DEPARTMENT OF VETERANS AFFAIRS
ROBERT J. DOLE
MEDICAL AND REGIONAL OFFICE CENTER
WICHITA, KANSAS

MEDICAL STAFF BYLAWS, RULES, AND REGULATIONS

REVISED JUNE 2011

BYLAWS OF THE MEDICAL STAFF

DEPARTMENT OF VETERANS AFFAIRS

ROBERT J. DOLE VA MEDICAL CENTER

Wichita, Kansas

PREAMBLE

Recognizing that the Medical Staff is responsible for the quality of care delivered by its members and accountable to the Governing Body for all agents of that care, the Medical Staff practicing at the Robert J. Dole VA Medical Center, hereby organize themselves for self-governance in conformity with the general policies of VHA and the Bylaws, Rules and Regulations hereinafter stated.

DEFINITIONS AND CLARIFICATIONS

1. The term ***Medical Staff*** means all physicians, osteopathic physicians, oral surgeons, dentists, optometrists, and podiatrists holding unrestricted licenses, who are privileged to attend patients in the health care facility. The medical and dental staffs are departmentalized and function under their respective Clinical Service Director who serves under the Chief of Staff.

2. The term ***House Staff*** refers to those individuals who are graduates of medical, osteopathic, or dental schools engaged in a formal program of postgraduate training and education at the Medical Center with or without compensation.

3. The term **G*overning Body*** means the Center Director whom the Department of Veterans Affairs has delegated authority for local facility management and planning.

4. ***Veterans Integrated Services Network #15*** is one of 21 nationwide networks of VA hospitals and consists of Medical Centers in Marion, Illinois; Columbia, Kansas City, Poplar Bluff and St. Louis Missouri; Leavenworth, Topeka (Eastern Kansas Healthcare System) and Wichita, Kansas.

5. The ***Clinical Practice Council*** (CPC) serves as the Medical Staff Executive Committee for the Medical Center.

6. The term ***Chief Executive Officer*** means the Center Director, who is appointed by the Department of Veterans Affairs Headquarters to act in its behalf in the overall management of the Center.

7. The term ***Licensed Independent Practitioner (LIP)*** means any individual permitted by law and the facility to provide patient care services independently; i.e., without supervision or direction, within the scope of the individual's license and in accordance with individually granted clinical privileges.

8. The term ***Service Director*** refers to the Director or head of a specific multidisciplinary clinical service (Service team). There are eight (8) clinical programs within the Medical Center: Primary Care, Specialty Care, Behavioral Health, Clinical Support, Extended Care, Surgery, Medical Surgical Unit, and Emergency Department. The terms "Clinical Service Director" and "Service Director" are interchangeable.

9. The ***Professional Standards Board (PSB)*** serves as a permanent sub-committee of the CPC and functions as the Medical Center's credentialing and privileging body chaired by the Chief of Staff. The PSB is composed of a minimum of three (3) members of the medical staff appointed by the Chief of Staff. It is recommended, but not required, that one of the members be credentialed in the discipline of the applicant.

10. The ***Chief of Staff***, appointed by the Department of Veterans Affairs Veterans Integrated Service Network (VISN) Office, is designated and functions as the "President of the Medical Staff." There are no other officers of the Medical Staff.

11. ***Management/Executive Leadership*** means the Center Director, Associate Director, Chief of Staff and Nurse Executive.

12. ***Clinical privileges*** means permission is granted to a licensed practitioner to independently render specific diagnostic, therapeutic, medical or surgical services.

13. The ***Dean's Committee*** is a committee established by formal memorandum of affiliation between the Dole VA and the Kansas University School of Medicine-Wichita. Membership is composed of members of the affiliate, and the Clinical Service Directors previously listed, as well as the Center Director and Chief of Staff. The Committee advises on development, management, and evaluation of all educational and research programs conducted at the Medical Center.

14. A ***Nursing Home Care Unit, The Transitional Living Center (TLC)*** functions as part of the medical center to provide nursing care for eligible patients identified through evaluation by an interdisciplinary medical center team.

15. ***Community Based Outpatient Clinics (CBOC*)** have been established throughout the state of Kansas by this medical center to enhance ease of access to outpatient care for eligible veterans. Required Medical Staff services may either be contracted or provided directly by this medical center as location and conditions warrant.

ARTICLE I - NAME

The name of this organization shall be the Medical Staff of the Department of Veterans Affairs Robert J. Dole VA Medical Center, Wichita, Kansas.

ARTICLE II - PURPOSE

The purpose of this organization shall be:

1. To insure that all patients admitted to this hospital, TLC, or treated on an ambulatory basis at this facility or community based outpatient clinic (CBOC) supervised by this medical center receive the best possible care.

2. To account for the quality of patient care rendered by all practitioners authorized to practice in the Medical Center through the following measures:

a. A continuing professional education program fashioned, at least in part, on the needs demonstrated through the quality improvement process.

b. The utilization program to allocate inpatient services based upon a specific determination of individual patient's health care needs.

c. An organizational structure that promotes continuous improvement of patient care practices through developing and implementing performance improvement plans, evaluating its effectiveness and making modifications as required.

3. To review qualifications, privilege delineations, appointments, and reappointments to ensure that highly qualified Medical Staff are privileged to attend patients at the Medical Center.

4. To provide a means whereby problems of a medical administrative nature may be discussed by the Medical Staff with administrative authorities.

5. To provide opportunity for continuing education and training in medical and administrative areas within the health care facility's capabilities; to establish such opportunities; and to maintain standards of endeavor in such projects as are acceptable to National and/or State accrediting bodies.

6. To provide opportunities for research activities.

7. To initiate and maintain rules and regulations for the self-governance of the Medical Staff.

ARTICLE III – APPOINTMENT TO THE MEDICAL STAFF

Section 1. Criteria for Medical Staff Membership

Membership on the Medical Staff is a privilege which shall be extended only to fully credentialed physicians, oral surgeons, dentists, optometrists, and podiatrists who continuously meet the qualifications, standards, and requirements set forth in these bylaws and by the directives of the Department of Veterans Affairs. Individuals must be fully credentialed and privileged prior to appointment or reappointment after a break in service of more than 15 work days.

Section 2. Qualifications for Credentialing Medical Staff Membership

a. All applicants for membership on the Medical Staff shall be citizens of the United States. Exceptions to the citizenship requirement may be made when it is not possible to recruit qualified citizen physicians and with the approval, when required, of the Under Secretary for Health. Medical Staff members shall be graduates of an approved college or university who are legally licensed or legally authorized to practice medicine or dentistry in one of the States or Territories of the United States or the District of Columbia. In addition, applicants must possess a current unrestricted license and provide information related to medical malpractice allegations or judgments, loss of medical staff membership, voluntary resignations and/or loss or reduction in clinical privileges, any challenges to licensure, and all other information requested in the application for credentialing and privileging or appraisal.

b. Applications for appointments to the Medical Staff will include the qualifications and references of each applicant and shall give an account of his/her professional training and experience. The application shall be submitted to the Chief of Staff along with the Clinical Service Director's recommendation. The Chief of Staff shall be responsible for investigating and verifying the character, qualifications, and standing of the applicant as well as documenting the applicant’s physical and mental capability to perform required duties. The application and supporting credentials will be referred to the medical staff

as represented by the Professional Standards Board. Upon their recommendation to the CPC, a final recommendation will be presented to the Center Director.

Acceptance of appointment on the Medical Staff shall constitute the staff member's agreement to strictly abide by Medical Staff Bylaws. It will also constitute agreement to abide by the Rules and Regulations of the Medical Staff, to accept the supervision of the Clinical Service Director, and abide by the Department of Veterans Affairs Code of Patient Concern (Appendix A), and by the Principles of Medical Ethics of the American Medical Association (Appendix B), or by the Principles of Ethics and Code of Professional Conduct of the American Dental Association (Appendix C), the Code of Ethics of the American Podiatry Association (Appendix D), or the Code of Ethics of the American Osteopathic Association (Appendix E), Code of Ethics of the American Optometrist Association (Appendix F), whichever is applicable. These documents have been appended to and made a part of these Bylaws.

c. Appointment for membership to the Medical Staff shall not be denied on the basis of race, color, religion, sex, age, national origin, physical difference, or any other criterion lacking professional justification.

Section 3. Procedures for Credentialing/Initial Appointment

a. All applicants for Medical and consulting staff positions, including contract physicians, will be subject to the qualifications and appointment procedures in accordance with the regulations of the Department of Veterans Affairs including requirements to demonstrate English language proficiency. The size of the medical staff and specialty/sub-specialties will be determined by the leadership of the Robert J. Dole VA Medical Center, Wichita, KS.

b. Applications for appointment to the Medical Staff shall be submitted to the Professional Standards Board (PSB) on prescribed forms that are signed by the applicant. Applications shall outline in detail the clinical privileges that the applicant requests. Recommendations to approve or deny appointment and grant privileges are then made by the PSB and the Center Director.

c. Prior to appointment by the Director, the applicant will submit to the Chief of Staff the following material, which constitutes a complete application.

1. Documentation of professional training, professional school and residency program, and any specialty board certifications Documentation will also include evidence of current full and unrestricted license, current competence, residence geographic location, and DEA registration of those who have DEA certificates (if held by the applicant).

2. A list of at least three references who are knowledgeable about the individual's clinical competence and ethical character, including one reference from the current or most recent employer where the individual trained or is holding active Medical Staff privileges. References should be individuals who are qualified as peers or supervisors to provide authoritative information regarding experience, competence, and quality of care, as well as physical and mental capability.

3. A statement concerning any previous or currently pending challenges to licensure, registration or certification.

4. A statement concerning liability claims or judgments. This will include all final judgments and/or settlements.

5. A statement concerning previous denial, revocation, suspension, reduction, non-renewal, or voluntarily relinquished privileges at a VA or any other health care organization.

6. A copy of current and/or most recent clinical privileges at present or most recent health care facility at which the applicant has practiced or is practicing

7. A statement concerning previous loss, suspension or denial of professional licensure or professional society membership.

8. A statement of reasons for leaving present position, unless leaving a training position at the completion of training.

9. Professional liability insurance (applies only if not a VA employee).

10. Authorization for release of information including written consent to inspect records and documents pertinent to the complete application and consent to appear for an interview, if requested.

11. A statement regarding health status, including physical and mental capability to perform required duties and/or any problems with alcohol, drugs, or other forms of substance use/abuse.

12. A statement about voluntary or involuntary termination of a medical staff membership.

d. Credentials verification will be performed by the Credentialing Department personnel using primary source, National Practitioner Data Bank verification and other applicable searches.

e. Appointments shall be made by the Medical Center Director upon recommendation of the Clinical Practice Council and Professional Standards Board. The initial appointment is provisional, during which time the applicant's performance and clinical competence will be evaluated by the appropriate Clinical Service Director, Clinical Practice Council, and Professional Standards Board. See Medical Center policy concerning the Focused Professional Practice Evaluation process. At the end of two years, if the applicant has demonstrated an acceptable level of performance, the probationary status will be converted to a permanent appointment.

f. When review of credentials and recommendations regarding initial appointment are adverse to the applicant, the applicant is entitled to a review and a hearing with the Professional Standards Board. All hearing and appellate reviews shall be in accordance with prescribed regulations of the Governing Body (MP-5, Part 11, Chapter 2, Change 34, Chapters 4, 8, 9, and their supplements).

g. Reappointment to employment will occur when there is a break of 15 workdays between periods of service at VA. All information required in the appointment process must be updated and resubmitted. Reappointment due to a break of 15 or more days of VA service is based on the re-appraisal of the individual at the time of reappointment and will include information required in Article III, Section 3.c.

Section 4. Conflict of Interest Policy

Conflict of interest will be avoided by the Medical Staff. Resolution of existing or apparent conflict of interest shall be in accordance with Department of Veterans Affairs directives.

All government employees, whether full-time, part-time or a special government employee are prohibited from participating personally and substantially in a particular matter in which the employee, to

the employee's knowledge, has a financial interest, if the matter would directly and predictably affect that financial interest.

Section 5. Ethics

The conduct of each physician, dentist, optometrist and podiatrist shall conform to the code of ethics of their respective professional groups, to provisions of these Bylaws, Rules and Regulations, and to Department of Veterans Affairs directives.

Physicians will not accept fees or gifts directly or indirectly from other physicians, patients, or patients' relatives.

ARTICLE IV - DELINEATION OF CLINICAL PRIVILEGES

Section 1. Responsibilities in Medical Staff Appointment

a. ***All physicians, podiatrists, oral surgeons, optometrists, and dentists*** (including consultants, attendings, and contract or fee basis) must apply for appointment to the Medical Staff. All practitioners providing direct patient care shall receive initial clinical privileges. They shall be renewed at least every two years. Additional privileges require documentation that supports the practitioner's competence.

b. The ***Center Director*** has overall responsibility for credentialing and privileging. He/She is the approving authority for all appointments and the granting, reducing, revoking, or restricting of clinical privileges. The Center Director is held accountable for establishing mechanisms to assure that all individuals with clinical privileges function within the scope of privileges granted, and that sufficient resources are devoted to the credentialing and privileging process to achieve compliance with internal and external rules and regulations.

c. The ***Chief of Staff*** shares in the responsibility to meet all internal and external requirements for credentialing and privileging. As Chairperson of the Professional Standards Board and the Clinical Practice Council, he/she provides direction and guidance to the Medical Staff to ensure that all members of the medical staff have a current unrestricted license, relevant training and/or continuing medical education, and are clinically competent.

d. The ***Professional Standards Board*** is responsible for reviewing and discussing the applicant's documents when granting initial clinical privileges and recommending clinical privileges within the scope of the practitioner's professional capability and the Medical Center's ability to provide support. Documentation of discussion will include licensure, health status, quality improvement information, experience, competence, and other information that may influence the granting of clinical privileges.

e. The ***Clinical Service Director*** is responsible for reviewing the application and making a recommendation to the PSB based on the applicant's current licensure, education, training, experience, peer recommendations, and information from previous employer, associates, and/or training director, concerning current competence and the physical and mental capability of the applicant. Involvement in professional liability actions, challenges and voluntary or involuntary relinquishment of any license or registration/clinical privileges, and voluntary or involuntary termination of Medical Staff membership will be reported.

Section 2. Initial Appraisal and Privileging

a. Every category of physician practitioner, including contract, consultant and fee basis physicians must be credentialed and privileged to the same standards using the same procedures as active staff.

b. Clinical privileges are granted for a period not to exceed two years. Medical Staff membership shall confer on the appointee only such clinical privileges as specified. Every practitioner practicing at this Medical Center by virtue of Medical Staff membership or otherwise, shall, in connection with such practice, be entitled to exercise those clinical privileges granted to him by the Medical Center Director.

c. Every initial application for appointment must be accompanied by a separate request for the specific clinical privileges desired by the applicant and appropriate to the types of services provided at this Medical Center. The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated current clinical competence, judgment, physical and mental capability, peer recommendations and other relevant information.

d. Privileges to admit must be specifically requested and will be granted only to qualified physicians, oral surgeons, and podiatrists. Pathologists, dentists, optometrists, and radiologists may not admit patients.

e. After the Clinical Service Director's review and recommendation, the request for privileges will be submitted to the Professional Standards Board (PSB). The PSB will ensure that all basic criteria have been met and that adequate clinical information is available to support the granting of privileges. After the request is reviewed by the PSB, concurrence/approval is sent to the Clinical Practice Council. A final recommendation is then forwarded to the facility Director.

f. Copies of current privileges for each member of the medical staff will be maintained electronically on the “VA Common Drive” for reference in a Provider Privileges folder.

Section 3. Reappraisal and Reprivileging

a. Reappraisal is the process of evaluating the professional credentials and clinical competence of all practitioners who have been granted clinical privileges.

b. Reappraisal for renewal of clinical privileges will be conducted on each practitioner every two years at the time of reappointment to the Medical Staff. Evaluation of professional performance, judgment, and clinical and/or technical competence and skills will be based in part on results of quality assurance activities. On-going reviews conducted by Clinical Service Directors will include quality of care data specific to the practitioner’s duties. This data will be maintained on file by the appropriate Clinical Service Director for each medical staff member. See Medical Center policy on the Ongoing Professional Practice Evaluation process. It will be considered by the Clinical Service Director, Professional Standards Board and Clinical Practice Council when reprivileging staff physicians.

c. Reprivileging is the renewal of clinical privileges, and will be conducted at least every two years. The reprivileging process will include the practitioner’s statement regarding successful or pending challenges to any licensure or registration, voluntary or involuntary relinquishment of licensure or registration, limitation, reduction or loss of privileges at another hospital, loss of Medical Staff membership, mental and physical status, and any other reasonable indicators of continuing qualifications. The practitioner applying for clinical privileges will provide documentation of training/experience not previously submitted, status on all licenses and certifications held, and documentation of continuing

medical education consistent with the area and scope of clinical privileges. As an administrative responsibility, practitioners must request renewal of privileges in a timely manner prior to the expiration date of current privileges. Requirements for reprivileging are determined by the Executive Medical Staff.

d. The Clinical Service Director will review peer recommendations. Peer recommendations include written information regarding the practitioner's current: medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism. The Clinical Service Director will also address any disciplinary actions, challenges to licensure, loss of medical staff membership, changes in clinical privileges at another hospital, or involvement in any malpractice actions.

e. After review of all data listed in paragraphs c and d of this section, the Clinical Service Director will make a recommendation to the Professional Standards Board (PSB). The PSB will further review the data and make a recommendation to the Clinical Practice Council. The decision is then forwarded to the Medical Center Director. The final decision regarding approval of privileges will be made by the Director.

Section 4. Expedited Process for Granting Privileges

a. An expedited process can be used for initial appointments through a subcommittee of two members of the Professional Standards Board.
b. The expedited process may only be used for what are considered "clean" applicants. The following is a listing of criteria that would cause an applicant to be ineligible for this process; an incomplete application, committee makes a final recommendation that is adverse or has limitations, there is a current challenge or a previously successful challenge to the individual's licensure, applicant has received an involuntary termination of medical staff membership at another hospital, applicant has had clinical privileges involuntarily limited, reduced, denied or revoked, or an unusual pattern, or excessive number of professional liability actions resulting in a judgment against the applicant is noted.
c. The Expedited Appointment cannot begin until the physician completes the credentials package. The Medical Center must also confirm the following; education and training, an active, current, unrestricted license, declaration of health, query of licensure history, two peer references, current comparable privileges held in another institution, and no matches found from the NPDB.
d. Full credentialing must then be completed within 60 calendar days of the Medical Center Director's signature.
e. The expedited process does not relieve the Medical Center from reviewing the DHHS, LEIE, or other Human Resources requirements.

Section 5. Dental, Oral Surgeons, Optometrists and Podiatry Staff

The same procedures for credentialing and privileging Dental, Oral Surgeons, Optometrists and Podiatry staff will be used with appropriate modifications to reflect the specific training and procedures for these specialties. Privileges granted shall be based on training, experience, demonstrated competence, references, health status, and other relevant information. The scope and extent of surgical procedures performed by oral and maxillofacial surgeons shall be delineated on the basis of verified specialty board credentials, specific privileges and the facility's ability to support the privileges. Surgical procedures performed in the operating room shall be under the overall supervision of the Surgery Service Director. All hospitalized dental and podiatry patients shall receive the same basic

medical appraisal as patients admitted for other surgical services. A consultation with a physician member of the medical staff is required for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization.

Section 6. Credentialing Physician Assistants (PAs) and Advance Practice Nurse Practitioners (ARNPs)

PA and ARNP staff will be credentialed, privileged and reprivileged through a process similar to the medical staff. The process will evaluate the applicant's credentials, current competence, include peer review and quality of care data specific to their duties. The information will be presented to the appropriate Professional Standards Board for review and appointment. The results of the Board will be reported to the Clinical Practice Council. Credentials will be updated and reviewed a minimum of every two years.

ARTICLE V - INVESTIGATION AND ACTION

Section 1. Request for Investigation

Whenever the behaviors, activities and/or professional conduct of any practitioner with delineated clinical privileges are considered to be detrimental to patient care, to pose a threat to patient safety, or to be lower than the standards of the medical staff; an investigation of such practitioner may be requested by a Clinical Service Director, the Chief of Staff or the Medical Center Director. All requests for investigation must be made in writing to the Chief of Staff supported by reference to specific activities or conduct, which constitute the grounds for the request. The Chief of Staff promptly notifies the Director of the receipt of all requests for corrective action. Material that is obtained as part of a protected performance improvement program (i.e., under 38 U.S.C. 5705), may not be disclosed in the course of any action to reduce or revoke privileges, nor may any reduction or revocation of privileges be based directly on such performance improvement data. If such information is necessary to support a change in privileges, it must be developed through mechanisms independent of the performance improvement program, such as administrative reviews and boards of investigation. In these instances, the performance improvement data may have triggered the review; however, the quality improvement information is confidential and privileged in accordance with 38 U.S.C. 5705, and therefore must be rediscovered through the administrative review or investigation process. **NOTE**: If the person under review, is an employee then the processes must also follow VA Directive 5021 - Management of Employees.

a. Whenever the Chief of Staff receives a request for investigation as described above, a fact finding process will be implemented. This fact-finding process should be completed within 30 days or there needs to be documentation as to why that was not possible. If the results of the fact-finding process indicate that there is reasonable cause to believe that the behaviors, activities and/or professional conduct the practitioner are likely to be detrimental to patient care, to pose a threat to patient safety, or to be lower than the standards of the medical staff, the Chief of Staff may impose a summary suspension of privileges in accordance with the Medical Staff Bylaws and will initiate a review by an ad hoc investigation committee.

b. The investigation committee will investigate the charges and make a report to the Chief of Staff within 14 days. Pursuant to the investigation, the practitioner being investigated has an opportunity to meet with the committee to discuss, explain or refute the charges against him/her. This proceeding does not constitute the Fair Hearing process. An investigation is an administrative matter and not an adversarial hearing. A record of such proceeding is made and included with the committee's findings, conclusions and recommendations to the Chief of Staff.

c. Within 14 days after receipt of a report, the Chief of Staff will act upon the request. If the action being considered involves a reduction, suspension or revocation of clinical privileges, or a suspension or revocation of medical staff membership, the practitioner is permitted to meet with the Chief of Staff prior to the action on such request. This proceeding does not constitute the Fair Hearing process.

d. The Chief of Staff may reject or modify the recommendations; issue a warning, a letter of admonition, or a letter of reprimand; impose terms of probation or a requirement for consultation; recommend reduction, suspension or revocation of clinical privileges; recommend that an already imposed suspension of clinical privileges be terminated, modified or sustained; or recommend that the practitioner's staff membership be suspended or revoked.

e. Any recommendation by the Chief of Staff for the reduction, suspension, or revocation of clinical privileges, or for the suspension or revocation of medical staff membership, entitles the practitioner to the rights set forth in Article VI of these Bylaws the Fair Hearing process.

f. Reduction of privileges may include, but not be limited to, functioning under supervision, restricting performance of specific procedures, or restricting the prescribing and/or dispensing of controlled substances. Reduction of privileges may be time limited and/or have restoration contingent upon some condition, such as demonstration of recovery from a medically disabling condition or further training in a particular area.

g. Revocation of privileges refers to the permanent loss of clinical privileges.

Section 2. Summary Suspension of Privileges

The Director has the authority, whenever immediate action must be taken in the best interest of patient care, to summarily suspend, for cause, or a portion of, a practitioner's delineated clinical privileges. Such suspension shall become effective immediately.

a. The Chief of Staff convenes an ad hoc investigation committee to investigate the matter, meet with the practitioner if requested and make a report to the Chief of Staff within fourteen (14) days after the effective date of the Summary Suspension.

b. Immediately upon the imposition of a Summary Suspension, the Clinical Service Director provides alternate medical coverage for the patients of the suspended practitioner.

Section 3. Automatic Suspension of Privileges

The medical staff membership and clinical privileges of any practitioner with delineated clinical privileges shall be automatically suspended immediately if any of the following occurs:

- The practitioner is being investigated, indicted or convicted of a misdemeanor or felony that could impact the quality and safety of patients.
- Failure on the part of any staff member to complete medical records in accordance with system policy will result in progressive disciplinary action to possible indefinite suspension.
- The practitioner is being investigated for fraudulent use of the Government credit card.
- Failure to maintain the mandatory requirements for membership to the medical staff.

a. The Chief of Staff convenes an ad hoc investigation committee to investigate the matter and make a report within fourteen (14) days after the effective date of the Automatic Suspension.

b. Immediately upon the occurrence of an Automatic Suspension, the Clinical Service Director provides alternate medical coverage for the patients of the suspended practitioner.

c. If there are more than three automatic suspensions of privileges in one calendar year, or more than 20 days of automatic suspension in one calendar year, a thorough assessment of the need for the practitioner's services must be performed and documented and appropriate action taken.

ARTICLE VI - FAIR HEARING

Section 1. Reduction of Privileges:

<***NOTE**: All time frames in this section are required by VHA Handbook 1100.19>*

a. Prior to any action or decision by the Director regarding reduction of privileges, the practitioner will receive written notice of the proposed changes in privileges from the Chief of Staff. The notice will include:

   i) A description of the reason(s) for the change.

   ii) A statement of the practitioner‘s right to be represented by counsel or a representative of the individual’s choice throughout the proceedings.

b. The practitioner will be allowed to review all evidence not restricted by regulation or statute upon which proposed changes are based. Following that review, the practitioner may respond in writing to the Chief of Staff’s written notice of intent. The practitioner must submit a response within l0 workdays of the Chief of Staff’s written notice. If requested by the practitioner, the Chief of Staff may grant an extension for a brief period, normally not to exceed l0 additional workdays except in extraordinary circumstances.

c. Information will be forwarded to the Director for decision. The Director will make a decision on the basis of the record. If the practitioner disagrees with the Director’s decision, a hearing may be requested. The practitioner must submit the request for a hearing within five (5) workdays after receipt of decision of the Director.

Section 2. Convening a Panel:

The facility Director must appoint a review panel of three unbiased professionals within 5 workdays after receipt of the practitioner's request for hearing. These three professionals will conduct a review and hearing. At least two members of the panel must be members of the same profession. If specialized knowledge is required, at least one member of the panel must be a member of the same specialty. This review panel hearing is the only hearing process conducted in connection with the reduction of privileges. Any other review processes must be conducted on the basis of the record. The hearing will proceed as follows:

a. The practitioner must be notified in writing of the date, time, and place of the hearing. The date of the hearing must not be less than 20 workdays and not more than 30 workdays from the date of notification letter.

b. During such hearing, the practitioner has the right to:

   i. Be present throughout the evidentiary proceedings.

ii. Be represented by an attorney or other representative of the practitioner's choice. ***NOTE:*** *If the practitioner is represented, this individual is allowed to act on behalf of the practitioner including questioning and cross-examination of witnesses.*

iii. Cross-examine witnesses.

NOTE: *The practitioner has the right to purchase a copy of the transcript or tape of the hearing.*

c.In cases involving reduction of privileges, a determination must be made as to whether disciplinary action should be initiated.

d. The panel must complete the review and submit the report within 15 workdays from the date of the close of the hearing. Additional time may be allowed by the facility Director for extraordinary circumstances or cause.

e. The panel's report, including findings and recommendations, must be forwarded to the facility Director, who has authority to accept, reject, accept in part, or modify the review panel's recommendations.

f. The facility Director must issue a written decision within 10 workdays of the date of receipt of the panel's report. If the practitioner's privileges are reduced, the written decision must indicate the reason(s). The signature of the facility Director constitutes a final action and the reduction is reportable to the National Practitioner Data Bank (NPDB).

g. If the practitioner wishes to appeal the Director's decision, the practitioner may appeal to the appropriate VISN Director within 5 workdays of receipt of the facility Director's decision. This appeal option will not delay the submission of the NPDB report. If the Director's decision is overturned on appeal, the report to the NPDB must be withdrawn.

h. The VISN Director must provide a written decision, based on the record, within 20 workdays after receipt of the practitioner's appeal. ***NOTE:*** *The decision of the VISN Director is not subject to further appeal.*

Section 3. The Hearing Panel Chair

The hearing panel chair shall do the following:

a. Act to ensure that all participants in the hearing have reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process.

b. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay. In general, it is expected that a hearing will last no longer than a total of 15 hours.

c. Maintain decorum throughout the hearing.

d. Have the authority and discretion to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence.

e.Act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the hearing is considered by the hearing panel when formulating its recommendations.

f. Conduct argument by counsel on procedural points and do so outside the presence of the hearing panel.

g. Seek legal counsel when he or she feels it is appropriate. Regional Counsel to the facility should advise the panel chair.

Section 4. Practitioner Rights:

a. The practitioner has the right to be present throughout the evidentiary proceedings, represented by counsel or a representative of practitioner's choice, cross-examine witnesses, and to purchase a copy of the transcript or tape of the hearing.

b.The panel will complete its review and submit its report within 15 workdays of the date of the hearing. Additional time may be allowed by the Director for extraordinary circumstances or cause. The panel's report, including findings and recommendations, will be forwarded to the Director, who has authority to accept, accept in part, modify, or reject the review panel's recommendations.

c. The Director will issue a written decision within l0 workdays of the day of receipt of the panel's report. If the practitioner's privileges are reduced, the written decision will indicate the reason(s) for the change.

d. The practitioner may submit a written appeal to the VISN Director within five workdays of receipt of the Director's decision.

e. The VISN Director will provide a written decision based on the record within 20 workdays after receipt of the Practitioner's appeal. The decision of the VISN Director is not subject to further appeal.

f.A practitioner who does not request a review panel hearing but who disagrees with the Director's decision may submit a written appeal to the appropriate VISN Director within five workdays after receipt of the Director's decision.

g. The review panel hearing defined in Section 2 will be the only hearing process conducted in connection with the reduction of privileges; any other review processes will be conducted on the basis of the record.

h. If a practitioner surrenders or voluntarily accepts a restriction of his/her clinical privileges, or resigns or retires from his/her medical staff position with the Department of Veterans Affairs while the practitioner's professional competence or professional conduct is under investigation to avoid investigation; if greater than 30 days such action is reported without further review or due process to the NPDB and the appropriate state licensing boards.

Section 5. Revocation of Privileges:

a. Proposed action taken to revoke a practitioner's privileges will be made using VHA procedures.

i) In instances where revocation of privileges is proposed for permanent employees, the proposed revocation will be combined with action to discharge the employee under Section 7461-7464 of Title 38, United States Code and VA Handbook 5021 Employee/Management Relations.

ii) For probationary employees appointed under 38 U.S.C. 7401(1) and 38 U.S.C. 7405, the proposed revocation will be combined with probationary separation procedures, which constitutes an automatic revocation as contained in VA Handbook 5021 Employee/Management Relations.

b. Revocation procedures will be conducted in a timely fashion. If discharge, separation during probation, or termination of appointment is not proposed, then revocation of clinical privileges may not occur. Even though a revocation of privileges requires removal from both employment and appointment to the medical staff, in extremely rare cases, there may be a credible reason to reassign the practitioner to a position not requiring clinical privileges. Such an action may still result in reporting to the NPDB if the revocation and reassignment is for substandard care, professional incompetence, or professional misconduct. For example a surgeon's privileges for surgery may be revoked and the surgeon reassigned to a non-surgical area when doing so is beneficial to meeting other needs of the facility. Any recommendation by the Clinical Practice Council for the reduction, suspension, or revocation of clinical privileges, or for the suspension or revocation of medical staff membership, entitles the practitioner to the rights set forth in Article VI of these Bylaws.

Section 6. Reporting to the National Practitioner Data Bank

a. Tort ("malpractice") claims are filed against the United States government, not individual practitioners. There is no direct financial liability for named or involved practitioners. Government attorneys (Regional Counsel, General Counsel, U.S. Attorney) investigate the allegations, and deny, settle, or defend the case. Claims that are denied may subsequently go to litigation.

b. When a claim is settled or a judgment is made against the Government (and a payment made), a VA review is conducted to determine if the involved practitioners should be reported to the NPDB. The review must determine that there was substandard care, professional incompetence, or professional misconduct and if so, is attributable to a licensed practitioner in order to meet reporting requirements.

c. Practitioners are also identified and notified at the time a tort claim is filed so that they may assist regional and general counsel in defending the case and in decisions concerning denial or settlement.

d. Post payment reviews are performed nationally by the office of Medical-Legal Affairs. Accordingly, a letter is now sent to physicians involved in the plaintiff's case when a tort claim settlement is submitted for review.

e.VA only reports adverse privileging actions that adversely affect the clinical privileges of Physicians and Dentists after a professional review action or if the practitioner surrenders clinical privileges while under investigation. The professional review action is the due process (e.g. fair hearing and appeal process) afforded the practitioner for a reduction or revocation of clinical privileges. The reference for this is 38 CFR part 46.4. The notice of summary suspension to the practitioner must include a notice that if a final action is taken based on professional competence or professional conduct; both the summary suspension (if greater than 30 days) and the final action will be reported to the NPDB. After the final action, the reduction or revocation as well as the summary suspension (if greater than 30 days) will be reported.

Section 7. Reporting to State Licensing Boards

VA has a responsibility to report to state licensing boards appointed or suspended members of the medical staff whose behavior or clinical practice so substantially fails or failed to meet generally accepted standards of clinical practice, as to raise reasonable concern for the safety of patients.

Section 8. Management Authority

Nothing in these procedures restricts the authority of management to detail or reassign, on a temporary basis, an employee to non-patient care areas or activities, thus suspending privileges, during the pendency of any proposed reduction of privileges or discharge, separation, or termination proceedings. Further, the Director, on the recommendation of the Chief of Staff, may summarily suspend privileges, on a temporary basis, when there is sufficient concern regarding patient safety or specific practice patterns. Individuals appointed under authority of 38 U.S.C.7401(1) and 7405 may be terminated when this is determined to be in the best interest of VA in accordance with provisions of VHA Handbook 5021 Employee/Management Relations.

ARTICLE VII - TEMPORARY OR DISASTER PRIVILEGES

a. ***Temporary Privileges*** - The Medical Center Director/designee may grant temporary clinical privileges for the care of a specific patient need or for a period not to exceed sixty (60) days during which time application procedures shall have been completed. Such decisions will be based upon reasonably reliable information as to the training, current competence, ethical and moral standing of the practitioner and will be made only with the concurrence of the appropriate Clinical Service Director and the Chief of Staff. In exercising such privileges, the applicant shall act under the supervision of the Clinical Service Director to which he/she is assigned. Verification of current licensure and National Practitioner Data Bank screening will have been obtained and either evidence of current privileges at another facility or evidence of satisfactory completion of appropriate training prior to making such an appointment.

b. Temporary appointments shall be considered by their very nature "provisional" and as such the clinical and overall professional performance of the temporary staff member shall be under the close scrutiny of the Clinical Service Director, Chief of Staff and/or the Center Director prior to receipt of references or verification of other information and action by the Clinical Practice Council.

c. Special requirements of supervision and reporting may be imposed on any practitioner granted temporary privileges by the Service Director concerned. The Medical Center Director may at any time, upon recommendation of the Chief of Staff, terminate a practitioner's temporary privileges. Such individuals are not entitled to a hearing or appeal.

d. ***Disaster Privileges*****:** When the Emergency Management Plan has been activated, and the organization is unable to handle the immediate patient needs, the Medical Center Director/designee has the option to grant disaster privileges, on a case by case basis. The credentialing staff will ensure that the primary source verification process of licensure of individuals who receive *disaster privileges* begins as soon as the immediate situation is under control or within 72 hours from the time the individual presents to the Medical Center, whichever comes first. See Disaster Privileging Policy for complete details.

ARTICLE VIII - CATEGORIES OF THE MEDICAL STAFF

Section 1. Active Medical Staff

Physicians, dentists, oral surgeons, optometrists and podiatrists may be employed in a full-time, part-time, intermittent, or without compensation (WOC) status, on-station fee-basis, on contract, or sharing agreement. The active staff shall consist of those physicians, dentists, optometrists and podiatrists who have been appointed pursuant to the professional and administrative requirements specified in these Bylaws and in accordance with Department of Veterans Affairs directives.

Section 2. Consultant Staff

The Consultant Staff are not members of the Medical Staff and consist of physicians and dentists of recognized competence who perform specific services and whose primary practice is outside this medical center. These physicians and dentists visit the hospital on a regular or "on-call" schedule to consult with the Active Staff in the care and treatment of patients. They are also active in teaching, training, and research programs. All consultant staff are credentialed and privileged in accordance with Article IV.

Section 3. House Staff

The House Staff are not members of the Medical Staff and consist of those individuals who are graduates of medical or osteopathic schools engaged in a formal program of postgraduate training and education at the Robert J. Dole VA Medical Center.

They will function under the supervision of, and within the clinical privileges granted to a qualified practitioner who has clinical privileges in the area being supervised. Prior to caring for patients, documentation of medical school graduation and licensure must be completed. The level of supervision of house staff by attending physicians is based on house staff year of training, documented performance and successful completion of a required number of procedures as outlined in the Resident Privileges folder on the Common Drive.

ARTICLE IX - IMMUNITY FROM LIABILITY

Section 1. Federal Tort Claims Act

a. The Federal Tort Claims Act provides for civil actions against the United States for monetary damages "...for injury or loss of property or personal injury or death caused by the negligent or wrongful act or omission of any employee of the government while acting within the scope of his office or employment, under circumstances where the United States, if a private person, would be liable to the claimant in accordance with the law of the place where the act or omission occurred." (28 U.S.C. 1346(b)). Excepted from the application of the Act are claims arising out of certain intentional torts such as assault, battery, false imprisonment, libel, slander, and misrepresentation (28 U.S.C. 2680).

b. While the Federal Tort Claims Act provides a remedy against the government, a type of statutory immunity from malpractice liability exists with respect to medical personnel of the Department of Veterans Affairs; a person claiming "damages for personal injury, including death, allegedly arising from malpractice or negligence of a physician, dentist, podiatrist, optometrist, nurse, physician assistant, expanded function dental auxiliaries, pharmacist, or paramedical (for example, medical and dental technicians, nursing assistants, and therapists) or other supporting personnel in furnishing medical care or treatment while in the exercise of such person's duties in or for the Department of Veterans Affairs has only a possible remedy against the Government and not against the employee (38 U.S.C. 4116(a)). Residents, interns, and "without compensation employees," (e.g. - medical students), may be included provided they are working under the supervision and direction of Department of Veterans Affairs personnel.

c. In a situation where the immunity statute would not apply, such as a physician being sued for battery on a patient (one of the exceptions under the Federal Tort Claims Act) with a judgment being obtained against the physician, the immunity statute provides that the Secretary of Veterans Affairs may pay the judgment.

ARTICLE X – ORGANIZATION OF CLINICAL AND PROFESSIONAL SERVICES

Section 1. Organization of the Medical Staff

a. **Officers:** By VA regulations, the Chief of Staff (COS) serves as the president of the medical staff and is its sole officer. The COS must be a member of the medical staff and must be a board-certified physician. He/she is chosen in accordance with VA regulations and policy and according to the criteria and qualifications contained therein. His/her tenure as president of the medical staff continues as long as he/she is COS. Procedures for removal of a COS are determined by VA regulations.

b. **Executive Committee:** The Clinical Practice Council is the Executive Committee of the Medical Staff. The Chief of Staff serves as Chairperson by VA regulation.

c. **Clinical Services:** The following clinical services are established at this Center, and the physicians, dentists, oral surgeons, optometrists and podiatrists assigned thereto constitute the Medical Staff. Assignment of physicians to a given service is dependent upon the individual's professional qualifications as determined by the Clinical Practice Council. Each member of the medical staff will be assigned to at least one service team.

(1) Primary Care

(2) Specialty Care (includes subspecialties of Internal Medicine, Cardiology, Radiology, etc.)

(3) Clinical Support (includes Dental, Pathology and Laboratory Medicine, Physical Medicine and Rehabilitation).

(4) Behavioral Health (Mental Health Clinics and Behavioral Health Specialty Services)

(5) Surgery Service

(6) Extended Care Service

(7) Emergency Department

(8) Medical/Surgical Unit

Section 2. Organization of the Clinical Services

a. Each Clinical Service shall be organized as a component of the staff as a whole. Each service shall have a Clinical Service Director who has general supervision over the clinical work occurring within the service, and who is responsible to the Chief of Staff for the function of the service. Medical staff members are administratively and clinically responsible to their Clinical Service Director. In the event that a Clinical Service Director is not a physician or dentist, a physician or dentist supervisor will be designated to provide clinical oversight of the medical staff member's performance. The physician who oversees the medical staff member must be board certified, or in the case of dentists, have completed one year of residency. Clinical Service Directors who are physicians must also be board certified. Dentists serving as Clinical Service Directors must have completed one year of residency.

b. Each clinical service shall meet separately a minimum of ten times a year. Meeting agendas will include discussion of findings from performance improvement activities. Minutes of the meetings shall be prepared and sent to the Chief of Staff for review and co-signature. Items or issues contained in service staff meeting minutes may be referred to the Clinical Practice Council by the COS for further discussion as necessary.

Section 3. Responsibilities of Clinical Service Directors**:**

Each Clinical Service Director is responsible for the administration, budget, human resources, and clinical performance of their service. He/she reports to the Chief of Staff and Clinical Practice Council. Each Clinical Service Director shall assure that performance improvement is conducted in accordance with the Medical Center's Performance Improvement Plan. The Chief of Staff selects/removes Clinical Service Directors.

(1) The Clinical Service Director is responsible for:

(a) All clinical activities of the service

(b) Promoting patient care outcomes through implementation of the Center's Performance Improvement Plan and the reporting on accomplishments to QPC

(c) Ensuring that all quality management activities conducted are purposeful and meaningful, and that proper follow-up and evaluation of corrective action is implemented

(d) Maintaining records of indicators, assessments, methods, criteria, findings, recommendations, and follow-up actions, which are readily available for review during internal and external surveys

(e) Monitoring and reporting on the professional performance of all individuals who have delineated clinical privileges in the Service

(f) Recommending to the Medical Staff the criteria for clinical privileges in the Service

(g) Recommending clinical privileges for each member of the team

(h) Assessing and recommending off-site sources for needed patient care, treatment and services not provided by the hospital

(i) Coordinating and integrating inter-departmental and intra-departmental services

(j) Developing and implementing policies and procedures that guide and support the provision of care, treatment and services

(k) Determining the qualifications and competency of personnel who are not LIPs and who provide care

(l) Orientating and ongoing education of staff in his/her Service

(m) Recommending space and other resources needed by the Service

ARTICLE XI - COMMITTEES

Section 1. Standing Committees

a. Standing clinical committees shall be appointed by the Medical Center Director upon recommendation by the Chief of Staff except that the Dean's Committee shall be appointed by the Medical Center Director upon recommendation of the Dean of the Kansas University School of Medicine-Wichita. All Committees are charged with the duty of assuring that Medical Staff are in compliance with VA and Joint Commission requirements applicable to their area of responsibility, including peer review. The purpose, function, membership, and organization of specific committees are delineated in Medical Center Circulars.

b. Other committees or functions specified in M-1, Part 1, Chapter 1, Sections 1.75-1.79 or as determined by the Clinical Practice Council, meet as required.

Section 2. Committee Records

Each committee will maintain written minutes of meetings to include attendance, agenda items, recommendations, and follow-up on open action items. Standing committee minutes will serve as a mechanism to provide feedback to Service Directors and other appropriate groups/individuals. The Chief of Staff and/or the Medical Center Director, as appropriate will review these minutes at regular intervals.

Section 3. Clinical Practice Council (Executive Committee of the Medical Staff)

The Clinical Practice Council (CPC) is a diverse clinical council designed to provide oversight and guidance to the Center Director for the management of patient care and governance of medical staff practices and policies. Policies and procedures are established to enhance a framework for the measurement of performance that is consistent with Medical Center philosophy, Joint Commission, and standards of the Department of Veterans Affairs. Meetings are held regularly to review organizational performance, patient care processes and outcomes, take actions to improve organizational performance, and to make recommendations directly to the Center Director.

a. Membership: The CPC is chaired by the Chief of Staff and composed of physician and dental members of the medical staff, Nurse Executive, other designated staff, and ex-officio membership of the Medical Center Director/designee in accordance with Center Policy. All members may vote on issues presented to the Council. A simple majority of the CPC membership must be members of the medical staff. All active members of the medical staff are eligible for membership. In general, membership is comprised of clinical Service Directors whose memberships continue as long as they serve in that position. Procedures for removal of a clinical Service Directors are determined by VA regulations. The Council acts on the behalf of the medical staff between medical staff meetings. The Council will consist of at least 10 members; the Chief of Staff will select/remove members from the Council.

a. Responsibilities: The CPC has oversight for the self-governance activities of the medical staff. The CPC acts on the behalf of the medical staff between medical staff meetings and is responsible for continuous improvement and evaluation of major functions of patient care. The CPC reviews and acts on reports from other medical staff committees, Service Directors, results of VA monitors, and facilitates communication of findings to the Medical Center Director. It also may commission special performance improvement groups in response to identified clinical needs. The duties of the CPC are outlined in the CPC Center Circular.

Section 4. Professional Standards Board

The Professional Standards Board is a permanent sub-committee of the CPC and will carry out all functions as outlined in the Supplement to MP-5, Part 11, Chapter 2 including:

a. Reviewing the credentials of all applicants and making recommendations directly to the Clinical Practice Council for membership and delineation of clinical privileges

b. Reviewing, evaluating, and proposing action on the recommendations of Clinical Service Directors, along with all other information available, regarding the competence of current practice of staff members for recredentialing and reprivileging

c. Reviewing, evaluating, and proposing action on the recommendations of non-physician Clinical Service Directors, along with all other information available, regarding the criteria and initial privileging and reprivileging of professional personnel

d. Recommending promotion and special advancement of physicians

e. Analyzing information and making recommendations to the Medical Center Director regarding actions related to conduct and ethics

Section 5. Infection Control Committee

The Infection Control Committee shall be responsible for:

a. Prevention and control of infections

b. Review, analysis and dissemination of information

c. Environmental surveillance and control

d. Development of effective mechanisms for investigation when problems occur

e. Development and promotion of preventive and corrective programs or studies designed to evaluate or minimize infection and environmental hazards as they affect both employees and patients

f. Supervision of infection control practices, aseptic technique, and standard precautions, as required, in all phases of the Medical Center's activities

g. Provide consultation related to purchase of supplies, equipment, and agents as well as the procedures and schedules for use of these items as they relate to infection control

h. Develop and implement an orientation and continuing education program for Medical Center personnel

i. Participate in the preparation of a bioterrorism response

Section 6. Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics Committee shall be responsible for the development and surveillance of all drug and diagnostic testing material utilization policies and practices within the Medical Center in order to assure acceptable clinical results and a minimum potential for hazard. The Committee shall assist in the formulation of broad professional policies regarding the evaluation, appraisal, handling, selection, procurement, storage, distribution, safety procedures, and all other matters relating to drugs in the Medical Center. The Committee shall also perform the following specific functions:

a. Review and evaluate data (including usage, cost, safety, restrictions) and make recommendations on new drugs requested for use by members of the medical staff

b. Assist the Research Committee in the approval of protocols and control and use of investigational and experimental drugs

c. Develop and review periodically the formulary and/or drug list for use in the Medical Center

d. Review and make recommendations regarding adverse drug reactions and usage of dangerous drugs

e. Review the use of medications. This includes prescription ordering, preparation and dispensing, administration, and monitoring of medication effects. Action will be taken to improve the use of drugs or resolve problems.

Section 7. Research Committee

The functions of this committee are set forth in the Robert J. Dole VA Medical Center, Research & Development, Human Studies Subcommittee, Standard Operating Procedures in accordance with the Belmont Report, Office of Research Oversight Directive 1058 dated February 9, 2009, and VHA Directive 1200, dated July 9, 2009. All research and IRB functions take place through the Kansas City VA Medical Center.

Section 8. Integrated Ethics Council

The Integrated Ethics Council serves in an advisory/consultative capacity to medical staff, patients and family members, and other facility employees on clinical ethics issues associated with patient care. The Council also participates in the development of Medical Center policies relating to medical ethics and patient rights issues.

Section 9. Physicians Professional Practices Group (General Staff)

This group consists of all active medical staff members and other providers, which includes physicians, dentists, podiatrists, optometrists, oral surgeons, anesthesiologists, certified registered nurse anesthetists, nurse practitioners, and physician assistants. It serves primarily to involve providers who are not on the CPC in the discussion of issues and serves as a vehicle to communicate information on topics of current interest.

Section 10. Peer Review Committee

The purpose of the committee is to provide oversight of peer review activities. The committee takes into consideration the findings from the initial reviewer, pertinent medical records, and other relevant data,

and then makes a final determination if the standard of care was met or not, as well as the final level determination.

Section 11. Operative and Invasive Procedures Committee

The purpose of the committee is to perform ongoing reviews concerning the quality of care pertaining to operative and invasive procedures. Recommendations are made to the Clinical Practice Council as needed.

ARTICLE XII - MEDICAL STAFF MEETINGS

Section 1. Regular Meetings

Regular meetings involving medical staff are held routinely through various formats as follows:

a. Clinical Service staff meetings – a minimum of 10 times per year
b. Clinical Practice Council - meets a minimum of 10 times per year
c. Pharmacy and Therapeutics Committee - meets a minimum of 10 times per year
d. Infection Control Team - at least quarterly
e. Research Committee/IRB - Quarterly
f. Physicians and Dentists Professional Practice Group - at least quarterly

Section 2. Meetings and Reports

a. An agenda for each meeting shall be prepared.

b. All Service staff meetings, committees and boards shall keep minutes and provide copies of minutes to the Chief of Staff for review. Minutes shall include a record of attendance at meetings.

c. All committee and board recommendations for action are subject to review and approval by the Clinical Practice Council and ultimate approval by the Center Director.

d. Committee chairpersons or designee will report a summary of each committee or board's accomplishments to CPC on an as needed basis.

Section 3. Appointment of Committee Chairpersons

a. Committee chairpersons shall be selected either from the committee membership in accordance with applicable VA Center Circulars, or as specified by current VA directives.

b. Committee chairpersons may appoint subcommittees and task forces and charter teams either for permanent action or on a temporary basis to investigate areas which require such action. Subcommittees shall make reports to the committee chairperson. Such reports shall be incorporated into the minutes of that particular committee.

c. Medical Staff Committee chairpersons are responsible for the performance, effectiveness, and compliance of their review committees.

Section 4. Attendance at Regularly Scheduled Meetings

a. Attendance at general staff meetings, Clinical Service meetings, and committees is strongly encouraged of Medical Staff members. Members of a board or committee of the Medical Center should attend all required meetings except in the event of an emergency or annual or sick leave. In those cases, the member will appoint a designee to represent his/her service or function whenever possible.

c. Clinical Practice Council: Medical Staff appointed to the CPC are required to attend regularly scheduled meetings of the board. A satisfactory rating for attendance by medical staff who are appointed to the CPC is defined as being present for at least 60% of scheduled CPC meetings.

d. Boards and committees must have a quorum to make decisions on agenda items. A quorum is defined as a simple majority of the committee membership. All professional services shall hold monthly meetings to consider findings from the ongoing monitoring and evaluation of the quality and appropriateness of care and treatment provided to patients.

Section 5. Special Meetings

a. Special meetings of the staff shall be called at any time upon the request of the Center Director or the Chief of Staff.

b. At any special meeting, no business shall be transacted other than that stated in the meeting notice agenda.

ARTICLE XIII - RULES AND REGULATIONS

a. The Medical Staff, through action of the CPC, shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within the guidelines of the Governing Body. These shall relate to the proper conduct of Medical Staff organization activities as well as embody the level of practice that is to be required of each practitioner in the Medical Center. As an organization affiliated with a graduate medical education program, policies shall also be developed to specify the mechanisms for the supervision of house staff by medical staff

b. No bylaws, rules, regulations, or amendments shall conflict with those issued by the Department of Veterans Affairs.

c. Center Directives shall be considered as extensions of the Rules and Regulations.

d. The Medical Staff Bylaws, Rules and Regulations are available to all staff electronically on the VA Common Drive and in hard copy in the Office of the Chief of Staff.

ARTICLE XIV - REVIEW, ADOPTION, AND AMENDMENTS OF BYLAWS

a. The Bylaws shall be reviewed at least every two years (may be extended as necessary, not to exceed one year), revised as necessary to reflect current practices, and dated to indicate the date of the last review. A proposed amendment to these Bylaws, Rules and Regulations and attendant policies may be submitted in writing to the Chief of Staff by any Clinical Service Director or any member of the Medical Staff.

b. Proposed amendments will be coordinated through the Chief of Staff Office and distributed to the physician members of CPC for review. No approval action may be taken on a change to the Bylaws until the proposed change is considered by CPC at its next regular meeting. A period of not less than fifteen (15) days will be allowed for receipt of further written comments from the CPC physicians on proposed changes Neither the medical staff nor the governing body may amend the bylaws unilaterally. To be adopted, an amendment shall require a majority vote of CPC physicians. Amendments shall then be presented at the next Professional Practice Group meeting (general medical staff) for concurrence. If there is no conflict, the adoption of the amendment will stand approved. Should a conflict arise, the conflict management process noted in Section N. will be followed. Amendments shall be effective when approved by the Medical Center Director.

ARTICLE XV - INTERPRETATION OF BYLAWS OF THE MEDICAL STAFF AND RULES AND REGULATIONS

Section 1. Authority to Interpret

The Clinical Practice Council shall have the authority to interpret Bylaws, Rules and Regulations. Such interpretations shall be subject to approval by the Center Director.

ARTICLE XV I- BOUND BY BYLAWS AND REGULATIONS

All physicians, dentists, optometrists and podiatrists granted clinical privileges will be provided with a copy of the Medical Staff bylaws at the time of application and must agree to accept the professional obligations reflected therein. A written statement of acknowledgment will be maintained on station for all active Medical Staff.

The Medical Staff bylaws have been submitted for review to the Clinical Practice Council of the Medical Center and have been recommended for approval.

ADOPTED BY THE MEDICAL STAFF ON _____7/6/11_____
Date

RECOMMENDED:

6/13/11

_____ _____

JAMES PARKER, DDS
Interim Chief of Staff Date

APPROVED:

6/13/11

_____ _____

THOMAS J. SANDERS, FACHE
Medical Center Director Date

RULES AND REGULATIONS OF THE MEDICAL STAFF

DEPARTMENT OF VETERANS AFFAIRS
Robert J. Dole VA Medical Center
Wichita, Kansas

Section A. Admission and Care of Inpatients Acute and Long-Term Care

1. Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis or a valid reason for admission has been documented in the medical record. An admission progress note shall be documented at the time of admission.

2. Physician orders shall be written at the time of admission, dated and signed.

3. Admission orders, histories and physicals (H&P) written by a physician assistant or ARNP shall be countersigned by a Medical Staff member preferably at once, and in no event later than 24 hours after the order is written. A complete history and physical will contain present and past medical history, social history, review of systems and a provisional diagnosis. Orders written by medical students shall NOT be implemented until countersigned or authorized by verbal or written approval of a licensed independent practitioner. All verbal orders will be signed within 24 hours of initial communication.

4. Every patient admitted shall be assigned to a physician staff member for a physical examination and systemic evaluation and treatment, even if admitted primarily for dental care.

5. A complete H&P shall be documented in the medical record within 24 hours of admission to the hospital and 72 hours in the nursing home. Dentists and podiatrists are responsible for that portion of the history and physical exam that relates to dentistry and podiatry respectively. If a patient is being readmitted within 30 days, a new H&P is not required, however, the previous H&P must be reviewed, the patient examined, and any updates noted within 24 hours. This shall be documented using the note title of H&P, or making an addendum to the previous H&P stating that the H&P dated ____ was reviewed, the patient examined, and there were no changes, or the changes are _____.

6. A Medical Staff member, having knowledge that his or her patient may be a source of harm or danger to himself or herself, or to others, shall be responsible for making this known to other hospital personnel as appropriate.

7. If patients who have been admitted to the hospital have brought in their medications from home, they will be sent home with family members. If no family is present, the pharmacy will mail the drugs to the patient's home.

8. A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Medical Center, for the prompt completeness and accuracy of the medical record, for necessary special instructions and for transmitting reports of the condition of the patient to the referring practitioner if applicable.

9. All patients presenting themselves in the Emergency Department will be promptly evaluated and treated prior to final disposition.

Section B. Consultations

1. Consultations may be written by a member of the Medical Staff, House Staff, Psychologists, Advanced Practice Nurses or Physician Assistants. Time limits for completion of the consultation will be dependent upon the urgency of the care required. Generally routine inpatient or long term care consults to other physician specialties will be initiated within 24 hours, consultations to dietetics, social work, physical therapy, etc., will be determined by patient need/the availability of the service. Stat or urgent consults will be answered within 4 hours. Outpatient consultation requests will be entered into CPRS and providers should indicate the urgency of the consult. Registered nurses may request consultations to allied health services such as dietetics, social work, dental, prosthetics, optometry, psychiatry, etc. Masters Social Workers may request consultation to behavioral health programs, hospice/palliative care, care coordination home telehealth, etc. Registered nurses and Masters Social Workers will not make consultations to specialties such as cardiology, rheumatology, orthopedics, surgery, etc.; this is the role of the provider staff.

2. A psychiatric consultation shall be routinely requested on any patient who poses a threat or arouses suspicion of being suicidal or homicidal. Responses to such consultation shall be expedited, but no longer than 4 hours from notification.

3. Each consultation report will contain a written opinion by the consultant that reflects, when appropriate, an actual examination of the patient in the medical record.

4. Consultation shall be obtained if the diagnosis is obscure or if additional expertise is deemed advisable. Consultation shall be obtained if the patient so requests, within reason. Consultation will be completed prior to surgery except in emergencies.

Section C. Transfer of Patients

1. When the therapeutic needs of the patient cannot be met at this health care facility, arrangements shall be made to transfer the patient to another VA facility, or, if authorized, to a community hospital for the provision of medical services. Completion of the transfer authorization form and documentation of acceptance by the receiving facility in the medical record is required.

2. The Medical Staff member or Nocturnist (may be an MD, ARNP of PA) responsible for the care of the patient shall initiate the transfer request. Consent of the patient for transfer, clarification of clinical stability, and consent of the receiving provider shall be documented. If the Nocturnist is an ARNP or PA they must at a minimum discuss the case with the appropriate Attending and document this conversation in the medical record.

3. In the event of a patient's transfer, all critical information shall accompany the patient to the receiving facility, an appropriate summary shall be dictated and a copy sent with the patient. If the transfer is emergent, a written discharge summary should accompany the patient, with a dictated discharge summary to follow.

4. Transfer of patients that occur within the Medical Center, including treating specialty changes; will require the completion of the Patient Transfer Note (PTN) prior to the transfer. It is essential to record diagnoses for all symptoms treated, major diagnostic procedures completed and to list surgical interventions.

Section D. Medical Records

1. The assigned Medical Staff member is responsible to complete the medical record for every patient accepted for medical and/or dental care. The consolidated medical record (CMR) consists of the paper (hard) copy and the electronic record (CPRS) maintained in the Veterans Health Information System Technology Architecture (VISTA).

2. In order to ensure timely completion of medical records within 30 days, providers shall complete their portion of the record within 7 days of the visit or discharge.

3. In the case of readmission, all previous medical records shall be made available to the Medical Staff member.

4. Free access to all medical records shall be afforded the Medical Staff member for a bona fide study or research consistent with the preservation of confidentiality of personal information and preservation of the dignity of the individual person.

5. A flagging mechanism in CPRS is used for denoting Do Not Resuscitate (DNR) and Advance Directives.

6. All clinical entries made in the patient's medical record shall be accurately dated and signed. Clinical entries not recorded on the date of the visit will be entered into the appropriate note title and designated at the beginning of the note as a "Late entry for visit on (date of visit)".

7. Progress notes must be made frequently enough by Medical Staff members to clearly reflect the fact that the patient's status is being observed and documented. Attending physicians who supervise house staff in the outpatient clinic have the same documentation requirements. (See Section K Role of Attending Staff/House Staff for specifics).

8. Entry of the DNR Note/Order. After it has been determined that a DNR order is appropriate for a particular patient, the order and progress note should be entered in the patient's medical record by the attending physician. (See Section K for requirements related to House Staff entering DNR orders/notes).

9. An appropriate entry shall be made in the medical record when patient education materials are given to the patient. This entry shall be signed and state the type of material disseminated, date provided, purpose, and title of the person providing it.

10. Restraints will be employed utilizing established procedures and current policy.

11. Behavioral Health patients will have an individualized treatment plan based upon the assessment/evaluation of the patient's medical, psychological, social and spiritual needs. Removal of a patient from suicidal observation and development of a treatment plan shall be under the direction of an attending licensed independent practitioner.

12. At time of discharge, a discharge progress note or the equivalent shall be made and signed by the Medical Staff member or Nocturnist (may be an MD, ARNP or PA). The discharge progress note shall not take the place of a Discharge Summary. If the Nocturnist is an ARNP or PA, the discharge progress note shall be cosigned by the appropriate Attending.

13. The medical record is confidential. Medical records shall not be released without the written consent of the patient in accordance with legislation governing the release of medical information.

14. Records may be removed from the Medical Center's jurisdiction and safekeeping only in accordance with VA regulations. All records are the property of the Medical Center and shall not otherwise be taken away without permission of the Director. Unauthorized removal of charts from the Medical Center is grounds for suspension of the clinical privileges of the Medical Staff. VA disciplinary action may also be invoked.

15. In the event that a provider is no longer employed by VA and the medical record contains unsigned orders or notes, the Clinical Director or Chief of Staff will review them and sign, as appropriate, making any changes as needed.

Section E. Discharge from the Hospital

1. The patient shall be discharged only upon the written order of a licensed independent practitioner or Nocturnist (may be an MD, ARNP or PA). If the Nocturnist is an ARNP or PA, they must at a minimum discuss the pending discharge with the appropriate Attending physician and document this conversation in the medical record.

2. Discharge summaries for all discharges shall be dictated or entered into CPRS within 24 hours of the patient's release. This includes deaths or irregular discharges. The documentation may be completed by the appropriate Attending physician, Resident or Nocturnist ARNP/PA. The Attending physician must cosign the discharge summary.

3. A full discharge summary is not required for brief (less than 48 hours), uncomplicated hospitalizations in which the abbreviated medical record is used as the form of documentation. The patient’s discharge, condition at discharge, instructions, and follow-up must be documented. The abbreviated medical record may not be used for patients admitted to critical care units, regardless of the length of stay. If the documentation is completed by other than the Attending physician as in #2 above, again a co-signature will be required.

4. The discharge summary shall not contain any abbreviations in the diagnosis or the operation/procedure portions.

5. The discharge summary shall clearly reflect the ability or inability of the patient to return to work if applicable.

6. The discharge summary shall refer to the patient’s Discharge Instruction sheet where the name of the medications is clearly listed along with dosage, refills and special instructions/side effects as applicable.

7. The discharge summary shall clearly indicate any dietary restrictions the patient must follow. If there are limitations, they shall be specified as to what the limitations are, and for how long the patient is to be restricted.

8. The discharge summary shall clearly indicate any ambulatory restrictions the patient must follow. If there are limitations, they shall be specified as to what the limitations are, and for how long the patient is to be restricted.

9. The discharge summary shall clearly indicate any need for future care and where that care should be obtained. If a future appointment has been made, it shall be documented in the summary.

10. The discharge summary shall indicate mental status and competency to handle VA affairs.

11. The discharge summary shall document patient education performed by the licensed independent practitioner or Nocturnist ARNP/PA.

12. Discharge planning is to be initiated at the time of admission. Discharge planning will be documented in the medical record and adhere to local policy and procedures.

Section F. Medications

1. Drugs used in the health care facility shall be those which meet the United States Pharmacopoeia, National Formulary, VISN Formulary, and drugs which have been approved by the Pharmacy and Therapeutics Committee and which are listed in the Hospital Formulary. Exceptions to this rule must be justified by the prescribing medical staff member and approved through a Prior Approval drug request consult.

2. Drug orders must be written and signed in the manner specified in the VA Directive regarding drug policy. Route of administration, dosage, and frequency shall be included in the order.

3. Investigational drugs shall not be used by medical staff members except in strict compliance with VA regulations. They will be used only when approved by the Research and Development Committee and administered under approved protocol.

4. Automatic Treatment Stop Orders: Drugs and/or treatments are discontinued after physician notification unless renewed under the following conditions:

a. Antibiotics may be prescribed up to 28 days for inpatients unless the physician specifies another stop date.

b. Schedule II Narcotic Controlled Substances will be automatically discontinued for inpatients in 7 days. Under special circumstances up to 30 days may be prescribed provided justification for the extended duration is included in the order.

c. Respiratory Inhalation Therapy

(1) The chart will be flagged 24 hours before therapy is discontinued. This will allow the physician one full day (24 hours) to write new orders if continued therapy is necessary.

(2) All oxygen orders will be discontinued if the patient has not used the oxygen for 72 hours, unless new orders are written.

Section G. Invasive Procedures/Surgery: Required Assessment and Monitoring

1. Invasive procedures requiring moderate sedation or anesthesia require a pre-procedure history and physical whether performed on an ambulatory or inpatient basis. A complete history and physical is not required on ambulatory procedures requiring only local anesthesia, e.g. flexible sigmoidoscopy, skin lesion removal, oral surgery done in clinic, etc. For these types of procedures only a review of the appropriate system, relevant to the procedure is required.

2. Surgical procedures require an H&P and a pre-op note with preoperative diagnosis to be completed prior to surgery. It is acceptable to put all the requirements on a single note if desired. If a full H&P was done within 30 days for the same condition, a new H&P is not required, however, the previous H&P must be reviewed, the patient examined, and any updates noted within 24 hours. Documentation shall state that the H&P dated ____ was reviewed, the patient examined, and there were no changes or the changes are ____. This shall be documented using the note titles of Surgery H&P/Pre Op H&P or Surgery Consult, or by making an addendum to the previous H&P.

3. When a dentist or podiatrist plans to perform an invasive procedure/surgery requiring moderate sedation or anesthesia, the pre-procedure H&P is to be completed by the Veteran's primary care physician. The dentist/podiatrist is responsible to see that the H&P is completed within 30 days of the scheduled procedure, as well as the pre-op note with preoperative diagnosis prior to the procedure/surgery. Within 24 hours prior to the procedure, the anesthesia provider is responsible to review and update the H&P as in #2 above.

4. In an emergency, a progress note will be written**.** The progress note must contain sufficient findings to lead to a tentative diagnosis and to justify surgical intervention.

5. An invasive procedure shall not be performed until informed consent is obtained. If the patient lacks the capacity to give informed consent, a properly selected surrogate may sign the consent form. If the patient is alone and an appropriate surrogate does not exist or cannot be contacted after reasonable attempts, the Service Director, Chief of Staff or Officer of the Day may sign. For a list of procedures requiring informed consent, refer to the Informed Consent policy.

6. Pre and post anesthesia evaluations shall be documented in the proper spaces on the anesthesia form. Entries made by anesthesia staff shall be signed, dated and timed. The form shall be scanned into CPRS upon completion of the case.

7. Within 1 hour following surgery, a brief operative note will be completed in CPRS (by either the Attending or Resident) documenting findings, technical procedures used, specimens removed and post-operative diagnosis. The note shall include the name of the primary surgeon and any assistant surgeons. A complete operative note shall be dictated within 24 hours (by either the Attending or Resident).

8. All tissues, teeth or foreign objects removed at the time of an operation/procedure, shall be sent to the pathologist; except when determined by the surgeon to be an unnecessary submission. This shall be noted in the operative report, as well as any surrender of foreign objects to law enforcement.

9. The operating surgeon shall have as first assistant in a major operation another Medical Staff member capable of continuing the operation if necessary.

10. Consultation will always be obtained and documented prior to surgery on patients considered as poor risks.

11. All Operation Reports will be dictated immediately following surgery.

12. Cardiac catheterization patients receive their post-cath monitoring in the recovery area of the cath lab, but there may be instances where a late case may have the final aspect of their monitoring completed in a medical bed. In this case, the nurse is merely finishing the monitoring of the cath lab nurse and there is no need for the patient to be admitted to the hospital. The cath lab physicians continue the care of the patient until the monitoring is completed and the patient is ready to go home. However, if the patient stay is greater than 6 hours, the patient will need to be placed in a 23 hour observation bed requiring an H&P, discharge note and instructions.

13. Patients are not routinely admitted for blood transfusions. During business hours the Oncology Clinic or Ambulatory Surgery Unit are available to give blood transfusions on an outpatient basis. On off tours, the Emergency Department can perform this function on a resource available basis.

Section H. Research and Development

1. All Research and Development activities shall be done in strict compliance with VA Regulations and VA Center policy. The Research and Development Committee/IRB shall assure that all activities are properly requested, approved, and documented.

2. Proper documentation of research activities shall be made in the medical record when a patient is involved.

3. Any individual who is not an employee of the Department of Veterans Affairs who participates in any type of research activity shall be processed as an employee without compensation (WOC).

Section I. General

1. The use of ***Standing Orders*** will be permitted provided the need is justified and with the approval of the Clinical Practice Council. All standing orders will be reviewed at least every two years by the appropriate service and submitted to CPC for approval.

2. ***Medical orders*** written by a medical staff member or other provider within their scope of practice shall be dated and signed. As appropriate, orders shall be countersigned by a Medical Staff member no later than 24 hours after the orders are written. Delays in patient care shall not be allowed due to waiting for countersignature.

3. ***Verbal orders*** (including telephone orders) are those issued by an active Medical Staff member or other provider to a registered nurse or other authorized licensed professional as follows:

-Respiratory therapy orders may be taken by a certified respiratory therapist
-Pharmacy orders may be taken by a registered pharmacist
-Physical and occupational therapy orders may be taken by a certified physical therapist and occupational therapist
-Dietary orders may be taken by a registered dietitian
-Radiology orders may be taken by a certified radiology technician

4. The orders shall be signed as soon as possible, but no longer than 24 hours later.

5. Medical Staff members shall react to and participate in the relief of any disaster in accordance with their assignments as reflected in the Center Disaster Plan. Provisions for disaster privileges for community physicians will be in accordance with VA policy.

6. Medical staff must pledge in writing to provide continuous care to his or her patients.

7. Full-time physicians, optometrists and dentists in the Department of Veterans Affairs are subject to call back for emergency, disaster, or other patient care needs, 24 hours per day, 7 days per week. Full-time physicians may provide care for non-VA patients outside their tour of duty. However, due to the call back provisions, employees are to provide management with information on how they can be reached outside their VA tour of duty.

8. Only those abbreviations and symbols appearing on the list of abbreviation guidelines shall be used. A list of these guidelines, as well as a list of abbreviations *NOT TO USE*, is maintained on the Common Drive.

9. Autopsies are encouraged at this Medical Center in order to provide opportunities to improve care, and to enhance medical education. Permission to perform an autopsy will be requested in all deaths at this medical center in a compassionate manner by a physician or Nocturnist (MD, ARNP or PA). The physician or nocturnist will make the request to the next of kin to perform the autopsy. Documentation of the request for autopsy will be included in the patient's medical record.

10. Emergency services at the Robert J. Dole Medical Center are classified as a Level II trauma facility providing 24-hour medical staff coverage and nursing support. All patients who present to the Emergency Department will be evaluated, and their condition stabilized prior to final disposition.

11. Residents who are board qualified/certified may be appointed as Medical Officer of the Day in the Emergency Department with an attending physician on-call.

12. In the outpatient setting, providers will enter a progress note for each visit on the day of the visit. Encounters associated with the visit will be completed on the date of the visit, either in CPRS, Appointment Management or Event Capture. Complete encounters must include at a minimum; a primary diagnosis, an evaluation and management code (CPT-4 code), primary provider, checkout date and time, additional procedure codes and classification questions as appropriate.

13. Primary Care providers will complete at least a Level 3 examination for new patients upon the initial visit, and then at least bi-annually after that. Only vested patients will be provided pharmaceuticals, prosthetic items, specialty clinic visits and non-VA care.

Section J. Patient Rights and Responsibilities

1. All patients are assured of their rights in accordance with the information booklet on "*Patient's Rights and Responsibilities*," unless medically contraindicated. This booklet will be provided to all inpatients upon admission. The same information will be posted in outpatient areas, and the booklet will be available to outpatients.

2. All patients or their designated representative have the right to participate in the consideration of the ethical issues that arise in the provision of his or her health care. They have the right to be informed about, to consent to, or to refuse the recommended medical treatment, including forgoing or withdrawing of life support, withholding of resuscitation (DNR), and participation in investigational studies and/or clinical trials. Problem resolution, withholding life support (DNR) and advance directive policy and procedures are described in current Center Circulars.

Section K. Role of Attending Staff/House Staff

Staff physicians who supervise residents are responsible for assuring that diagnostic, therapeutic, and surgical procedures performed by residents on patients assigned to them are medically indicated and properly executed. Residents will function under the supervision of and within the clinical privileges granted to a qualified staff physician who has privileges in the area being supervised. Medical staff members who choose not to participate in a teaching program are not subject to denial or limitation of privileges for this reason alone. The following requirements are specific to supervision and documentation;

Outpatient Clinic Setting;

Attending must be physically present in the clinic. Documentation may be done in one of 4 ways;

1. Attending makes a separate note.
2. Attending cosigns the resident's note.
3. Attending makes an addendum to the resident's note.
4. Resident clearly articulates in note, the name of the Attending, a summary of the discussion and a statement of their oversight related to the assessment, dx and tx plan.
5. **For new patients to the facility, the Attending must document using methods (1.), (3.) or (4.). In this case a co-signature is not sufficient (p.12).

Emergency Department Setting;

Attending must be physically present and documentation completed as in methods (1.), (3.) or (4.) above. A co-signature is not sufficient for this setting.

Operating Room Setting;

Level A – Attending does the operation, resident may assist.
Level B – Attending scrubbed and in the OR, directly involved in the procedure. The resident may perform a major portion of the procedure.
Level C – Attending in the OR, not scrubbed, observes and provides direction to the resident.
Level D – Attending in the OR Suite, immediately available for supervision or consultation as needed.
Level E – Emergent situation, necessary to preserve life or prevent serious impairment. The Attending has been contacted.
Level F – Non-OR procedure, routine bedside or clinic procedure done in the OR, the Attending is identified.

Inpatient Setting;

Admission Note – Attending can write a separate note, or an addendum to the resident note, within 24 hours. A dictated note will NOT meet the timeframe. For planned admissions the Attending can write a pre-admission note, but no greater than 24 hours before the patient is admitted. Additionally, it must be the same Attending doing the note, which will also be providing the resident supervision.

Pre-procedure note – Attending must evaluate the patient and write a pre-procedural note or an addendum to the resident's pre-procedure note describing the findings, diagnosis, plan for treatment/choice of specific procedures to be done. This may be done up to 30 days in advance of the procedure. It may also serve as the admission note if it is written within 1 calendar day of admission by the Attending with responsibility for continuing care of the inpatient. The note must meet the criteria for both the admission and pre-operative note.

Night Float Admissions – in cases where a night float resident admits a patient, and then the care is transferred to another inpatient ward team, the Attending must physically meet and examine the patient within 24 hours of admission, irrespective of the time the ward team assumes responsibility for the patient.

H&P – Attending must cosign.

TLC Admissions – Attending must see and examine the patient within 72 hours, a separate note or an addendum to the resident note can be completed.

Continued Stay – Attending documentation may be in one of the 4 ways listed above under outpatient setting.

Inter-service or inter-ward transfers – Attending must treat the patient as a new admission and write an independent note or an addendum to the resident's transfer acceptance note.

Discharge from inpatient status – The provider must complete a discharge progress note and/or instruction sheet for each period of hospitalization. It must contain date and the type of discharge, diagnoses, discharge medications, recommendations relative to diet, exercise, limit of disability, condition on discharge (to include character of surgical wound, if appropriate), place of disposition, recommendations for follow-up, and patient education. The involvement of the attending physician in discharge planning may be reflected by co-signature, an independent note or addendum, or by reference in the resident's discharge note or discharge instructions.

DNR Orders/Progress Notes;

Attending physicians are responsible to write DNR orders and DNR progress notes. Residents may enter DNR orders only when the Attending is not readily available, provided that the resident first;

Obtains consent from the patient or the patient's authorized surrogate
Discusses the order with the Attending responsible for the patient's care
Obtains the Attending physician's concurrence and
Documents the conversation with the Attending in the patient's medical record

In addition, the Attending must countersign the progress note documenting the conversation and rewrite the DNR order within 24 hours.

Section L. Impaired Professional Program

The organized medical staff has an obligation to protect patients, its members and other persons present in the hospital from harm. Education is available concerning LIP health, at risk criteria for impaired conditions and the process for reporting. The focus is for rehabilitation, rather than discipline, to aid the LIP to retain optimal professional functioning that is consistent with protection of patients. The Clinical Service Director, Chief of Staff or Medical Center Director will be involved in the evaluation/investigation of the credibility of a complaint, allegation or concern toward an impaired LIP.

The conclusion of the investigation will determine the monitoring required for the affected LIP and the safety of patients, until the rehabilitation or disciplinary process is complete and periodically thereafter. The medical staff leadership will be informed of instances in which an LIP is providing unsafe treatment.

An Employee Assistance Program as described in Center Circular 001F-03-45 is available to members of the medical staff. In conjunction with the Medical Center program, an Impaired Physician Program is available through the Kansas Medical Society.

Section M. General Behavioral Expectations

The organized medical staff has an obligation to model behaviors that contribute to a work environment that is safe, dignified and respectful for patients, visitors and employees. The work environment should be free from intimidation, hostility, and verbal/physical abuse. Employees who in good faith report behavior or behaviors that undermine a culture of safety or verbal/physical abuse will not be subject to retaliation for reporting those concerns.

Section N. Conflict Resolution & Management

For VA to be effective and efficient in achieving its goals, the organization must have clear objectives and a shared vision of what it is striving to achieve. Therefore, there must be a mechanism for the recognition of conflict and its resolution of conflict in order to avoid a lack of progress in meeting these established goals. Conflict management is the process of planning to avoid conflict when possible and manage to resolve such conflict quickly and efficiently when it occurs. VA Handbook 5978.1, *Alternative Dispute Resolution Program,* addresses the conflict resolution and management process available in VA, as well as resources to engage in mediation as well as non-binding, or binding arbitration. This mechanism can be utilized to manage conflict between the Clinical Practice Council and the general medical staff on issues including, but not limited to proposals to adopt a rule or regulation or policy or amendment thereto. Nothing in the foregoing is intended to prevent medical staff members from communicating with the Medical Center Director on a rule, regulation or policy adopted by the Clinical Practice Council.

APPENDIX A
DEPARTMENT OF VETERANS AFFAIRS
CODE OF PATIENT CONCERN

The Department of Veterans Affairs is committed to providing high quality medical care for its patients. It is also committed to providing this care in a climate in which the human needs and concerns of the patient are met, and in which individual interests are protected. This climate must be based on respect for the dignity of the patient as an individual, and on care which is provided in a courteous, concerned, and compassionate manner. In order to achieve these goals, the dedication of each employee to the principles outlined in this document is essential. It is only through the willing assumption of this responsibility on the part of the staff that this health care facility will be able to provide the kind of patient care to which it is committed. To this end, this Code of Patient Concern reaffirms the commitment of the Department of Veterans Affairs.

1. Each patient must be accorded dignity as an individual, and treated with compassion and respect.

2. Each patient seeking advice or assistance will be helped in a prompt, courteous, and responsive manner.

3. Every effort should be made to make the patient feel that all employees care about him/her as an individual.

4. In all cases, the needs and feelings of the patient and family will be given primary consideration.

5. Each employee in contact with patients and their families is responsible for creating and fostering an atmosphere of mutual acceptance and trust.

6. The physician responsible for the care of the patient, or a designated employee will provide the patient with information concerning diagnosis, treatment, and prognosis in terms the patient can reasonably be expected to understand. When it is not medically advisable or feasible to give such information to the patient, the information should be made available to the next-of-kin, or other person designated by the patient upon acceptance of care except when existing law does not permit the release of information without written consent of the patient.

7. The physician responsible for the care of the patient, or a designated employee, will make certain that the patient is aware of the person who is responsible for coordinating the patient's care.

8. The physician will, prior to the initiation of any procedure with a recognized element of risk, provide the patient with sufficient information for the patient to form the basis of a reasonable request for such procedure. Except in emergencies, such information should include the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care and treatment exist, or when the patient requests information concerning medical alternatives, this information will be provided. The patient also will be told the name of the person responsible for the procedure and/or treatment. In the case of a patient who is considered mentally incapable of making a rational decision and request for a procedure, the sponsor or legal guardian <u>for health care decisions will</u> be provided with sufficient information to form the basis of a reasonable request for such procedure to be performed on the patient.

9. The patient may elect to refuse treatment. In this event, the patient must be informed of the medical consequences of this action. In the case of a patient who is mentally incapable of making a

rational decision, approval will be obtained from the guardian, next-of-kin, or other person legally entitled to give such approval.

10. ***Patient care conflict resolution*** is stipulated by Center medical ethics policy and the Ethics Committee. Medical Staff members may request not to participate in an aspect of patient care (see Plan for Provision of Care).

11. The privacy of the patient, including matters concerning the patient's own medical care program, will be respected. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly.

12. All records and communications pertaining to the care of the patient must be treated as confidential.

13. This health care facility, within its capacity, will be responsive to the request of a patient for service, as determined to be medically appropriate.

14. In the event any investigative (Research) procedures are contemplated involving a patient, the patient will be fully advised and informed consent secured. The patient will not be included in the investigative procedures if such informed consent is not given. Any exception to the rule must be submitted to review by an approved mechanism which clearly provides protection of the patient's interest (i.e., Ethical Review Committee). No attempt will be made to influence the patient to give consent if he/she is reluctant to do so. In the case of patients who are considered mentally incapable of executing an informed consent, approval will be obtained from the power of attorney for health care decision making, guardian, next-of-kin, or other person legally entitled to give consent.

15. The patient will be provided continuity of care within the applicable laws and policies which govern the Department of Veterans Affairs and within the resources available. The patient's physician, or designated employee, will provide appropriate guidance and recommendations for further medical care to the patient who is being discharged from the Department of Veterans Affairs medical care program.

16. In the hospital setting, the physician responsible for the care of the patient, or the designated employee, will insure that discharge planning is initiated early in the period of hospitalization. The patient will be assisted, where necessary, in making appropriate plans for follow-up medical care, rehabilitation, and living arrangements after the episode of hospitalization.

17. The patient will be provided with this health care facility's rules and guidelines which apply to his/her responsibility as a patient.

18. All of the above concerns are equally applicable to veterans placed in Personal Care Homes and Community Nursing Homes under VA contract. VA staff, non-VA staff and sponsors providing patient care in the community setting are expected to willingly assume responsibility for carrying out all elements of the Code of Patient Concern.

No set of guidelines alone will insure that the patient receives the kind of care and treatment that the Department of Veterans Affairs is committed to give. It is imperative, therefore, that each employee be concerned about each patient as a human being, and carry out the spirit and intent of this Code of Patient Concern.

APPENDIX B

AMERICAN MEDICAL ASSOCIATION PRINCIPLES OF MEDICAL ETHICS

Preamble

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

Principles of medical ethics

I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

IX. A physician shall support access to medical care for all people.

Adopted by the AMA's House of Delegates June 17, 2001.

www.ama-assn.org/ama/pub/category/2512.html

APPENDIX C

AMERICAN DENTAL ASSOCIATION

Principles of Ethics
And
Code of Professional Conduct

Section 1 - PRINCIPLE OF PATIENT AUTONOMY

1. A. PATIENT INVOLVEMENT: The dentist should inform the patient of the proposed treatment, and any reasonable alternatives, in a manner that allows the patient to become involved in treatment decisions.

1. B. PATIENT RECORDS: Dentists are obliged to safeguard the confidentiality of patient records. Dentists shall maintain patient records in a manner consistent with the protection of the welfare of the patient. Upon request of a patient or another dental practitioner, dentists shall provide any information that will be beneficial for the future treatment of that patient.

Section 2 - PRINCIPLE: NONMALEFICENCE

2. A. EDUCATION: The privilege of dentists to be accorded professional status rests primarily in the knowledge, skill, and experience with which they serve their patients and society. All dentists, therefore, have the obligation of keeping their knowledge and skill current.

2. B. CONSULTATION AND REFERRAL: Dentists shall be obliged to seek consultation, if possible, whenever the welfare of patients will be safeguarded or advanced by utilizing those who have special skills, knowledge, and experience. When patients visit or are referred to specialists or consulting dentists for consultation:

1. The specialists or consulting dentists upon completion of their care shall return the patient, unless the patient expressly reveals a different preference, to the referring dentist or, if none, to the dentist of record for future care.

2. The specialists shall be obliged when there is no referring dentist and upon a completion of their treatment to inform patients when there is a need for further dental care.

2. C. USE OF AUXILIARY PERSONNEL: Dentists shall be obliged to protect the health of their patients by only assigning to qualified auxiliaries those duties which can be legally delegated. Dentists shall be further obliged to prescribe and supervise the patient care provided by all auxiliary personnel working under their direction.

2. D. PERSONAL IMPAIRMENT: It is unethical for a dentist to practice while abusing controlled substances, alcohol or other chemical agents which impair the ability to practice. All dentists have an ethical obligation to urge chemically impaired colleagues to seek treatment. Dentists with first-hand knowledge that a colleague is practicing dentistry when so impaired have an ethical responsibility to report such evidence to the professional assistance committee of a dental society.

Section 3 - PRINCIPLE: BENEFICENCE

3. A. COMMUNITY SERVICE: Since dentists have an obligation to use their skills, knowledge, and experience for the improvement of the dental health of the public and are encouraged to be leaders in their community, dentists in such service shall conduct themselves in such a manner as to maintain or elevate the esteem of the profession.

3. B. GOVERNMENT OF A PROFESSION: Every profession owes society the responsibility to regulate itself. Such regulation is achieved largely through the influence of the professional societies. All dentists, therefore, have the dual obligation of making themselves a part of a professional society and of observing its rules of ethics.

3. C. RESEARCH & DEVELOPMENT: Dentists have the obligation of making the results and benefits of their investigative efforts available to all when they are useful in safeguarding or promoting the health of the public.

3. D. PATENTS AND COPYRIGHTS: Patents and copyrights may be secured by dentists provided that such patents and copyrights shall not be used to restrict research or practice.

3. E. CHILD ABUSE: Dentists shall be obliged to become familiar with the signs of abuse and neglect and to report suspected cases to the proper authorities consistent with state laws.

Section 4 - PRINCIPLE: JUSTICE (fairness)

4. A. PATIENT SELECTION: While dentists, in serving the public, may exercise reasonable discretion in selecting patients for their practices, dentists shall not refuse to accept patients into their practice or deny dental service to patients because of the patient's race, creed, color, sex or national origin.

4. B. EMERGENCY SERVICE: Dentists shall be obliged to make reasonable arrangements for the emergency care of their patients of record. Dentists shall be obliged when consulted in an emergency by patients not of record to make reasonable arrangements for emergency care. If treatment is provided, the dentist, upon completion of treatment, is obliged to return the patient to his or her regular dentist unless the patient expressly reveals a different preference.

4. C. JUSTIFIABLE CRITICISM: Dentists shall be obliged to report to the appropriate reviewing agency as determined by the local component or constituent society instances of gross or continual faulty treatment by other dentists. Patients should be informed of their present oral health status without disparaging comment about prior services. Dentists issuing a public statement with respect to the profession shall have a reasonable basis to believe that the comments made are true.

4. D. EXPERT TESTIMONY: Dentists may provide expert testimony when that testimony is essential to a just and fair disposition of a judicial or administrative action.

4. E. REBATES AND SPLIT FEES: Dentists shall not accept or tender "rebates" or "split fees."

Section 5 - PRINCIPLE: VERACITY

5. A. REPRESENTATION OF CARE: Dentists shall not represent the care being rendered to their patients in a false or misleading manner.

5. B. REPRESENTATION OF FEES: Dentists shall not represent the fees being charged for providing care in a false or misleading manner.

5. C. DISCLOSURE OF CONFLICT OF INTEREST: A dentist who presents educational or scientific information in an article, seminar or other program shall disclose to the readers or participants any monetary or other special interest the dentist may have with a company whose products are promoted or endorsed in the presentation. Disclosure shall be made in any promotional material and in the presentation itself.

5. D. DEVICES AND THERAPEUTIC METHODS: Except for the formal investigative studies, dentists shall be obliged to prescribe, dispense, or promote only those devices, drugs and other agents whose complete formulae are available to the dental profession. Dentists shall have the further obligation of not holding out as exclusive any device, agent, method or technique if that representation would be false or misleading in any material respect.

5. E. PROFESSIONAL ANNOUNCEMENT: In order to properly serve the public, dentists should represent themselves in a manner that contributes to the esteem of the profession. Dentists should not misrepresent their training and competence in any way that would be false or misleading in any material respect.

5. F. ADVERTISING: Although any dentist may advertise, no dentist shall advertise or solicit patients in any form of communication in a manner that is fall or misleading in any material respect.

5. G. NAME OF PRACTICE: Since the name under which a dentist conducts his or her practice may be a factor in the selection process of the patient, the use of a trade name or any assumed name that is false or misleading in any material respect is unethical. Use of the name of a dentist no longer actively associated with the practice may be continued for a period not to exceed on year.

5. H. ANNOUNCEMENT OF SPECIALIZATION AND LIMITATION OF PRACTICE: This section is designed to help the public make an informed selection between the practitioner who has completed an accredited program beyond the dental degree and a practitioner who has not completed such a program. (Remainder of information not published in this document since it does not apply to dental practice at the Department of Veterans Affairs).

Excerpted from ADA Principles of Ethics and Code of Professional Conduct from American Dental Association

APPENDIX D

AMERICAN PODIATRY ASSOCIATION
CODE OF ETHICS

APMA
Code of Ethics
APRIL 2005
American Podiatric Medical Association, Inc.
9312 Old Georgetown Road
Bethesda, Maryland 20814-1698

APMA CODE OF ETHICS
PREAMBLE

All podiatrists have the responsibility of aspiring to the highest possible standards of conduct and ethical behavior, assuring that the best care is provided for the individuals and groups whom they serve. As members of the American Podiatric Medical Association (APMA), podiatrists accept and take seriously the common values and principles established within this Code of Ethics. This Code applies to all aspects of professional life of podiatrists as they go about the implementation of their work within a variety of contexts as health care providers, administrators, educators, researchers, consultants, and employers.

The following statements and precepts are considered to be dynamic and may be interpreted and applied to an ever changing society.

MEDICAL ETHICS (ME)
ME1.0 Professional Judgment

The podiatrist has an obligation to facilitate patient care, placing the welfare and rights of the patient above all other considerations. The competence of a podiatrist extends beyond technical skills alone. Recognizing the extent of one's ability to perform and knowing when it is appropriate to seek consultation or make referrals when the welfare of the patient is safeguarded or advanced is imperative.

ME1.1 National Standards (Representing a Model to be Used by Individual States)

ME1.11 The podiatrist strives to maintain the highest standards of practice in accordance

with the responsibilities conferred by the state, profession, and society. (See

interpretive guideline.)

ME1.12 The podiatrist recognizes his/her competencies and limits the practice to those situations that are consistent with those competencies.

ME1.13 The podiatrist freely utilizes the expertise of other podiatric physicians and professionals of other disciplines to enhance the welfare of the patient.

ME1.14 The podiatrist maintains continuing competence by participating in professional

study and life long learning activities designed to ensure that his/her skills and

knowledge are consistent with ongoing developments in the art and science of podiatric medicine.

ME1.2 Practice Guidelines

ME1.21 The podiatrist strives to provide care consistent with established practice guidelines adopted by recognized podiatric medical organizations that utilize the opinions of authoritative experts. (See interpretive guideline.)

ME1.3 Patient Management

ME1.31 Within the responsibility of a podiatrist is the need to evaluate the patient prior to initiating care decisions and deciding on the best treatment plan. The treatment plan must take into account the entirety of the patient and utilize appropriate consultation or referral. (See interpretive guideline.)

ME1.32 The podiatrist is responsible for ensuring appropriate follow-up care for his/her patient when he/she is not directly available to render such care. (See interpretive guideline.)

ME1.33 The podiatrist should refrain from providing care for any individual with whom he/she has a relationship of a nature that may cause him/her to provide care with reduced objectivity, interfering with the exercise of sound medical judgment.

ME2.0 Informed Consent

The doctrine of informed consent is premised upon the right of the patient to exercise control over his or her body by deciding whether or not to undergo a proposed treatment regimen. The duty of the podiatrist is always to disclose relevant information to the patient and obtain the consent of a competent patient or someone legally authorized to give consent on behalf of the patient before initiating treatment. (See interpretive guideline.)

ME2.1 What a Patient Needs to Know About the Proposed Treatment

ME2.11 The podiatrist strives to ensure that the patient is cognizant of the nature of the illness or condition, the treatment proposal or its alternatives with reasonable explanations of expected outcomes, potential complications, and length of recovery.

ME2.2 Disclosure of Experience and Outcomes

ME2.21 The podiatrist provides truthful representations of the his/her experience and outcomes.

ME2.3 Economic Interests

ME2.31 The podiatrist strives to ensure that any economic benefit involving services, materials, medications, or facilities shall not interfere with his/her primary responsibility for the welfare of the patient and shall comply with applicable legal requirements.

ME3.0 Confidentiality

The podiatrist and his/her staff must maintain strict confidentiality (subject to federal and state laws) as to the condition and treatment of all patients. Release of any information must be premised on the consent of the individual patient. (See interpretive guideline.)

ME3.1 Medical Records

ME3.11 The podiatrist acts in a manner that protects the confidentiality of the patient and the records of the patient.

ME3.12 The podiatrist ensures that the staff over whom he/she has responsibility or supervises, has an essential knowledge of the duty to maintain the confidentiality of the patient records.

ME3.2 Diagnosis

ME3.21 The podiatrist respects the confidentiality of the patient's diagnosis and does not release the diagnosis without the consent of the patient unless mandated by law.

ME3.3 Treatment

ME3.31 The podiatrist respects the confidentiality of the patient treatment information and does not release the treatment information without the consent of the patient unless mandated by law.

ME4.0 Patient Respect/Advocacy

Respect for the patient and advocating for the welfare of the patient should be the supreme concern of the podiatrist. A podiatrist should acknowledge cultural, individual, and ethnic differences of patients and he/she has an obligation to set aside personal biases that could result in potentially discriminatory practices.

ME4.1 Do No Harm

ME4.11 The podiatrist will evaluate the patient and use appropriate treatments in the care of the patient, taking into consideration any physical, financial, cultural, or emotional limitations that may result in harm during the treatment process. (See interpretive guideline.)

ME4.2 Nondiscrimination

ME4.21 The podiatrist shall not discriminate against any patient because of race, religion, ethnicity, gender, sexual orientation, disability, socioeconomic status, or health status.

ME4.3 Harassment

ME4.31 The podiatrist shall not engage in any deliberate act of emotional abuse, physical abuse, sexual abuse, sexual misconduct, or sexual exploitation related to the podiatrist's position as a health care provider, administrator, educator, researcher, consultant, or employer. (See interpretive guideline.)

ME4.4 Patient Abandonment

ME4.41 The podiatrist shall not cease to provide care or to be available to provide care without giving the patient sufficient notice and/or the opportunity to seek continuing treatment from another health care practitioner.

ME5.0 Professionalism

The podiatrist should, at all times, act in a professional manner before patients, colleagues, and the general public. This conduct should extend not just to the podiatrist's professional life but should encompass his/her public and private lives as well.

ME5.1 Compassion, Respect, Honesty, and Integrity

ME5.11 The podiatrist has the responsibility to carry out all aspects of his/her career with compassion, respect, honesty, and integrity.

ME5.2 Accountability in Providing Expert Testimony

ME5.21 The podiatrist providing expert testimony is expected to have relevant experience, training, and knowledge in the area in which the podiatrist has agreed to testify. Testimony must be objective and be limited to the area of expertise held by the podiatrist. Expert testimony should be based upon recognized medical and scientific principles, theories, facts, and standard of care.

ME5.22 The podiatrist serving as an expert witness shall offer testimony that is honest and truthful. A breach of these ethics would exist if a podiatrist knowingly provides false or misleading testimony.
ME5.23 The podiatrist may accept compensation for testimony offered but such compensation should not in any way be related to or based upon the outcome of the litigation.

ME6.0 Impaired Physicians

The podiatrist has the obligation to act upon the recognition of impairment(s) in him/herself and in other health care providers and to ensure that the treatment of patients is not compromised because of such impairments.

ME6.1 Physical, Mental, Chemical, or Emotional Impairment

ME6.11 The podiatrist who is physically, mentally, chemically, or emotionally impaired should withdraw from those aspects of practice that could be detrimentally affected by the impairment. If the podiatrist does not withdraw, other podiatrists who know of the impairment have the duty to take action to prevent the impaired podiatrist from harming him/herself or others. (See interpretive guideline.)

ME7.0 Research Ethics

Research conducted by podiatrists must be scientifically based with data, results, and outcomes reported in an accurate and truthful manner. Support for research may be obtained from any source but should not influence or bias the outcomes.

ME7.1 Integrity and Concern for Participants

ME7.11 The podiatrist shall maintain the integrity of the study to ensure that decisions by participants and subjects are made in an unbiased and fully informed manner.

ME7.12 The podiatrist shall not subject any patient to an experimental diagnostic modality or treatment method without prior review of the experiment protocol by his/her peers and with full disclosure to the patient. (See interpretive guideline.)

ME7.13 The podiatrist conducts research competently with due concern for the dignity and welfare of the participants.

ME7.2 Reporting

ME7.21 The podiatrist shall report truthfully in scientific and scholarly papers, lectures, accounts, and communications. (See interpretive guideline.)

ME7.22 The podiatrist shall avoid all forms of plagiarism, or otherwise taking credit for

the work or ideas of others, by properly acknowledging the source.

APPENDIX E

AMERICAN OSTEOPATHIC ASSOCIATION
CODE OF ETHICS

The American Osteopathic Association has formulated this Code to guide its member physicians in their professional lives. The standards presented are designed to address the osteopathic physician's ethical and professional responsibilities to patients, to society, to the AOA, to others involved in healthcare and to self.

Further, the American Osteopathic Association has adopted the position that physicians should play a major role in the development and instruction of medical ethics.

Section 1. The physician shall keep in confidence whatever she/he may learn about a patient in the discharge of professional duties. The physician shall divulge information only when required by law or when authorized by the patient.

Section 2. The physician shall give a candid account of the patient's condition to the patient or to those responsible for the patient's care.

Section 3. A physician-patient relationship must be founded on mutual trust, cooperation, and respect. The patient, therefore, must have complete freedom to choose her/his physician. The physician must have complete freedom to choose patients whom she/he will serve. However, the physician should not refuse to accept patients because of the patient's race, creed, color, sex, national origin or handicap. In emergencies, a physician should make her/his services available.

Section 4. A physician is never justified in abandoning a patient. The physician shall give due notice to a patient or to those responsible for the patient's care when she/he withdraws from the case so that another physician may be engaged.

Section 5. A physician shall practice in accordance with the body of systematized and scientific knowledge related to the healing arts. A physician shall maintain competence in such systematized and scientific knowledge through study and clinical applications.

Section 6. The osteopathic medical profession has an obligation to society to maintain its high standards and, therefore, to continuously regulate itself. A substantial part of such regulation is due to the efforts and influence of the recognized local, state and national associations representing the osteopathic medical profession. A physician should maintain membership in and actively support such associations and abide by their rules and regulations.

Section 7. Under the law a physician may advertise, but no physician shall advertise or solicit patients directly or indirectly through the use of matters or activities, which are false or misleading.>

Section 8. A physician shall not hold forth or indicate possession of any degree recognized as the basis for licensure to practice the healing arts unless he is actually licensed on the basis of that degree in the state in which she/he practices. A physician shall designate her/his osteopathic school of practice in all professional uses of her/his name. Indications of specialty practice, membership in professional societies, and related matters shall be governed by rules promulgated by the American Osteopathic Association.

Section 9. A physician should not hesitate to seek consultation whenever she/he believes it advisable for the care of the patient.

Section 10. In any dispute between or among physicians involving ethical or organizational matters, the matter in controversy should first be referred to the appropriate arbitrating bodies of the profession.

Section 11. In any dispute between or among physicians regarding the diagnosis and treatment of a patient, the attending physician has the responsibility for final decisions, consistent with any applicable osteopathic hospital rules or regulations.

Section 12. Any fee charged by a physician shall compensate the physician for services actually rendered. There shall be no division of professional fees for referrals of patients.

Section 13. A physician shall respect the law. When necessary a physician shall attempt to help to formulate the law by all proper means in order to improve patient care and public health.

Section 14. In addition to adhering to the foregoing ethical standards, a physician shall recognize a responsibility to participate in community activities and services.

Section 15. It is considered sexual misconduct for a physician to have sexual contact with any current patient whom the physician has interviewed and/or upon whom a medical or surgical procedure has been performed.

Section 16. Sexual harassment by a physician is considered unethical. Sexual harassment is defined as physical or verbal intimation of a sexual nature involving a colleague or subordinate in the workplace or academic setting, when such conduct creates an unreasonable, intimidating, hostile or offensive workplace or academic setting.

Section 17. From time to time, industry may provide some AOA members with gifts as an inducement to use their products or services. Members who use these products and services as a result of these gifts, rather than simply for the betterment of their patients and the improvement of the care rendered in their practices, shall be considered to have acted in an unethical manner. (Approved July 2003)

www.do-online.osteotech.org/index.cfm?PageID=aoa_ethcis

APPENDIX F

American Optometrist Association
Code of Ethics

It Shall Be the Ideal, the Resolve, and the Duty of the Members of the American Optometric Association:

- **TO KEEP** the visual welfare of the patient uppermost at all times;
- **TO PROMOTE** in every possible way, in collaboration with this Association, better care of the visual needs of mankind;
- **TO ENHANCE** continuously their educational and technical proficiency to the end that their patients shall receive the benefits of all acknowledged improvements in visual care;
- **TO SEE** that no person shall lack for visual care, regardless of his financial status;
- **TO ADVISE** the patient whenever consultation with an optometric colleague or reference for other professional care seems advisable;
- **TO HOLD** in professional confidence all information concerning a patient and to use such data only for the benefit of the patient;
- **TO CONDUCT** themselves as exemplary citizens;
- **TO MAINTAIN** their offices and their practices in keeping with professional standards;
- **TO PROMOTE** and maintain cordial and unselfish relationships with members of their own profession and of other professions for the exchange of information to the advantage of mankind.

www.aoa.org/x1887.xml