MEDICAL STAFF RULES AND REGULATIONS

Martin Memorial Medical Center, Inc.
Stuart, Florida

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ARTICLE I

ADMISSION

1.1 WHO MAY ADMIT PATIENTS
A patient may be admitted to the Hospital only by individuals who have been appointed to the Medical Staff and granted privileges to admit patients by the Board of Directors.

1.2 ADMITTING MEDICAL STAFF RESPONSIBILITIES
Each patient shall be the responsibility of a designated appointee to the Medical Staff. The Medical Staff member shall be responsible for the medical care and treatment, for the prompt completeness and accuracy of the medical record. Whenever these responsibilities are transferred to another Medical Staff member a note covering the transfer of responsibility shall be entered on the order sheet of the medical record. Transfer of these responsibilities will be by mutual consent of both practitioners involved. The attending practitioner shall be responsible for giving such information as may be necessary to assure the protection of the patient from self harm and to assure the protection of others whenever this patient might be a source of danger from any cause whatever. A Medical Staff member who is responsible for the medical care and treatment of any inpatient (or their appropriately credentialed designee) must at all times be immediately available for consultation via cellular phone, beeper or home telephone number. It shall be the responsibility of each Medical Staff member to ensure that current contact numbers for their cellular phone, beeper and home phone telephone are reported to Medical Staff Services for entry into the Hospital’s physician data base related to after hours contact.

1.3 ALTERNATE COVERAGE
Each Medical Staff member shall provide assurance of immediate availability of adequate professional care for his/her patients in the Hospital by being available or having available an alternate Medical Staff member with whom prior arrangements have been made and who has clinical privileges at the Hospital sufficient to care for the patient. Failure to meet the above requirements may result in loss of clinical privileges. A Medical Staff member who will be unavailable for a given period of time shall, on the order sheet of the chart of each of his/her patients, indicate in writing the name of the Medical Staff member who will be assuming responsibility for the care of the patient during his/her absence. In case of failure to name such a Staff member, the President of the Medical Staff, or Chairperson of the Department concerned, shall have authority to call any member of the Attending Staff in such an event.

1.4 PRIORITIES FOR ADMISSION
In any case in which the patient requires admission, the admitting practitioner shall first contact the Admitting Department to ascertain whether there is an available bed. Except in an emergency, no patient shall be admitted until a provisional diagnosis or valid reason for admission has been stated. In case of an emergency, such statement shall be recorded as soon after admission as possible. The Admitting Department will admit patients on the basis of the following order of priorities:
(a) **Emergency Admissions** - This category includes those patients whose life is in immediate danger or whose condition is such that lack of immediate treatment could result in serious or permanent harm and any delay in admitting the patient for treatment would add to that harm or danger. On the day of an emergency admission, the attending practitioner may be required to furnish to the Utilization Management Committee, or the Committee’s designee, documentation of need for this admission. Failure to furnish this documentation, or evidence of willful or continued misutilization of this category of admission, will be brought to the attention of the Medical Executive Committee for appropriate action.

(b) **Urgent Admissions** - This category is for non-emergency patients whose admission is considered urgent and no bed is available. An admitting practitioner may contact the Chairperson of the Utilization Management Committee and request that his/her patient be admitted on an urgent basis. This patient will be given first priority on available beds other than emergency and, in no case, will admission be delayed beyond seventy-two (72) hours.

(c) **Preoperative Admissions** - This category includes all patients already scheduled for surgery. If it is not possible to handle all such admissions, the Chairperson/Chairperson of the Utilization Management Committee may decide the urgency of any specific admission.

(d) **Routine Admissions** - This category includes elective admissions involving all services.

If there is any question concerning the admission of a patient, the Chairperson of the Utilization Management Committee shall determine the necessity for, or deferment of, the admission.

### 1.5 IN-HOUSE PATIENT TRANSFERS

In-house transfer priorities shall be as follows:

(a) Emergency Department to appropriate bed;

(b) From Medical Intensive Care Unit to general care area;

(c) From Surgical Intensive Care Unit to general care area;

(d) From Obstetrical patient care area to general care area, when medically indicated;

(e) From temporary placement in an inappropriate geographic or a clinical service area to the appropriate areas for that patient.

No patient will be transferred without prior consultation with the responsible Medical Staff member.
1.6 EMERGENCY ADMISSIONS
The history and physical examination must clearly justify any admission on an emergency basis and must be recorded on the patient's chart as soon as possible, not to exceed twenty-four (24) hours, after admission. In case of emergency admissions, patients who do not already have a personal admitting practitioner will be assigned to a Medical Staff appointee with privileges in the clinical department to which the diagnosis indicates an assignment. Where departmental responsibility is not clear, the ranking available officer of the Medical Staff shall have the ultimate responsibility to determine the appropriate clinical department. Medical Staff Services, under the direction of the Medical Staff President, shall provide an emergency call schedule for attendance to such patients.

1.7 PREADMISSION AND POSTADMISSION LABORATORY TESTS
Laboratory studies will be performed at the discretion of the practitioner for each patient admitted to the hospital, inpatient or outpatient, except for newborns. Newborns shall have those laboratory tests required by state law.
ARTICLE II

MEDICAL ORDERS

2.1 GENERAL REQUIREMENTS

(a) All orders must be dated, timed and authenticated promptly by the ordering practitioner.

(b) Orders must be entered into the electronic medical record or, in special or unusual situations, can be written clearly, legibly and completely for the hospital staff to enter the orders electronically into the medical record. Written orders which are illegible or improperly written will not be carried out until they are rewritten and are fully understood by person(s) responsible to carry out the order.

(c) Previous orders for Medication & Diet are canceled when patients go to surgery.

(d) All orders will be completely reviewed when a patient is transferred from one service to another and rewritten when medication or treatment is to be resumed after an automatic stop order has been employed.

(e) Only the abbreviations, signs and symbols approved by the Health Information Management Department shall be used in the medical record.

2.2 WHO MAY WRITE ORDERS

Members of the Medical Staff shall have the authority to write orders consistent with their clinical privileges.

2.3 VERBAL ORDERS

Verbal orders (either in person, via telephone or by facsimile transmission) for medication or treatment shall be accepted when it is impractical for such orders to be entered in the electronic medical record by the responsible Medical Staff member. Verbal orders shall be taken only by qualified personnel who shall transcribe the orders in the proper place in the medical record of the patient. All verbal orders shall be read back to the ordering practitioner immediately after the verbal order is given. The order shall include the date, time and signature of the person taking the order and shall be countersigned by the prescribing practitioner. All verbal orders must be authenticated by the ordering/covering practitioner in a timely manner, not to exceed 30 days, providing if the verbal order is an order admitting a patient, it must be authenticated prior to the entry of a discharge order and no later than 24 hours after the admission.

Acceptance of a verbal order is limited to only the following personnel, with noted restrictions:

(a) a Medical Staff member with appropriate privileges;

(b) a professional Nurse;
(c) a Licensed Practical Nurse;
(d) a Pharmacist who may transcribe verbal orders pertaining to drugs;
(e) a Physical Therapist who may transcribe verbal orders pertaining to physical therapy regimens;
(f) a Respiratory Therapist who may transcribe verbal orders pertaining to respiratory therapy treatments;
(g) a Registered Dietician who may transcribe verbal orders pertaining to nutrition support; and
(h) other licensed professionals authorized by Florida statute to receive orders in their specialty.

2.4 ORDERS FOR SPECIFIC PROCEDURES

(a) Unless the cause for ordering any of the following procedures is apparent in the patient’s record, practitioners will be encouraged to document the reason for requesting x-ray, MRI, EKG, EEG and ultrasound examination. The radiologist should contact the ordering practitioner if additional information is required. An order for a serial electrocardiogram must specify both the desired frequency and the duration of the series.

(b) All orders for therapy shall be entered in the patient's record and signed by the practitioner.

(c) Therapeutic diets shall be prescribed by the attending practitioner in written orders on the patient's chart. Orders for diets must be specific.
ARTICLE III

CONSULTATIONS

3.1 WHO MAY GIVE CONSULTATIONS
Any qualified Medical Staff member with clinical privileges in this Hospital can be asked for consultation within his/her area of expertise. Consultation by practitioners associated in the same office, for required consultations, should be avoided insofar as possible. In circumstances of grave urgency, or where consultation is required by the rules of the Hospital, the President of the Medical Staff and the appropriate Department Chairperson or their designees shall at all times have the right to call in a consultant or consultants. In the absence of a readily available consultant, the most appropriate on-call practitioner shall provide the required consultation.

3.2 CONSULTATIONS
(a) Consultation shall be required in all non-emergency cases when:

(1) requested by the patient or his/her family;
(2) the patient exhibits severe symptoms of mental illness or psychosis; or
(3) the patient has attempted suicide (it must be documented in the medical record that psychiatric consultation was, at least, offered).

(b) Consultation is suggested when:

(1) the patient is a poor surgical risk; or
(2) unusually complicated situations are present that may require specific skills of other practitioner;

The attending practitioner is responsible for requesting consultation when indicated and for calling in a qualified consultant.

(c) Additional requirements for consultation may by established by the appropriate Medical Staff committees as required. It shall be the responsibility of the attending practitioner to obtain any required consultation, and his/her request for a consultation shall be entered on the practitioner's order sheet in the medical record. If the history and physical is not on the chart and the consultation form has not been completed, it shall be the responsibility of the practitioner requesting the consultation to provide this information to the consultant.

(d) If a Nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, she shall call this to the attention of her superior who, in turn, may refer the matter to the Nursing Supervisor. The Nursing Supervisor may bring the matter to the attention of the Chairperson of the Department in which the practitioner has clinical privileges. In all situations which require it, the Chairperson of the Department may himself/herself request a consultation after appropriate discussion with the attending practitioner.
(e) It is the duty of the Medical Staff, through the Credentials Committee, the Department Chairpersons and the Medical Executive Committee, to make certain that members of the Staff request consultations when needed.

3.3 CONTENTS OF CONSULTATION REPORTS
For required content of consultation report, see Article VII, Medical Records, Section 7.7.
ARTICLE IV

SURGICAL CARE

4.1 SCHEDULING SURGERY

(a) The operating surgeon must be named when the case is scheduled and is responsible for the surgical care of the patient before, during and after the operation. If the operating surgeon is more than fifteen (15) minutes late for any scheduled case, without contacting the Operating Room Supervisor, that case shall be canceled and the patient returned to his/her room by the Operating Room Staff. In no case shall anesthesia be started until the operating surgeon is present in the operating suite. Operating time will be released promptly when a case is canceled or the patient and surgical team are not available on schedule.

(b) Contemplated procedures must be designated on the schedule with the name of the patient. Cases requiring frozen sections should be posted as such at the time the case is scheduled.

(c) Emergency Surgery - This category includes those patients whose life is in immediate danger or whose condition is such that lack of immediate surgery could result in serious or permanent harm or danger. After giving due consideration to the added medical and anesthetic risks of treating the patient as an emergency, the attending surgeon will determine when his/her case qualifies as an emergency.

(d) Urgent Surgery - This category includes patients who in the best judgment of the surgeon need surgery at the earliest possible time. After giving due consideration to the medical and anesthetic risks of treating the patient in this category the attending surgeon will determine when his/her case qualifies as an urgent case.

(e) Elective Surgery - This category includes all patients for whom preparation and scheduling for surgery can be accomplished in the routine fashion.

4.2 ANESTHESIA RULES AND RECORDS

(a) The surgeon is to identify his/her patient prior to administration of the anesthetic and to remain in the Operating Room area in operating attire during induction. He/She may be asked to assist or supervise the position of his/her patient and must be available in the event of an emergency.

(b) The findings of a preanesthetic examination by an anesthesiologist or nurse anesthetist shall be recorded prior to surgery. Postanesthetic follow-up findings shall be recorded by an anesthesiologist or nurse anesthetist within the early postoperative period.
4.3 POST ANESTHESIA RECOVERY ROOM

The surgeon is to remain in the hospital until his/her patient is admitted to post anesthesia recovery. Postoperative orders must be written by the surgeon immediately following surgery. The anesthesiologist will subsequently examine the patient and write orders to discharge the patient from the post anesthesia recovery.

4.4 DENTAL PATIENTS

A patient admitted for dental surgery is the dual responsibility of the attending dentist and practitioner.

(a) Dentist's responsibilities:

(1) a detailed dental history justifying hospital admission;
(2) a detailed description of the examination of the oral cavity and preoperative diagnosis;
(3) a complete operative report, describing the findings and technique used. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue, including teeth and fragments, shall be sent to the pathologist for examination;
(4) progress notes pertinent to the oral condition;
(5) clinical summary or statement;
(6) discharge order.

(b) Practitioner's responsibilities:

(1) medical history pertinent to the patient's general health;
(2) a physical examination to determine the patient's condition prior to anesthesia and surgery;
(3) supervision of the patient's general health status while hospitalized.

Dentists with documented advanced training, under special circumstances, may be granted privileges to admit, supervise and evaluate their own patients, including the performance of the admitting history and physical examination.

4.5 PODIATRIC PATIENTS

A patient admitted for podiatric surgery is the dual responsibility of the attending podiatrist and practitioner.

(a) Podiatrist's responsibilities:

(1) a detailed history justifying hospital admission and, if permitted under the Medical Staff Bylaws and otherwise credentialed to do so, a medical history pertinent to the patient's general health;
(2) if permitted under the Medical Staff Bylaws and otherwise credentialed to do so, a physical examination to determine the patient's condition prior to anesthesia and surgery;
(3) a detailed description of the examination of the foot and preoperative diagnosis;
(4) a complete operative report, describing the findings and technique used;
(5) pertinent progress notes;
(6) clinical summary or statement;
(7) discharge order.

(b) Practitioner's responsibilities:

(1) unless performed by the attending podiatrist, medical history pertinent to
the patient's general health;
(2) unless performed by the attending podiatrist, a physical examination to
determine the patient's condition prior to anesthesia and surgery;
(3) supervision of the patient's general health status while hospitalized.

4.6 PATHOLOGY REPORT
All tissues removed during a surgical procedure shall be properly labeled and sent to the
laboratory for examination by the pathologist, who shall determine the extent of
examination necessary for diagnosis. Scars and placenta may be submitted at the
discretion of the surgeon. The specimen must be accompanied by pertinent clinical
information, including its source and the preoperative and postoperative surgical
diagnosis. The pathologist shall sign his/her report which becomes a part of the patient's
medical record. Any exception to this requirement may be made by the Medical
Executive Committee.
ARTICLE V

DELIVERY ROOM

5.1 ADMISSION
Obstetrical patients may be admitted on a twenty-four (24) hour basis via the Emergency Department or Admitting Office. Patients scheduled for Cesarean sections are admitted at least two (2) hours prior to scheduled surgery. Nursing personnel shall notify the attending practitioner when the patient is admitted. No maternity patient shall be denied a bed because of the presence of gynecological patients in the unit. If necessary, gynecological patients shall be transferred to other areas of the Hospital.

5.2 REQUIRED LABORATORY PROCEDURES
Laboratory studies will be performed at the discretion of the practitioner for each patient admitted to the Hospital, inpatient or outpatient, as required by state law.

5.3 MEDICAL RECORDS
Complete medical records must accompany the patient to the Delivery Room. Obstetrical records should include all prenatal information. A durable, legible original or reproduction of the office or clinic prenatal record is acceptable.

5.4 IDENTIFICATION
Hospital means of patient identification shall be attached to the mother and newborn infant before they are removed from the Delivery Room.

5.5 DELIVERY ROOM ROSTER
An on-call roster shall be established and maintained to insure that a practitioner with obstetrical/gynecological privileges is readily available at all times.
ARTICLE VI

NURSERY AND CARE OF NEWBORN

6.1 ON-CALL ROSTER
A practitioner on-call schedule shall be posted in the Nursery to insure that a practitioner
is available at all times to come to the hospital immediately to deal with emergency
situations.

6.2 EXAMINATIONS
All newborn infants shall have a complete physical examination by a practitioner within
twenty-four (24) hours after admission to the Nursery, and the results of the examination
shall be recorded in the infant's medical record. Any infant who displays abnormal signs
and symptoms at any time shall be examined by a practitioner as soon as possible. Every
newborn infant shall be examined by his/her attending practitioner within one (1)
day prior to discharge, and the findings shall be recorded in the infant's medical record.

6.3 HIGH RISK INFANTS
The practitioner to be in charge of the infant and the nurses in charge of the Nursery
shall be notified when the delivery of a potentially high risk infant is expected. Continuity
of care for all infants and especially for high risk infants is to be initiated in the delivery
area, with constant observation of newborns for distress.

6.4 IDENTIFICATION
The identification of each infant and his/her mother shall be carefully checked again at
the time of discharge from the Hospital. Infants discharged or transferred to another
nursery or hospital shall be carefully identified.

6.5 TRANSPORTATION OF INFANTS
Care for the protection of the infant shall be taken when transporting the newborn to the
Nursery from the Delivery Room. Transfer of distressed infants to the Nursery shall be
done in such a manner as to minimize heat loss and to insure adequate oxygenation.

6.6 PROPHYLAXIS AGAINST GONORRHEAL OPHTALMIA
Prophylaxis against gonorrheal opthalmia with a current acceptable preparation shall
be carried out as soon as the condition of the infant permits.

6.7 MEDICAL RECORD
Every newborn shall be examined at the time of delivery and the following noted on
his/her medical record:

(a) condition at birth including APGAR score or its equivalent;

(b) any physical abnormalities or pathological states;

(c) any evidence of distress.
The record of the newborn infant shall accompany him/her from the place of delivery to the Nursery and be immediately available to Nursery personnel. In addition to the information listed above, this record shall also include information concerning prenatal history, course of labor, delivery, drug administration to mother and infant, relevant conditions of the mother, procedures performed on the infant in the Delivery Room, complications of any type, and other facts and observations. A complete medical record for every newborn should include the following information:

(a) description of complications of pregnancy or delivery;
(b) complicating maternal disease;
(c) drugs taken by the mother during pregnancy, labor and delivery;
(d) duration of ruptured membranes;
(e) maternal antenatal blood serology, rubella titer, blood, typing, Rh factors, and where indicated, a Coombs test for maternal antibodies;
(f) anesthesia, analgesia and medications given to mother and infant;
(g) condition of infant at birth, including the one and five minute APGAR Scores or its equivalent, resuscitation, details of physical abnormalities, pathological states observed and treatments given before transfer to the Nursery;
(h) any abnormalities of the placenta and cord vessels;
(i) date and hour of birth, birth weight, and length, and period of gestation;
(j) a written verification of eye prophylaxis;
(k) report of initial physical examination, including any abnormalities, signed by the attending practitioner or his/her authorized delegate;
(l) discharge physical examination, including head circumference and body length, unless previously done; recommendations and signature of the attending practitioner or his/her delegate;
(m) a listing of all diagnoses since birth, including discharge diagnosis.
ARTICLE VII

MEDICAL RECORDS

7.1 GENERAL RULES
The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient under his/her care. Its contents shall be pertinent and current. A single attending practitioner shall be identified in the medical record as being responsible for the patient at any given time. A practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, but must be dated and signed by the attending practitioner. Only the abbreviations, signs and symbols approved by the Health Information Management Department shall be used in the medical record.

7.2 AUTHENTICATION
(a) All clinical entries in the patient’s medical record shall be accurately dated, timed and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient. Authentication means to establish authorship by written signature, identifiable initials, computer keys.
(b) Verbal orders must be authenticated in a timely manner, not to exceed 30 days, by directly signing, dating and timing the order.

7.3 CONTENTS
A complete medical record shall include:
(a) identification data;
(b) date of admission and discharge;
(c) history, including:
   (1) chief complaint
   (2) details of the present illness
   (3) relevant past, social and family histories
   (4) drug reactions
   (5) current medications
   (6) review of systems
(d) conclusions or impressions drawn from the assessment of the patient;
(e) physical examination, which, for inpatients and overnight observation patients, should generally include:
   (1) vital signs and general description of patient;
   (2) chest and general cardiovascular examination;
(3) examination of body systems, as is applicable to the patient’s admitting diagnosis (which may include but not be limited to breast, genitalia, extremities, neck, visual and auditory systems);
(4) abdominal examination;
(5) significant neurological abnormalities;
(6) if in question, an evaluation of capacity to communicate knowing healthcare decisions.

(f) results of diagnostic and therapeutic tests and procedures;
(g) evidence of appropriate informed consent;
(h) clinical observations, progress notes, all orders, nursing notes, consultation reports;
(i) reports of procedures, tests and the results:
   (1) preoperative diagnosis and operative report
   (2) pathology reports
   (3) clinical laboratory examination reports
   (4) radiology and nuclear medicine examination and treatment reports
   (5) anesthesia records
(j) discharge plan and discharge planning evaluation;
(k) final diagnosis, condition on discharge, summary or discharge note;
(l) autopsy report, when performed.

7.4 HISTORY AND PHYSICAL

(a) A history and physical examination (containing the elements outlined in 7.3(c) [1-6], (d) and (e) [1-6]) must be completed and documented for each patient by a treating practitioner no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services regardless of whether care is being provided on an inpatient or outpatient basis.

The term “treating practitioner” as used in this section may include other qualified licensed individuals such as Advanced Registered Nurse Practitioners and Physician Assistants who are credentialed and privileged through the Medical Staff Process and authorized in accordance with their scope of practice, State law, and Hospital policy.

(b) A legible copy of the complete history and physical must be placed within the patient’s medical record within 24 hours of admission or registration, or prior to surgery or a procedure requiring anesthesia services, whichever comes first.

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1 If the admission H&P is performed by an Advanced Registered Nurse Practitioner or Physician Assistant, the supervising physician must see the patient within 24 hours of admission or registration and sign off on the H&P.
(c) For patients who present to the emergency room who require emergency surgery or a procedure requiring anesthesia services, a treating practitioner in attendance must perform and document a complete history and physical as soon as practical, but not more than 24 hours following admission or registration. For such a patient, a brief preoperative note must be entered into the patient’s medical record before surgery or procedure stating that the surgery is emergent; and document the patient’s condition prior to the induction of anesthesia and start of surgery or procedure.

(d) When the H&P requisites outlined in 7.3(c) [1-6], (d) and (e) [1-6] are not recorded within the patient’s medical record prior to surgery or procedure requiring anesthesia services, then the surgery or procedure shall be cancelled unless the attending physician or surgeon documents in the patient’s medical record that such delay would be detrimental to the patient.

(e) In the event the history and physical of patients undergoing surgery or procedure requiring anesthesia services is not completed within 30 days prior to or 24 hours after admission or registration, or prior to surgery or procedure requiring anesthesia services, then: the consult note may serve as a history and physical as long as:
   (1) it contains the required elements outlined in 7.3(c) [1-6], (d) and (e) [1-6];
   (2) is performed by a treating practitioner who is privileged to perform a history and physical, and
   (3) the patient’s medical record is documented that the consult note serves as the H&P for this surgery or procedure requiring anesthesia services.

   The attending physician must still complete the history and physical within 24 hours of admission.

(f) When the history and physical examination has been completed within 30 days prior to admission or registration, an updated examination of the patient, including any changes in the patient’s condition, must be completed and documented in the patient’s medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

   The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a treating practitioner credentialed and privileged to perform H&Ps through the Medical Staff Process and authorized in accordance with their scope of practice, State law, and Hospital policy

   In all cases, the update must take place prior to surgery or a procedure requiring anesthesia services.

   The update note must document an examination for any changes in the patient's condition since the patient's H&P was last performed that might be significant for the planned course of treatment.
The treating practitioner uses his/her clinical judgment, based upon his/her assessment of the patient’s condition and co-morbidities, if any, in relation to the patient’s planned course of treatment to decide the extent of the update assessment needed as well as the information to be included in the update note in the patient’s medical record.

If, upon examination, the treating practitioner finds no change in the patient's condition since the H&P was completed, he/she may indicate in the patient's medical record that the H&P was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the H&P was completed.

Any changes in the patient's condition must be documented by the treating practitioner in the update note and placed in the patient’s medical record within 24 hours of admission or registration, but prior to surgery or a procedure requiring anesthesia services.

Additionally, if the treating practitioner finds that the H&P performed before admission is incomplete, inaccurate, or otherwise unacceptable, the treating practitioner reviewing the H&P, examining the patient, and completing the update may disregard the existing H&P, and conduct and document in the medical record a new H&P within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia.

Ultimately, compliance with the History and Physical requisites is the primary responsibility of the admitting physician.

7.5 PROGRESS NOTES
Progress notes made by the Medical Staff should give a pertinent chronological report of the patient's course in the Hospital. Progress notes shall be legible, recorded by the end of the calendar day of observation, and shall contain sufficient content to insure continuity of care if the patient is transferred. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be written at least daily. Pertinent progress notes shall also be made by others such as house staff, individuals who have been granted clinical privileges, and specified professional personnel.

7.6 OPERATIVE REPORTS
Operative reports shall be dictated and written immediately and contain the following:
(1) the name(s) of the licensed independent practitioner(s) who performed the procedure and his/her assistant;
(2) preoperative diagnosis;
(3) the name of the procedure;
(4) gross pathology’
(5) a description of the findings;
(6) the technical procedures used;
(7) the specimens removed;
(8) any estimated blood loss (if none, so state);
(9) the postoperative diagnosis. The completed operative report should be authenticated by the surgeon and filed in the medical record immediately after surgery. Unless the full operative report is prepared immediately after surgery, a brief operative note shall be entered in the electronic medical record immediately after surgery and the full operative report must thereafter be prepared within 24 hours after surgery.

7.7 CONSULTATION REPORTS
Each consultation report should contain a written opinion and recommendations by the consultant that reflects, when appropriate, an actual examination of the patient and the patient's medical record. This report shall be made a part of the patient's record. A limited statement, such as "I concur" does not constitute an acceptable consultation report. When operative procedures are involved, the consultation note shall be recorded prior to the operation except in emergency situations so verified on the record.

7.8 DISCHARGE SUMMARIES
(a) All relevant diagnoses established by the time of discharge, as well as all operative procedures performed, should be recorded, using acceptable disease and operative terminology that includes topography and etiology as appropriate. The final diagnoses shall be dated and signed by the attending practitioner at the time of discharge.

(b) A clinical discharge summary shall be dictated and made part of the medical records of all patients (including all patients who expire while hospitalized unless they were hospice patients) except those with minor problems who require less than a forty-eight (48) hour period of hospitalization, normal newborn infants and uncomplicated obstetrical deliveries. A final progress note may be substituted for the discharge summary for these patients, which should include any instructions given to the patient or family.

(c) The discharge summary shall include the reason for hospitalization, the significant findings, the procedures performed and the care, services, and treatment rendered, the condition and the disposition of the patient on discharge, and any specific instructions given to the patient or family, as pertinent, and provisions for follow-up care. The condition of the patient on discharge should be stated in terms that permit a specific measurable comparison with the condition on admission. When preprinted instructions are given to the patient or family, the record should so indicate and a copy of the instruction sheet used should be on file in the Health Information Management Department. All summaries shall be authenticated by the attending practitioner.
7.9 POSSESSION AND ACCESS

(a) All medical records are the physical property of the Hospital and shall not be taken from the confines of the Hospital without permission of the Health Information Management Department. Medical records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. Unauthorized removal of charts from the Hospital is grounds for suspension from the Medical Staff and shall require that the matter be turned over to the Medical Executive Committee for appropriate action.

(b) Upon written approval of the Chief Executive Officer, access to the medical records of all patients shall be afforded to appointees of the Medical Staff for bona fide study and research, consistent with preserving the confidentiality of personal information concerning individual patients. All such projects shall be approved by the Executive Committee of the Medical Staff before records can be studied. Subject to the discretion of the Chief Executive Officer, former members of the Medical Staff shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital. Any publication of compiled data from the Hospital's patients' medical records is forbidden without written approval of the Chief Executive Officer.

(c) Written consent of the patient is required for release of medical information to those not otherwise authorized to receive this information.
ARTICLE VIII

INFORMED CONSENT

8.1 RESPONSIBILITY FOR OBTAINING INFORMED-consent
An admission consent form signed by the patient or his/her representative must be obtained at the time of admission. The Admitting Office should notify the attending practitioner whenever such consent has not been obtained. In addition to obtaining the patient's general consent to treatment, a specific consent that informs the patient of the nature of and substantial risks, benefits and alternatives of any special treatment or surgical procedure shall be obtained. Except in emergencies, a failure to include a completed consent form in the patient's chart prior to the performance of the procedure shall automatically cancel the procedure. Whenever the patient's condition prevents the obtaining of a consent, every effort shall be made, and documented, to obtain the consent of the patient's legal representative prior to the procedure. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, these circumstances should be fully explained on the patient's record. A consultation shall be obtained before the operative procedure is undertaken, if possible. Should a second operation be required during the patient's stay in the Hospital, a second consent should be obtained. If two (2) or more specific procedures are to be done at the same time and this is known in advance, they may all be described and consented to on the same form. The consent forms used in the Hospital shall be those consent forms approved by the Risk Management Department.

8.2 DEFINITIONS
The following definitions shall be applied when obtaining the patient's consent to treatment in the Hospital:

(a) Informed Consent - Consent obtained from the patient after being informed of the nature and substantial risks, benefits and alternatives of the proposed treatment.

(b) Emergency - A situation when, in competent medical judgment, the proposed surgical or medical treatment or procedure is immediately necessary and any delay caused by an attempt to obtain a consent could jeopardize the life, health or safety of the patient.

8.3 WHO MAY CONSENT

(a) A competent adult may authorize any surgical procedure to be performed upon his/her body, and the consent of no other person is required or valid.

(b) Written consent shall be obtained from the parents or legal guardian of a minor before any surgical or medical procedure is performed on the minor, except in the following cases in which minors may consent for their own care:

(1) emergencies;
(2) married pregnant minors seeking care related to their pregnancy;
(3) minors seeking treatment of their own minor children.

(c) Written consent shall also be obtained, in all nonemergency situations, from the legal representative of any incompetent adult before any surgical or medical procedure is performed.

8.4 RELEASE OF MEDICAL RECORDS
Written consent of the patient is required for release of medical information to those not otherwise authorized to receive this information.

8.5 ABORTIONS

(a) Refusal to Participate in Abortions: Florida law does not require any hospital or any person to participate in an abortion, and hospitals and persons refusing to participate are free from liability. Any practitioner who objects to abortion based upon moral or religious grounds may not be compelled to participate in such a procedure, nor can his/her refusal to participate be grounds for disciplinary action against him.

(b) Written Consents: Written informed consents for abortion shall follow state law.
ARTICLE IX

PHARMACY

9.1 GENERAL RULES
All drugs and medications administered to patients shall be listed in the latest edition of "United States Pharmacopoeia," "National Formulary," "American Hospital Formulary Service" or "A.M.A. Drug Evaluations" with the exception of drugs for bona fide clinical investigations whose use is in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and approved by the appropriate committees.

9.2 SELF-ADMINISTRATION; PATIENT'S OWN DRUGS
Self-administration of drugs by patients may be permitted as prescribed in writing by the attending practitioner. If patients bring their own drugs to the Hospital, these drugs shall not be administered unless the attending practitioner has written an order for their administration. If the drugs are not ordered by the attending practitioner, they shall be packaged, sealed and returned to the patient at the time of his/her discharge from the hospital. Controlled substances as listed in the Controlled Substances, Drug, Device and Cosmetic Act shall not be returned to the patient without approval of the attending practitioner.

9.3 STOP ORDERS
A "STOP" order drug policy shall be in effect and shall apply, among others, to narcotics, depressant and stimulant drugs and antibiotics.
ARTICLE X

DISCHARGE

10.1 WHO MAY DISCHARGE
Patients shall be discharged only on the order of the attending practitioner or his/her designee. Should a patient leave the Hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record, and the patient shall be asked to sign the Hospital's release form.

10.2 TRANSFER OF PATIENTS
A patient shall not be transferred to another medical care facility unless prior arrangements for admission to that facility have been made. Clinical records of sufficient content to insure continuity of care shall accompany the patient.

10.3 DISCHARGE OF MINORS AND INCOMPETENT PATIENTS
Any individual who cannot legally consent to his/her own care shall be discharged only to the custody of parents, legal guardian, person standing in loco parentis or another responsible party unless otherwise directed by the parent, guardian or court order. If the parent or guardian directs that discharge be made otherwise, that individual shall so state in writing, and the statement shall become a part of the permanent medical record of the patient.

10.4 AUTOPSIES AND DISPOSITION OF BODIES

(a) The remains of any deceased patient, including a fetal death or a neonatal death, shall not be subjected to disposition until death has been officially pronounced by a practitioner or two (2) Registered Nurses, the event adequately documented within a reasonable period of time by the attending practitioner or another designated Medical Staff member and only with the consent of the parent, legal guardian, or responsible person. Death certificates are the responsibility of the attending practitioner and must be completed within seventy-two (72) hours of the death.

(b) It shall be the duty of all Medical Staff members to secure consent to meaningful autopsies whenever possible. An autopsy may be performed only with the proper consent in accordance with state law. All autopsies shall be performed by the Hospital pathologist or by his/her designee. Provisional anatomic diagnoses shall be recorded on the medical record within forty-eight (48) hours and the completed protocol shall be made a part of the medical record within thirty (30) days.
ARTICLE XI

EMERGENCY SERVICES

11.1 EMERGENCY DEPARTMENT CONSULTANTS

(a) All Attending Staff Members shall serve as consultants to Emergency Department practitioners on a rotating basis as assigned by the President of the Medical Staff.

(b) All Attending Staff Members shall be designated to have a principal facility affiliation for serving as Emergency Department consultants. The assigned principal facility affiliation designation shall be to the affiliation option where each Attending Staff member has the most clinical activity as determined by the MEC in its discretion. For the purpose of this designation, Martin Medical Center / Martin Hospital South shall be considered one affiliation option, and Tradition Medical Center / Martin Emergency Department St. Lucie West shall be considered the other principal affiliation option. A Medical Staff Member may elect to designate both and provide on-call coverage at both, provided that they can demonstrate to the satisfaction of the Medical Executive Committee and the Board that the quality and efficiency of patient care will not be adversely affected.

(c) The Medical Staff President shall endeavor to achieve full emergency coverage of specialty call to the extent practical through the combined utilization of facilities and obligated or otherwise available practitioners for Emergency Department service calls.

(d) If the facility in which the Emergency Department is located has the needed specialty coverage, staffing, facilities and equipment, a patient presenting there shall generally be treated there. If it is determined that the patient requires care that is not available at that facility at that time, however, the patient will be transported to the nearest Martin Medical Center facility able to provide the needed care unless transfer to another facility is directed by the patient or the services required are not available at any affiliated facility. The appropriate facility to provide needed care will be determined by the Emergency Department physician attending the patient, based upon that physician’s determination of what is in the best interest of the patient. All Martin Memorial Medical Center, Inc. affiliated Emergency Departments and hospital facilities are operated under a single license, and the transportation of patients by and between those departments and separate hospital campuses are considered intra-facility transfers as opposed to transfers to different hospitals.

(e) On call practitioners shall provide their services for the care and treatment of patients in the Emergency Department(s) or Operating Rooms of the Hospital. On-call practitioners must respond to a call or page by the Emergency Department staff by initiating a telephone call to the Emergency Department within thirty (30) minutes and/or Emergency Department protocol. Thereafter, the on-call practitioner must attend to the needs of the patient within a reasonable time and appropriate to the patient’s condition, as determined by the Emergency Department practitioner in consultation with the on-call practitioner. If the on-call practitioner is not available for
any reason, it is his/her responsibility as a member of the Medical Staff to arrange for substitute Emergency Department consultation coverage and to notify the Emergency Department of such change. Failure to do so will be reviewed by the Medical Executive Committee.

(f) A practitioner may be relieved of this responsibility, at his/her request, with six (6) months’ notice and upon Board approval, when the sum of his/her age plus number of years of service at this Hospital is equal to seventy (70) or more. Any member of the Attending Staff may be relieved from Emergency Department call for reasons of health or at the discretion of the President of the Medical Staff. (This is known as the "Rule of 70.")

(g) It shall be the responsibility of the on call practitioner to give the referred Emergency Department patient a follow up appointment within a time appropriate to the patient’s condition, regardless of the patient’s ability to pay. The referred patient shall be instructed by the Emergency Department practitioner to call the on call practitioner’s office within forty-eight (48) hours of being discharged from the Emergency Department (weekends and holidays being taken into consideration) to make arrangements for the follow up care. The on call practitioner shall arrange to provide the follow-up visit in a manner consistent with applicable laws and regulations. The practitioner may not make payment a condition for providing the follow-up visit, but may bill the patient for such services in a manner consistent with applicable laws and regulations. The required follow-up visit shall be solely for the purpose of evaluating the appropriateness of the emergency department discharge and to provide such additional follow-up care as the emergency medical condition requires.

11.2 EMERGENCY DEPARTMENT PATIENT RECORDS

(a) An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient’s Hospital record, if such exists. The record shall include:

(1) adequate patient identification;
(2) information concerning the time of the patient's arrival, means of arrival and by whom transported;
(3) pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his/her arrival at the Hospital;
(4) description of significant clinical, laboratory and roentgenologic findings;
(5) diagnosis;
(6) treatment given;
(7) condition of the patient upon discharge or transfer; and
(8) final disposition, including instructions given to patient or family, relative to necessary follow-up care.

(b) Each patient’s medical record shall be signed by the Medical Staff member in attendance who is responsible for its clinical accuracy.
There shall be a monthly review of Emergency Department records by the Emergency Service to evaluate the quality of emergency medical care. The records of all patients dying within twenty-four (24) hours of admission to the Emergency Department shall routinely be reviewed.

11.3 DISASTER PLANNING

(a) During a disaster, all designated practitioners shall be assigned to posts, either in the hospital or in mobile casualty stations, and it is their responsibility to report to their assigned stations. The Disaster Planning Committee Chairperson and the Chief Executive Officer shall work as a team to coordinate activities and directions. In cases of evacuation of patients from one section of the Hospital to another or evacuation from the premises, the Disaster Planning Committee Chairperson or the Chief Executive Officer will authorize the movements of patients during the disaster. All policies concerning direct patient care will be a joint responsibility of the Department Chairpersons and the Chief Executive Officer, or their designees.

(b) The disaster plan shall be rehearsed at least twice a year, preferably as part of a coordinated drill in which other community emergency service agencies participate. The drills shall involve the Medical Staff, Hospital Management, Nursing, and other Hospital personnel. There should be a written report and evaluation of all drills.
ARTICLE XII

SPECIAL CARE UNITS

If any question as to the validity of admission to or discharge from the Medical Intensive Care Unit should arise, that decision is to be made through consultation with the designated member of the Department of Medicine. In similar circumstances concerning admission to or discharge from the Surgical Intensive Care Unit, the designated member of the Department of Surgery is to be consulted.

Medical Intensive Care Unit (MICU), Surgical Intensive Care Unit (SICU), Coronary Care Unit (CCU), Telemetry Unit, and Progressive Care Unit (PCU):

(a) If a need for a bed in a Special Care Unit arises and none is available, the nurse in charge will determine which patient appears most ready for transfer out and will contact the appropriate practitioner. If the bed shortage problem cannot be resolved at this level, the Medical Director/Staff Advisor to the Special Care Unit will be contacted; if the problem still cannot be resolved by the Medical Director/Staff Advisor, then the appropriate Practitioner's Committee shall be contacted.

(b) The MICU Practitioner's Committee consists of:

(1) The Medical Director/Staff Advisor to MICU;
(2) The Chairperson of the Department of Medicine;
(3) The Chairperson of the Department of Family Practice.

(c) The SICU Practitioner's Committee consists of:

(1) The Medical Director/Staff Advisor to SICU;
(2) The Chairperson of the Department of Surgery;
(3) The Immediate Past Chairperson of the Department of Surgery.

(d) The CCU Practitioner's Committee consists of:

(1) The Medical Director/Staff Advisor to CCU;
(2) The Chairperson of the Department of Medicine;
(3) The Chairperson of the Department of Family Practice.

(e) The Telemetry Unit Practitioner's Committee consists of:

(1) The Medical Director/Staff Advisor to the Telemetry Unit;
(2) The Chairperson of the Department of Medicine;
(3) The Chairperson of the Department of Family Practice.

(f) The PCU Practitioner's Committee consists of:

(1) The Medical Director/Staff Advisor to PCU;
(2) The Chairperson of the Department of Surgery;
(3) The Immediate Past Chairperson of the Department of Surgery.

(g) When there is a bed shortage in a Special Care Unit and someone must make a decision as to which patients shall or shall not be admitted to a Special Care Unit, and there is a disagreement between the attending practitioner and the Medical Director/Staff Advisor to the Special Care Unit, the attending practitioner may contact the second member of the appropriate Committee. Whatever two (2) members out of three (3) of a Committee decide shall be a final, binding decision as to who shall or shall not be admitted to the Special Care Unit when there is a bed shortage. Members of the Committee, by the same process, will also have the power to move patients out of the Special Care Unit when they feel patients with a greater need should be admitted to the Special Care Unit when there are no beds otherwise available in the Special Care Unit.

A two-thirds (2/3) majority of the Committee shall be able to discharge patients from the Special Care Unit in these circumstances even if the attending practitioner disagrees. The attending practitioner shall always be notified when one of his/her patients is going to be moved from a Special Care Unit.
ARTICLE XIII

MEDICAL STAFF DUES

The Medical Executive Committee (MEC) will establish the amount and manner of expenditure of annual dues. Notice of dues will be given to the Staff at the October meeting and communicated by some reasonable mechanism in writing to the Medical Staff. Dues are payable on or before January 2 of each year. If dues are not paid by February 1, a special notice of delinquency is sent to the practitioner and he may be asked to appear before the MEC to explain his/her delinquency.

All new Staff members will be billed for annual dues for the current year without proration upon their appointment to the Staff. Payment shall be made within thirty (30) days. Special Assessments may be voted by action of the Medical Staff or the MEC and rules of payment similar to those described above in terms of time frame will apply.

Invitational Staff members are exempt from payment of dues and assessments. Attending Staff members on an approved leave of absence shall be responsible only for the prorated portion of annual dues for time they are in active service on the Medical Staff.
ARTICLE XIV

MEDICAL STAFF PRECEPTORSHIP

New procedures and techniques are constantly being developed and refined which enable the members of the Medical Staff to improve the quality of care provided at the Hospital. Quite often, Medical Staff members requesting new clinical privileges were not trained to perform the procedures or techniques in medical school or in their post-graduate training program, or have otherwise not performed the procedures or techniques for a lengthy period of time. Accordingly, the Medical Executive Committee may, from time to time, recommend that the Board of Directors impose a probationary period involving a preceptorship requirement as a condition to the exercise of a newly granted clinical privilege.

When, upon the recommendation of the Medical Executive Committee, the Board of Directors deems it necessary to impose a probationary period involving a preceptorship requirement as a condition to the exercise of a newly granted clinical privilege, said probationary period shall be for a period of up to one (1) year within which the involved practitioner will be required to exercise the clinical privilege in the presence of a preceptor for a specified number of cases. The clinical privilege must be so exercised at Martin Medical Center, Martin Hospital South or another healthcare facility operated by a Martin Health System-affiliated entity. In either event, the preceptor must be a member of the Medical Staff at the Hospital. In the event the involved practitioner fails to exercise the clinical privilege the specified number of times in the manner stated above within the probationary period, Medical Staff Services shall bring the matter to the attention of the Credentials Committee. The Department Chairperson and the Chairperson of the Credentials Committee will make a recommendation to the Credentials Committee regarding whether the probationary period should be extended and, if so, the length of such extension and whether any additional education requirements or other special limitations or conditions should be imposed. Such recommendation shall thereafter be reviewed in accordance with the procedures set forth in the Credentialing Procedures Manual. For the purpose of such review, however, an extension of the probationary period involving continuation of the preceptorship requirement and/or a requirement of additional education but without a reduction in clinical privileges shall be deemed a favorable recommendation.

Upon the imposition of a probationary period involving a preceptorship requirement, the involved practitioner shall be advised of the length of the initial probationary period, which shall not exceed one (1) year, and shall further be advised of the number of cases to be preceptored. The involved practitioner shall also be advised not to exercise the clinical privilege outside the presence of a preceptor, unless it is necessary to do so to protect the life of any patient or to reduce the likelihood of injury or damage to the health or safety of any patient. In the event a preceptor is not available, the involved practitioner shall notify the Chairperson of the Credentials Committee who may waive the preceptorship requirement for a given case if to do so is deemed to be in the best interest of patient care.

All preceptors are required to report on each case preceptored. The preceptor's reports shall be forwarded to the Credentials Committee. Upon receipt of preceptorship reports for the required number of cases, the Credentials Committee shall review those reports and prepare a written report with recommendation for, and any special limitations on, the continued exercise of the
clinical privilege. The procedures set forth in Credentialing Procedures Manual shall thereafter be followed.

Martin Memorial Medical Center, Inc. shall indemnify preceptors from all civil liabilities in presenting reports to the Credentials Committee and other appropriate bodies. These reports shall be the property of Martin Memorial Medical Center, Inc. and shall be considered confidential. Access to the reports shall be limited to the appropriate Department Chairperson, Credentials Committee, Medical Executive Committee, and the Board of Directors.

The policies and procedures for the implementation of a preceptorship are as follows:

1. It is the duty and responsibility of the involved practitioner to arrange for a preceptor prior to scheduling the case.

2. Inherent in the privilege and responsibility of serving on the Medical Staff of Martin Memorial Medical Center, Inc. is the requirement that each Staff member serve as a preceptor upon reasonable notice and so long as it would not result in an unavoidable scheduling conflict.

3. The preceptor shall be physically present during the major portion of the procedure/technique and shall evaluate the applicant's competence and shall submit a narrative evaluation of each case preceptored without unreasonable delay, and shall submit such additional evaluation or documentation as may be required by the Credentials Committee, appropriate Department Chairperson, Medical Executive Committee, or the Board of Directors.

4. A preceptor shall notify the Credentials Committee and the appropriate Department Chairperson of any conflicts with the involved practitioner.

5. All preceptor reports shall be submitted to the Credentials Committee within fourteen (14) days of the date the case was preceptored. The practitioner undergoing the preceptorship requirement has the burden of ensuring his/her preceptor submits the report to Medical Staff Services within the time period referenced. Reports not received in a timely fashion will be addressed by the Credentials Committee and may be considered a voluntary relinquishment of the preceptored procedure.