a cement mixture rendered radiopaque is injected into the fracture for stabilization and pain

relief. The procedure requires expertise in imaging guided needle placement, a thorough understanding of fluoroscopy with detailed attention to the location of the radiopaque cement injection, as well as familiarity with the potential complications of the procedure and the procedural techniques used to limit the occurrence of these.

b) Kyphoplasty is a variation of the Vertebroplasty procedure used for compression fractures of the vertebral bodies. During Kyphoplasty, there is placement of a needle under radiologic guidance into the fractured vertebral body. Coaxially, through this needle, a balloon is inflated restoring some of the lost height from the compression fracture. Subsequently, a cement mixture rendered radiopaque is placed filling the void created by the balloon procedure. Expertise in this procedure is similar to the above-described Vertebroplasty.

c) Criteria for granting these privileges. Privileges are based upon successful completion of a medical education course pertaining to Vertebroplasty, which included a hands-on or workshop type format. In addition, the physician must have performed either as primary operator or cooperator at least one case with a physician experienced in Vertebroplasty. In addition, the physician must have structured experience related to spine anatomy and radiographically-assisted invasive procedures of the spine.

D. Provisional status. All newly appointed staff members shall be governed during their provisional status in accordance with the Medical Staff Bylaws.

E. Monitoring.

1. Monitoring of the quality of patient care provided by members will be done in accordance with the Medical Staff Bylaws; and, the Elkhart General Healthcare System Performance Improvement Plan.

2. Monitoring will include the routine collection of patient care information based on approved objective criteria, assessment of the information to identify opportunities to improve care and to identify important problems in patient care, actions to improve patient care, monitoring to determine the effectiveness of the action, and documentation and reporting of the monitoring to the appropriate areas.

F. Additional privileges. Additional privileges may be requested, in writing, and will be processed in the same manner as listed above in IV.B. "Granting of privileges."

G. Request for privileges by non-department members. Privileges may be requested by non-department members in writing and will be processed in the same manner as listed above in IV.B. "Granting of privileges."

1. Special radiological privileges may be granted and limited to those radiologic procedures that the applicant is qualified to perform as determined by individual evaluation.

2. The granting of privileges to perform specific limited studies requires demonstration of special qualification of training and experience in the use of the equipment and in the interpretation of the results as well as practice in a field of related diagnostic/therapeutic activities. To verify the requisite training and experience, the applicant must submit objective proof of such qualifications in the form of a letter from a physician qualified to testify to the applicant's

a) training and experience in the specific limited interpretive radiologic study;

b) expected competence equivalent to a full-time radiologist performing the same service;

c) expected conformance to established patterns of patient care; and,

d) be subject to Radiology Department Rules and Regulations, and Medical

Staff Bylaws.

3. Such credentials must be submitted both to the Radiology Department and to any other department or committee designated to review these credentials by the Medical Staff Bylaws; and, is Board-certified in the specialty of the individual's practice.

4. The privilege to participate in radiologic procedures will be granted only for specific procedures or closely related groups of procedures. Each category applied for will be considered as a separate application to be taken on its own merit.

5. The granting of clinical privileges will be in accordance to the American College of Radiology Standards. Exceptions will be made by majority vote of the Radiology Department.

V. SPECIFIED PROFESSIONAL PERSONNEL

A. Qualifications for appointment. Appointment of specified professional personnel shall be in accordance with the Medical Staff Bylaws.

B. Privileges. Granting of clinical privileges shall be in accordance with the Medical Staff Bylaws.

C. Monitoring. Monitoring will be done as above in IV.E.

VI. OFFICERS AND DUTIES

A. The officers shall be a Chairman and a Vice Chairman. Qualifications and duties are as outlined in the Medical Staff Bylaws.

B. Duties of the Chairman:

1. The Chairman shall have discretionary powers regarding utilization of Department facilities, in order to insure their safe, efficient and economical use. To insure that the primary mission of the Department is achieved, i.e., the delivery of high quality imaging and therapy services to the patients of referring physicians, the utilization of these facilities shall be governed in such a manner that regularly scheduled inpatient and outpatient procedures shall have appropriate triage. Responsible arrangements will be made in all medially urgent circumstances.

2. The Chairman shall be responsible for the protection of personnel and patients against radiation hazards and the maintenance of proper safety precautions as required in the standards of the Joint Commission as well as assisting in meeting other requirements for accreditation of the Radiology Department as may be imposed by law.

3. The Chairman shall be actively involved in the future planning of the Department and the Hospital, and should assume the responsibility of being adequately informed in the matters of new technology and treatment.

4. The Chairman should be kept informed of and participate in the operations and changes in the Department.

5. The Chairman will assist the Director of the Department in decisions involving selection, evaluation and termination of non-physician personnel.

6. The Chairman shall serve, or appoint another member to serve, as the Radiation Safety Officer.

7. The Vice Chairman shall serve in the absence of the Chairman and assume the duties and responsibilities of the Chairman.

C. Other department officers. Depending upon the size and complexity of the department, other officers such as secretary, or division directors, may be established.

VII. CONSULTATION

. Consultation requirements. Consultations are to be obtained within the guidelines of sound medical practice. Specific indications may vary and Medical Staff Bylaws and Departmental Policies and Procedures dictate specifically many instances where consultation is

standard practice.

A. **DEPARTMENT MEETINGS**. Meetings of the Department shall be held in accordance with the Medical Staff Bylaws.

B. Frequency of meetings. The Department will meet at least four times throughout the year. Two (2) meetings will be electronic (meeting on paper) and two (2) meeting will be in person.

C. Purpose of meetings. The purpose of the meetings shall be to review and evaluate the quality and appropriateness of care provided to patients by the department and to discuss any other matters concerning the department.

D. Quorum. The presence of one quarter (1/4) of the members eligible to vote shall constitute a quorum for any regular or special meeting.

E. Manner of action. The action of a majority of members present at a meeting at which a quorum is present shall constitute proper authorization.

F. Attendance at Department meetings. Attendance requirements are outlined in the Medical Staff Bylaws. Administration and other hospital staff members may also be invited to attend meetings. Members of the Radiology Department with Radiation Oncology Privileges will be required to attend 1/3 of the Radiology Quality Improvement Committee meetings. Attendance at Radiology Department meetings may be required of Radiation Oncology physicians as necessary.

VIII. DEPARTMENTAL COMMITTEES

A. Standing and special committees shall be appointed as are deemed necessary and appropriate. Committee members shall be appointed by the Chairman and the Chairman shall be an ex officio member of each committee.

B. The Department shall maintain the following standing committees:

1. Radiology Quality Improvement Committee.

a) The Committee has the ongoing responsibility for quality assurance and peer review which will be done in accordance with Medical Staff Bylaws; and the Elkhart General Hospital Performance Improvement Plan.

b) Monitoring will include the routine collection of patient care information based on approved objective criteria, assessment of the information to identify opportunities to improve care and to identify important problems in patient care, actions to improve patient care, monitoring to determine the effectiveness of the action, and documentation and reporting of the monitoring to the appropriate areas.

IX. **THE RULES OF ORDER**. Any parliamentary questions not specifically resolved by the provisions set forth in the Medical Staff Bylaws or these Rules shall be subject to the latest edition of Robert's Rules of Order.

X. **AMENDMENTS TO DEPARTMENT RULES**. The Radiology Department Rules may be amended, changed or repealed by a majority vote of the entire Department at any regular or special meetings through procedure established in the Bylaws.

XI. **ARTICLE XII. POLICIES AND PROCEDURES**. Policies and procedures will be developed to manage the day to day functioning and the monitoring of quality of care of the Radiology Department. Policies and procedures will be developed by the Radiology Department, will be approved by the Radiology Department and the Medical Executive Committee, and will be reviewed and revised every three (3) years.

XII. ADOPTION. These Rules and Regulations are hereby adopted, superseding and replacing any and all previous Radiology Department Rules and Regulations, pursuant until such time as they are amended in accordance with the terms of the Medical Staff Bylaws.

ELKHART
GENERAL HOSPITAL

MEDICAL STAFF RULES AND REGULATIONS
ANESTHESIA DEPARTMENT

Revised 2004, 7/07, 4/10, 9/10, 9/11, 10/12, 01/13, 8/13, 10/14, 2/17, 4/17
Reviewed 2/96; 3/96; 1/99; 3/02; 9/02, 8/03, 6/04, 2/07, 02/10. 10/14, 9/20

I. NAME. The name of the clinical department shall be: The Anesthesia Department of the Medical Staff of Elkhart General Hospital.

II. PURPOSE. The purpose of this clinical department shall be:

- **A.** To provide competent and quality anesthesia service, including
- **B.** The management of patients who are rendered unconscious and insensible to pain and emotional stress during surgical, obstetrical, and other medical procedures (involves preoperative, intraoperative, and postoperative evaluation and treatment of these patients).
- **C.** The protection of life functions and vital organs (e.g. brain, heart, lungs, kidneys, liver) under the stress of anesthetic, surgical, obstetric, and other medical procedures.
- **D.** The management of problems in pain relief.
- **E.** The management of cardiopulmonary resuscitation.
- **F.** The management of problems in pulmonary care.
- **G.** The management of critically ill patients in special care units.
- **H.** To maintain a high level of professional performance with delineation of clinical privileges and continuing review of physicians' and non-physicians ethical conduct and professional performance.
- **I.** To provide an educational setting where appropriate.
- **J.** To formulate standard procedures for implementation of principles found within the general Medical Staff Bylaws and Rules and Regulations.

III. DEPARTMENTAL MEMBERSHIP

- **A.** Membership obligations. A member of the Anesthesia Department is obligated
  - **1.** To abide by the Medical Staff Bylaws, department and committee Rules and Regulations, and Policies.
  - **2.** To accept and faithfully discharge Department assignments.
  - **3.** To participate in fulfilling the requirements for providing emergency care.
  - **4.** The prime responsibility of the anesthetist is to provide the best possible patient care. Competence and availability are necessary prerequisites.
- **B.** Qualifications for membership. Physicians who have been appointed to membership on the Active Medical Staff as provided by the Bylaws, and who perform anesthesia as a specialty, part-time specialty or practice a subspecialty of Pain Medicine, shall be qualified for appointment to the Anesthesia Department.
- **C.** Appointment procedure. Initial appointment will be processed in accordance with the Medical Staff Bylaws.
- **D.** Reappointment process. Reappointment will be processed in accordance with the Medical Staff Bylaws.
- **E.** Required Certifications.
  - **1.** Basic Life Support (BLS) certification is required for all Active members of the medical staff according to Medical Staff Policy #910.

2. Requirements for Advanced Life Support certification is determined by Department. All Active members of the Anesthesia Department are required to obtain and maintain ACLS certification.

IV. CLINICAL PRIVILEGES

A. Scope of privileges. Clinical privileges will be delineated on the approved Anesthesia Department clinical privileges forms.

B. Granting of privileges. Granting of clinical privileges will be in accordance with Medical Staff Bylaws.

C. Criteria for granting of privileges. Privileges are based upon education, clinical training, demonstrated skills, and capacity to manage procedurally related complications.

1. Physicians: An applicant must have completed an accredited residency in Anesthesia or have documentation of appropriate education and/or experience for the privileges requested.

2. Non-physicians: An applicant must be a certified registered nurse anesthetist (C.R.N.A.) who satisfies state licensure requirements and can demonstrate appropriate education and/or experience in the privileges requested.

3. Anesthesia privileges are divided into the following three categories:

a. Category 1 privileges are granted to all physicians and all C.R.N.A.'s.

b. Category 2 privileges are granted to those individuals who are qualified to perform specific anesthetic procedures under specified conditions.

c. Category 3 privileges are granted to those individuals who by anesthesia training and experience are competent in the management of procedures for rendering a patient insensible to pain and emotional stress during surgical, obstetrical, and certain medical procedures using general anesthesia, regional anesthesia, and/or parenteral sedation to a level at which a patient's reflexes may be obtunded; and in the support of life functions under the stress of anesthetic and surgical manipulations.

4. Chronic Pain Medicine privileges. Practitioners who request privileges in pain management must have completed an accredited fellowship in Pain Management, or have documentation of appropriate education and/or experience for the privileges requested.

D. Provisional status. All newly appointed staff members shall be governed during their provisional status in accordance with Anesthesia policy 68 – Provisional Year.

E. Monitoring.

1. Monitoring of the quality of patient care provided by members will be done in accordance with the Medical Staff Bylaws, and the Quality Review Program.

2. Monitoring will include the routine collection of patient care information based on approved objective criteria, assessment of the information to identify opportunities to improve care and to identify important problems in patient care, actions to improve patient care, monitoring to determine the effectiveness of the action, and documentation and reporting of the monitoring to the appropriate areas.

F. Additional privileges. Additional privileges may be requested, in writing, and will be processed in the same manner as listed in IV.B. "Granting of privileges."

G. Privileges for non-department members. Privileges may be requested by non-department members in writing and will be processed in the same manner as listed in IV.B. "Granting of privileges."

1. Conscious (moderate) sedation for non-anesthesiologists.

a. Criteria:

(1) Moderate (conscious) sedation implies a medically controlled state of depressed consciousness without the loss of protective reflexes. The patient is able to respond to verbal instruction or physical stimuli. It is recognized, however, that the loss of protective reflexes including the ability to maintain a patent airway independently may occasionally occur and that the physician administering moderate sedation must be capable of managing these complications.

(2) The applicant must meet, and supply proof of, one of the following criterion:

(a) have current board certification in Critical Care, Emergency Medicine or Pulmonology;

(b) have taken airway management training as part of the residency program;

(c) have current ACLS certification; OR,

(d) have completed an EGH-approved or provided airway management course, such as BLS, along with reviewing the EGH-approved medication agent module, and passed the module's competency test.

(3) The applicant must list the primary drug that he/she will use, and the procedure with which he/she will use it.

b. COMPETENCY TEST. All EGH-approved anesthetic agent modules and their competency tests will be prepared and approved by the Pharmacy and Therapeutics Committee, and referred to the Anesthesia Department for final action and approval.

c. MONITORING. Initial screening will be done by the Pharmacy and Therapeutics Committee. Cases requiring additional review will be referred to the Anesthesia Department for further peer review and action.

2. Deep sedation in the non-intubated patient for non-anesthesiologists.

a. CRITERIA.

(1) Deep sedation implies the intent to depress consciousness, which may cause associated loss of airway reflexes, depressed respiratory and cardiovascular function.

(2) The applicant must meet, and supply proof of,

(a) current privileges for Conscious (Moderate) Sedation; AND

(b) one of the following criterion:

(i) have had at least six (6) months of anesthesia training;

(ii) have current ACLS certification, reviewed the EGH-approved anesthetic agent module, and passed the module's competency test; OR,

(iii) taken an airway management training as part of the residency program, reviewed the EGH-approved anesthetic agent module, and passed the module's competency test; OR,

(iv) have current board certification in Critical Care, Emergency Medicine or Pulmonology; AND

(c) having reviewed the EGH-approved anesthetic agent module and passed the competency test.

(3) The applicant must list the primary drug that he/she will use, and the procedure with which he/she will use it.

b. COMPETENCY TEST. All EGH-approved anesthetic agent modules and their competency tests will be prepared and approved by the Pharmacy and Therapeutics Committee, and referred to the Anesthesia Department for final action and approval.

c. MONITORING. Initial screening will be done by the Pharmacy and Therapeutics Committee. Cases requiring additional review will be referred to the Anesthesia Department for further peer review and action.

V. SPECIFIED PROFESSIONAL PERSONNEL

A. Qualifications for appointment. Certified Registered Nurse Anesthetists (CRNA's) who meet the state licensing qualifications who perform anesthesia as a specialty may be granted privileges in accordance with the Medical Staff Bylaws.

B. Privileges. Granting of clinical privileges shall be in accordance with the Medical Staff Bylaws.

C. Monitoring. Monitoring will be done as in #1 and #2 above.

VI. OFFICERS AND DUTIES

A. The officers shall be a Chairman and 2 Vice Chairmen. Qualifications and duties are as outlined in the Medical Staff Bylaws.

1. The Vice Chairman shall assume all duties of the Chairman during the Chairman's absence.

2. The Chairman or his designee shall assign anesthetists and anesthesiologists to cases daily, in an equitable manner, according to the Department policies.

3. The Chairman shall be a member of the Operating Room Committee.

4. The Chairman shall attend meetings of the Surgery Department, ex officio, to be a liaison between the Anesthesia and Surgery departments.

B. Method of election for department officers. Department officers shall be elected by a majority of members present at a meeting at which a quorum is present.

C. There shall also be a Pain Medicine Liaison position.

1. The duties are to review all matters pertaining to pain management, and to make recommendations pertaining to them, to the Anesthesia Department Chairman.

2. This position will be appointed by the Chief of Staff annually.

3. Requirements are to have privileges in Pain Management and to be a member of the Anesthesia Department.

4. The Pain Medicine Liaison Position is the Chairman of the Pain Medicine Committee.

VII. CONSULTATION.

An anesthesiologist consultation may be requested for all patients expected to present unusual or difficult anesthesia problems.

VIII. DEPARTMENT MEETINGS

A. Meetings of the Department shall be held in accordance with the Medical Staff Bylaws.

B. Frequency of meetings. The Department will meet at the discretion of the Chairman on an

"as needed" basis.

C. Purpose of meetings. The purpose of the meetings shall be to review and evaluate the quality and appropriateness of care provided to patients by the department and to discuss any other matters concerning the department.

D. Quorum. The presence of one-fourth (1/4) of the members eligible to vote shall constitute a quorum for any regular or special meeting. Once a quorum has been found, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

E. Manner of action. The action of a majority of members present at a meeting at which a quorum was established shall constitute proper authorization.

F. Attendance at Department meetings. Attendance requirements are outlined in the Medical Staff Bylaws. The Medical Associates with clinical privileges shall be invited (requested) to attend Department meetings and to take part in the Department activities but will not be eligible to vote since they are not members of the Medical Staff. Administration and other hospital staffs shall also be invited to attend meetings. Members of the Anesthesia Department with Pain Medicine Privileges will be required to attend 1/3 of the Pain Medicine Committee meetings. Attendance at additional Department meetings may be required of Pain Medicine physicians as necessary.

IX. DEPARTMENTAL COMMITTEES

A. Operating Room Committee.

1. Purpose. The purpose of the Operating Room Committee is to act as an advisory group to review rules and regulations, policies, procedures and concerns relating to running the operating room, including budgetary items such as physician's requests for new or replacement items, and to make recommendations concerning these to the Surgery Department and/or Administration for final action. The Operating Room Committee ("ORC") is directly accountable to the Department of Surgery. The primary role of this group is to oversee the operational initiatives directed by the Departments of Surgery and Anesthesia and in collaboration with hospital leadership. The secondary role of this committee is to evaluate clinical operations as a performance improvement body. The committee would be responsible for developing initiatives and directing working groups that support surgical "Best Practices".

2. Meetings. The Operating Room Committee will meet as needed, or as set by the Surgery Department Chairman.

3. Composition.

a. The Committee will be composed of the Chairman of the Surgery Department who will serve as Chairman, the Chairman of the Anesthesia Department, and at least four members of the Surgery Department who will be appointed by the Chairman of the Surgery Department.

b. The ORC will also be comprised of the following non physician voting members: Administrative Representative, Director of Surgical Services, and the Manager Operating Room.

c. Ex officio members will be the Medical Staff Quality Improvement Coordinator, Manager Out Patient Surgery, and the Director Performance Improvement/ Medical Staff Management.

4. Quorum. The presence of at least four surgeons (not including the chairman) and at

least one non physician voting member at any regular or special meeting shall constitute a quorum for all actions. All actions taken shall be binding while a quorum exists.

5. Objectives:

a. The ORC will direct ad hoc items, working groups, hospital staff, or other appropriate committee resources to support and complete the operational directives from the Departments of Surgery and Anesthesia.

b. The ORC will follow an agenda of performance improvement as established by the members. This agenda will be developed from internal drivers of quality, patient safety, efficiency, clinical effectiveness, and patient through put.

c. The ORC will work as a multidisciplinary clinical leadership team consisting of physician and nursing leadership in conjunction with clinical quality/risk management and performance improvement leadership staff.

d. The ORC will utilize the collective facility resources as working groups and operational managers to assist and perform the needs assessment analysis, implementation, and outcome assessments associated with each initiative. Experts both internal and external may be used to support the completion of these phases of any project or directive.

e. The ORC will be a leadership body that pursues operational efficiency and effectiveness.

f. The ORC will develop an annual meeting calendar and update an agenda after each meeting. The committee will be bound by the deadlines set at the Departments of Surgery and Anesthesia and members will be expected to work with their local staffs to assure timely completion of work plans.

g. The ORC will provide regular updates as to the progress and status of any work plans to the Departments of Surgery and Anesthesia.

6. Reports. Minutes will be kept and reported to the Surgery and Anesthesia departments.

B. Anesthesia Department Quality Improvement Committee (ADQIC)

1. Purpose. The Committee has the ongoing responsibility for Anesthesia Department quality assurance and peer review which will be done in accordance with Medical Staff Bylaws; and the Elkhart General Healthcare System Performance Improvement Plan.

2. Policy. The ADQIC functions according to established policy and criteria approved by the Anesthesia Department in accordance with monitoring guidelines established in the Medical Staff Bylaws, the Anesthesia Department Rules and Regulations, and policies. Based on their evaluations and proposed action plans, the ADQIC will make recommendations to the Anesthesia Department.

3. Meetings. The ADQIC will meet as needed, or as set by the Anesthesia Department chairman.

4. Composition. The Committee chairman and members are appointed by the Anesthesia Department chairman and will include: two Vice-Chairs of the Anesthesia Department, one physician member of the Anesthesia Department, Chief CRNA, Chief of Pain Medicine, and a representative of the Surgery Department. Ex officio members will be 1 (one) representative from each OB/GYN, Cardiothoracic Surgery and Nursing Management, along with the Vice President of Medical Affairs

and Medical Staff Quality Improvement Coordinator.

5. Quorum. The presence of one-third (1/3) of the total Anesthesia physician membership eligible to vote at any regular or special meeting shall constitute a quorum for all actions.

C. The Pain Medicine Committee. The purpose and composition will be in accordance to the Pain Medicine Committee Rules and Regulations.

D. The Chairman may appoint special committees as are deemed necessary and appropriate from time to time.

X. RULES OF ORDER. Any parliamentary questions not specifically resolved by the provisions set forth in the Medical Staff Bylaws or these Rules shall be subject to the latest edition of Robert's Rules of Order.

XI. AMENDMENTS TO DEPARTMENT RULES. The Anesthesia Department Rules may be amended, changed or repealed by a majority vote of the entire Department at any regular or special meetings through procedure established in the Bylaws.

XII. POLICIES AND PROCEDURES. Policies and procedures will be developed to manage the day to day functioning and the monitoring of quality of care of the Anesthesia Department. Policies and procedures will be developed by the Anesthesia Department, will be approved by the Anesthesia Department and the Medical Staff Executive Committee, and will be reviewed and revised at least every three years.

XIII. ADOPTION. These Rules and Regulations are hereby adopted, superseding and replacing any and all previous Anesthesia Department Rules and Regulations, pursuant until such time as they are amended in accordance with the terms of the Medical Staff Bylaws.

ELKHART
GENERAL HOSPITAL

MEDICAL STAFF RULES AND REGULATIONS
SURGERY DEPARTMENT

Reviews/Revisions: 12/95; 11/98; 2/99; 4/04, 1/07; 5/07; 09/07; 09/08; 06/11, 09/12, 3/14, 9/15, 7/17, 4/20

I. NAME. The name of the clinical department shall be: The Surgery Department of the Medical Staff of Elkhart General Hospital.

II. PURPOSE. The purpose of this clinical department shall be:

- **A.** To provide competent and quality medical care.
- **B.** To maintain a high level of professional performance with delineation of clinical privileges and continuing review of physicians' ethical conduct and professional performance.
- **C.** To provide an educational setting where appropriate.
- **D.** To formulate standard procedures for implementation of principles found within the general Medical Staff Bylaws and Rules and Regulations.

III. DEPARTMENTAL MEMBERSHIP.

- **A.** Membership obligations. A member of the Surgery Department is obligated to
  - **1.** abide by the Medical Staff Bylaws, department and committee Rules and Regulations, and Policies,
  - **2.** accept and faithfully discharge Department assignments,
  - **3.** and participate in fulfilling the requirements for providing emergency care.
- **B.** Qualifications for membership. Physicians who have completed a full residency in one or more of the surgical specialties and who have been appointed to membership on the Medical Staff as provided by the Bylaws, shall be qualified for appointment to the Surgery Department.
- **C.** Appointment procedure. Initial appointment will be processed in accordance with the Medical Staff Bylaws.
- **D.** Reappointment process. Reappointment will be processed in accordance with the Medical Staff Bylaws.
- **E.** Required certification.
  - **1.** Physicians who are Board Eligible will need to have proof of compliance regarding life support certification until they become Board Certified. (Medical Staff Policy #910)
  - **2.** For Board Certified Members, Basic Life Support (BLS) certification and/or Advanced Life support Certification(s) (ACLS, ATLS, PALS, NRP) is needed only if required by privileges.

IV. CLINICAL PRIVILEGES

- **A.** Scope of privileges. Clinical privileges will be delineated on the approved Surgery Department clinical privileges form.
- **B.** Granting of privileges. The granting of clinical privileges will be in accordance with the Medical Staff Bylaws.
- **C.** Criteria for granting of privileges. Privileges are based upon education, clinical training, demonstrated skills and capacity to manage procedurally related complications. Applicants should meet all of the following requirements that pertain to the privileges they are requesting.

1. Medical Staff
- **a.** One of the following for all procedures:
  - **(1)** Completion of a residency in each sub-specialty for which, or a residency which incorporates structured experience in, the privileges that are requested.
  - **(2)** Completion of an approved course with demonstration of competency documented by an approved credentialing society; a specified number of cases done under the supervision of a colleague who is credentialed in and currently doing the procedure may be required.
  - **(3)** Evidence of satisfactory knowledge with a specified number of cases done under the supervision of a colleague who is credentialed in and currently doing the procedure.
- **b.** For Obstetrical care and procedures:
  - **(1)** Category 1 privileges designate a degree of patient care in which the disease process or usual therapy poses a minimal risk to the life of the patient; qualifications are significant experience, or a minimum of three months structured graduate training in obstetrics in addition to demonstrated competence in the care of these conditions.
  - **(2)** Category 2 privileges designate a degree of patient care in which there is a major disease process or more complicated therapy that presents increased risk to the life of the patient; qualifications are successful completion of a formal residency training and demonstrated competence in Obstetrics. Caesarean Section is a privilege designated for Board Certified/Board eligible OB/GYN who has completed an OB/GYN residency.

2. Allied Health Professional staff:
- **a.** Podiatry procedures: A doctor of podiatric medicine who satisfies state licensure requirements and can demonstrate training in the privileges requested.
- **b.** Dental procedures: A doctor of dental science who satisfies state licensure requirements and can demonstrate training in the privileges requested.
- **c.** One of the following for all procedures:
  - **(1)** Completion of a residency in each sub-specialty for which, or a residency which incorporates structured experience in, the privileges that are requested.
  - **(2)** Completion of an approved course with demonstration of competency documented by an approved credentialing society; a specified number of cases done under the supervision of a colleague who is credentialed in and currently doing the procedure may be required.
  - **(3)** Evidence of satisfactory knowledge with a specified number of cases done under the supervision of a colleague who is credentialed in and currently doing the procedure.
- **d.** Nurse Midwives. Criteria for granting of privileges, meeting attendance requirements, and proctoring requirements for nurse midwives shall be governed by the Rules and Regulations of the Perinatology Committee.

D. Provisional status.

1. All newly appointed staff members shall be governed during their provisional status

in accordance with the Medical Staff Bylaws.

E. Monitoring.

1. Monitoring of the quality of patient care provided by members will be done in accordance with the Medical Staff Bylaws; and, the Elkhart General Healthcare System Performance Improvement Plan.

2. Monitoring will include the routine collection of patient care information based on approved objective criteria, assessment of the information to identify opportunities to improve care and to identify important problems in patient care, actions to improve patient care, monitoring to determine the effectiveness of the action, and documentation and reporting of the monitoring to the appropriate areas.

3. The Surgery Department delegates monitoring of all surgical procedures to the Surgical Review Committee.

4. The Surgery Department delegates monitoring of obstetrical procedures, including Cesarean section deliveries, to the Medical Staff Perinatology Committee.

5. Additional privileges. Additional privileges may be requested, in writing, and will be processed in the same manner as listed above.

F. Request for privileges by non-department members. Privileges may be requested by non-department members in writing and will be processed in the same manner as listed above.

V. SPECIFIED PROFESSIONAL PERSONNEL

A. Qualifications for appointment. Appointment of specified professional personnel shall be in accordance with the Medical Staff Bylaws.

B. Privileges. Granting of clinical privileges shall be in accordance with the Medical Staff Bylaws.

C. Monitoring. Monitoring will be done as above in IV.B.

VI. OFFICERS AND DUTIES

A. The officers shall be a Chairman and a Vice Chairman. Qualifications and duties are as outlined in the Medical Staff Bylaws.

1. The Chairman shall serve a term of two consecutive years, with no limit on the number of terms.

2. The Vice Chairman shall assume all duties of the Chairman during the Chairman's absence.

3. The Chairman, or the designated replacement in the Chairman's absence, shall be empowered to cancel a scheduled surgical procedure or restrict at any time a surgeon from performing surgery under circumstances that may be injurious to the welfare of the patient. The President of the Hospital shall be notified immediately when such measures are taken.

4. The Chairman shall serve as Chairman for the Operating Room Committee and shall appoint three members from the Surgery Department to serve on that Committee.

5. The Chairman shall appoint members to the Surgical Review Committee and shall be an ex officio member of that Committee.

6. The Chairman or his/her representative shall attend meetings of the Anesthesia Department, ex officio, to be a liaison between the Anesthesia and Surgery departments.

7. The Vice Chairman or his/her representative shall attend meetings of the Medical Record Committee.

B. Method of election for department officers.

1. The Vice Chairman shall be elected by a majority of members present at a meeting at

which a quorum is present.

2. The current Vice Chairman shall become Chairman when his/her term as Vice Chairman is over, and s/he shall serve until a new Vice Chairman is appointed.

VII. CONSULTATION. Consultation requirements. Consultations are to be obtained within the guidelines of sound medical practice. Specific indications may vary and Medical Staff Bylaws and Departmental Policies and Procedures dictate specifically many instances where consultation is standard practice.

VIII. DEPARTMENT MEETINGS. Meetings of the Department shall be held in accordance with the Medical Staff Bylaws.

A. Frequency of meetings. The Department will meet as needed to conduct business, or as set by the Chairman.

B. Purpose of meetings. The purpose of the meetings shall be to review and evaluate the quality and appropriateness of care provided to patients by the department and to discuss any other matters concerning the department.

C. Quorum. The presence of one-fourth (1/4) of the members eligible to vote shall constitute a quorum for any regular or special meeting. Once a quorum has been found, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

D. Manner of action. The action of a majority of members present at a meeting at which a quorum is present shall constitute proper authorization.

E. Attendance at Department meetings. Attendance requirements are outlined in the Medical Staff Bylaws. The Medical Associates with clinical privileges shall be invited (requested) to attend Department meetings and to take part in the Department activities but will not be eligible to vote since they are not members of the Medical Staff. Administration and other hospital staffs shall also be invited to attend meetings.

IX. DEPARTMENTAL COMMITTEES

A. Surgical Review Committee.

1. Purpose. The purpose of the Surgical Review Committee is to evaluate the hospital's surgical activity and ascertain that the surgery performed is justified and that the quality of care provided is satisfactory. The Committee makes recommendations based on this evaluation to the Surgery Department.

2. Meetings. The Surgical Review Committee will meet as needed, or as set by the Department chairman.

3. Composition. The Committee chairman and members representative of the surgical subspecialties are appointed by the Surgery Department chairman and will include a minimum of five (5) members with at least one representative from General Surgery and one representative from Orthopedics. Ex officio members will be the, Vice President of Medical Affairs and Medical Staff Quality Improvement Coordinator.

4. Policy. The Surgical Review Committee functions according to established policy and criteria approved by the Surgery Department in accordance with monitoring guidelines established in the Medical Staff Bylaws and the Surgery Department Rules and Regulations and policies.

5. Quorum. The presence of one-third (1/3) of the total membership eligible to vote at any regular or special meeting shall constitute a quorum for all actions. Once a quorum has been found, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the

meeting.

B. Operating Room Committee.

1. Purpose. The purpose of the Operating Room Committee is to act as an advisory group to review rules and regulations, policies, procedures and concerns relating to running the operating room, including budgetary items such as physician's requests for new or replacement items, and to make recommendations concerning these to the Surgery Department and/or Administration for final action. The Operating Room Committee ("ORC") is directly accountable to the Department of Surgery. The primary role of this group is to oversee the operational initiatives directed by the Departments of Surgery and Anesthesia and in collaboration with hospital leadership. The secondary role of this committee is to evaluate clinical operations as a performance improvement body. The committee would be responsible for developing initiatives and directing working groups that support surgical "Best Practices".

2. Meetings. The Operating Room Committee will meet as needed, or as set by the Surgery Department Chairman.

3. Composition.

a. The Committee will be composed of the Chairman of the Surgery Department who will serve as Chairman, the Chairman of the Anesthesia Department, and at least four members of the Surgery Department who will be appointed by the Chairman of the Surgery Department.

b. The ORC will also be comprised of the following non physician voting members: Administrative Representative, Director of Surgical Services, and the Manager Operating Room.

c. Ex officio members will be the Medical Staff Quality Improvement Coordinator, Manager Outpatient Surgery, and the Director Performance Improvement/ Medical Staff Management.

4. Quorum. The presence of at least four surgeons (not including the chairman) and at least one non physician voting member at any regular or special meeting shall constitute a quorum for all actions. All actions taken shall be binding while a quorum exists.

5. Objectives:

a. The ORC will direct ad hoc items, working groups, hospital staff, or other appropriate committee resources to support and complete the operational directives from the Departments of Surgery and Anesthesia.

b. The ORC will follow an agenda of performance improvement as established by the members. This agenda will be developed from internal drivers of quality, patient safety, efficiency, clinical effectiveness, and patient through put.

c. The ORC will work as a multidisciplinary clinical leadership team consisting of physician and nursing leadership in conjunction with clinical quality/risk management and performance improvement leadership staff.

d. The ORC will utilize the collective facility resources as working groups and operational managers to assist and perform the needs assessment analysis, implementation, and outcome assessments associated with each initiative. Experts both internal and external may be used to support the completion of these phases of any project or directive.

e. The ORC will be a leadership body that pursues operational efficiency and effectiveness.

f. The ORC will develop an annual meeting calendar and update an agenda after each meeting. The committee will be bound by the deadlines set at the Departments of Surgery and Anesthesia and members will be expected to work with their local staffs to assure timely completion of work plans.

g. The ORC will provide regular updates as to the progress and status of any work plans to the Departments of Surgery and Anesthesia.

6. Reports. Minutes will be kept and reported to the Surgery and Anesthesia departments.

C. The Chairman may appoint special committees as are deemed necessary and appropriate from time to time.

X. THE RULES OF ORDER. Any parliamentary questions not specifically resolved by the provisions set forth in the Medical Staff Bylaws or these Rules shall be subject to the latest edition of Robert's Rules of Order.

XI. AMENDMENTS TO DEPARTMENT RULES. The Surgery Department Rules may be amended, changed or repealed by a majority vote of the entire Department at any regular or special meetings through procedure established in the Bylaws.

XII. POLICIES AND PROCEDURES. Policies and procedures will be developed to manage the day to day functioning, including scheduling, and the monitoring of quality of care, of the Surgery Department. Policies and procedures will be developed by the Surgery Department, will be approved by the Surgery Department and the Medical Staff Executive Committee, and will be reviewed and revised every three (3) years.

XIII. ADOPTION. These Rules and Regulations are hereby adopted, superseding and replacing any and all previous Surgery Department Rules and Regulations, pursuant until such time as they are amended in accordance with the terms of the Medical Staff Bylaws.