

SUTTER MEDICAL CENTER, SACRAMENTO

MEDICAL STAFF RULES

March 14, 2011

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Sutter Medical Center, Sacramento – Medical Staff Rules

ARTICLE I. PREAMBLE

- 1.01 These Rules are intended to provide for the operation and governance of the Medical Staff in accordance with the guidance and structure set forth in the Medical Staff Bylaws (“Bylaws”). In the event of any conflict between the Bylaws and the Rules, the Medical Staff Bylaws shall prevail.
- 1.02 All Rules contained herein have been recommended by the Medical Executive Committee of the Sutter Medical Center, Sacramento Medical Staff and approved by the Board of Trustees in accordance with Section 15.01 of the Medical Staff Bylaws. These Rules are incorporated by reference and are a part of those Bylaws, carrying with them the Bylaws’ force and effect.
- 1.03 Except for this Article I, the Rules are organized to correspond to the parallel article of the Medical Staff Bylaws that addresses the same issue (although the section numbers will not be identical).
- 1.04 All definitions contained in the Bylaws are incorporated in these Rules.

ARTICLE II. PURPOSES AND RELATIONSHIPS TO HOSPITAL’S GOALS

RESERVED

ARTICLE III. MEDICAL STAFF MEMBERSHIP

3.01 QUALIFICATIONS FOR MEMBERSHIP-LIABILITY INSURANCE REQUIREMENTS

Each Practitioner granted Medical Staff membership or Clinical Privileges in the Hospital shall maintain in force professional liability insurance from a company authorized to sell insurance in the State of California with minimum limits of at least \$1 million per occurrence and \$3 million in the aggregate. All policies of insurance should be issued by carriers who carry a minimum financial rating of B+VII or better in A.M. Best’s Key Rating Guide. Exceptions will be considered on an individual basis if adequate financial resources are documented to assure coverage. In lieu thereof, the Member may participate in a trust agreement entered into pursuant to California statute or may demonstrate to the Medical Executive Committee, in the exercise of its sole discretion, that the Member has obtained insurance or made other provision not satisfying the requirements of this paragraph, affording equivalent financial security for the payment of any judgment or award, in no less than said minimum amounts. Subject to the approval of the Board, upon written request, the Executive Committee, for good cause shown, may waive this requirement with regard to such Member as long as such waiver is not granted or withheld on an arbitrary, discriminatory or capricious basis. In determining whether an individual exception is appropriate, the following factors may be considered:

- (a) Whether the Practitioner has applied for the requisite insurance;
- (b) Whether the Practitioner has been refused insurance, and if so, the reasons for such refusal;
- (c) Whether insurance is reasonably available to the Practitioner, and if not, the reasons for its unavailability;

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- (d) The Practitioner’s ability to demonstrate alternative means of satisfying financial responsibilities in the event of professional negligence.

ARTICLE IV. CATEGORIES OF THE MEDICAL STAFF

RESERVED

ARTICLE V. PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

5.01 APPLICATION FOR INITIAL APPOINTMENT

5.01-1 Pre-application

- (a) In order to have an application for Medical Staff membership accepted for review, the applicant must be able to document compliance with certain minimum objective criteria described in Section 3.02-1(a) of the Bylaws. This is done by completion of a PreApplication Questionnaire for Medical Staff Membership. The information that must be provided in completing this form includes: license and (if applicable) DEA permit; documentation of board certification, board admissibility, completion of an approved residency, or previous ten years of practice; documentation of insurance coverage; documentation of where the applicant has practiced for the previous five years; and confirmation of office/home locations.
- (b) If the applicant’s responses on the PreApplication Questionnaire demonstrate prima facie compliance with Section 3.02-1(a) of the Bylaws, then he or she may proceed with the submission of the Application Form.
- (c) An applicant who is unable to satisfy Rules 5.01-1(a) and (b), above shall not be entitled to apply for Medical Staff membership. Moreover, such a Practitioner shall not be entitled to the procedural rights set forth in the Bylaws, but may, and is encouraged, to submit comments and a request for reconsideration of the specific Bylaws or Rule(s) which have adversely affected such Practitioner. Processing of such comments and requests shall be in accordance with Article IX of the Bylaws.

5.01-2 Application

- (a) Upon satisfaction of Rules 5.01-1(a) and (b) above, the applicant shall complete an Application for Medical Staff Membership Form and return it to the Chief of Staff or his or her designee.
- (b) The application form shall be deemed a Credentials Committee record. It shall be developed by the Credentials Committee, and shall be subject to approval by the Medical Executive Committee and the Board. The application shall include a statement of agreement to abide by the Medical Staff Bylaws and Rules, and such lawful and reasonable requirements imposed by the Hospital. The Credentials Committee shall inquire regarding the applicant’s involvement in any professional liability actions, previously successful or currently pending challenges to any licensure or registration or the voluntary relinquishment of such licensure or registration, voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of Clinical Privileges while under investigation or disciplinary action at another hospital, health facility, or

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health care entity, participation in continuing medical education and obtain three professional references.

- (c) Applicants must provide a signed authorization that permits the Medical Staff to conduct a full criminal background check the nature and scope of which will be disclosed to the applicant. Criminal back ground checks will be conducted at time of initial application.

5.01-3 Effect of Application

By completing the PreApplication Questionnaire, applying for, or accepting appointment or reappointment to the Medical Staff, the applicant:

- (a) Signifies his or her willingness to appear for interviews in regard to his or her application for appointment.
- (b) Authorizes Medical Staff and Hospital representatives to consult with other hospitals, persons or entities who have been associated with him or her and/or who may have information bearing on his or her competence and qualifications.
- (c) Consents to the inspection, by Hospital representatives, of all records and documents that may be material to an evaluation of his or her professional qualifications and ability to carry out the Clinical Privileges he or she requests as well as of his or her professional ethical qualifications for Staff membership, regardless of who is in possession of these records.
- (d) Releases from liability to the fullest extent of the law the Medical Staff and the Hospital and its representatives for their acts performed in connection with evaluating the application and his or her credentials.
- (e) Releases from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to Hospital representatives concerning the applicant's ability, professional ethics, character, physical and mental health, emotional stability, and other qualifications for Staff appointment and Clinical Privileges.
- (f) Authorizes and consents to Hospital representatives providing other hospitals, professional societies, licensing boards, and other organizations concerned with provider performance and the quality of patient care with relevant information the Hospital may have concerning him or her, and releases Hospital representatives from liability for so doing.
- (g) Signifies the applicant's willingness to abide by all the conditions of membership, as stated on the application form, the reapplication form, and in these Rules and the Bylaws.

For purposes of this Section, the term "Hospital representative" includes the Board, its individual Trustees and committee members; the Chief Operating Officer, the Administrator; all Medical Staff officers, department officers, committee, and team members having responsibility for collecting or evaluating the applicant's credentials; and any authorized representative of any of the foregoing.

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5.01-4 Processing the Application

- (a) **Applicant's Burden:** The applicant shall have the burden of producing adequate information for a proper evaluation of his or her experience, background, training, demonstrated ability, and, upon request of the Medical Executive Committee or of the Board, physical and mental health status, and of resolving any doubts about these or any of the other basic qualifications specified in Section 3.02-1 of the Bylaws.
- (b) **Verification of Information:** The applicant shall deliver a completed application form to the Chief of Staff, who shall, within 30 days, seek to verify the information submitted. The application will be complete when all necessary verifications have been obtained, including current license, DEA certificate if appropriate, verification of all practice from professional school through the present, current malpractice liability insurance, criminal background check and professional reference letters. The Chief of Staff shall then transmit the application and all supporting materials to the Chair of each department in which the applicant seeks Privileges, and to the Credentials Committee.
- (c) **Incomplete Application:** If the Chief of Staff is unable to verify the information, or if all necessary references have not been received, or if the application is otherwise significantly incomplete, the Chief of Staff may delay transmitting the information to the departments or appropriate committees, or may transmit only the available information with an indication that further information will be forwarded upon receipt. If the processing of the application is delayed for more than 60 days and if the missing information is reasonably deemed significant to a fair determination of the applicant's qualifications, the Affected Practitioner shall be so informed. He or she shall then be given the opportunity to compel the continued processing of his or her application, but shall be informed that such an election shall not relieve him or her from the provisions of Rule 5.01-4(a).
- (d) **Department Action:** Upon receipt, the Department Administrative Committee shall review the application and supporting documentation, may conduct a personal interview with the applicant in accordance with the Policy for Determining Categories for initial applications. The Department shall transmit to the Credentials Committee on the prescribed form a written report and recommendations as to Staff appointment and Clinical Privileges.
- (e) **Credentials Committee Action:** The Credentials Committee shall review the application, the supporting documentation, the department's report and recommendations, and such other information available to it that may be relevant. The Credentials Committee may conduct a personal interview with each applicant in accordance with the Policy for determining categories for initial applications. It shall then transmit to the Medical Executive Committee on the prescribed form a written report and recommendations as to Staff appointment, department and section affiliations, and Clinical Privileges.
- (f) **Medical Executive Committee Action:** At its next regular meeting after receipt of the Credentials Committee report and recommendations, the Medical Executive Committee shall consider the report and such other relevant information available to it. The Medical Executive Committee shall then forward to the Board through the Administrator, a written report and recommendations as to Staff appointment,

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department and section affiliations, Clinical Privileges to be granted, and any special conditions to be attached to the appointment.

- (1) Favorable Recommendation: When the recommendation is favorable, the Administrator shall promptly forward, on the prescribed written form, the recommendations of the Department Chief and the Credentials Committee to the Board.
- (2) Adverse Recommendation: When the recommendation is adverse the Administrator shall immediately inform the Practitioner by Special Notice, and he or she shall be entitled to the procedural rights as provided in Article VIII of the Bylaws.

For the purposes of this section, an “adverse recommendation” by the Medical Executive Committee is as defined in Sections 8.04-1 and 8.04-2(a) of the Bylaws. A “minority report” is a dissenting opinion on the recommendation, together with the reasons for the dissent.

- (g) Deferral: The department, the Credentials Committee, or the Medical Executive Committee may defer its recommendation in order to obtain or clarify information, or in other special circumstances. A deferral must be followed up within 60 days of receipt of information with a subsequent recommendation for appointment and such Privileges as are to be granted, or for rejection for Staff membership.
- (h) Board Action
 - (1) On Favorable Medical Executive Committee Recommendation: The Board shall adopt, reject, or modify a favorable recommendation of the Medical Executive Committee, or shall refer the recommendation back to the Medical Executive Committee for further consideration, stating the reasons for the referral and setting a time limit within which the Medical Executive Committee shall respond. If the Board’s action is adverse to the applicant, the Administrator shall promptly inform the applicant by Special Notice, and he or she shall be entitled to the procedural rights as provided in Article VIII of the Bylaws.
 - (2) Without Benefit of Medical Executive Committee Recommendation: If the Board does not receive a Medical Executive Committee recommendation within the time period specified in Rule 5.01-4(k), the conflict resolution procedures described in Rule 5.01-4(i), below, shall be implemented. Thereafter, if the Board renders an adverse recommendation, the Administrator shall promptly so inform the applicant by Special Notice, and he or she shall be entitled to the procedural rights as provided in Article VIII of the Bylaws.
 - (3) After Procedural Rights: In the case of an adverse Medical Executive Committee recommendation pursuant to Rule 5.01-4(f)(2) or an adverse Board decision pursuant to Rule 5.01-4(h)(1) or (2), the Board shall take final action in the matter only after the applicant has exhausted or has waived his or her procedural rights as provided in Article VIII of the Bylaws. Action thus taken shall be the conclusive decision of the Board, or the Board may defer final determination by referring the matter back for further

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reconsideration. Any such referral shall state the reasons therefor, shall set a reasonable time limit within which reply to the Board shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. After receipt of such reply and of any new evidence in the matter, the Board shall make a final decision either to appoint or reject the applicant.

- (i) Conflict Resolution: The Board shall give great weight to the actions and recommendations of the Medical Executive Committee and in no event shall act in an arbitrary and capricious manner. Whenever the Board's proposed decision is contrary to the Medical Executive Committee's recommendation, or if the Medical Executive Committee has not yet rendered its recommendation, the Board or its designated representative shall consult with the Medical Executive Committee, and thereafter may issue a directive to the Medical Executive Committee to investigate or initiate a recommendation. If the Medical Executive Committee shall fail to render a recommendation within a reasonable period of time of any such directive, the Board may, after written notice to the Medical Executive Committee, render its recommendation with respect to the application. The provisions of this Rule 5.01-4(i) do not apply where the applicant has received or waived a hearing in accordance with Article XIII of the Bylaws.
- (j) Notice of Final Decision
 - (1) The Administrator shall give notice of the Board's final decision to the Chairpersons of the Medical Executive and the Credentials Committees, to the Chief of each department and section concerned, and (by Special Notice, if adverse) to the applicant.
 - (2) A decision and notice to appoint shall include: the Staff category to which the applicant is appointed; the department and section (if any) to which he or she is assigned; the Clinical Privileges he or she may exercise; and any special conditions attached to the appointment.
- (k) Time Periods for Processing: Applications for Staff appointments shall be considered in a timely and good faith manner by all individuals and groups required by the Bylaws to act thereon and, except for good cause, shall be processed within the time periods specified in the Bylaws, and summarized in this Rule 5.01-4(k). The Chief of Staff shall transmit an application to the appropriate departments upon completing the information collection and verification tasks. The department shall act on an application within 30 days after receiving it from the Chief of Staff, and the Credentials Committee shall act within 30 days of receipt of the department report. The Medical Executive Committee shall review the application and make its recommendation to the Board within 30 days after receiving the Credentials Committee report. The Board or the appropriate committees thereof shall then take action on the application at the next regular meetings. These time periods are provided to assist in the processing of the application and not to create rights for applicants to have their applications processed within these periods.
- (l) Adverse Action: As used in this section, adverse actions are as defined in Section 8.04-1 and 8.04-2(c) of the Fair Hearing Plan (see Article VIII of the Bylaws).

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- (m) In the event the Board should delegate some or all of its responsibilities described in this Article to one or more of its committees, the Board shall nonetheless retain ultimate authority to accept, reject, modify or return for further action or hearing, the recommendations of its committee.

5.02 REAPPOINTMENT PROCESS

5.02-1 Information Form for Reappointment

At least 150 days prior to the expiration date of each Staff Member's term of appointment, the Chief of Staff shall provide the Member with a reappointment form. Completed reappointment form shall be returned to the Chief of Staff within 30 days. Failure, without good cause, to return the form shall be deemed a voluntary resignation effective at the expiration of the Member's current term.

5.02-2 Content of Reappointment Form

The reappointment form shall be a prescribed form and shall seek at least the following: information necessary to update the Medical Staff file on the Staff Member's health-care-related activities other than as a Member of the Staff; a statement detailing the amounts of malpractice insurance carried; and a renewed request for Clinical Privileges. This form shall be developed by the Credentials Committee, and be approved by the Medical Executive Committee and the Board. In addition to completing the information requested on the reappointment form, the Staff Member shall submit his or her biennial dues, and he or she shall be responsible to provide any physical or mental health evaluations. The application shall also include statements regarding the applicant's involvement in any professional liability actions of claims, suits, settlements and dismissals, one peer reference when sufficient peer review information is not available, previously successful or currently pending challenges to any licensure or registration or the voluntary relinquishment of such licensure or registration, voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital, health facility, or health care entity and participation in continuing medical education..

5.02-3 Continuing Compliance with Requirements

- (a) By applying for reappointment and by accepting reappointment to the Medical Staff, the Staff Member signifies his or her continuing acknowledgment and acceptance of the provisions of Rule 5.01-3.
- (b) Continued membership and exercise of Clinical Privileges shall require at least the following:
 - (1) Documentation of continuing satisfaction of the Qualifications set forth at Section 3.02 of the Bylaws; and insofar as Clinical Privileges are concerned, compliance with the then-applicable requirements of his or her clinical department, including, if deemed necessary, requirements of additional proctoring with respect to Clinical Privileges that are used so infrequently as to make it difficult or unreliable to assess current competency without additional proctoring;

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- (2) Satisfactory results in Medical Staff performance improvement reviews, or satisfactory correction of any significant problems identified through such reviews; and
- (3) Obtain and document “reporting endorsements” (tail coverage) or “prior acts coverage” (nose coverage) when changing insurance companies.
- (4) Written notification to the Chief of Staff of any subsequently occurring changes in the information submitted during the appointment or reappointment process.

5.02-4 Processing the Application

- (a) Except as provided in this Section 5.02-4, the reappointment application shall be processed in substantially the same manner and subject to the same conditions described in Rule 5.01-4, above, and a personal interview need not be conducted by the Credentials Committee. For purposes of reappointment, the terms “applicant” and “appointment” as used in those sections shall be read, respectively, as “Staff Member” and “reappointment.”
- (b) The appropriate Department Administrative Committee shall appraise the Staff Member’s performance over the previous two years and shall report thereon to Credentials Committee.
- (c) The department administrative committee shall review the information provided by the Peer Review Committee, as well as any other pertinent information available to it, and shall consider the Staff Member’s physical and mental health status. The department Chief shall document this appraisal, as well as the department’s recommendations for reappointment and Privileges.

5.02-5 Reinstatement

Applicants who were formerly in good standing and who have left the Medical Staff for less than five years will be given a modified application form. The process of credentialing will be the same as for reappointment, except that the applicant’s burden shall be the same as that of an initial applicant. Reinstatement requests in excess of five years’ absence will be considered to be and processed as a new application for appointment. The requirement for proctoring of the applicant on return to the Medical Staff will be at the discretion of the administrative committee of the department in which the applicant is applying. In all cases, applicants for reinstatement shall be given the same fair hearing rights, including application of the same burden of proof, as initial applicants under the Bylaws.

5.03 REQUESTS FOR MODIFICATION OF APPOINTMENT

- (a) A Staff Member may, at any time, request modification of his or her department or section assignment, or Clinical Privileges, and a non-Provisional Staff Member may request modification of his or her Staff category by submitting a written application to the Chief of Staff on the prescribed form. Such application shall be processed in substantially the same manner as provided in Rule 5.02 for reappointment, except that the time periods for processing are extended by 45 days to enable evaluation and input by the responsible Peer Review/Department Administrative Committee and all affected departments.

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- (b) The Medical Executive Committee may recommend to the Board that a change in Staff category of a current Staff Member or the granting of additional Privileges to a current Staff Member be made provisional in accordance with procedures similar to those outlined in Section 4.05 of the Bylaws for initial appointments.

5.04 SYSTEMWIDE COOPERATION

Practitioners desiring to exercise Privileges through more than one System Affiliate are subject to the following provisions regarding Systemwide appointments and reappointments.

5.04-1 System Application Form

A single application form may be developed for use among all participating System Affiliates, and the applicant shall indicate those System Affiliates in which he or she desires to exercise Privileges, together with the Privileges desired.

- (a) An applicant requesting appointment/Privileges with an affiliated medical foundation must first demonstrate a contractual or employment relationship with such medical foundation.
- (b) Except for the consulting second opinion Privileges described in Section 6.03 of the Bylaws, an applicant requesting Privileges in a facility or department subject to an exclusive contracting arrangement must first demonstrate a contractual or employment relationship with the party holding the exclusive contract.
- (c) In addition to the provisions of subparagraphs (a) and (b), above, all Clinical Privileges shall be limited by the scope of Privileges normally available at each System Affiliate.

5.04-2 System Investigation

- (a) A coordinated investigation may be conducted in accordance with any Systemwide Credentialing Program rules. Such Program may delegate investigatory responsibility to one or more participants in the Program.
- (b) The results of the investigation shall be reported to the appropriate department for processing in accordance with Rule 5.01-4(d).

ARTICLE VI. DETERMINATION OF CLINICAL PRIVILEGES

6.01 CREDENTIALING PROCEDURE FOR ALLIED HEALTH PROFESSIONALS

6.01-1 Application Procedures

Applications for AHP Privileges will be processed in substantially the same manner as specified in Rule 5.01; however, the following special procedures apply as well:

- (a) The applicant and the sponsoring physician or responsible department Chief will obtain and complete an application form that has been developed by the Credentials Committee and approved by the Board.

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- (b) Upon receipt, the Department Administrative Committee shall review the application and supporting documentation and may conduct a personal interview with the applicant in accordance with the Policy for Determining Categories for Initial Applications. The department shall transmit to the Interdisciplinary Practices Subcommittee on a prescribed form a written recommendation for AHP approval and for practice parameters.
- (c) The applicant may be interviewed by the Interdisciplinary Practices Subcommittee in accordance with the Policy for Determining Categories for Initial application. The Subcommittee will make a recommendation through the chair of the Credentials Committee to the Medical Executive Committee.
- (d) The Medical Executive Committee shall make a recommendation to the Board through the Administrator.
- (e) Applications shall be processed in timely fashion appropriate to the circumstances of the case; strict compliance with Rule 5.01-4(k) is waived.

6.01-2 Frequency of Credentials Review of AHPs

The Interdisciplinary Practices Subcommittee of the Credentials Committee shall develop policies and procedures (which shall become effective upon approval by the Board) to implement the following:

- (a) All new AHPs shall be subject to a one-year period of formal observation and review.
- (b) Upon successful completion of the observation period, the credentials of each AHP practicing in the Hospital shall be reviewed at least biennially. The input of the Peer Review/Department Administrative Committee shall be obtained at the time of biennial review.

6.02 CIRCUMSTANCES FOR GRANTING TEMPORARY PRIVILEGES

Upon the written concurrence of the Chief of the department where the Privileges will be exercised and of the Chief of Staff, the Administrator, as a representative of the Board, or his or her designee in his or her absence or the Board may grant temporary Privileges in the following circumstances:

- (a) Pendency of Application: After receipt of an application for Staff appointment, including a request for specific temporary Privileges, an appropriately licensed applicant may be granted temporary Privileges at such time as (1) the applicant's credentials file is complete; and (2) after the applicant has met with the department administrative committee (or Chairperson) and the Credentials Committee (or Chairperson) and the file has been signed by those committees; and (3) the department Chief, Chief of the Medical Staff and the Administrator or his/her designee, or a member of the Board shall then review the file, and if such temporary Privileges are approved by them, sign the file evidencing the granting of temporary Privileges for a period not to exceed 120 days. In exercising such Privileges, the applicant shall act under the supervision of the Chief of the department to which he or she is assigned, and in accordance with the conditions specified in Section 6.07-3 of the Bylaws.

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Locum Tenens: Request for locum tenens status will be considered when failure to provide the services of the physician would result in undue hardship for the hospital or in cases of a documented important patient care need. A Practitioner applying for temporary Privileges in a locum tenens capacity shall follow the procedure outlined in the medical staff policy for temporary privileges. After receipt of an application for locum tenens appointment, including a request for specific temporary Privileges, an appropriately licensed Practitioner of documented competence who is serving as a locum tenens for a Member of the Medical Staff may be granted temporary Privileges for a period not to exceed three months and not less than two weeks duration.

6.02 -1 CIRCUMSTANCES FOR GRANTING EMERGENCY PRIVILEGES IN A DISASTER

During a period of officially declared emergency (as declared by local, state, or national officials) in which the emergency management plan has been activated and the organization is unable to meet immediate patient needs, a Practitioner who is not a Member of the Medical Staff may be granted temporary Privileges as needed to assist in staffing for the emergency. The Administrator or Chief of Staff or their designees, or the Medical Staff Director (as identified under the Hospital's Emergency Management Plan) have the option of granting emergency privileges, on a case-by-case basis, to non-staff licensed independent practitioners. Volunteers considered eligible to act as licensed independent practitioner must at a minimum present a valid government issued photo identification issued by a state or federal agency (e.g. driver's license or passport) and at least one of the following:

- ◆ A current picture hospital ID card that clearly identifies professional designation
- ◆ A current license to practice
- ◆ Primary source verification of the license
- ◆ Identification indicating that the individual is a member of a Disaster medical Assistance Team (DMAT) or MRC, ESAR-VHP or other recognized state or federal organization or groups
- ◆ Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state or municipal entity)
- ◆ Identification by current hospital or medical staff members(s) who possesses personal knowledge regarding volunteer's ability to act as a licensed independent practitioner during a disaster

Primary source verification of licensure begins as soon as the immediate situation is under control and is completed within 72 hours from the time the volunteer practitioner presents to the organization.

The Medical Staff Director shall determine the duties and area of assignment of those with emergency privileges. The Practitioner will be assigned to work with a currently credentialed Medical Staff Member. The practitioner will wear an SMCS issued photo ID badges that indicate they have emergency privileges. The Chief of Staff, or designee will make a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster privileges initially granted. The mechanism for evaluation will be direct observation or medical record review.

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Allied Health Professionals may be similarly considered for temporary privileges, and shall be subject to the same general conditions of supervision except that supervision may be performed by an AHP with current like Privileges.

Emergency temporary privileges may be rescinded at any time, and there shall be no rights to any hearing or review, regardless of the reason for such termination.

6.03 CIRCUMSTANCES FOR GRANTING NON-STAFF MEMBERS LIMITED MEDICAL ATTENDANCE PRIVILEGES

6.03-1 Special Consultants

With the prior written approval of the Administrator, the Chief of Staff, and the involved department Chief, licensed Practitioners of recognized expertise in their fields may be called in as special consultant to examine patients who have been admitted by a Staff Member and to consult with the Staff Member regarding patients' treatment. Such consultations shall be limited to no more than three per year; to perform additional consultations the Practitioner must apply for and be granted Consulting Staff membership.

6.03-2 Education and Training Programs

Licensed Practitioners who are not Members of the Medical Staff may be permitted to participate in education and training programs being conducted by Medical Staff Members. The precise description of such programs shall be set forth in written form by the affected department or Medical Staff committee and shall be approved by the Medical Executive Committee and the Board of Trustees.

6.03-3 Emergency Use of Hospital by Dentists

Emergency use of the Hospitals shall be available to dentists not on the Medical Staff with the approval of the Chair of the Dental Section, the Chief of Surgery or the Chief of Staff, and the Administrator. Emergency use of the Hospitals by dentists shall be limited to:

- (a) Relief of pain;
- (b) Acute injury to teeth not involving oral surgery; or
- (c) Continuation of therapy that cannot be postponed, or treatment that, if interrupted or delayed until the patient's release from the Hospital, will result in regression of a dental condition.

6.03-4 Organ Transplant Teams

- (a) Upon meeting all the legal requirements regarding donor and consents, surgical teams from recognized organ transplant units may enter the Hospital and use the operating room suites for the purpose of harvesting of appropriate organs from a legally dead person with the approval of the Chief of Staff.
- (b) Those surgical teams shall consist of health care professionals who have privileges at their respective hospitals to perform organ removal procedures, and who maintain professional liability insurance in the minimum amounts required for Medical Staff Members.

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6.04 FELLOWS, RESIDENTS, AND MEDICAL STUDENTS

6.04-1 Assignment to Hospitals

- (a) Fellows, residents, and medical students (“trainees”) and other trainees to include Nurse Practitioner, Physician Assistants and RN First Assist students may be assigned to the Hospital and its Staff, for training, and they may attend patients pursuant to the provisions of affiliation arrangements, approved by the Board of Trustees and Medical Executive Committee, and setting forth their respective responsibilities. The precise definition of such educational programs shall be set forth in written form by each affected department, and each department shall be responsible for participants in its approved program.
- (b) Resident physicians will be selected by an ACGME-accredited training institution and warranted to be licensed physicians in good standing or identified as unlicensed.
- (c) A letter of assignment will be provided to the Vice President for Clinical Integration, Sutter Health Central. This letter will identify the resident, assigned preceptor, and dates of rotation.
- (d) All trainees are to wear photo identification.
- (e) Professional liability insurance for the fellows, residents, and medical students will be provided by the primary training institution. Professional liability insurance covering risks associated with teaching and resident supervision for preceptors who have UCD faculty affiliations and appointments will be covered by UCD while supervising trainees.
- (f) Patients will be notified at admission that this is a teaching hospital and that portions of their care may be rendered by trainees under the supervision of Staff preceptor/attending physicians. If they decline same, this must be discussed between patient and attending physician with resolution prior to resident care.
- (g) Fellows from UCD or another ACGME institution shall require no specific credentialing if their practice is to remain within the scope of their fellowship area of specialty and if the fellowship is for one year or less. If practice is anticipated outside the scope of the fellowship, the full credentialing process will be accomplished. For non-UCD or non-ACGME institution fellows, the advanced practitioner policy will apply if the fellowship is for less than one year. However, if the fellowship is for greater than one year or if the practice is to extend outside the scope of the fellowship, a full credentialing will be accomplished.

6.04-2 Supervision

- (a) Trainees will at all times be under the supervision of a preceptor/attending physician. (“Preceptor” is defined as the physician who has undertaken to supervise the trainee. “Attending” is defined as the physician who has an on-going physician/patient relationship with the patient and who has admitted the patient to the hospital. The same physician may be both the preceptor and the attending physician.) The attending physician shall be ultimately responsible for all aspects of

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patient care. All patient care administered by the resident shall be coordinated with the preceptor/attending physician.

- (b) (1) The attending physician shall ultimately be responsible for all aspects of patient care. All patient care administered by the residents shall be coordinated with the preceptor/attending physician. The Preceptor must be a non-Provisional member of the Medical Staff and must have clinical privileges consistent with the nature and scope of the activities to be supervised. It is expected that when a resident contacts a faculty member and requests his/her presence to help manage a patient, the faculty member will respond to this request in an appropriate fashion and come in to evaluate the patient.
- (2) The patient must be seen on a daily basis and that visit documented. If the preceptor/attending physician is the primary physician, then documentation of that daily visit by the preceptor is required. If the preceptor/attending physician is a consultant only on the case, then each visit, daily or not, shall be documented. The only exception to this shall be by department policy.
- (3) Authorizations for admission, history and physical, discharge orders, operative reports, and cover sheets will either be completed or co-signed by the staff preceptor/attending physician. At the discretion of the attending physician, progress notes and orders written by licensed or registered trainees do not need to be countersigned. Medical students and other trainees must have all orders and progress notes co-signed.
- (4) The competency of the resident in specific procedures shall be determined by the attending physician/preceptor.
- (5) Each department should specify those procedures which require another surgeon to act as first assistant, in which case the resident may act as second assistant. The competency of the resident to first assist on any surgical procedure shall be determined by the attending physician/preceptor.
- (6) At the conclusion of the resident's rotation, an evaluation of the resident's activities should be completed according to the Evaluation Plan located in the Family Medicine Resident Handbook or similar document approved by the Medical Executive Committee. Additionally, the resident should be provided with an evaluation sheet for assessing activity of the preceptor/attending physician. This latter document should be kept on file in the Family Medicine Residency Program office.

6.04-3 Authority

- (a) Patients may be admitted or transferred to an ICU or telemetry unit by a resident under the supervision of the preceptor/attending physician if the preceptor is appropriately privileged in the critical care units. Alternately, an attending physician with intensive care privileges who has agreed to attend the patient may either assume full care or assume responsibilities as preceptor for the resident. Medical care within critical care units may be provided by residents only in conjunction with ICU-privileged preceptor/attending physicians. Specifics of care of individual

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patients will be closely coordinated with the ICU-privileged preceptor/attending physician in all circumstances.

- (b) Nursing staff will carry out resident and fellows patient orders. If there is question on appropriateness of any order or procedure to be performed on the unit, Hospital personnel are encouraged to verify the order with the resident then, if indicated, directly contact the preceptor/attending physician to verify treatment plans.
- (c) Trainees may participate in deliveries and cesarean sections at the discretion and under the supervision of the preceptor/attending physician.
- (d) Participation of trainees (with any level of training) in surgery or performing invasive procedures (including first assistant in surgery) will be at the discretion of the attending physician.
- (e) Induction of anesthesia for surgical or obstetrical procedures should not, in general, be initiated prior to the arrival of the preceptor/attending physician. Exceptions to this general policy may be made via direct contact between the attending physician and the anesthesiologist.

6.04-4 Medical Records

- (a) With the consent of the attending physician, residents may dictate histories and physicals, discharge summaries, and operative reports, but such dictation must be countersigned by the preceptor/attending physician. At the discretion of the attending physician, progress notes and orders written by licensed or registered trainees do not need to be countersigned.
- (b) When nonlicensed and nonregistered trainees are actively involved in the care of patients and are making entries in the medical record, evidence of active participation in, and supervision of, patient care should be documented in the medical record by the attending physician. The preceptor/attending physician shall co-sign all orders and progress notes.
- (c) Completion of the medical record is ultimately the responsibility of the attending physician. The residency director will act as an intermediary/facilitator to resolve any issues of records delinquency by a resident.

6.04-5 Resident Handbook

Policies and procedures for Resident physicians are outlined in the Sutter Health Family Medicine Residency Program Resident Handbook. A copy of the Handbook is located in the Residency Department and the Medical Staff Office. The Resident Handbook is to be approved by the MEC and Governing Board triennially, and more often if revisions occur.

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6.05 PROCTORING

6.05-1 Procedure

All requests for Clinical Privileges by new (whether Provisional, Consulting, or Affiliate Staff and current Members shall be subject to the restrictions regarding proctoring outlined in Section 4.05 of the Bylaws.

6.05-2 Role of Department Administrative Committee

Proctoring shall be conducted under the auspices of the department administrative committees. The Chief of Staff or the appropriate department Chief shall appoint proctors, and the persons appointed shall be deemed members of the responsible department administrative committee while serving as proctor.

6.05-3 Proctoring Guidelines

The department administrative committee shall develop department Rules (subject to approval by the department, the Medical Executive Committee, and the Board) to implement the following proctoring guidelines:

- (a) For all initial appointees to the Medical Staff, proctoring will begin immediately, with the first case scheduled or admitted, or shift in the case of Diagnostic Imaging & Radiation Oncology, eICU, Emergency Medicine and Laboratory Medicine, following appointment to the Provisional or Temporary (including locum tenens) Staff.
- (b) For Members who are granted new Clinical Privileges for which proctoring is required and Members seeking reappointment of unused or rarely used Privileges, proctoring will begin immediately, with the first scheduled case or admission, following appointment or reappointment.
- (c) In other cases, proctoring commencement and frequency shall be as determined by the department administrative committee.
- (d) The duty of the proctor is not to participate in patient care, but to review and report to the performance improvement committee.
- (e) Proctors shall submit written reports on appropriate evaluation forms promptly following each case/shift evaluated.
- (f) The department administrative committee shall require sufficient evaluations to provide adequate bases for determining competency or defining Privileges.

ARTICLE VII. CORRECTIVE ACTION

7.01 MEDICAL RECORDS DELINQUENCY

7.01-1 The responsible Staff Member shall be automatically suspended if the physician, dentist or podiatrist fails to complete the record within 7 days after notification. Such suspension shall

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be summary in nature, and shall remain in effect until the delinquent records have been completed to the standards of the Medical Staff.

- 7.01-2 The Medical Staff Member shall be responsible for notifying the Medical Record Director or his or her designee of the Member's inability to comply with Staff requirements for completing medical records in the event of illness or prolonged vacation. Notice of vacation must be given prior to the vacation. Any record for which a 7-day notice has been received must be completed before departure on vacation.
- 7.01-3 Practitioners whose Privileges are suspended for incomplete medical records shall be denied the following Privileges:
- (a) Admission of new patients;
 - (b) Scheduling of patients for any operative or invasive procedure;
 - (c) Assisting in any operative or invasive procedures;
 - (d) Consultations; and
 - (e) Treating patients in the Emergency Room (with the exception of treating and admitting no-doctor patients while on Emergency Room back-up call).
- 7.01-4 Effect of cumulative suspensions:
- (a) Any Staff Member under automatic summary suspension pursuant to Rule 7.01-1 above, must complete the delinquent medical records within 14 days of the suspension. If the records are not completed within this 14-day time frame, the Member's parking permit shall be immediately suspended. The Member (or the Member's office if he/she is unavailable) and the Chief of the Member's Department shall be notified of the parking permit suspension as soon as practicable.
 - (b) If a Medical Staff Member is suspended for a continuous period greater than 25 days, the Medical Staff shall incontestably presume that the Member no longer desires to practice in the Hospital and the Member's Medical Staff membership shall be automatically terminated, effective the 26th day. The procedural rights of Section 7.04-8 of the Medical Staff Bylaws shall apply.
 - (c) Reinstatement to the Medical Staff following the automatic termination described in paragraph (b) above shall require completion of all past records and permission of Chief of Staff or designee and Chief Operating Officer or designee. As this termination is not deemed an adverse action, the waiting period provided in the Medical Staff Bylaws, Section 5.04 shall not apply.

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ARTICLE VIII. INTERVIEWS, HEARINGS AND APPELLATE REVIEW-FAIR HEARING PLAN

RESERVED

ARTICLE IX. REVIEW OF BYLAWS, RULES AND MEDICAL STAFF POLICIES

RESERVED

ARTICLE X. MEDICAL STAFF OFFICERS AND MEDICAL DIRECTOR

RESERVED

ARTICLE XI. COMMITTEES AND TEAMS

11.01 STANDING COMMITTEES

(a) In accordance with Article XI of the Bylaws, there shall be the following standing committees of the Medical Staff:

- Bioethics, with the following standing subcommittee:
 - Fetal Therapy Board
- Bylaws
- Clinical Practices Review Council
- Credentials, with the following standing subcommittee:
 - Interdisciplinary Practices Subcommittee
- Critical Care
- Death and Tissue
- Joint Conference
- Medical Executive Committee
- Medical Staff Well-Being
- Oncology
- Quality Council
- Peer Review Committee

(b) Additionally, there shall be the following standing teams, as further described in Rule 11.14:

- Pharmacy and Therapeutics
- Infection Control
- Education
- Transfusions
- Utilization Review/Clinical Effectiveness
- Medical Records
- Council on Patient Care Standards

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- Safety

(c) Additionally, there shall be the following standing committee of the Sutter Health System, as further described in Rule 11.15:

- Sutter Health Patient Safety and Quality Committee

11.02 GENERAL PROVISIONS

The following provisions apply (but not by way of limitation) to all standing committees and teams of the Medical Staff.

11.02-1 Composition

- (a) All Medical Staff members of committees and teams shall be appointed by the Chief of Staff with the approval of the Medical Executive Committee.
- (b) The Chief of Staff and the Administrator or his or her designee may attend each committee or team, without vote.
- (c) The Chair of each committee shall be appointed by the Chief of Staff; the Vice Chair shall be appointed by the Chair from among the committee members.
- (d) Team Leaders shall be appointed by the Chief of Staff.

11.02-2 Term

- (a) Ordinarily, committee and team members will be appointed to serve for two years, subject to unlimited renewal.
- (b) Ordinarily, committee and Team Leaders Chairs shall serve a two-year term.
- (c) The Chief of Staff shall have the discretion to reappoint committee or team members or Chairs or Team Leaders to serve more than two consecutive terms.

11.02-3 Duties

Each Staff committee and team is responsible to:

- (a) Develop policies and procedures describing how it will carry out its purpose; and, upon approval by the Medical Executive Committee and the Board, implement these policies and procedures.
- (b) Unless otherwise provided by Hospital policy, maintain permanent records of its activities in accordance with Section 14.01 of the Bylaws.

11.02-4 Authority

Each Staff committee and team shall have the following authority:

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- (a) To review all records and charts pertinent to the purposes of the committee or team and to perform performance improvement activities as requested.
- (b) To require the appearance before it of any Practitioner or nurse whose conduct is being reviewed, or who has information relevant to the purposes of the committee or Team.

11.02-5 Accountability and Relationships

- (a) Each committee shall be accountable:
 - (1) To its Chair.
 - (2) The Chair of each committee shall be accountable to the Medical Executive Committee and the Chief of Staff.
 - (3) Each Chair shall regularly report to the Medical Executive Committee, through the Chief of Staff.
- (b) Each team shall be accountable:
 - (1) To its Team Leader.
 - (2) To the Quality Council, with respect to general process and quality improvement matters.
 - (3) To the department administrative committee(s), with respect to process and quality improvement matters affecting the department(s).
 - (4) To the responsible Peer Review Committees, with respect to physician-specific problems.

11.02-6 Meetings

Unless otherwise specified in the Bylaws or these Rules, all committees and subcommittees shall meet at least quarterly or more frequently if requested by the committee Chair, the Medical Executive Committee or the Chief of Staff as necessary to fulfill their purpose.

11.03 BIOETHICS COMMITTEE

11.03-1 Composition

The Bioethics Committee shall be comprised of at least the following members: Seven physicians, one of whom should be a psychiatrist; two registered nurses; one clergy; one medical social worker; one member of Hospital administration; and two non-Hospital local community members-at-large. Additional members may be appointed by the Chief of Staff. The Chair shall be a physician appointed by the Chief of Staff, and the Vice-Chair shall be a physician or non-physician Sutter Medical Center employee selected by the Chair. If the Vice-Chair is a non-physician, he/she is not eligible to ascend to the committee Chair position.

11.03-2 Purpose

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The purpose of the Bioethics Committee is to impact positively upon the quality of health care provided by Sutter General and Memorial Hospitals, Sutter Center for Psychiatry, and the Sutter Continuing Care facilities by:

- (a) Providing assistance in decision-making processes which have bioethical implications.
- (b) Educating members within Sutter’s hospital community on bioethical issues and dilemmas.
- (c) Facilitating communication about ethical issues and dilemmas among members of Sutter’s hospital community, in general, and among participants involved in bioethical dilemmas and decisions, in particular.

11.03-3 Meetings

The Bioethics Committee shall meet on an as-needed basis. Meetings shall be called by the Chair.

11.03-4 Fetal Therapy Board

The Fetal Therapy Board shall be a subcommittee of the Bioethics Committee.

(a) Composition

The Fetal Therapy Board shall be comprised of five Senior Staff Members, one each representing the specialties of genetics, pediatrics, perinatology, neonatology, and obstetrics and gynecology; one advanced life support-qualified registered nurse, one social worker, one member of the clergy, and non-Hospital local community member.

(b) Purpose

The Purpose of the Fetal Therapy Board is to impact positively upon the quality of health care provided to obstetrical, perinatal and neonatal patients by:

- (1) Providing assistance in decision-making processes which have bioethical implications relating to these patients.
- (2) Educating members within Sutter’s hospital community on bioethical issues and dilemmas relating to these patients.
- (3) Facilitating communication about ethical issues and dilemmas among members of Sutter’s hospital community, in general, and among participants involved in bioethical dilemmas and decisions, in particular, as it relates to these patients.

(c) Reporting Obligation

The Fetal Therapy Board shall report to the Bioethics Committee.

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(d) Meetings

The Fetal Therapy Board shall meet on an as-needed basis. Meetings shall be called by the Chair.

11.04 BYLAWS COMMITTEE

11.04-1 Composition

The Bylaws Committee shall be comprised of at least five Members of the Senior Staff which shall include the immediate past Chief of Staff.

11.04-2 Purpose

The purposes of the Bylaws Committee are to ensure that the Medical Staff Bylaws and Rules adequately and accurately describe the purposes and functioning of the Medical Staff organization, and to ensure that such Bylaws and Rules are reviewed at least biennially and updated as necessary.

11.04-3 Meetings

The Bylaws Committee will meet on an as-needed basis as requested by the Bylaws Committee Chair or Chief of Staff.

11.05 CLINICAL PRACTICES REVIEW COUNCIL

11.05-1 Composition

The Clinical Practices Review Council shall be comprised of one physician member of the Medical Staff, appointed by the Chief of Staff, and one or more representatives of nursing administration, appointed by the Areawide Patient Care Executive.

11.05-2 Purpose

The purpose of the Clinical Practices Review Council is to oversee quality improvement and performance improvement activities pertaining to the Hospitals' nursing services.

11.05-3 Meetings

The Clinical Practices Review Council shall meet at least quarterly, and shall regularly report on its activities to the Medical Executive Committee.

11.06 CREDENTIALS COMMITTEE

11.06-1 Composition

The Credentials Committee shall be comprised of five Senior Staff Members.

11.06-2 Purpose

The purpose of the Credentials Committee is to evaluate the qualifications of all applicants for Medical Staff appointment, reappointment, promotions, Privileges, or changes in Staff

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categories. The Committee shall coordinate the credentials review activities within the various departments, maintain records used in evaluation of applicants, and shall develop recommendations based on its own and the department Chiefs' evaluations of each applicant.

11.06-3 Other

A confidential file on each applicant, Staff Member, and Allied Health Professional shall be maintained by the Credentials Committee in the office of the Medical Staff Services Manager.

11.06-4 Interdisciplinary Practices Subcommittee

(a) Composition

The Interdisciplinary Practices Subcommittee shall be comprised of an equal number of Medical Staff and nursing staff members as follows: two physician Members of the Senior Staff and two registered nurses, at least one of whom shall represent nursing administration and who shall be voting members of the Subcommittee. In addition, representatives of the various allied health professions should serve as consultants on an as-needed basis, and, if available, shall be included in the committee proceedings when a member of the specialty is applying. The Chairperson or Vice-Chairperson of the Credentials Committee will chair the Interdisciplinary Practices Subcommittee.

(b) Purpose

The purpose of the Interdisciplinary Practices Subcommittee is to oversee, in accordance with State regulations, the credentialing and performance of registered nurses performing standardized procedures and of Allied Health Professionals practicing in the Hospital.

(c) Reporting Obligation

The Interdisciplinary Practices Subcommittee shall report to the Credentials Committee and the Medical Executive Committee as described in the Interdisciplinary Practices Subcommittee Guidelines for Allied Health Professionals.

11.07 CRITICAL CARE COMMITTEE

11.07-1 Composition

The Critical Care Committee shall be comprised of at least eight Members to include the directors of the critical care units. In addition, one critical care nurse (appointed by Nursing Administration) and a representative of Hospital administration (appointed by the Administrator) shall be non-voting members of the Committee.

11.07-2 Purpose

The purpose of the Critical Care Committee is to develop, implement and maintain a well-defined plan for continuous delivery of quality care rendered in the critical care units of the Hospital. This plan shall include the manner of selection and supervision of the directors of the Hospital's critical care units, and shall ensure 24-hour in-hospital or on-call coverage of

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the unit by the directors or their designees. Critical care unit directors shall refrain from voting on matters relating to the selection and supervision of the directors of the Hospital's critical care unit.

11.08 MULTIDISCIPLINARY PEER REVIEW COMMITTEE

11.08-1 Composition

The Multidisciplinary Peer Review Committee shall be comprised of at least seven Members of the Senior Staff and should include one critical care specialist and one cardiologist. Chief of Staff or Committee Chair can designate alternates.

11.08-2 Purpose

The purposes of the Multidisciplinary Peer Review Committee are to review the following types of cases:

1. Cases of deaths according to department criteria
2. All removed tissue where the tissue is found to be normal or not consistent with the clinical diagnosis
3. All cases in which a major discrepancy exists between preoperative and postoperative (including pathologic and/or radiological) diagnoses
4. Multidisciplinary Quality Action Reports (QARs) referred by Medical Staff Leadership
5. Referred cases by the department peer review committee
6. Requests for reconsideration as outlined in the Medical Staff Policy on Peer Review

The Multidisciplinary Peer Review Committee can also recommend measures to correct any problems discovered. Additional screening mechanisms based on pre-determined criteria may be developed to identify types of cases that may be excluded from review and to identify other cases for more intense evaluation. The Committee shall also develop and implement measures to promote the Hospital's autopsy policy.

11.08-3 Other

1. The committee will conclude each case using the established committee Decision Choices currently used by the quality Improvement Committees.
2. If the same chart is reviewed at the Department QI level as well as the Multidisciplinary Peer Review Committee, and each peer review body reaches a different conclusion, the final peer review finding will be that of the Multidisciplinary Peer Review Committee after receiving input from the applicable Department QI Committee.
3. The Chair shall establish formal and regular communications with the Chairs of the Peer Review Committees and share the peer review findings. Formal communication is also required for cases that were referred to the committee by the Medical Staff Leadership and physicians/AHPs who requested reconsideration.

11.09 JOINT CONFERENCE COMMITTEE

11.09 -1 Composition

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The composition of the Joint Conference Committee shall be as defined in Section 11.02-1 of the Bylaws.

11.09-2 Purpose

The Committee's purpose, responsibilities and authority shall be as described in Section 11.02-2 of the Bylaws.

11.09-3 Other

Unresolved problems shall be referred to the Medical Executive Committee in a timely fashion.

11.10 MEDICAL EXECUTIVE COMMITTEE

11.10-1 Composition

The composition of the Medical Executive Committee shall be as defined in Section 11.03-1 of the Bylaws.

11.10-2 Purpose

- (a) The Committee's purpose shall be as described in Section 11.03-2 of the Bylaws.
- (b) An additional purpose of the Medical Executive Committee shall be to develop, implement and maintain a well-defined plan for emergency care based on community needs and the capabilities of the Hospital so as to ensure that adequate appraisal, advice or initial treatment shall be rendered to all ill or injured persons who present themselves to the Hospital.

11.10-3 Authority

The Medical Executive Committee shall have the authority to:

- (a) Summarily suspend any Practitioner in accordance with Section 7.03 of the Bylaws.
- (b) Require any Practitioner to appear before the Committee whenever the Committee considers it necessary in order to carry out its duties and responsibilities.
- (c) Appoint subcommittees to study and advise on any matters before the Committee. Subcommittees may consist of Practitioners other than those on the Medical Executive Committee, but each subcommittee shall be chaired by a member of the Medical Executive Committee.
- (d) Take any action which the Committee deems necessary in discharging its duties and responsibilities.

11.10-4 Accountability and Relationships

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- (a) The Medical Executive Committee is directly responsible and accountable to the Chief of Staff. The Medical Executive Committee shall report through the Chief of Staff:
 - (1) To the Board, on at least the following:
 - a. The discharge of the functions of the Medical Staff organization as stated in the Medical Staff Bylaws.
 - b. The quality of medical care rendered in the Hospital as reflected by ongoing performance improvement programs.
 - c. All disciplinary actions in progress.
 - d. The conduct or professional performance of any Practitioner or Allied Health Professional or any other matter when so requested by the Administrator.
 - (2) To any committee of the Board whenever such committee requests a report.
 - (3) At least quarterly to the Staff, and at any special Staff meetings or at any other meeting of the Staff when requested to do so by any Member.
- (b) The Medical Executive Committee shall communicate on an ongoing but as-needed basis with the Quality Council as to general process and quality improvement matters.

11. 11 MEDICAL STAFF WELL-BEING COMMITTEE

11. 11-1 Composition

- (a) The Medical Staff Well-Being Committee shall be comprised of no less than six Senior Staff Members, a majority of whom, including the Chair, shall be physicians and two of whom shall be psychiatrists.
- (b) Insofar as possible, members of this committee shall not serve as active participants on other peer review or quality assessment committees while serving on this committee.

11. 11-2 Purpose

- (a) The purpose of the Medical Staff Well-Being Committee shall be to improve the quality of care and promote the competence of the Medical Staff by attempting to resolve matters relating to Medical Staff Members' health, well-being or impairment prior to their evolving into significant patient care problems.
- (b) The Medical Staff Well-Being Committee may receive reports related to the health, well-being, or impairment of Medical Staff Members and, as it deems appropriate, may investigate such reports. With respect to matters involving individual Medical Staff Members, the Committee may, on a voluntary basis, provide such advice, counseling, or referrals as may seem appropriate. Such activities shall be confidential; however, in the event information received by the Committee

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substantially demonstrates that the health or impairment of a Medical Staff Member may pose a risk of harm to Hospital patients (or prospective Hospital patients), that information shall be referred for corrective action. The Committee shall also consider general matters related to the health and well-being of the Medical Staff and, with the approval of the Medical Executive Committee, develop educational programs or related activities.

11. 11-3 Meetings

The Committee shall meet on an as-needed basis. It shall maintain only such records of its proceedings as it deems advisable, but shall report on its activities on a routine basis to the Medical Executive Committee.

11. 12 ONCOLOGY COMMITTEE

11. 12-1 Composition

The Oncology Committee shall be comprised of Senior Staff Members as follows: Required physician members, one representative each from the following specialties:

- Family Medicine
- Pathology
- Gynecology
- Pediatrics
- General Surgery
- Diagnostic Radiology
- Radiation Oncology
- Pain Control/Palliative Care
- Medical Oncology , one of whom shall be the Chair of the Hematology-Oncology Section
- Medical Director of the Sutter Cancer Center
- Cancer Liaison Physician (CLP)-a physician of any specialty may be selected to be the CLP and this position will also fulfill the role of the Vice Chair of the committee.
- A Representative from the Section of Urology shall be a resource member of the Committee.

In addition, required non-physician members shall include:

- Cancer program administrator
- Oncology nurse
- Social worker or case manager
- Certified tumor registrar (CTR)
- Performance improvement or quality management representative
- Clinical research representative

Based on assessment of the scope of services, additional members recommended, but not required include the following:

- Dietary/nutrition specialist
- Pharmacist
- Rehabilitation representative
- Pastoral care representative
- Psychiatric or mental health professional
- American Cancer Society staff representative

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The cancer committee/leadership body Chair is a physician, who may also fulfill the role of one of the required physician specialties. Individual members of the committee are designated to coordinate one of each of the following four major areas of program activity: Cancer Conference, Quality Control of Cancer Registry Data, Quality Improvement and Community Outreach .

11.12-2 Purpose

The Oncology Committee is multidisciplinary and provides leadership to the Cancer Program. The Committee is responsible for goal setting, planning, initiating, implementing, evaluating and improving all cancer-related activities in the facility. The Committee will follow the requirements outlined in the most current Commission on Cancer (CoC) Programs Standards. The Committee will appoint such subcommittees it deems necessary for the maintenance of CoC standards or other regulatory standards at the Hospital.

11.13 QUALITY COUNCIL

11.13-1 Composition

The Quality Council shall be comprised of the Chief of Staff, the Vice Chief of Staff, the Chief Operating Officer, the Chief Financial Officer, the Support Services Director, the Areawide Patient Care Executive, and a representative of the Hospital's Quality Information Management Department. Resource personnel shall be appointed by the Chief of Staff to assist the Committee.

11.13-2 Purpose

The purpose of the Quality Council is to direct and integrate all performance improvement activities conducted within the Hospital to ensure an ongoing and comprehensive Performance Improvement Program designed to improve patient care services; to ensure integration of data to enhance effectiveness and eliminate duplicative efforts; to ensure appropriate actions are taken to eliminate identified problems; to monitor corrective actions through to resolution; to prioritize issues for continuous improvement efforts; to allocate resources for performance improvement projects; to identify important aspects of care provided by the Medical Staff; to identify indicators to be used to monitor the quality of care, and the evaluation of care provided; to integrate information as appropriate to improve patient outcomes; to communicate to appropriate committees, departments, teams, and Members the findings, conclusions, recommendations, and actions taken; and to maintain records that substantiate program effectiveness in improving patient care.

11.13-3 Other

- (a) The Quality Council shall meet monthly.
- (b) The Quality Council shall report to the Medical Executive Committee and to the Medical Affairs Committee of the Governing Body.

11.14 STANDING TEAMS

11.14-1 Composition

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The Quality Council shall determine the appropriate composition of the standing teams listed in Rule 11. 01(b). The Medical Staff members of the teams shall be appointed by the Chief of Staff, and representative of Hospital administrative or clinical departments shall be appointed by the Chief Operating Officer (or his/her designee(s)).

11. 14 -2 Purpose

The standing teams shall be responsible to perform the following Medical Staff functions:

- (a) Pharmacy and Therapeutics – Develop and implement professional policies regarding evaluation, selection, procurement, distribution, administration, safety, and other matters pertinent to drug use in the Hospital; and develop and implement related educational activities to meet the needs of physicians, pharmacists, and nurses in the Hospital; maintain compliance with JCAHO standards for pharmacy and therapeutics, with special reference to antibiotic usage and diagnostic testing materials. (A special team shall be assigned to develop and implement professional policies for Sutter Center for Psychiatry regarding evaluation, selection, procurement, distribution, administration, safety, informed consent, and other matters pertinent to drug use, including a drug formulary, for psychotropic medications and psychiatric patients; and to develop and implement related educational activities to meet the needs of physicians, pharmacists, and nurses who care for psychiatric patients.) The P&T Team shall also be responsible to oversee nutrition and dietetics programs.
- (b) Infection Control – Develop and implement mechanisms designed to reduce the risks of endemic and epidemic nosocomial infections, and monitor the Hospital’s infection control program and the Staff’s treatment of infectious disease, including review of the clinical use of antimicrobials.
- (c) Education – Establish (subject to approval of the Board) continuing education requirements; and assure ongoing in-house education programs that meet the needs of the Medical Staff, and that are responsive to the results of all the performance improvement activities performed by the Staff. (A special team shall also be established to meet the educational needs of the Sutter Center for Psychiatry.)
- (d) Transfusions – Oversee collection and analysis of data related to the use of blood and blood components.
- (e) Utilization Review/Clinical Effectiveness – Oversee all utilization review and clinical effectiveness activities conducted in the Hospitals; to review all reports on utilization and clinical effectiveness activities; to analyze admissions and develop and implement rules and regulations for hospital resource management and utilization, including lengths of stay, discharge practices, and services ordered and provided; and to develop a resource management and utilization review plan complying with JCAHO requirements.
- (f) Medical Records – Review of medical records to ensure that all patient records are complete, accurate, and contain sufficient information to justify the diagnosis and treatment, and that they are completed within the time period required by state law. This team will also oversee the Hospital’s Health Information Services (HIS) reporting system.

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- (g) Council on Patient Care Standards – Promote multi-disciplinary review and standardization of policies, protocols, procedures, forms, form guidelines, and patient care standards.
- (h) Safety – Develop and implement safety policies and procedures to ensure that the Hospitals’ facilities are functionally safe for patients, visitors and employees.

11.14-3 Other

- (a) The standing teams shall meet on a regular schedule as needed to fulfill their responsibility.
- (b) They shall report to the Quality Council as to general matters within their purview; but shall provide information directly to the Department Administrative Committees and/or the appropriate Peer Review Committees, when necessary to address problems involving specific practitioners.

11.15 SUTTER HEALTH PATIENT SAFETY AND QUALITY COMMITTEE

11.15 -1 Composition

The Committee shall be appointed by the Sutter Health System, and shall consist of appropriate experts and representatives, including medical staff leaders from this or other Sutter Affiliate hospitals, to discharge the duties described below.

11.15 -2 Purpose

The purposes of the Medical Staff, as described in the Medical Staff Bylaws, include a dedication to strive to maintain and improve the quality of care rendered within the Medical Center and to provide oversight of care, treatment, and services provided by all practitioners authorized to practice in the Medical Center. In pursuing these activities, the Medical Staff is aided by the guidance and coordination provided by the Medical Executive Committee.

The Medical Executive Committee recognizes that some evaluation functions which directly affect, and which are specifically designed to enhance, the quality of care rendered in the Medical Center are best performed at the Sutter Health system-wide level so as to assure the provision of quality patient care. Such functions include, but are not limited to, the implementation and monitoring of the system-wide electronic health record, Midas Project Support and development and review of system standard order sets. These quality review and evaluation activities are best performed at a system level because of the broader data base available which provides valuable information about the experiences of other Sutter Health affiliated hospitals and providers in the specific areas under review. The additional, broader based information obtained from other Sutter Health affiliates, and the analysis done at the system level, assists the Medical Executive Committee in making improvements and enhancements to the quality of care rendered in the Medical Center.

Through appropriate action taken by the Medical Executive Committee as reflected in these Rules and Regulation, the Medical Executive Committee authorizes the Sutter Health Patient Safety and Quality Committee to perform, on behalf of and in appropriate collaboration with the Medical Executive Committee, quality activities related to system-wide functions. Such activities shall include, but not be limited to, intake of reports, data gathering, data trending,

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investigating, evaluating and taking action on the processes and systems which are performed at the system-level to improve the quality care.

The data reviewed by the Sutter Health Patient Safety and Quality Committee shall not include information regarding peer review recommendations or actions taken relative to a specific provider.

The Sutter Health Patient Safety and Quality Committee shall report to the Medical Executive Committee at least quarterly, or more frequently as deemed appropriate by either the Medical Executive Committee or the Sutter Health Patient Safety and Quality Committee. The activities of the Sutter Health Patient Safety and Quality Committee are intended to supplement and enhance, not replace the quality activities of the Medical Executive Committee. Accordingly, the records and proceedings of the Sutter Health Patient Safety and Quality Committee are considered confidential and intended to be protected under California Evidence Code 1157.

Further, any information that is provided by the Medical Staff to the Sutter Health Patient Safety and Quality Committee is conveyed in reliance upon that protection and in the expectation that appropriate confidentiality and privacy will be maintained, consistent with the needs of these Sutter Health system-wide programs.

ARTICLE XII. DEPARTMENTS AND CLINICAL SECTIONS

12.01 DEPARTMENTS AND CLINICAL SECTIONS

The current departments and their clinical sections are:

- Anesthesia
- Cardiovascular Disease
- Diagnostic Imaging and Radiation Oncology
 - Interventional Radiology
- Emergency Medicine
- Family Medicine
- Laboratory Medicine
- Medicine, including the following clinical sections:
 - Gastroenterology
 - Hematology/Oncology
 - Internal Medicine
 - Nephrology
 - Neurology
 - Pulmonary
- Obstetrics and Gynecology
- Pediatrics
- Psychiatry, including the following clinical section:

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- Child and Adolescent Psychiatry
- Surgery, including the following clinical sections:
 - General Surgery
 - Neurosurgery
 - Ophthalmology
 - Oral and General Dentistry
 - Otolaryngology
 - Orthopedics
 - Plastic Surgery
 - Podiatry
 - Spine
 - Urology

12.02 DEPARTMENT FUNCTIONS

Each department is responsible for the quality of care within the department, and for the effective performance of the following relating to the members of the department and Allied Health Professionals practicing within the department:

- (a) Patient care review, observation, and monitoring (including periodic demonstrations of ability), consistent with general guidelines developed by the Quality Council, and approved by the Department Administrative Committee, and the Medical Executive Committee.
- (b) Credentials review, consistent with guidelines developed by the Credentials Committee, the Department Administrative Committee, and the Medical Executive Committee.
- (c) Discipline in accordance with Article VII of the Bylaws.
- (d) Continuing education, consistent with guidelines developed by the Education Team and the Medical Executive Committee.
- (e) Planning and budget review, consistent with guidelines developed by the Medical Executive Committee, including, but not limited to, making recommendations for a sufficient number of qualified and competent persons to provide patient care/service, and for space and other resources needed by the department.

12.03 DEPARTMENT OFFICERS

Each department shall have a Chief, Vice Chief and Secretary, who shall be Members of the Senior Staff.

12.03-1 Qualifications

Each Chief, Vice Chief and Secretary shall:

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- (a) Be board certified or board admissible in his or her appropriate specialty.
- (b) Have demonstrated clinical competence in his or her field of practice sufficient to demand the respect of the members of his or her department.
- (c) Have an understanding of the purposes and functions of the Staff organization and a demonstrated willingness to promote patient safety over all other concerns.
- (d) Have an understanding of and willingness to work with the Hospital towards the attainment of its lawful and reasonable goals.
- (e) Have an ability to work with and motivate others to achieve the objectives of the Staff organization in the context of the Hospital's lawful and reasonable objectives.
- (f) Be (and remain during tenure in office) a Member in good standing of the Senior Medical Staff.
- (g) Have had no disciplinary action (as listed under Section 8.04-1 of the Bylaws) imposed against him or her by the Medical Executive Committee in the past 12 months.

12.03-2 Selection

- (a) Each department, through its administrative committee (or a nominating committee whose membership includes the Vice Chief of Staff and at least two other Members of the Senior Staff of the department), shall nominate at least one person meeting the qualifications in Rule 12.03-1, above, for each of the offices of Chief, Vice Chief and Secretary.
- (b) In addition, the department members may select candidates for office by a petition signed by at least 10 Members of the Senior Staff of the department.
- (c) Upon Medical Executive Committee approval of the slate of candidates (including those nominated by petition), department officers shall be elected by a majority of the votes cast by the Senior Staff Members of the department.
- (d) The Chiefs of Anesthesia, Laboratory Medicine, Obstetrics and Gynecology, Psychiatry, and Medicine shall be selected in odd-numbered years; the Chiefs of Emergency Medicine, Family Medicine, Pediatrics, Diagnostic Imaging and Radiation Oncology, and Surgery shall be selected in even-numbered years.

12.03-3 Duties

- (a) Each department Chief shall:
 - (1) Provide for the effective performance of department functions, as described in Rule 12.02.
 - (2) In conjunction with the Chief of Staff and the department administrative committee, establish objectives for the quality medical care within the department; and assist in developing programs to achieve these objectives.

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- (3) Establish, maintain and enforce professional standards within the department and the continuing improvement of the quality of care rendered in the department, including criteria for Clinical Privileges.
- (4) Exercise such authority as he or she deems necessary so that in his or her department patient welfare takes precedence over other concerns.
- (5) Make recommendations to the Medical Executive Committee regarding the integration of the department into the primary functions of the Hospital and the coordination and integration of interdepartmental and intradepartmental services.
- (6) Assess and recommend to Hospital Administration, off-site sources for needed patient care services not provided by the department or the organization.
- (7) In conjunction with the Medical Education Team and the department administrative committee, develop and periodically evaluate programs for the continuing education and orientation of members of his or her department.
- (8) Establish and enforce in conjunction with the Chief of Staff and the department administrative committee, written policies and Rules for the department that guide and support the provision of services which shall be reviewed at least annually.
- (9) Supervise, or cause to be supervised, all Staff Members and Allied Health Professionals holding temporary Privileges or a probationary appointment in his or her department.
- (10) Keep the Members and Allied Health Professionals in his or her department informed as to established departmental objectives and policies and the progress being made toward fulfillment of those objectives and policies.
- (11) Implement any medical care policies and procedures approved by the Medical Executive Committee and the Board as they pertain to his or her department.
- (12) At least biennially and with the assistance of the department administrative committee and the responsible PRC, review the Privileges granted Members and Allied Health Professionals in his or her department for the purpose of making recommendations for the maintenance, increase, or reduction of such Privileges. Such recommendations shall be based upon performance improvement reports, observations of clinical performance, review of patient records, and other sources of information concerning the Practitioner's clinical performance and his or her satisfactory compliance with applicable Medical Staff, department and Hospital policies.
- (13) Chair all department meetings, receive recommendations concerning medical care policies and procedures, and report such recommendations to the Chief of Staff and the Medical Executive Committee.

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- (14) Serve as an *ex officio* member of all committees of his or her department and attend such committee meetings as deemed necessary for adequate information flow.
 - (15) Ensure that records of performance are maintained and updated for all members of his or her department.
 - (16) Report on activities of the Medical Staff to the Board when called upon to do so by the Chief of Staff or the Administrator.
 - (17) Be a member of the Medical Executive Committee.
- (b) Each Vice Chief shall:
- (1) Assist the department Chief in the performance of his or her duties, and, in the absence or disability of the department Chief, is responsible to perform the duties of the department Chief.
 - (2) Be a member of the Department Administrative Committee and the Peer Review Committee
- (c) Each Secretary shall:
- (1) Ensure that accurate and complete minutes of the Department Administrative Committee and department meetings are maintained.
 - (2) Assist the department Chief and Vice Chief in the performance of his or her duties, and in the absence or disability of the department Chief and Vice Chief, perform all duties of the department Chief.
 - (3) Be a member of the Department Administrative Committee and the appropriate Peer Review Committee.

12.03-4 Authority

- (a) Each department Chief shall have authority:
- (1) To suspend temporarily the Privileges of any Member in his or her department whenever the personal or professional conduct of the Member jeopardizes or will jeopardize the safety or best interests of a patient unless immediate action is taken, or constitutes a willful disregard of Hospital policies.
 - (2) To require consultations whenever, in his or her discretion, he or she deems it necessary.
 - (3) To appoint the Chairs and members of all committees within his or her department.
- (b) When acting in the role of or at the direction of the department Chief, the Vice Chief shall have the authority described in paragraph (a) above.

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- (c) When acting in the role of or at the direction of the department Chief, the Secretary shall have the authority described in Paragraph (a) above.

12.03-5 Accountability and Relationships

- (a) Each department Chief shall:
 - (1) Be immediately responsible to the Chief of Staff and Medical Executive Committee.
 - (2) Regularly report to the Chief of Staff and the Medical Executive Committee regarding:
 - (a) The discharge of the functions of the Medical Staff organization as they pertain to his or her department.
 - (b) The quality of medical care rendered within his or her department as reflected by ongoing performance improvement programs.
 - (c) All disciplinary actions in progress or being contemplated regarding any member of his or her department.
 - (d) The conduct or professional performance of any Member or Allied Health Professional in his or her department or any other matter when so requested by the Chief of Staff or the Executive Committee.
 - (3) Keep the Chief of Staff informed of all violations of Hospital policies which put patient welfare in jeopardy, and report on what action is being taken to prevent such incidents from recurring.
 - (4) Keep the Chief of Staff appraised of the progress being made toward attaining those objectives which have been agreed upon for his or her department.
- (b) Each department Vice Chief and Secretary shall be accountable to the department Chief. When acting in the capacity of department Chief, each Vice Chief and secretary shall be accountable as described in paragraphs (a)(1) through (4) above.
- (c) Section heads shall be accountable to their department Chief.
- (d) Members of each department shall be accountable to the department Chief.

12.04 DEPARTMENT COMMITTEES

12.04-1 Overview

Each department shall have an administrative committee and such other committees as the department Chief deems essential to the effective functioning of the department.

12.04-2 Department Administrative Committees

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(a) Composition

The administrative committee shall be comprised of the department Chief, the Vice Chief, a Secretary, the immediate-past department Chief, and such other representatives of the various clinical specialties within the department as the department Chief may appoint. A representative of Hospital administration (appointed by the Administrator) shall be a nonvoting member of each department's administrative committee. The department Chief shall chair the committee.

(b) Purpose

The purpose of the department administrative committee is to assist the department Chief in the formulation and enforcement of department policies, programs, and objectives, and to help ensure the effective performance of all functions assigned to the department.

(c) Duties and Authority

The department administrative committee shall have such duties and authority as designated by the department Chief.

(d) Accountability and Relationships

(1) The administrative committee is accountable to the department Chief.

(2) The role of the administrative committee is advisory. The department Chief is responsible for the duties assigned to him or her and may not delegate that responsibility to the administrative committee. However, he or she may request the assistance and advice of the administrative committee in all matters for which he or she is responsible.

12.05 OTHER DEPARTMENT COMMITTEES

12.05-1 Mandatory Committees

The Diagnostic Imaging and Radiation Oncology Department shall maintain a Radiation Safety Committee meeting the requirements and performing the functions required by California Hospital Licensing Regulations.

12.05-2 Optional Committees

The departments may have such additional committees as the department Chief determines necessary.

12.05-3 Requirements Applicable to All Department Committees

For each committee established in the department, Rules shall be developed to specify the committee's:

(a) Composition and manner of appointment.

(b) Purpose.

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- (c) Duties, including frequency of meetings if other than monthly.
- (d) Authority, accountability and relationships.

In addition, each department committee shall maintain permanent records, unless otherwise provided by Hospital policy. All committee rules and regulations shall be subject to approval by the Medical Executive Committee, the Chief of Staff, the Administrator and the Board.

ARTICLE XIII. MEETINGS

RESERVED

ARTICLE XIV. IMMUNITY AND RELEASES

RESERVED

ARTICLE XV. GENERAL PROVISIONS

15.01 DEPARTMENTAL RULES AND REGULATIONS

15.01-1 Consultation Requirements

Mandatory consultation requirements, if any, shall be specified in each department's rules and regulations.

15.01-2 Emergency Room Coverage

Availability and assignment for coverage for emergency room back-up shall be in accordance with regulations formulated by the departments.

ARTICLE XVI. ADOPTION AND AMENDMENT OF BYLAWS

RESERVED

ARTICLE XVII. PATIENT CARE

17.01 ADMISSION AND ATTENDANCE POLICIES

17.01-1 Patients will be admitted in conformity with the admission policies of the Hospital. Such policies shall be subject to approval by the Medical Executive Committee.

17.01-2 No patient shall be admitted to the Hospital unless a provisional diagnosis has been given by the attending Medical Staff Member.

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- 17.01-3 Unless otherwise specified in Department Rules, each inpatient shall be seen daily by the attending Staff Member or by his or her designated alternate. In addition, either the attending Staff Member or his or her alternate shall be available on call 24 hours per day to meet the needs of the patient.
- 17.01-4 Staff Members admitting patients with communicable diseases or psychological problems shall be held responsible for giving such information as may be necessary to assure the protection of other hospitalized patients.
- 17.01-5 Any patient who demonstrates suicidal tendencies shall be cared for pursuant to the guidelines developed by the Psychiatry Administrative Committee.
- 17.01-6 Members of the Medical Staff shall not be involved in the direct provision of medical services to a member of their family being treated in any facility of Sutter Medical Center, Sacramento. A family member is defined as a spouse, domestic partner, parent, child, sibling or other close relative. Exceptions to this rule may be made by the Chief of the appropriate Medical Staff Department or the Chief of Staff.
- 17.01-7 The management and coordination of each patient's care, treatment, and services is the responsibility of a practitioner with appropriate privileges. A patient's general medical condition is managed and coordinated by a physician and there is communication among all practitioners involved in a patient's care, treatment and services.
- 17.01-8 The Medical Staff shall participate in the coordination of care, treatment and services with other practitioners and hospital personnel, as relevant to the care, treatment, and services of an individual patient.

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17.02 CONSENTS

17.02-1 No surgical or invasive procedure and no treatment involving unusual risk to the patient shall be performed without both of the following documented in the record:

(a) The “informed consent” of a patient or legally authorized representative. It shall be the responsibility of the operating physician, dentist or podiatrist to obtain an informed consent. Informed consent shall include at least the following:

- (1) An explanation of the procedure, appropriate alternatives and respective benefits;
- (2) An explanation of the significant risks, complications, and alternative options. The patient may be informed that he or she has the right to refuse this explanation.
- (3) An explanation of the possible consequences of refusing the proposed treatment or procedure.

The physician, dentist, or podiatrist shall document in the medical record that an informed consent has been obtained.

(b) The patient’s written consent to treatment on an approved Hospital form. It shall be the responsibility of the Practitioner to provide the admitting nurse (or appropriate nursing personnel on the unit) with a written or verbal order indicating the name of the procedure to be performed.

17.02-2 Sterilization consents shall be obtained in accordance with State and Federal law.

17.02-3 No experimental procedures or treatment shall be performed on Hospital patients without their written consent on forms approved by the Institutional Review Committee.

17.02-4 Informed consent for psychotropic medications shall be obtained in accordance with applicable Hospital policy.

17.03 CONSULTATIONS

17.03-1 Departments shall identify instances where consultation will be required as a matter of course.

17.03-2 Consultation is required when the care is beyond the scope of practice of the practitioner.

17.03-3 Consultations shall be arranged personally by the attending Staff Member.

17.03-4 Except as provided in Rule 6.03-1, consultants shall have Privileges in the area in question.

17.03-5 Each consultation report shall contain a written opinion by the consultant that reflects, when appropriate, an actual examination of the patient and the patient’s medical record.

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17.04 DENTAL PATIENTS

17.04-1 Surgical procedures performed by dentists shall be under the overall supervision of the Chief of Surgery.

17.04-2 For patients in Class I or II anesthesia risk, the Oral/Maxillo-facial Surgeon, who has the privilege to perform a general history and physical, may perform the history and physical examination to determine the ability of the patient to undergo the proposed oral surgical procedure. The Oral/Maxillo-facial surgeon must arrange for a physician Member of the Medical Staff to assume responsibility for the care of any medical problems that are present or that arise during hospitalization.

17.04-3 For patients in Class III, IV or V anesthesia risk, prior to admission the Oral/Maxillo-facial surgeon must arrange for a physician Member of the Medical Staff to assume responsibility for the history and physical in addition to responsibility for the care of any medical problems that are present or that arise during hospitalization.

17.04-4 Patients admitted to the Hospital for dental care shall receive the same basic medical appraisal as patients admitted for other services. This shall include the performance and recording of the findings in the medical record by a physician Member of the Medical Staff of an admission history and physical examination and an evaluation of the overall medical risk. The responsible dentist shall take into account the recommendations of this consultation in the overall assessment of the specific procedure proposed and the effect of the procedure on the patient. When significant medical abnormality is present, the final decision shall be a joint responsibility of the dentist and the medical consultant. The dentist shall be responsible for that part of the history and physical examination related to dentistry.

17.04-5 A physician Member of the Medical Staff shall assume responsibility for the care of medical problems that may be detected on admission or that may arise during hospitalization of dental patients; however, the physician shall not be responsible for the professional performance of the dentist, or for the outcome of the dental procedure. The dentist shall be responsible for notifying the physician Member if medical problems arise after admission.

17.05 DISCHARGES TO OTHER FACILITIES

No patient shall be discharged to another health facility unless arrangements have been made in advance for admission to that health facility and the person legally responsible for the patient has been notified; or attempts have been made over a 24-hour period, and a responsible person cannot be reached. Discharge shall not be carried out if, in the opinion of the patient's physician, such discharge would create a medical hazard.

17.06 EMERGENCY DEPARTMENT

(a) All patients in the Emergency Department will be seen and evaluated in the order of severity of their problem, as determined by the Emergency Department staff. No exceptions shall be made. Staff Members may see patients in the Emergency Department with the understanding that this policy shall apply to their patients as well.

(b) All patients who present to the Hospital, including the Emergency Department and the Labor and Delivery Unit, and who request examination and treatment for an emergency medical condition or active labor, shall be evaluated for the existence of

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an emergency medical condition or, where applicable, active labor. This screening examination may be performed by the following persons:

- *In the Emergency Department:* by a registered nurse who has been determined by the ER nurse manager to be qualified and experienced in emergency nursing and who is required to follow standardized procedures approved by the Medical Staff.
- *In the Labor and Delivery Unit:* by a registered nurse who has been determined by the L&D nurse manager to be qualified and experienced in obstetrical nursing and who is required to follow standardized procedures approved by the Medical Staff.
- *In all circumstances:* in the event the RN performing the screening examination is uncertain about the nature of the patient's condition or the existence of an emergency or active labor, a physician from either the Emergency Department or Labor and Delivery shall be required to examine the patient and make the determination of the existence of an emergency or active labor.

Upon the determination that an emergency medical condition or active labor exists, all available medical treatment within the capability of the Hospital will be provided to the patient to alleviate the emergency, deliver the child or transfer the patient to another hospital in accordance with the Hospital's emergency treatment and transfer policies.

- (c) All Departments shall formulate Rules that provide for adequate Emergency Department back-up availability and provide a date specific list for coverage.

17.07 HOSPITAL FORMULARY

- 17.07-1 The Hospital Formulary shall be maintained by the Pharmacy and Therapeutics Team for the purpose of designating therapeutic drug entities which shall be maintained in the pharmacy inventories to provide an adequate, safe and effective armamentarium of medications for treating the needs of all patients.
- 17.07-2 The Pharmacy and Therapeutics Team shall also designate medications which may be dispensed on a generic and/or therapeutic equivalent basis for medications prescribed by a trade or proprietary name. Provision shall be made to provide exception to this Rule at the request of the prescribing Practitioner.
- 17.07-3 All medications prescribed for administration to patients within the Hospital shall be dispensed from the Hospital pharmacies. Exceptions may be granted by policy for selected products, such as birth control medications, eye drops, outpatient investigational drugs and other non-formulary drugs, to provide continuity of therapy. All medications in the "exception group" must also be prescribed on the physician's chart order.

17.08 LABORATORY

- 17.08-1 There are no routine laboratory procedures applicable to all patients. All admission laboratory procedures are the responsibility of the admitting Practitioner.

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- 17.08-2 Any studies done as pre-surgical evaluation shall be accomplished and recorded within 72 hours prior to surgery.
- 17.08-3 Examinations done by outside laboratories will be approved only with specific prior authorization from the Medical Executive Committee. This list of laboratories shall be updated at least annually and as the need arises.
- 17.09 MEDICAL RECORDS
- 17.09-1 All records shall be accurate and the responsibility of the attending Staff Member. Records for dental or podiatric patients are the responsibility of the dentist or podiatrist and a physician Member of the Medical Staff, as further described in Rules 17.04 and 17.13.
- 17.09-2 All entries placed in the medical record (or called in verbally) by the responsible Practitioner shall be signed and dated and timed by the responsible Practitioner.
- 17.09-3 A physician Member of the Medical Staff shall be responsible for performing an adequate history and physical examination on all patients within 24 hours of admission. Psychiatric and psychological examinations of psychiatric patients shall be performed in compliance with the Psychiatric Department Rules. Advanced Practice RNs (Nurse Practitioner and CRNAs) and Physician Assistants are permitted to perform H&Ps as long as they are credentialed and have been approved for H&P privileges. The H&Ps must be countersigned and dated by the supervising physician within 30 days of care.
- 17.09-4 In case of readmission of a patient, all previous records shall be available for use of the attending Practitioner.
- 17.09-5 All operations and high-risk procedures performed shall be fully described by the operating physician, dentist or podiatrist on the patient's medical record, or dictated immediately following the procedure. The report shall contain the name of the physician and assistants, procedures performed and description of procedure, findings, estimated blood loss, specimens removed, disposition of each specimen and postoperative diagnosis. When the operative report is not placed in the medical record immediately after surgery (for example, there is a transcription and/or filing delay), an operative progress note is to be entered into the medical record immediately after surgery to provide pertinent information for any individual required to attend to the patient.
- 17.09-6 Final diagnoses, to include complications, should be documented on the medical record by the responsible Practitioner at the time of patient discharge.
- 17.09-7 The medical record shall be completed within 14 days following discharge of the patient. Therefore, as soon as possible, but no later than seven days after discharge, a discharge summary shall be written or dictated by the responsible Staff Member. A discharge summary is required for all hospital deaths, either inpatient or outpatient. The discharge summary shall include the final diagnosis, reason for admission, hospital course, including procedures performed and treatment rendered, significant findings, the patient's condition on discharge, any specific instructions given to patient and/or family, and the type of diet, medication and activity to be followed upon leaving the Hospital.

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17.09-8 The responsibility for control of delinquent medical records shall be delegated to the Medical Records Team. Seven days after discharge of the patient, the Medical Record Department will notify the Medical Staff Member of medical records not yet completed.

17.09-9 All original written medical records are the property of the Hospital and shall not be removed from the Hospital premises or storage unless required by appropriate court order, subpoena, or statute. Except as otherwise allowed by law, the information contained in the record shall be made available only to persons or agencies to whom the patient has specifically authorized the release.

17.09-10 The Medical Record is to contain only approved abbreviations.

17.10 OBSTETRICAL PATIENTS

Consultation with a Staff Member with full Privileges in obstetrics is required in all seriously ill obstetrical patients, in cases of doubtful diagnosis or treatment, or in complications with the potential of great risk to mother and baby. The consultation will be recorded in the patient's Hospital chart.

17.11 ORDERS

17.11-1 Medical Staff Members and AHPs may write orders and prescribe medications within the limits of their licensure and any applicable provisions of the Medical Staff Bylaws and these Medical Staff Rules or the departmental Rules. The Medical Staff Office will provide information to the Pharmacy of limitations on prescribing or ordering for Medical Staff members and AHPs.

17.11-2 All orders for treatment shall be in writing. Verbal orders or orders dictated over the telephone for medication may be accepted in accordance with Rule 17.11-3.

17.11-3 Verbal orders:

- (a) Physicians should write their own orders while they are on the unit.
- (b) Acute Care and Psychiatric Patients: In conformance with California acute and psychiatric hospital licensing regulations, verbal orders for medications for acute care and psychiatric patients may be accepted if made by a Medical Staff Member to a registered nurse or licensed pharmacist. Such verbal order shall be signed by the person to whom dictated, and shall indicate the name of the Practitioner issuing the order. The Practitioner who issued the order shall countersign the order within 48 hours.
- (c) Licensed vocational nurses, licensed psychiatric technicians, dietitians, X-ray technologists, laboratory technologists, cardiopulmonary or pulmonary technologists, respiratory therapists or physical therapists may take verbal treatment orders for limited use in their specialty as outlined in the Rules of the respective departments.
- (d) Skilled Nursing Bed Patients: In conformance with California regulations for skilled nursing facilities, verbal medication orders for Sutter Oaks Nursing Center - Midtown patients may be accepted if made by a Medical Staff Member to a registered nurse, licensed vocational nurse or licensed psychiatric technician. Verbal

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orders for administration of drugs may also be given to a licensed pharmacist.
Verbal orders for respiratory care may be given to a licensed respiratory therapist.

- 17.11-4 Automatic Stop Orders: When narcotic, toxic or other dangerous drugs are ordered, the following procedure shall be used for automatic stop order. Physicians will be notified 72, 48 and 24 hours in advance of the expiration time before the drug will be discontinued. This notice will be provided by the computer system on an “Auto-Stop Medication Report,” which will be placed in the chart. If the order is not signed, the drugs shall be discontinued at 72 hours. Throughout the Hospital, all physicians must designate an automatic stop date for all laboratory tests and chest X-rays.
- 17.11-5 Open-ended Orders: When a Staff Member orders a “sliding scale” strength on a medication, it shall be given as follows:
- (a) Give the lowest dose;
 - (b) Wait 30 minutes;
 - (c) If desired results have not been obtained, give additional medication to total highest amount.
- 17.11-6 Standing Orders
- (a) A Staff Member must notify the Hospital in writing of any standing orders, the use of which is subject to prior approval and annual review by the department administrative committee and the Pharmacy and Therapeutics Team.
 - (b) Standing orders shall specify:
 - (1) The circumstances under which the drug is to be administered;
 - (2) The types of medical conditions of patients for whom the standing orders are intended; and
 - (3) The drug dosage, route, and frequency of administration.
 - (c) A copy of standing orders for a specific patient shall be dated, promptly signed by the Practitioner, and included in the patient’s medical record.
- 17.11-7 Withholding or Withdrawing Life-sustaining Treatment: Medical Staff Members are expected to comply with the Hospital’s Guidelines for Withholding or Withdrawing Life-Sustaining Treatment, as approved by the Medical Executive Committee and the Board.
- 17.11-8 Restraints: Medical Staff Members and AHPs are expected to comply with the Hospital’s policies on restraints, as approved by the Medical Executive Committee and the Board.
- 17.12 PATHOLOGY
- 17.12-1 All specimens removed in surgery are the property of the Hospital and shall be sent to the pathologist of the Hospital, who shall make such examinations as ordered by the operating Staff Member, or as the pathologist may consider necessary to arrive at a diagnosis.

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- 17.12-2 All requests for laboratory tests shall be made in writing or by electronic means. Orders or requisitions for inpatient and ambulatory care patient services shall clearly identify the patient, the requesting individual, the tests required, any special handling required, the date and (when relevant) the time the specimen was collected, and the date and time the request and/or specimen reached the laboratory. Requests for examinations of surgical specimens shall also contain a concise statement of the reason for the examination.
- 17.12-3 The laboratory shall perform tests and examine specimens on the written request of: individuals authorized by the Medical Staff to order such evaluations and receive the results; those physicians or dentists who are not Members of the Medical Staff but who have authorization from the Medical Staff and Administration to request such support services from the Hospital; and to the extent permitted by law, other persons authorized by the Hospital and licensed to engage in direct treatment of patients.
- 17.12-4 Laboratory reports and a report of the pathologist's findings shall be filed with and shall remain a part of the patient's record.
- 17.13 **PODIATRIC PATIENTS**
- 17.13-1 Surgical procedures performed by podiatrists shall be under the overall supervision of the Chief of Surgery.
- 17.13-2 For patients in ASA Class I or II anesthesia risk, the Podiatric surgeon, who has the privilege to perform a general history and physical, may perform the history and physical examination to determine the ability of the patient to undergo the proposed podiatric surgical procedure. The Podiatric surgeon must arrange for a physician Member of the Medical Staff to assume responsibility for the care of any medical problems that are present or that arise during hospitalization.
- For patients in ASA Class III, IV or V anesthesia risk, prior to admission the Podiatric surgeon must arrange for a physician Member of the Medical Staff to assume responsibility for the history and physical in addition to responsibility for the care of any medical problems that are present or that arise during hospitalization.
- 17.13-3 Patients admitted to the Hospital for podiatric care shall receive the same basic medical appraisal as patients admitted for other services. This shall include the performance and recording of the findings in the medical record by a physician with history and physical privileges, of an admission history and physical examination prior to any operative or invasive procedure intervention or within 24 hours, whichever occurs first. The podiatrist shall be responsible for that part of the history and physical examination that is related to podiatry for patients ASA Class III or higher.
- 17.13-4 A physician Member of the Medical Staff shall assume responsibility for the care of medical problems that may be detected on admission or that may arise at or during hospitalization of podiatric patients; however, the physician shall not be responsible for the professional performance of the podiatrist or the outcome of the podiatric procedure. The podiatrist shall be responsible for notifying the physician Member if medical problems arise after admission. The physician responsible for evaluating the general medical status of a podiatric patient shall render, with consultation if necessary, an overall assessment of the risks and benefits associated with the proposed procedure.

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17.14 REPORTABLE DEATHS AND AUTOPSIES

17.14-1 Coroner's cases: A physician SHALL immediately notify the coroner when he or she has knowledge of a death which occurred or has charge of a body in which death occurred as a result of certain statutorily-defined causes or circumstances, including:

- (a) Violent, sudden or unusual deaths;
- (b) Unattended deaths;
- (c) Deaths wherein the deceased has not been attended by a physician in the 20 days before death;
- (d) Where the attending physician is unable to state the cause of death;
- (e) Known or suspected sudden infant death syndrome;
- (f) Known or suspected homicide or suicide;
- (g) Known or suspected self-induced or criminal abortion as defined by the law relating to coroner's cases and abortions;
- (h) Known or suspected accidental poisoning;
- (i) Deaths known or suspected as resulting in whole or in part from or related to accident or injury either old or recent;
- (j) Under such circumstances as to afford a reasonable ground to suspect that the death was caused by the criminal act of another or occasioned in whole or in part by criminal means (including but not limited to cases of known or alleged rape or crime against nature);
- (k) Cases of possible but not diagnosed contagious disease and constituting a public hazard;
- (l) Starvation;
- (m) Death in prison or while under sentence;
- (n) Occupational diseases or occupational hazards;
- (o) Aspiration;
- (p) Drug or alcohol addiction;
- (q) Exposure (including but not limited to deaths as a result of heat prostration);
- (r) Stabbing or cutting;
- (s) Hanging or strangulation;
- (t) Gunshot;

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- (u) Fire;
- (v) Drowning;
- (w) Deaths occurring within 24 hours of admission to the hospital;
- (x) Fractures (excluding spontaneous pathological fractures);
- (y) Therapeutic misadventure;
- (z) Operative death (in operating room under influence of anesthesia or patient recovery area);
- (aa) Death of a patient in a state hospital serving the mentally or developmentally disabled;
- (bb) Fetal and neonatal deaths:
 - when trauma to the mother is suspected or known;
 - when the mother received no prenatal care
 - when the mother used drugs during pregnancy
(which the physician believes may have contributed to the demise)

17.14-2 Autopsies

- (a) For non-coroner's cases, Medical Staff Members should attempt to secure autopsies on all in-patient hospital deaths. However, autopsies are felt to be of particular value in the following circumstances and the Medical Staff is encouraged to actively seek family permission for autopsy for all in-patient deaths meeting these criteria:
 - (1) Deaths where there are significant questions related to the effectiveness of therapy.
 - (2) Deaths where there are significant questions relating to the extent of disease.
 - (3) Deaths where antemortem diagnostic procedures have resulted in unusual or unexplained findings.
 - (4) Deaths where genetic diseases are suspected but not confirmed prior to death.
 - (5) Deaths in all patients who have received organ transplants at Sutter Hospitals.
- (b) Individuals who expire outside the Hospital or in one of the Hospital's emergency rooms are not considered in-patient deaths. In these cases, there is frequently little or no information relating to the circumstance of death or recent pertinent health history. Therefore, for non-coroner's cases, the autopsy is usually not warranted. The few exceptions to this would include:

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- (1) Decedents who have received organ transplants at Sutter Memorial or Sutter General Hospitals.
 - (2) Individuals who expire outside of the Hospital but who have been an in-patient in the Hospital within the last 30 days may be entitled to a Hospital autopsy. In these cases, the request for autopsy should originate from the attending physician (an active Staff physician) with appropriate consent and permission from the family.
 - (c) No autopsy shall be performed without written consent (see Permission for Autopsy Procedures outlined in the Pathology Department Procedure Manual). In the event the person who is to authorize the autopsy is not available to sign a consent, a telegram from him or her may be considered temporary authorization to proceed. A signed consent should be obtained from such individual as soon as possible thereafter. In all cases, the final decision for the performance of an autopsy should be made after consultation between the attending physician and the pathologist.
- 17.14-3 All autopsies, except those performed by the Coroner, shall be performed by a physician with Privileges in the Department of Laboratory Medicine.
- 17.14-4 Each necropsy procedure, and the record thereof, shall be sufficiently thorough and detailed to meet the needs of the Medical Staff. Provisional anatomic diagnoses shall be recorded in the patient's medical record within 72 hours, where feasible; and a complete report should be made a part of the record within three months.
- 17.14-5 A copy of every necropsy procedure report should be sent to the Multidisciplinary Peer Review Committee and the attending Practitioner.
- 17.15 SURGERY
- 17.15-1 Assistant Surgeons
- The necessary qualifications for assistant surgeons, and a delineation of procedures or categories of procedures requiring assistant surgeons, shall be as defined by the Rules of the Department of Surgery and the Department of Obstetrics and Gynecology.
- 17.15-2 Criteria for Electrocardiograms Prior to Surgery Under General Anesthesia
- (a) All patients with known heart disease, symptomatic or not, shall have a preoperative electrocardiogram. This shall include patients with pacemakers, prosthetic heart valves, and adults with systemic hypertension and diabetes mellitus (because of the high frequency of coronary disease in this particular population).
 - (b) Patients on digitalis and diuretics and patients with a past history of any cardiac rhythm disturbance shall have a preoperative electrocardiogram.
 - (c) In patients with heart disease, as identified above, an electrocardiogram should be obtained within 72 hours of the surgery, either within the Hospital or from the doctor's office. EKGs from the doctor's office shall be completed and signed and placed on the patient's Hospital record prior to surgery. When the requested physician is not available to interpret the EKG, the Hospital cardiologist will read it.

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17.15-3 Examination and Consultation

Except in case of life-threatening emergency, prior to surgery, every case shall have a recorded history, physical examination or consultation by a surgeon, dentist or podiatrist, appropriate assessment by ancillary services, and consents. The operating physician should confirm agreement with said examination or consultation.

17.15-4 Operating Room Policies

All policies directly affecting a Practitioner's performance in the operating room(s) shall be considered and approved by the Surgery Administrative Committee.

17.15-5 Operating Room Register

An operating room register shall be kept. This shall note the date, name, age, sex, and Hospital case number of the surgical patient; the time of operation and the operating room number; the names of the surgeon, the assistant(s), the anesthesiologist or anesthesiologist, and the scrub and circulating assistants; and the surgical procedure, the pre- and post-operative diagnoses, the anesthetic agent used, and complications. The operating Staff Member shall be responsible for determining whether there were complications during surgery. The operating room supervisors shall designate those who will be responsible for obtaining and recording this information.

17.16 OTHER MATTERS

All matters pertaining to the business or welfare of the Staff which are not specifically covered by the Medical Staff Bylaws, or by these general Rules shall be referred to the Chief of Staff, and if appropriate, the Medical Executive Committee.

17.17 ADOPTION AND AMENDMENT

These Rules may be adopted, amended or repealed by majority vote of the Medical Executive Committee, and approval of the Board of Trustees. Further, in recognition of the ultimate legal and fiduciary responsibility of the Board of Trustees the organized Medical Staff acknowledges, in the event the Staff has unreasonably failed to exercise its responsibility and after notice from the Board to such effect including a reasonable period of time for response, the Board may impose conditions on the Staff that are required for continued State licensure, approval by accrediting bodies or to comply with a court judgment. In such event, Staff recommendations and views shall be carefully considered by the Board in its actions. Neither the Medical Staff nor the Board of Trustees may unilaterally amend Medical Staff Rules.

If significant changes are made in the medical staff bylaws, rule and regulations, or policies, medical staff members and other individuals who have delineated clinical privileges are provided with revised texts of the written materials.

Adopted by the Medical Executive Committee and approved by the Board of Trustees and effective as of March 14, 2011.

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MEDICAL STAFF RULES
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