

# SHANDS AGH

## MEDICAL STAFF RULES AND REGULATIONS

Effective July 1, 1998  
Amended January 22, 1999  
Amended May 26, 1999  
Amended December 4, 2000  
Amended February 5, 2001  
Amended April 2, 2001  
Amended June 4, 2001  
Amended August 6, 2001  
Amended September 11, 2001  
Amended October 8, 2001  
Amended January 7, 2002  
Amended March 4, 2002  
Amended June 3, 2002  
Amended January 22, 2003  
Amended February 26, 2003  
Amended August 27, 2003  
Amended September 24, 2003  
Amended October 22, 2003  
Amended February 23, 2005  
Amended July 26, 2006  
Amended June 18, 2007  
Amended July 25, 2007  
Amended February 27, 2008  
Amended June 25, 2008  
Amended July 23, 2008  
Amended September 24, 2008

## **A. ADMISSION, TRANSFER AND DISCHARGE**

1. The hospital will admit patients suffering from all types of disease provided that, in the case of the disease or condition that would be a hazard to other hospital patients, the admitting physician notifies the Hospital Administrator or her/his designee of the diagnosis or possible diagnosis of said disease or condition, and provided that proper and accepted precautions can be taken to protect other hospital patients and hospital personnel from hazard arising from that disease or condition.
2. Except in emergency, no patient shall be admitted to the hospital until after a provisional diagnosis has been stated and the consent of the Hospital Administrator or his authorized representative secured. In cases of emergency, the provisional diagnosis shall be stated as soon as possible.

## **B. CONSULT, SERVICE AND CALL RESPONSIBILITIES**

1. Physicians on the Active staff who have attained the age of 58 years, or who have been on staff for 25 years or greater, may choose not to participate in emergency service on call duty.
2. Active medical staff shall agree to assume all functions and responsibilities of appointment, including care for unassigned patients, emergency service on call duty and consultation, unless otherwise excepted through these rules. Active medical staff whose primary practice site is Shands at UF shall be excluded from the above stated call responsibilities until they attend, admit or are involved in the treatment of 25 patients in 365 day period at Shands at AGH.

A staff member may make arrangements with another staff member with like privileges for call coverage. The physician requesting such arrangement shall maintain the ultimate responsibility for call coverage.

3. Patients admitted under emergency status must have an admission note on the progress note sheet of the chart or a written history and physical examination at the time of admission outlining why, in the opinion of the admitting physician, the emergency exists.
4. Patients who, for any reason, do not have or do not express a choice of physician are considered Service Patients. They shall be assigned to the members of the active medical staff on duty at the time and assigned to the service to which the illness of the patient indicates. In the event of transfer of care or if consultation is required of another physician, it shall be to the staff members actively assigned to that section at that time.
5. Members of the medical staff shall agree to render consulting services, regardless of the patient's ability to pay, when requested by a member of the medical staff, or in the cases where consultation is required by the hospital rules, whether private or service cases.
6. Emergency Service Call Schedule Responsibilities.
  - a. The Chairman of each Department and/or Section Chief will be responsible for development of and timely delivery of a Service Call Schedule to members of the respective Departments/Sections and the Emergency Department showing those Service Call Staff Members responsible for the

medical/surgical/dental/podiatric care appropriate to that specialty for Service Patients (defined in Rules 4 and 11) and who are evaluated by the Emergency Department Physician and consultation is requested.

- b. Medical/surgical/dental/podiatric care of Service Call Patients by the Service Call Member includes discharge from the Emergency Department for either appropriate follow-up care as an outpatient or hospital admission. Refusal of the Service Call Staff Member to accept medical/surgical/dental/podiatric care responsibility for Service Call Patients appropriate to that physician's/dentist's/podiatrist's specialty will become grounds for disciplinary action, including loss of Active Staff Privileges.
- c. The responsible physician for those patients classified as ER Service Call is the physician on-call when the ER physician initiates the call for referral, not when the patient arrives in the ER nor during the time which the patient is being evaluated. Service call is from 7:00 a.m. to 6:59 a.m. the following morning.
- d. If an emergency consultation is desired, the requesting physician must initiate the consultation with a personal phone call to the consultant physician. Physicians who refuse to respond to emergency consultations, either in the ED or other acute care settings, shall be advised by the requesting physician that a formal complaint will be registered with the Operations Committee Chairperson for action on the next business day. For the purpose of this rule, an "emergency" is defined as a condition, defined by the requesting medical staff member, which would (a) result in serious or permanent harm to a patient or (b) in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.) Verbal notification of activation of this rule shall be given to the Director on Call and followed by a written report to the Chairman of the Operations Committee the next business day.

At the discretion of the Operations Committee Chairperson, a meeting of the appropriate department chairmen and the Administrator will be called. (Two of the four will represent a quorum). This committee shall review the details of the reported issue and decide if a warning is merited. When a warning is received, the corrective action deemed appropriate shall be taken, up to and including, placing the physician in question on a six month probationary period consisting of the following provisions:

- The physician will make arrangements for a second call physician as back-up during the probationary period. Documentation of the back-up will be maintained in the ED.
- Any further incident will result in a summary suspension of clinical privileges.

The Credentials Committee and Quality Resource Management will be made aware of the initial incident for follow-up and tracking.

7. Orders for consults should be second in priority only to "stat" orders for the unit clerk/nurse who transcribes orders. Physicians should advise the unit clerk/nurse that a consult request is on the chart to facilitate this process.
8. All consults will be called to the physician on call at the time the order is transcribed. Consult orders brought to the attention of the unit clerk/nurse between the hours of 10 p.m. – 7 a.m. will be held for the morning clerk who will call these as close to 7 a.m. as possible.
9. A request for consult by a specific physician not on service call will be executed by hospital staff, however, if staff are unable to contact the requested physician or if the requested physician refuses the consult, the ordering physician shall be notified as soon as practicable. A consulted physician not on call has no obligation to accept the consult.
10. Consult orders written as "see today/tonight" are not considered routine consult requests and such requests must be made physician to physician.
11. Consult orders written as "consult in a.m." will be interpreted as a routine consult; i.e. may be responded to within the allowed 24 hour time period. The preferred language is "routine consult".
12. To provide good patient care and to allow the consultant to appropriately prioritize the consult visit, the requesting physician must provide the consultant with the reason for the consult. The unit clerk/nurse will give this information to the physician or his/her designee when placing a consult request.
13. Consults should be restricted to those health matters that must be addressed during the current hospitalization.
14. Requests for consultation must be responded to within 24 hours of notification, unless otherwise specified by the referring physician. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion, recommendations and/or orders. This report shall be made a part of the patient's record. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation. The name of the requesting physician and date must appear on all consultation forms.
  - a. All consultation requests are to be responded to by physicians or other healthcare professionals, as appropriate, in one of the following methods:
    - 1) The consultation report form is to be completed, or
    - 2) The consultation is to be documented in the progress notes in the patient's medical record and labeled "Consultation" or
    - 3) The consultation is to be dictated.
  - b. In each situation listed above, the following information must be included:
    - 1) The name of the requesting physician.
    - 2) Reason for the consultation.
    - 3) The consultation must be signed by the attending consultant.

Follow-up consultations must be designated as such and must be signed by the attending consultant.

15. Physicians on service call must respond to consults regardless of the insurance/payor status of the patient.
16. All entries into the medical record by an ARNP or PA for consult, must be cosigned by the appropriate physician by the end of the next calendar day.
17. The care of any patient admitted for a private attending physician by the night time admitting service physician between 7:00 p.m. and 7:00 a.m. becomes the responsibility of that attending physician upon admission.
18. Consultations shall be required when the patient's clinical needs exceed the scope of privileges or the competency of the responsible physician.
19. Dentists are responsible for the part of their patient's history and physical examination that relates to dentistry. Podiatrists are responsible for the part of their patient's history and physical examination that relates to podiatry. A credentialed M.D. or D.O. must confirm the findings and conclusions of the H & P and assessment of risk(s) of a proposed operative or other procedure, requiring written informed consent pursuant to hospital policy, done by a Dentist (except Oral and Maxillofacial Surgeon) or Podiatrist, when the patient involved has a severe systemic disease that is considered a constant threat to the life of the patient.

### **C. MEDICAL RECORDS**

1. The attending practitioner is responsible for accurate, timely, and legible completion of a medical record for each patient. All records will be maintained under a medical record number that forms the basis for the unit record.

In all instances the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. Each medical record contains at least the following information as appropriate:

- the patient's name;
- address;
- date of birth;
- the name of any legally authorized representative; for patient's receiving mental health service;
- patient's legal status;
- emergency care provided to the patient prior to arrival, if any;
- the record and findings of the patient's assessment;
- a statement of the conclusions or impressions drawn from the medical history and physical examination;
- the diagnosis or diagnostic impression;
- the reason(s) for admission or treatment;
- the goals of treatment and the treatment plan with episodic review as appropriate;
- evidence of known advance directives;
- evidence of informed consent when appropriate;
- reports of operative and other procedures, tests and their results;
- progress notes made by the medical staff and other authorized individuals;
- all reassessments, when necessary;
- clinical observations;
- the response to the care provided;

- consultation reports;
- medications ordered or prescribed during treatment or upon discharge;
- all relevant diagnoses established during the course of care;
- conclusions at the termination of hospitalization;
- discharge summaries, or a final progress note or transfer summary;
- discharge instructions to the patient or family;
- any referrals and communications made to external or internal care providers and to community agencies;
- results of autopsy, when performed.

2. A history and physical examination shall be recorded in all cases within 24 hours after admission and as soon as conditions permit for emergency admissions. In addition, a pertinent history and physical examination is required prior to the performance of any invasive procedure (whether inpatient or outpatient) and for outpatients who are observation patients. For inpatients, a valid H & P performed at admission, may be used for all subsequent inpatient procedures. The attending physician shall confirm and countersign the history and physical examination documented by other health care professionals with privileges to perform these activities.

- a. An appropriate history and physical includes, at a minimum: chief complaint; history of present illness; medications; allergies with reactions; past medical history; social history; family history; review of systems including pain assessment; for children: immunizations and growth chart, as appropriate; appropriate physical examination. A comprehensive assessment should integrate the elements from the history and physical examination that support the reason for admission or need for intervention followed by the treatment plan.

In addition, if anesthesia or sedation is planned, the anesthesia assessment shall include, at a minimum: medication history, including drug allergies, previous experience with sedation and analgesia, results of relevant diagnostic studies, physical status assessment, airway assessment, and NPO status.

- b. If a history and physical examination has been performed by a Medical Staff member within thirty (30) days of the admission/procedure, a legible copy of it may be used in the patient's medical record; provided that, at the time of admission/the procedure, an appropriate assessment is performed and documented, including a physical examination of the patient to update any components of the patient's current medical status that may have changed since the prior H & P or to address any areas where more current data is needed. The assessment and note must also confirm that the necessity for the care/procedure is still present and the H & P is still current. The update note must be on or attached to the full H & P; or when the H & P was accessed on-line by the practitioner, must refer specifically to the date of the H & P being updated. Updates may be done by the attending practitioner, or his/her resident or appropriately privileged ARNP or PA.
- c. If a history and physical has been performed by a non-credentialed physician, then the history and physical must be reviewed by a credentialed physician and a note of concurrence entered into the medical record. The attending physician shall confirm and countersign the history and physical examination

documented by all resident physicians or other health care professionals with privileges to perform these activities.

- d. If an H&P is performed and dictated within 24 hours after admission, the Medical Staff member performing the H&P must make an entry in the record stating the H&P has been completed and dictated.
3. The current obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the referring practitioner's office record transferred to the hospital before admission, but an admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.
4. All patients within the hospital must be seen daily by their attending physician or physician providing coverage for the attending. The patient medical record shall evidence daily involvement through documentation (e.g. dated orders, dated progress notes. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress noted and correlated with specific orders as well as results of tests and treatment.
5. A pre-anesthesia assessment of each patient for whom anesthesia is contemplated and a determination that the patient is an appropriate candidate to undergo the planned anesthesia shall be performed within 48 hours prior to the procedure and shall be recorded by the Anesthesiologist. Immediately prior to induction, an evaluation of the patient is completed and documented. The patient's postoperative status is assessed on admission to and discharge from the post-anesthesia recovery area. If discharge criteria are to be used for patient discharge from post-anesthesia care, they must be approved by the Medical Staff. Post-operative documentation includes at least a record of vital signs and level of consciousness; medications (including intravenous fluids), blood and blood components; any unusual events or postoperative complications, including drug and transfusion reactions, and the management of those events; identification of who provided direct patient care; the patient's discharge from the post-anesthesia care area including documentation of the responsible physician or indication if discharge was by criteria. In addition, for inpatients, a post-anesthesia follow-up report by the individual who administered the anesthesia shall be written within 48 hours following anesthesia.
6. Sedation and analgesia for diagnostic, therapeutic and invasive procedures shall be ordered and supervised only by physicians/dentists/podiatrists credentialed to do so, and only in accordance with hospital.
7. Free access to all medical records of patients shall be afforded to staff physicians in good standing for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patients. Subject to the discretion of the Hospital Administrator, former members of the medical staff shall be permitted free access to information from the medical records of the patients.
8. Patients shall be discharged on written order of the attending physician. Upon discharge, a discharge/death summary shall be dictated for all inpatients, except for those hospitalized for less than 48 hours and with only minor problems (as defined

by the responsible physician), normal newborn, and obstetrical patients with uncomplicated deliveries, observation patients. In these cases a final progress note including the final diagnosis(es), procedures, patient's condition at discharge, discharge instructions, and follow-up care may be substituted for the dictated summary. The summary should recapitulate concisely the reason for hospitalization; the significant findings; the procedures performed and treatment rendered; the condition of the patient on discharge and any specific instructions give to patient and/or family, i.e., instructions relating to physical activity, medication, diet and follow-up care. All summaries shall be reviewed and approved by the responsible attending physician.

9. When preprinted instructions are given to the patient/family, the medical record shall so indicate, and a sample of the instruction sheet then in use shall be filed in the appropriate department.
10. All entries in the medical record shall be legible, dated, timed, and authenticated. Entries should be made in black ink. Authentication may be by handwritten signature or computer signature (unique computer code). When a computer key code is authorized, the individual signs a statement that he or she alone will use the computer key code. The use of physician stamps is not allowed.

Only those healthcare professionals who are employed by, or contract with Shands HealthCare, or are credentialed by the Shands HealthCare Board are authorized to make entries into the medical record.

- a. General requirements:
  - 1) All entries should be written legibly in black ink.
  - 2) The date of each entry will be included.
  - 3) The signature and title of the author will follow all entries.
  - 4) Entries will contain essential information only, recorded in scientific and professional manner.
  - 5) Non-physician authors will limit their subjects to those within their area of training.
  - 6) The patient's name and medical record number should appear on each page.
  - 7) The medical record must be left intact at all times and errors should be left in the chart but lightly cross out in such a way that they remain legible. Corrections should be entered, dated, and signed by the editor. Erasures and the use of ink eradicator is not permissible.
  - 8) Specific charting privileges of non-physician authors will be delineated and supervised by the department head or faculty member to whom the author reports.
- b. Locations of Entries Within the Medical Record:
  - 1) Departments with students or non-physician employees who make entries in medical records will have policies governing the location of these entries within medical records.
  - 2) These policies will be reviewed with the Director of Health Information and Record Management and will be maintained on file in the Health Information and Record Management Department.
- c. Students:

All students must work directly under the supervision of a licensed or registered professional. The term "student" includes individuals participating in internship or practicum phases of degree programs. It does not include individuals covered in the section on GME trainees.
- d. Co-Signatures:

- 1) Co-signature of a medical record signifies an acknowledgement by the co-signer that the entry was made. It implies concurrence with the statements or conclusions contained in the entry.
  - 2) If there is significant disagreement with the conclusion of the author, the co-signer should record such conclusions or expand on the entry as appropriate.
11. Original records may be removed from the hospital only in accordance with court order, subpoena or statute. All records are the property of the hospital and shall not otherwise be removed without permission of the Director of the Health Information and Record Management Department. Unauthorized removal of a record from the hospital is grounds for disciplinary action in accordance with the Medical Staff Bylaws and Policy on Appointment. Written consent of the patient or surrogate is required for release of medical information to persons not otherwise authorized to receive this information. Release of medical information to external users, whether from the paper medical record or the electronic record, shall be in accordance with the policies of the Department of Health Information and Record Management.
12. In case of readmission of a patient, previous records shall be available for the use of the attending practitioner. This shall apply whether the patient is to be attended by the same practitioner or by another.
13. A medical record shall not be permanently filed until the responsible practitioner completes it. If the responsible practitioner is unavailable for completion of the record and no other physician is adequately familiar with the care to allow completion of the record, it will be presented to the Patient Record Committee for closure.
14. Medical records of discharged patients are to be completed promptly, preferably before the patient leaves the facility but no longer than thirty (30) days following the date of discharge. Physicians are expected to visit the Health Information and Record Management Department at least every fourteen (14) days and complete all available records. Failure to visit HIRM and complete records may be cause for disciplinary action including the suspension of clinical privileges as provided for in the medical staff policy on Appointment and Reappointment and hospital policy.
15. Upon notification that a patient medical record has been recommended for outside review, a physician shall have a period of seven (7) days to complete the chart. Failure to comply will result in the suspension of elective admission privileges until such time as the chart is complete.
16. An order from a licensed independent practitioner must be in place for each instance of restraint. See the Administrative Policy Manual for details of the policy regarding Restraint and Seclusion.
17. Verbal medical orders (a.k.a. telephone orders) may be taken by a licensed or registered health care professional in an emergent situation or when the physician/podiatrist/dentist/ARNP/PA is not present in the nursing unit to write an order needed to prevent a delay in care. The verbal order taken must be related to the area of professional responsibility of the person taking the order. A Registered Nurse may take any verbal order related to the care of the patient. When a verbal order is taken, the health care professional receiving the order shall record the order in the medical record, indicating the date and time the order was received, the name of the physician/podiatrist/dentist/ARNP/PA giving the verbal order, and the

health care professional receiving the order. In an emergent situation, the patient's nurse must be informed of the contents of the verbal order by the person receiving that order. The verbal order, shall be authenticated (i.e., signed, dated, and timed) promptly by the provider, giving the verbal order. For the purposes of this policy, promptly shall mean within 48 hours. Verbal orders for restraint or seclusion of psychiatric patients shall be authenticated and dated within 24 hours of the initiation of the restraint/seclusion.

#### **D. SURGERY RULES**

1. Prior to pre-operative analgesia or sedation, and prior to operative or invasive procedures, the history and physical examination should be completed, with a note to that effect on the patient's chart. An admission note on the chart must include the admitting diagnosis and a brief resume of coexistent significant disease. Any indicated diagnostic tests should be completed and reported in the medical record.

It is the responsibility of the attending physician to obtain permission for an operative or invasive procedure. The hospital staff may assist in obtaining the signatures after the clearly defined intended procedure(s), the risks, benefits and options have been discussed. If the patient is providing the consent, signature must be obtained prior to the administration of pre-operative analgesia or sedation. The informed consent form must be completed in its entirety before the procedure begins.

These provisions are waived in the case of an emergency. Emergency cases are defined as those cases where delay until the next regularly scheduled procedure opportunity would result in additional threat to life or limb. The physician must state in writing that the delay would be detrimental to the patient.

2. Surgeons must be in the operating room and ready to commence operation at the time scheduled. The operating room will be held no longer than fifteen minutes after the time scheduled except for due cause.
3. Medical and paramedical personnel in training may be allowed in the operating room and the delivery rooms under supervision upon approval of the attending physician.
4. The attending surgeon shall be responsible for delivery to the pathologist of all tissue removed at operation with appropriate, signed documentation. The containers and documentation will indicate the tissues, name, and hospital number.
5. Operative reports shall include the name of the primary surgeon and assistants, blood loss, findings, technical procedures used, specimens removed and the postoperative diagnosis. Operative reports shall be dictated or written immediately following surgery for outpatients as well as inpatients, and authenticated and filed in the medical record as soon as possible after surgery. A progress note shall be entered in the patient's medical record before the patient moves to the next level of care (PACU or ICU). Dictation of the full operative report shall be completed by the end of the day.

#### **E. CLINICAL DEPARTMENTS AND FUNCTIONS**

The following clinical departments are established. Additional departments or sections within departments, as required from time to time, may be established by the Board after considering recommendations from the Operations Committee of the medical staff.

- Anesthesiology
- Emergency Medicine
- Medicine
- Pathology
- Perinatology/Gyn
- Radiology
- Surgery

**Functions of Departments:**

1. Each clinical department shall recommend to the Credentials Committee criteria for the assignment of clinical privileges within the department. Such criteria shall be consistent with and subject to the bylaws, policies, rules, and regulations of the medical staff and the hospital. These criteria shall be effective when approved by the Board. Clinical privileges shall be based upon demonstrated competence, training, and experience within the specialty covered by the department.
2. Each department shall monitor and evaluate medical care on a retrospective, concurrent, and prospective basis in all major clinical activities of the department and section. This monitoring and evaluation must at least include:
  - a. The routine collection of information about important aspects of patient care and provided in department and about the clinical performance of its members; and
  - b. The periodic assessment of this information to identify opportunities to improve care and to identify important problems in patient care. Each department shall recommend, subject to approval and adoption by the Operations Committee and Board, objective criteria that reflect current knowledge and clinical experience. These criteria shall be used by each department or section, or by the hospital's quality assessment program in the monitoring and evaluation of patient care. When important problems in patient care and clinical performance or opportunities to improve patient care are identified, each department or section shall document the actions taken and evaluate the effectiveness of such actions.
3. In discharging these functions, each department shall report to the Operations Committee.

**F. DEPARTMENT CHAIRPERSONS**

The Board shall approve the chairperson of each department after considering the recommendations of the department, the Operations and Medical Executive Committees. The initial term of a chairperson shall be for a period of two years. Re-approval by the Board may be made biennially thereafter. A vice-chairperson of each department or committee may be appointed and must be approved by the Board, if desired by the chairperson, after receiving the recommendation of the department and the chairperson. The vice-chairperson's tenure shall coincide with that of the chairperson.

The chairperson of all departments shall be an appointee to the Active Staff with voting rights in the department s/he is to represent and who is qualified by training, experience, and administrative ability for the position. Such individual must be certified by the

appropriate specialty board, unless waived by the Board, and must possess the qualification set forth in Article III, Section 2 of the bylaws.

Each chairperson shall:

- be responsible for evaluating clinical activities and administratively related activities of the department, not otherwise provided for by the hospital;
- be responsible for assisting in the integration of the department into the whole organization as well as the coordination and integration of activities with other departments;
- be a member of the Operations Committee, making specific recommendations and suggestions regarding patient care in the department;
- maintain continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the department and identify and initiate educational activity as needed for departmental members;
- recommend criteria for clinical privileges in the department;
- be responsible for enforcement within the department of the hospital policies and bylaws and the medical staff Bylaws and Rules and Regulations, and the establishment and implementation of clinically supportive departmental policies and procedures;
- be responsible for implementation within the department of actions and programs of the Board and the Executive Committee, including Quality Improvement activities;
- make a report to the Credentials Committee concerning the appointment, reappointment, and delineation of clinical privileges for each member and potential member of the department;
- report and recommend to hospital management, with respect to matters affecting patient care in the department, including staffing levels and competencies of those health care providers other than Licensed Independent Practitioners, supplies, space allocation, special regulations, standing orders, techniques and contracted patient care services as needed;
- assist hospital management in the preparation of annual reports and such budget planning pertaining to the department as may be required by the Administrator or the Board;
- recommend establishment of sections within the department as needed and appoint chiefs thereof, subject to the approval of the Executive Committee and Board;
- be accountable to the Chief of Staff with respect to meeting all applicable accreditation or licensure requirements affecting the department; and
- demonstrate a willingness to serve by acceptance of the position as granted by the Board and agreeing to support the objectives of the hospital and the Board.

## **G. OPERATIONS COMMITTEE**

### **1. OPERATIONS COMMITTEE**

The Operations Committee of Shands at AGH, as established in the Medical Staff Bylaws, shall be composed of the following voting members:

- Chairman of the Operations Committee
- Chairman-Elect, Operations Committee
- Immediate Past Chairman, Operations Committee
- Chairmen of all Departments
- Family Practice Residency Program Director
- Medical Director, Quality Regulatory Management
- Chairman, Quality Improvement Committee
- Administrator, Shands at AGH

The Operations Committee shall meet as often as needed to conduct the business of the medical staff, but no less than quarterly. Members unable to attend a meeting may send a representative who may participate in discussions but shall not vote. The administrator may assign members of the AGH management team to attend and participate in meetings as needed as non-voting participants.

The recommendations and/or minutes of the Operations Committee actions shall be forwarded to the Executive Committee as required by regulatory agencies, Medical Staff Bylaws, Policies or Rules

2. SAGH representation on the Medical Executive Committee shall consist of the current Operations Committee Chairman and the Chairman-Elect. These members, with concurrence of the Administrator, shall appoint the third member from the SAGH Operations Committee membership.

#### **H. GRADUATE MEDICAL EDUCATION TRAINEES**

Definitions:

Graduate Medical Education: Any Accreditation Council for Graduate Medical Education (ACGME) approved education program.

Resident: Any individual in an ACGME approved program.

The medical staff of SHANDS at AGH supports the clinical; education of Graduate Medical Education trainees. Medical staff members have the option of not participating in GME activity without jeopardizing their privileges or appointment.

##### **University of Florida GME Participants**

The qualifications and competency of GME trainees affiliated with the University of Florida may be verified through the University of Florida GME program. The scope of practice for the GME trainee will be defined by their documented training protocols provided by the program.

##### **All Other GME Participants**

Residents not affiliated with the University of Florida must have an identified sponsor. (Only medical staff members in good standing as Active medical staff may act as a sponsor for a trainee in participating GME programs). To ensure the quality of patient care and proper supervision of each trainee, the sponsoring physician shall:

- be totally responsible for the entirety of the patient's care;
- be present and directly supervise the resident throughout all procedures requiring the informed consent of the patient; except that residents may be granted permission to perform select procedures, without the direct supervision by the attending physician, based on experience and level of training. The Chairman for each GME program shall submit a list of select procedures, and the experience/level of training of residents approved to perform them, for approval to the Medical Operations Committee. This list must identify the required level of supervision/availability of the attending for each procedure. Once approved, the list will be distributed to hospital staff for reference;
- co-sign all orders within 24 hours.

##### **Rules for all GME Participants**

1. Emergency Room Consultations: Residents shall function in accordance with the following guidelines:
  - Residents may take first call for patient consults in the emergency department. At the request of the emergency department attending or the resident/fellow, the

attending physician will come to the emergency department to supervise the consultation directly.

- If the patient is admitted, the attending will see the patient by the end of the following work day unless the patient's condition warrants a more timely intervention.
- If a disagreement exists between the ER physician and the resident regarding the proper disposition of the patient, the attending shall come in to see the patient.

2. Inpatient Consultation Guidelines:

- A resident may make the first response to a consultation request. The attending physician will come to directly supervise the consultation if requested by the physician who desires the consult or the resident.
  - The attending physician will personally see the patient within 24 hours of the consultation order unless the patient's condition warrants a more timely intervention.
  - When the immediate presence of the attending consultant physician is required, the physician who desires the consult will contact the attending physician directly.
3. At SHANDS at AGH, the scope of practice for GME trainees will be defined by the protocols of the training program. However, the responsibilities delegated to the trainee will be dependent upon the knowledge, skills and experience of the trainee and the complexity and risk of procedures as determined by the sponsoring physician.
4. SHANDS at AGH may, at any time, withdraw or exclude any GME training program or resident from its facilities, premises or clinical areas, whose conduct or performance is not within the standards of the agreement or whose conduct is unprofessional, disruptive or detrimental to patient care. A written report of the circumstances of the withdrawal or exclusion shall be submitted to the program director.

**I. MISCELLANEOUS**

1. On an obstetrical patient, the attending physician will be allowed to provide a serology test for syphilis report for the hospital medical record provided the report is an actual report from an accredited laboratory in Florida and the physician is made responsible for seeing that the report is filed on the medical record.
2. Patients with suicidal tendencies should be transferred to the appropriate psychiatric receiving facility. Patients who have suicidal tendencies and have serious or critical medical or physical problems should be transferred to either the Medical or Surgical Intensive Care Unit. A third option is for the provision of mandatory round-the-clock coverage for the patient by the patient's family.
3. It shall be the responsibility of the attending physician to advise the Hospital Administrator or his/her representative and the family of the names of such patients as are considered in critical condition.
4. Interpretation of electrocardiograms may be made by physicians approved by the department of Medicine upon request of the physician in charge of the patient. If no choice is expressed, the interpretation will be made by the physician designated by the Department of Medicine. In either event, the original report will be kept on the

patient's medical record and a copy of the report filed in the office of Cardiovascular Studies.

5. In the event of the death of a hospitalized patient, it is the duty of the patient's physician to immediately pronounce the patient dead. At the physician's request, the nursing Supervisor, after consultation with the physician, may pronounce the patient dead.
6. Autopsies shall be performed upon consent from the deceased patient's next of kin or other legally competent person by a certified pathologist or under his supervision. Obtaining such consent is the responsibility of the attending physician or his physician representative. Documentation in the progress notes is necessary if the family declines or approves the autopsy. Provisional autopsy diagnosis will be recorded on the patient's medical record within 72 hours, and final diagnosis within two months except for reasonably qualifying circumstances. Detailed information regarding autopsies, including criteria and statutory indicators, can be found in the Shands at AGH Policy and Procedure Manual.
7. The pathologist shall make such examinations as he may consider necessary to establish diagnosis of all tissues removed by a physician from a patient in the operating room or elsewhere in the hospital. The original of the pathologist's consultation report will be made a part of the patient's medical record and a copy will be filed in the Department of Pathology.
8. All physicians applying for appointment and clinical privileges to the Active Staff-Category shall participate in the Physician Orientation Program.
9. All patients within the hospital must be seen daily by their attending physician or a physician providing coverage for the attending. Daily progress notes must be written in the chart of each patient by this MD.

Normal Newborns (as defined by Maternal Child Services policy) may be rounded on by an ARNP assigned to the pediatrician responsible for the patient. If at any point during hospitalization the patient no longer meets the criteria for "normal newborn" the pediatrician shall be required to see the patient daily. This exception does not alter in anyway the ultimate responsibility of the physician for the patient nor the documentation and co-signature requirements in place relative to chart entries by ARNPs.

Those physicians who do not comply with this will be reported to the Medical Operations Committee for corrective action. This information will be included in the credentialing process.

10. **RECOMMENDED GUIDELINES AND PROTOCOL FOR DISRUPTIVE PHYSICIANS:** The primary objective of this guideline is to set forth a logical and sequential protocol for disruptive situations and occurrences at Shands at AGH, which involve physicians. "Physician disruptive behavior will be defined as "Behavior which interferes with the orderly operation of the hospital and potentially interferes with the delivery of quality patient care".

- a. Once a written complaint is received, the appropriate Administrator shall coordinate a meeting as soon as practicable with the individuals involved. The Administrator shall use his/her discretion in determining if it is appropriate for the complainant to participate in a face-to-face meeting with the physician. The Department Chairman/Chairman of the Operations Committee should be notified of the complaint and meeting and determine if his/her participation in the meeting is warranted.
  - b. If the problem cannot be resolved in this meeting, the Operations Committee Chairperson and Administrator of Shands at AGH will meet with the physician or physicians involved to address the behavior. If the Operations Committee Chairperson and Administrator do not feel that resolution has occurred, the matter shall then be managed according to Article V. Corrective Action, of the Shands at AGH/UF Policy.
11. Members of the medical staff whose primary campus is Shands at AGH are required to attend 50% of all general, departmental and assigned committee meetings. Attendance is optional for staff members who are 58 years of age or greater or have been on staff for 25 years or longer.
  12. In an urgent situation, the practitioner must, in accordance with Medical Staff Bylaws, be located in sufficient proximity to the Hospital to be able to provide continuity of quality care to their patients at the Hospital. Sufficient proximity to the Hospital means that the practitioner can be on site in approximately 30 minutes when required to attend to an urgent need of his/her patient or when on-call.
  13. No elective surgery such as removal of moles and cysts shall be done in the Emergency Department except in the case of physically handicapped patients who need specialized facilities or treatment available only at the hospital.
  14. Physicians generally should not treat themselves or immediate family members\*, however there may be occasions where this is acceptable and appropriate.

Any physician, who desires to provide treatment to him/herself or a family member at Shands at AGH, must first contact the Chairman of his/her assigned department or the Chairman of the Operations Committee. The physician will disclose to the Chairman the nature of the problem and/or the intended treatment and advise the Chairman the reason a non-related physician is not providing the care. The Chairman will offer counsel to the requesting physician, referencing the American Medical Association's Code of Ethics statement on this issue, which is appended to these Rules and Regulations. Documentation of this conversation shall be submitted by the Chairman at his/her earliest convenience and maintained by Quality Resource Management

In situations where the physician chooses to proceed with the delivery of care to self or family members, contrary to the advice of the Chairman, concurrent chart review will be conducted.

*\*For purposes of this rule, parents, sibling, children (whether natural or by law) and spouses are considered to be immediate family members.*

American Medical Association  
Code of Medical Ethics

**8.19 SELF-TREATMENT OR TREATMENT OF IMMEDIATE FAMILY MEMBERS**

Physicians generally should not treat themselves or members of their immediate families. Professional objectivity may be compromised when an immediate family member or the physician is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered. Physicians may fail to probe sensitive areas when taking the medical history or may fail to perform intimate parts of the physical examination. Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the physician is an immediate family member. This discomfort is particularly the case when the patient is a minor child, and sensitive or intimate care should especially be avoided for such patients. When treating themselves or immediate family members, physicians may be inclined to treat problems that are beyond their expertise or training. If tensions develop in a physician's professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.

Concerns regarding patient autonomy and informed consent are also relevant when physicians attempt to treat members of their immediate family. Family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician. In particular, minor children will generally not feel free to refuse care from their parents. Likewise, physicians may feel obligated to provide care to immediate family members even if they feel uncomfortable providing care.

It would not always be inappropriate to undertake self-treatment or treatment of immediate family members. In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. In addition, while physicians should not serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems.

Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members. (I, II, IV)

Issued June 1993.