NWTHS MEDICAL STAFF
GENERAL RULES AND REGULATIONS

SECTION 1: Admission of Patients

A. Members of the Medical Staff of Northwest Texas Hospital may admit patients to the facilities of Northwest Texas Healthcare System. Non-physician members of the Medical Staff, such as dentists (except oral surgeons) and podiatrists must co-admit with a qualified physician who will perform a prompt medical evaluation of the patient.

B. Members of the Medical Staff of Northwest Texas Healthcare System will work collaboratively with hospital staff to ensure that care is appropriate to the patient's specific needs (including those needs dictated by the patient's age), and to the severity level of patient's disease, condition, impairment, or disability.

C. Information as necessary including an acceptable admitting diagnosis to effect proper admission and patient placement must be provided by the physician to the admitting office. Patient symptoms or surgical procedures are not considered acceptable admitting diagnoses.

D. Patients admitted to the hospital will be seen by the attending physician or the resident on-call within 12 hours of admission. Patients admitted to the critical care units will be seen within 4 hours of admission.

E. Upon admission to the hospital, all critically ill patients less than 16 years of age will be seen in consultation with or attended by a Pediatrician with level II privileges, unless the attending physician has the specific privileges to provide the care required. If such consultation is not forthcoming, the Chief of the Department of Pediatrics is contacted for consultation. Critically ill patients ages 16 to 21 do not require a Pediatric consult if they have a specified private physician with whom a current physician/patient relationship exists, and that physician has privileges to admit to the critical care units. Critically ill patient's ages 16 to 21 with no specified physician may be seen by either a Pediatrician or other practitioner with critical care privileges as deemed appropriate. Patients over 21 will be treated as an adult.

F. For patients with non-surgical, non-gynecological, non-obstetrical, and/or non-psychiatric conditions who have no specified private physician, Emergency Department consultation/referral will be as follows: Patients will be referred to Pediatrics if below age 18 years. Referral will be made to adult Medicine or to a physician with the appropriate level of adult medicine (Internal Medicine or Family Practice) privileges after the patient has reached their 18th birthday. For patients with surgical, gynecological, obstetrical, and/or psychiatric conditions, guidelines for referral are established in Department Structured Standards.

SECTION 2: Physician and Patient Records

A. Following the admission of each patient, a history and physical examination (H&P) by a physician, qualified oral surgeon, or other practitioner qualified with privileges to perform the history and physical, will be performed**.** Dentists and podiatrists are responsible for that portion of the history and physical which relates to their specialty. The history will include the chief complaint; details of the present illness, including, when appropriate, assessment of the patient's emotional, behavioral, and social status; relevant past, social and family history and inventory of body systems. The record of physical examination will reflect a comprehensive current assessment and will include the diagnosis or diagnostic impression.

A short form history and physical and a dictated or written history and physical examination must be completed on all patients placed in observation status or admitted to inpatient status. The prenatal record may be accepted as the history and physical for patients admitted to Labor and Delivery.

A statement of the conclusions or impressions drawn from the admission history and physical examination, and a statement of the course of action planned will also be a part of the initial progress note.

Prior to the performance of operative and other invasive procedures, whether inpatient or outpatient, there will be a current, thorough, documented physical examination on the medical record, and indicated laboratory exams, x-ray exams, and diagnostic tests have been completed and recorded in the medical record. If the history and physical has been dictated but not transcribed, a brief note will be documented in the medical record to include: any past major illnesses, the preoperative diagnosis, the procedure planned, and at least a cardiopulmonary assessment and an assessment of systems pertinent to the planned procedure.

For all patients scheduled for a non-emergent operative procedure under general anesthesia, performance of diagnostic exams will be at the discretion of the involved physician(s) and based on patient condition.

An emergent patient is defined as someone requiring medical intervention due to a life-threatening situation or which may cause serious harm to that patient's life. In emergent situations where delay in performance of an operative procedure may result in adverse patient outcome, the scope of pre-operative diagnostic exams and required pre-operative documentation is left to the professional discretion of the involved physician(s) based on his/her assessment of the patient's condition.

General or regional anesthesia is defined as the administration of anesthesia or sedation that renders the patient unconscious and/or insensible to pain and emotional stress during surgical, obstetrical and certain other medical procedures, involving preoperative, intraoperative, and postoperative evaluation and treatment of these patients.

Operative and other invasive procedures are procedures involving puncture or incision of the skin or insertion of an instrument or foreign material into the body, excluding superficial vascular access for blood specimens, intravenous fluids, and medication administration, and cystograms, enemas, barium enemas, urinary catheters, and feeding tubes.

B. When a diagnostic exam requires clinical interpretation, any relevant clinical information should be provided with the request.

C. Laboratory reports, x-ray reports, operative notes, anesthesiology records, and consultation notes will be appended to the chart within 24 hours. A copy of laboratory testing performed outside the institution should be placed in the patient's record or the physician in the patient record should note a report of values.

Autopsy reports should be completed and on the chart within 60 days except in coroner cases.

D. The patient's condition should be documented daily by appropriate progress notes reflecting

the medical necessity for admission and continued stay.

E. An operative or other high-risk procedure summary must be written or dictated immediately following surgery or the high-risk procedure, and before the patient is transferred to the next level of care. The summary must contain the following elements: the name of the procedure performed, a diagnosis and description the procedure and findings of the procedure, the technical procedures used, estimated blood loss, the specimens removed, a list of the drains placed, the post-operative diagnosis, and the name of the primary surgeon and any assistants.

F. Anesthesia records will summarize the following information for each patient anesthetized: diagnosis, pre-operative condition, including assessment immediately before anesthesia induction; all medications administered; all quantities of blood components and fluids administered; physiological assessment of the patient during and post-anesthesia; assessment of vital signs during and post procedure; and assessment of the patient's condition following the procedure, and at the time of admission and discharge from post-anesthesia recovery.

For those patients who are unable to participate in the post anesthesia evaluation (e.g., post-operative sedation, mechanical ventilation, etc.), a post anesthesia evaluation should be completed and documented within 48 hours with notation that the patient was unable to participate. This documentation should include the reason for the patient's inability to participate as well as expectations for recovery time, if applicable. For those patients who require long-acting regional anesthesia to ensure optimum medical care of the patient, whose acute effects will last beyond the 48-hour timeframe, a post anesthesia evaluation must still be completed and documented within 48 hours. However, there should be a notation that the patient is otherwise able to participate in the evaluation, but full recovery from regional anesthesia has not occurred and is not expected within the stipulated timeframe for the completion of the evaluation.

G. Cancer patients with biopsies or other pathologic specimens from outside institutions must have those specimens reviewed by a pathologist member of the NWTHS Medical Staff prior to undergoing definitive surgery. When outside slides are not readily available, as may be the case with specimens taken outside the United States, the patients may undergo definitive surgery if clinical evidence of cancer can be demonstrated.

H. All surgical specimens must be sent to pathology except for those listed below. Specimens that
do not have to be sent to pathology, unless requested by a physician:

- Cataracts
- Foreign bodies
- Teeth
- Partial rib removed for operative exposure
- Therapeutic radioactive sources
- Traumatic amputation
- Nails
- Orthopedic appliance
- Excessive tissue
- Newborn foreskin
- Carotid plaque
- Other specimens known to rarely, if ever, show pathological changes, at the discretion of the surgeon in consultation with the pathologist

Unless certain categories of specimens are specifically excluded from microscopic examination by departmental policy (in consultation with the pathologist), the decision to rely only on gross diagnosis is made sparingly. This decision is made conjointly by the pathologist and the attending surgeon, and is documented in the medical record.

The pathology report will include a gross description and if appropriate, a microscopic description of all specimens or "material" removed by operative procedures.

I.
1. The physician must complete and sign the face sheet (principal diagnosis, and, as appropriate, secondary diagnosis and co-morbidities/complications) within 24 hours of patient discharge. If tissue or laboratory results are pending, a final discharge diagnosis will be written as soon as such reports are received. Principal operations and/or procedures must also be listed, if applicable.
2. The physician must complete and sign the attestation statement within 24 hours of patient discharge.
3. At the time of transfer to/from the Pavilion and the acute care hospital, a written and/or dictated transfer/discharge summary is required.
4. A discharge summary to include the reason for hospitalization; significant findings; procedure(s) performed and treatment rendered; patient condition at discharge; instructions to patient/family; and a final discharge diagnosis will be appended to the chart following discharge of the patient. In death cases, there must be a physician's progress note on the chart within 72 hours addressing the death and possible cause.

J. Medical records for all newly diagnosed cancer patients must include the appropriately completed staging form as recommended by the American Joint Committee on Cancer.

K. All records are the property of the Hospital and may be temporarily removed from the Hospital only for performance of official functions or by court order, subpoena or statute, and must be in the possession of the Chief Executive Officer or his designee when outside the Hospital.

All prior records of a patient will be available for the use of the current attending physician or consultants.

Access to inpatient medical records will be limited to the following:

1. The attending physician, his or her consultants, and residents and medical students assigned to the case
2. Medical Staff Officers
3. Department Chiefs
4. Proctors
5. Committees that require access to inpatient medical records in the performance of their duties
6. Hospital employees in the performance of their duties.

L. Physicians not completing their records are considered delinquent on the 21st day from discharge. Physicians with records incomplete thirty (30) days from dismissal will receive automatic suspension, which includes suspension of admission privileges, and a denial of visitation of newborns, suspension of consulting of privileges, and a denial of the privilege of scheduling surgical cases.

The following exceptions are noted:

1. Physicians will continue to treat their patients previously admitted until the dismissal of the patient.
2. Physicians on the delinquent chart list who receive automatic suspension will be privileged to admit and operate on those patients deemed emergencies, but no more than five (5) days after suspension occurs. The five-day rule will be waived for delinquencies requiring signatures only.
3. Physicians who are inactive due to illness or other reasonable circumstances will be allowed an additional fourteen (14) days to complete their records following their return to practice. This extension will be made by the Chief Executive Officer or his designee.
4. Psychiatric patient record requirements are delineated in Article II, Departmental Rules and Regulations, Section 6, Department of Psychiatry, Paragraph F.

M. All entries in the patient's medical record must be dated, timed, legible and authenticated**.**

N. All physician orders must be reviewed and revised as appropriate by the attending or transferring physician upon transfer from one level of care to another**.**

O. An order to transfer care of a patient from one attending physician to another attending physician must be written in the chart. The admitting physician is the physician of record until such order is written.

SECTION 3: General Conduct of Care

A. 1. No physician will perform any procedure on any alert patient unless the patient or their duly authorized decision maker has been fully informed of the procedure and possible complications and/or risks and has accepted the physician by name. When the patient is unable to comprehend the nature of the procedure and risks, the responsible next of kin will give consent. If there is no next of kin available to give consent, two physicians, one of whom is not directly involved in the patient's care, must agree that the procedure is necessary. Consent forms will conform to the provisions of the Texas Medical Disclosure Law**.** Any relationships between healthcare providers, which might suggest a conflict of interest, business relationship, or connection to an educational institution, will also be discussed with the patient.

2. In the event of the absence of the physician due to sudden illness or unforeseen circumstances, the patient or immediate family, or the parents or legal guardian (if a minor) will be fully informed of the change of physician responsibility as soon as possible.

3. The Medical Staff will respond to emergency situations in all facilities of Northwest Texas Healthcare System.

B. All inpatient orders will be in writing and signed by a physician, or other licensed independent practitioner to whom treatment decisions have been delegated. All telephone/verbal orders require a verification "read-back" to the physician by the person receiving the order. All verbal orders must be dated, timed, and authenticated within 48 hours by the prescriber or another practitioner who is responsible for the care of the patient and has been credentialed by the medical staff and granted privileges, which are consistent with the written orders**.** Outpatient verbal orders will be cosigned upon receipt and return.

C. All physician orders must be properly documented in the patient's medical record. Only a

physician or other appropriately-credentialed individuals with delegated responsibility for a specific aspect of care as allowed by law may give written or verbal orders to a registered nurse for medications and other treatment for Hospital patients. Orders written by Medical Students shall be identified as such and shall not be honored by the nursing unit or ancillary personnel unless counter-signed by a physician. House Staff members are authorized to make entries into the medical record, including orders and progress notes. Such entries do not require co-signature. Other licensed (certified or registered) personnel who may receive orders for services in their field of competence or for services that they render are listed as follows:

Audiologist	Medical/Clinical Social Worker
Diagnostic Imaging Technologist	EEG Technologist
EKG Technologist	Graduate Nurse
Laboratory Medical Technologist	Licensed Vocational Nurse
Occupational Therapist Assistant	Surgical Technician
Pharmacist	Speech Pathologist
Physical Therapist	Physical Therapist Assistant
*Qualified Mental Health Professional	Respiratory Therapist
Registered Dietician	Physician Assistant
Psychologist	Occupational Therapist
Nursing Students in Clinical	Leadership Rotation

(*A qualified mental health professional is a licensed master's level social worker, a licensed professional counselor, or a registered nurse who meets requirements as stated in their job description.)

1. All entries in the medical record made by medical students and dependent allied healthcare personnel shall be identified as such, and must be countersigned by a physician member of the Medical Staff. Dependent Allied Healthcare Professionals include, but are not limited to, the following: Registered Nurses; Licensed Vocational Nurses; Mental Health Counselors; School of Pharmacy Faculty; and Perfusionist.

2. References in these Rules and Regulations related to responsibilities of the physician may be delegated to an Independent Allied Healthcare Professional, only as allowed by law and as authorized through the credentialing process. Independent Allied Healthcare Professionals include, but are not limited to, Certified Physician Assistants, Certified Registered Nurse Anesthetists, Advanced Practice Nurses, and Psychologists.

3. All entries made in the medical record by the independent allied healthcare professional will include their printed and signed name, title, and the physician sponsor with whom they are affiliated. If the entry is illegible, a name stamp may be used for the printed name. Signature stamps will not be allowed.

   Each individual entry made by the independently allied healthcare professional does not require co-signature by the physician sponsor; however orders to place the patient in in-patient status must be co-signed by the physician sponsor.

4. No Independent Allied Healthcare Professional shall perform any privilege not specifically granted to him by the Board of Governors. Requirements for physician sponsorship, if any, are established through the credentialing process. The physician sponsor(s) accepts full responsibility for all acts of any Independent Allied Healthcare Professional operating under his authority.

5. If granted the privilege to do so, the Independent Allied Healthcare Professional may make rounds on behalf of the physician, however, in no case shall the physician sponsor delegate the responsibility to an Independent Allied Healthcare Professional for making

rounds for a particular patient for two days in succession. The attending or consulting physician must see the patient at least every other day, with one exception: the Northwest Texas Healthcare System Rehabilitation Unit requires that the patient be seen three (3) times a week by an attending physician and may be seen on the other days by a credentialed Independent Allied Healthcare Professional. Additionally, the charts of patients seen by Independent Allied Healthcare Professionals must have an initial note appropriate to the level of care of the patient by a physician within 24 hours of admission**.**

6. Charts of patients cared for by House Staff must have an initial note appropriate to the Level of care of the patient by the attending faculty member within 24 hours of admission. A personal attending faculty progress note should be placed on the chart at the same frequency which is required by other Medical Staff members as outlined in the Rules and Regulations. The attending faculty physician should have a note on the chart prior to performance of surgery.

D. Consultation by a member of the Medical Staff with appropriate expertise is encouraged in all cases where the patient is seriously ill and the diagnosis is obscure and in all cases where the method of treatment for poor-risk patients is not uniformly accepted. Consultation is required when the patient requires treatment beyond the scope of a physician's privileges. The physician requesting consultation shall personally communicate the request to the physician of whom consultation is requested. The request shall be given as a physician order; and the consultation request shall contain one of the following options:

1) Consultation only with no further follow-up
2) Consultation with co-management–requires regular follow-up visits and documentation of such
3) Consultation with willingness to assume primary responsibility for care of the patient (ie. Accept patient in transfer). If the consultant agrees to assume the care, the attending physician needs to order the transfer of care as a formal order

The consultant's report shall contain the following: review of patient's record; pertinent findings on exam; and, opinion and recommendations.

The consulting physician shall see the patient within 24 hours with the exception of the trauma patient. The requirement for patients to be seen at least once daily by the attending physician will include the consulting physician unless the consulting physicians' services are no longer required daily and he/she has either a) signed off the case and documented such, or b) documented the expected interval at which the patient will be seen by the consulting service which will then become the agreed upon expectation for the consulting physician's face to face evaluations.

The admitting physician as the physician of record will be contacted with all pertinent/ significant changes in patient condition, unless said physician has documented in the patient record that the consultant(s) is/are to be contacted with changes specific to the condition(s) for which he/she was consulted.

E. Second opinions may be rendered at the request of the attending physician, third party payers, or other proper entities. Physicians rendering second opinions will not treat the patient nor will they be considered to have a doctor/patient relationship.

F. All patients in the Hospital must be visited daily by the attending physician or another

physician assuming his responsibilities or by a credentialed Independent Allied Healthcare professional. The attending or consulting physician must see the patient at least every other day, unless the patient is a patient of the Northwest Texas Healthcare System Rehabilitation Unit, and in that instance the attending or consulting physician must see the patient three (3) times a week and the patient may be seen on the other days by a credentialed Independent Allied Healthcare Professional.

G. Members of the Medical Staff who are absent from the community or are unavailable must arrange coverage for their patients with another member of the Medical Staff who is qualified by his privileges to care for any existing hospitalized patients of the physician requesting coverage, if such member is available in the community. Community is defined as Potter and Randall Counties.

H. In the event an attending physician cannot be reached in an emergency and the patient is in need of care or has expired, the nurse on duty is empowered to call the Chief of the Department involved, who will then delegate a member of the Staff to temporarily render those services required. If the Department Chief is not available, the Vice Chief will be called; if neither is available, the President of Medical Staff will be called.

I. The Chief Executive Officer or his designee, after consultation with the President of the Medical Staff or his substitute, may declare an emergency. The Hospital will then operate under the disaster plan until such time as the Chief Executive Officer or his designee declares the disaster at an end.

J. Medications

Physicians shall participate in the process to accurately and completely reconcile medications across the continuum of care, including at the time of admission (home medications), transfer to another level of care (transfer medications), transfer to another facility (transfer medications), discharge (discharge medications), or prior to any outpatient procedure with which medication administration might be expected. The Attending Physician is responsible for medication reconciliation of the patient's medications, but the Attending Physician may request, by physician's order, that consultants reconcile medications for medical conditions for which the consultant has been responsible, while the patient is in the hospital. If so desired, the physician may consult other physicians to assist with medication reconciliation.

All medication orders for pediatric patients weighing 50kg or less, prescribers are required to include the calculated dose and the dosing determination, such as the dose per weight (e.g., milligrams per kilogram) or body surface areas, to facilitate an independent double-check of the calculation by a pharmacist, nurse or both. This requirement is in effect for all pediatric patients in this weight class, regardless of the unit to which they have been admitted.

Exceptions to this are medications that do not lend themselves to weight-based dosing, such as topicals, ophthalmics, and vitamins.

Medication orders must be specific as to the medication, dosage, route, and frequency of administration. "PRN" (as needed) orders must specify the circumstances under which the medication is to be administered. Orders for medications that are not specific, legible or otherwise clear will be considered incomplete orders and will not be processed until clarified with the ordering physician.

1. Unless otherwise ordered by a physician, all oral medications will be discontinued when the patient is placed NPO prior to surgery.
2. NPO for radiological/diagnostic procedures will result in discontinuation of the patient's oral medications from midnight or the time indicated in the physician's order prior to the procedure until the patient returns to the unit. Radiological/diagnostic procedures include myelograms, proctoscopes, sigmoidoscopy, gall bladder, and barium enemas.
3. Metformin will be discontinued for 48 hours following IV contrast injections.
4. Prophylactic antibiotics will automatically be discontinued within 24 hours postoperative of wound closure and 48 hours for cardiac procedures unless there is documentation of an infection.
5. Insertion of a NG tube will automatically result in the discontinuation of all oral medication, unless they are specifically ordered per the NG tube. Removal of the NG tube will require orders for the medications to be given orally.
6. Medications must be reordered on the first post-operative orders. Orders written in the recovery room or the previous medications will not be resumed unless otherwise ordered by the physician.
7. Scopes, radium implants, and biopsies involving cutting are considered surgical procedures, and an order to resume medications after completion of the procedures must be given.
8. The attending physician shall be notified 48 hours prior to discontinuing such medication via computer-generated notification.
9. Should a medication order expire prior to the attending physician signing the renewal discontinue order; the unit will call the physician for discontinuation or renewal of orders.
10. The physician may specify that chronic medications be continued for any specified time period, including up to the time of dismissal, by writing orders stating the same. Rules with respect to discontinuation of medications prior to surgical procedures and resumption of medications following the procedure will remain in effect. Additionally, all orders must be reviewed and renewed at various points throughout the continuum of care, as per Integrated Manual Policy III-E.25 Medication Reconciliation Across the Continuum of Care.

K. All surgical procedures requiring general or spinal anesthesia will be performed in the surgical suites, delivery suites, special procedure rooms, or other designated areas.

L. All patients entering the Emergency Department will receive a medical screening examination per the requirements of Regulation 482.55 of the Medical Treatment Act (Section 1867, 1395dd). Personnel designated as qualified to perform this medical screening examination are physicians, physician assistants, and/or registered nurses.

M. All patients seen in the Emergency Department by an Emergency Department Physician must be discharged by an Emergency Department Physician, unless either of the following occurs: (1) care of the patient is transferred to another Attending Physician or (2) consultation is requested, and the patient is seen by, a physician credentialed to provide care.

The Independent Allied Healthcare Professional (NP/PA) may evaluate and discharge patients from the emergency department when their physician sponsor is on-call only after communicating directly with their physician sponsor and the physician sponsor has spoken directly with the emergency room physician.

N. The Medical Staff will support and participate in the patient safety plan of NWTHS. The

Medical Staff will participate in determining and implementing patient safety goals.

SECTION 4: Special Professional Services

A. Physicians who are members of the Northwest Texas Healthcare System (NWTHS) Medical Staff may agree to contract with NWTHS to serve on a panel of physicians whose responsibility will be to render formal professional interpretations for special studies and to receive reimbursement from NWTHS for such formal interpretations.

B. Special studies include, but are not limited to, electrocardiograms (EKG's), echocardiograms, cardiac stress tests, Holter monitor interpretations, electroencephalograms (EEG's), electromyograms (EMG's), sleep studies, and pulmonary function tests.

C. All physicians must meet the credentialing requirements necessary for privileges to interpret the special study in question.

E. Physicians, who by virtue of their training and experience are credentialed to interpret such studies, may do so for their own patients and for patients for whom they have been consulted; however, unless they are contracted with NWTHS to formally render interpretations of such special studies for reimbursement, they may not submit a charge to NWTHS for the interpretation of the special studies. In order to be reimbursed they must bill directly for their services.

SECTION 5: Clinical Medical Directors

A. Clinical Medical Directors are contracted by agreement with hospital Administration with approval of the Medical Executive Committee. Specific qualifications and duties required of the Clinical Medical Director are outlined in the appropriate Department Rules and Regulations.

SECTION 6: Death Pronouncements

A. Death pronunciation is the responsibility of the attending physician and must be performed within a reasonable time.

The attending physician may request that a nurse house supervisor perform the death pronouncement in accordance with hospital policy.

B. The attending physician shall request permission for autopsy in indicated cases, or may delegate the responsibility to the Nursing Service, with the understanding that the nurse has the option of refusal. Permission for autopsies should be sought in all cases of unusual death and in cases of medical/legal or educational interest. The attending physician shall directly communicate the request for an autopsy to the pathologist(s). (See also criteria for performance of autopsies.)

C. At the request of the attending physician, the Chief Executive Officer or his designee may contact the coroner concerning deaths, which are within the province of the coroner's authority.

SECTION 7: Military Service and Staff Status

A. Members of the Staff called into active duty in the military service must request, in writing, a leave of absence from the Staff during the period of duty. Returning physicians must be assigned by the Board of Governors to the same category of the Staff held at the time of approval of the leave of absence.

B. Members of the Staff while on military reserve duty is excused from all Hospital functions.

SECTION 8: Judicial Procedures and Staff Status

A. Members of the Staff are excused from Staff functions when summoned for jury duty.

SECTION 9: Prisoners

A. Patients who are prisoners or for whom warrants have been issued may be released, only upon approval of the administration, following medical discharge by a physician, and it will be the duty of administration to contact the legal authorities.

SECTION 10: Medical School

A. Graduate Medical Education

1. All patients cared for by the House Staff (residents) are the direct responsibility of the attending physician, who shall be a physician member of the Medical Staff.
2. The level of responsibility of each House Staff member is defined by the individual department job description and or guidelines submitted to the Hospital by the individual Departments of Texas Tech University HSC School of Medicine (Pediatrics, OB/Gyn, Internal Medicine, and Family Medicine). The job descriptions and or guidelines will be available on the intranet.
3. The Chief Medical Officer will serve on the Medical School Graduate Medical Education Committee (GMEC) to facilitate communication between the Medical School and Northwest Texas Healthcare System. The Chief Medical Officer will relate to the Medical Executive Committee issues raised at the meeting of the GMEC concerning the House Staff and medical education.
4. The Regional Dean of the Medical School is a member of the Medical Executive Committee and he is an ex-officio member of the NWTHS Board of Governors with a vote.

B**. Medical Students**

As the primary teaching hospital for Texas Tech University Health Sciences Center, Regional Academic Health Center at Amarillo, Northwest Texas Healthcare System will be a common site for a variety of the School of Medicine educational activities. In order to provide a setting for the optimal care of patients, and simultaneously allow for appropriate student learning experiences, the following guidelines apply to all medical students of TTUHSC, and any other institution with whom there is an agreement to participate in medical education, while at Northwest Texas Healthcare System facilities:

1. Students shall only see patients after the appropriate permission of the

attending physician or a delegated member of the house staff is obtained.

2. Students should have access to specific patient charts, x-rays and lab results as assigned by the attending physicians. Patient charts may not be removed from the floor, and it is the student's responsibility to return charts to the chart rack. X-rays may not be taken from the Diagnostic Imaging Department unless the appropriate sign out procedure is followed and may not be removed from hospital premises. It is the student's responsibility to return those x-rays checked out by the student to the Diagnostic Imaging Department.

3. When students are in the hospital, they must be in proper dress and identifiable as students. This means the students must wear the appropriate white coats with name tags issued by the School of Medicine, which clearly delineate the student's year of medical study.

4. Junior and Senior students may perform diagnostic and therapeutic procedures with the permission and direct supervision of attending physicians or delegated members of the house staff as a part of their regular teaching program. These procedures are to be in compliance with the Bylaws, Rules and Regulations of the respective clinical department in which the student is working, and the student is responsible for being knowledgeable about said Bylaws, Rules and Regulations.

5. Orders written by medical students will not be honored by the nursing unit or ancillary personnel unless counter-signed by the appropriate resident or attending physician.

6. Medical students who encounter problems while working at Northwest Texas Healthcare System should address their issues with their academic program director.

SECTION 11: Medical Staff Member Rights

A. In accordance with Article VIII B.1 of the Medical Staff Bylaws, each member of the Medical Staff has the right to an audience with the Executive Committee. In the event a Medical Staff member is unable to resolve a difficulty working with his/her respective department chief, that member may, upon presentation of a written notice to the President of Staff, meet with the Executive Committee to discuss the issue.

B. In accordance with Article VIII A.6 of the Medical Staff Bylaws, any Medical Staff member has the right to initiate a recall election of a Medical Staff officer. A petition for such recall must be signed by at least one third of the members of the Active Staff. Upon presentation of such valid petition, the Executive Committee will schedule a special General Staff meeting for purposes of discussing the issue and (if appropriate) entertain a no-confidence vote. In the event the officer is a Chief or Vice Chief of a department, the petition for recall must be signed by at least one-third of the Active Staff members in that department. The signed petition shall be presented to the President of the Medical Staff, who shall promptly initiate scheduling of a special meeting of the department to address the issue.

C. In accordance with Article IX A.2 of the Medical Staff Bylaws, any member may initiate the scheduling of a General Staff meeting. Upon presentation of a petition signed by

10% of the members of the Active Staff, the Executive Committee will schedule a General Staff meeting for the specific purpose addressed by the petitioners. No business other than that in the petition may be transacted.

D. Any Medical Staff member may raise a challenge to any rule or policy established by the Executive Committee. In the event that a rule, regulation or policy is felt to be inappropriate, any member may submit a petition signed by 10% of the members of the Active Staff. When the Executive Committee has received such petition, it will either: (1) provide the petitioners with information clarifying the intent of such rule, regulation, or policy and/or (2) schedule a meeting with the petitioners to discuss the issue.

E. Any section/subspecialty group may request a department meeting when a majority of the members/sub specialists believe that the department has not acted appropriately.

F. This section is common to Section A through E above. This section does not pertain to issues involving disciplinary action, denial of request for appointment or clinical privileges, or any matter relating to individual "credentialing" actions. Section G and the Fair Hearing Plan provide recourse in these matters.

G. Any member has a right to a hearing/appeal in the event any of the following actions are taken or recommended:

1. Denial of initial staff appointment
2. Denial of reappointment
3. Revocation of staff appointment
4. Denial or restriction of requested clinical privileges
5. Reduction of clinical privileges
6. Revocation of clinical privileges and
7. Suspension of staff appointment or clinical privileges if such suspension is for more than 30 days.