RULES AND REGULATIONS

of the

MEDICAL STAFF

St. Luke's Hospital
Quakertown, Pennsylvania

Adopted: March 23, 2004
Revised: June 2008
<table>
<thead>
<tr>
<th>TABLE OF CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. ADMISSION AND DISCHARGE OF PATIENTS ................................................................. 1</td>
</tr>
<tr>
<td>B. MEDICAL RECORDS ........................................................................................................... 2</td>
</tr>
<tr>
<td>C. GENERAL CONDUCT OF CARE .......................................................................................... 5</td>
</tr>
<tr>
<td>D. OTHER SERVICES AND DEPARTMENTS ............................................................................. 8</td>
</tr>
<tr>
<td>E. GENERAL PRINCIPLES OF PATIENT, PRACTITIONER AND HOSPITAL .......................... 9</td>
</tr>
<tr>
<td>F. MEDICAL STAFF DISRUPTIVE PHYSICIAN GUIDELINES ............................................. 11</td>
</tr>
<tr>
<td>G. MEDICAL EDUCATION ..................................................................................................... 13</td>
</tr>
<tr>
<td>H. COMPLAINT POLICY ......................................................................................................... 13</td>
</tr>
</tbody>
</table>
RULES AND REGULATIONS
OF THE MEDICAL STAFF OF SAINT LUKE'S HOSPITAL
OF QUAKERTOWN, PENNSYLVANIA

A. ADMISSION AND DISCHARGE OF PATIENTS

1. All patients must be admitted to the hospital by a member of the active, provisional, associate or courtesy medical staff. Admissions should have verbal or written orders within two hours of the time of admission.

2. A member of the Medical Staff will be designated in the patient's medical record as the attending. The practitioner, or his designated alternate, will be available at all times to respond to the needs that arise in the treatment of the patient. The attending may delegate in writing on the chart a specific aspect of the patient's care to another practitioner. The attending, however, maintains ultimate responsibility for the patient's care. When a patient undergoes major surgery, the surgeon performing the operation should be designated as the attending at the time of surgery and should continue in this function until the resolution of the surgical problem.

3. A provisional diagnosis or valid reason for admission must be stated at the time of admission to the hospital.

4. A patient to be evaluated on an emergency basis who does not have a physician, may request any practitioner in the applicable department to attend to/consult on him/her. If the requested physician is not on call and chooses not to accept the patient, then the on call physician for the applicable department will be assigned to the patient. (Added 8/03) Members of the active staff maybe responsible for participation in the schedule of emergency coverage, and the chief of each department shall provide to the emergency department a schedule for such assignments, subject to any applicable hospital policies. Any disputes in regard to the call schedule may be appealed directly to the Medical Executive Committee. (Added 8/02) All practitioners shall provide care for patients regardless of their ability to pay.

5. The chief admitting clerk will admit patients on the basis of the following order of priorities:

   (a) Emergency Admissions

       Within 24 hours following admission, the attending practitioner shall provide to the utilization management committee a signed, sufficiently documented admitting note explaining the need for this admission.

   (b) Routine Admissions

       This will include elective admissions involving all services.
7. No patient will be transferred out of the units without notification of the responsible practitioner.

8. The admitting physician is responsible for alerting fellow hospital caregivers as to the unstable or violent nature of his patient when appropriate so as to prevent potential harm to others as well as to prevent self induced patient injury.

9. Should a question arise as to the appropriateness of an admission or discharge from a special care unit or cardiac unit; the decision shall be made by the committee man and the attending physician. If a disagreement arises, the respective department chief will make the final decision.

10. The attending practitioner is required to document the need for continued hospitalization and plans for post hospital care.

11. Patients shall be discharged only on written/verbal order of the attending practitioner. Should a patient leave without the attending physician's discharge order or against the practitioner's advice, a notation of the incident will be made in the patient's medical record.

12. Dentists may admit or discharge their own patients. Consultation with a physician shall be required prior to surgery. The consultant shall record the medical portion of the admission history and physical examination and an evaluation of the overall medical risk. The consultant shall be responsible for the care of any medical problems that may be present, or arise, during the hospitalization and shall be responsible for the medical portion of the patient's record. The medical record of dental patients shall document a detailed description of the dental problems by the responsible dentist and pertinent instructions given to the patient and/or family at the time of discharge.

13. Podiatrists are responsible for the part of their patients’ history and physical examination that relates to podiatry. (Added 11/03)

B. MEDICAL RECORDS

1. The attending practitioner shall be responsible for the preparation of medical record and shall provide sufficient information to identify the patient, support the diagnosis, justify treatment, document the course and results accurately and facilitate the continuity of care.

2. A complete admission history and physical examination shall be performed and recorded within 24 hours of admission. If a complete history and physical examination has been performed within a 30 day time frame (added 6/06) and recorded prior to the patient's admission to the hospital, a copy of this report may be used in the patient's hospital medical record in lieu of the admission history and physical examination provided they were performed and recorded by a member of the medical staff. In such an instance, an interval admission note that includes all additions to the history and physical examination must always be recorded. If the H&P has been performed 24 hours or more prior to admission, out-patient procedure requiring general anesthesia or conscious sedation, an update note will be documented on the H&P form. The update note will state that no changes have
occurred and the reason for the procedure or surgery still exists. The update documentation may be accomplished with the pre-anesthesia assessment. The update notes will be dated, timed and signed by the attending physician (added 6/06).

In-patient H&P – chief complaint; history of present illness; past medical/surgical history; medications; allergies; family history; social history; review of systems; physical exam – vital signs, HEENT, neck, chest/lungs/heart, abdomen, extremities neurologic; impression; and plan. (Added Mar. 04)

An out-patient history and physical shall consist of a chief complaint, history of present illness, past medical history, allergies, medications, alcohol history, tobacco history, heart exam, lung exam, relevant organ exam and impression/plan. This is required for any patient receiving I.V. sedation or general anesthesia. (Added 11/04)

3. A long history and physical form is required on all in-patient admissions. (rev. 4/00) The record should be signed by the attending practitioner.

4. When the history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be cancelled, unless the attending practitioner states in writing that such delay would be detrimental to the patient.

5. The attending physician shall countersign histories, physicals and discharge summaries dictated by residents and other personnel involved in patient care. The attending physician shall countersign and date all entries in the medical record made by professional personnel designated by the Executive Committee of the Medical Staff, e.g. medical students, allied health professionals, etc.

6. Pertinent progress notes shall be recorded at the time of observation. Wherever possible each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be written at least once a day. Progress notes should be of a quality sufficient to permit continuity and transfer of care.

7. Permanent operative reports shall include the name of the licensed independent practitioner and assistants; procedure(s) performed and description of the procedure; findings; estimated blood loss, specimens removed; and postoperative diagnosis (added 6/06). A comprehensive operative/procedure progress note shall be written in the medical record immediately after surgery. The permanent operative report should be dictated within 24 hours after surgery. Failure to dictate operative reports within 24 hours will result in the report being considered delinquent. (Revised 4/99)

8. Consultants shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record.

9. The current obstetrical record shall include a complete prenatal record. A legible copy of the attending practitioner's office record transferred to the hospital before admission is acceptable. An interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.
10. All clinical entries in the patient's medical record shall be accurately dated, timed and signed.

11. Symbols and abbreviations may be used only when they have been approved by the medical staff. An official record of approved abbreviations shall be kept on file in the Medical Record Department.

12. The primary diagnosis shall be recorded by the attending physician, without the use of symbols or abbreviations, dated and signed by the responsible practitioner at the time of discharge of all patients.

13. A discharge summary shall be written or dictated on all medical records of patients hospitalized over 23 hours. For patients staying 23 hours or less, a final progress note is required to include the following: reason for hospitalization, significant findings, procedures performed and care, treatment and services provided, and condition at discharge. Written discharge instructions must be given to each patient (Rev 11/06).

14. Unauthorized removal of charts from the hospital is grounds for suspension of the practitioner for a period to be determined by the executive committee of the medical staff.

15. Free access to all medical records of all patients shall be afforded to members of the medical staff for bona fide study and research. All such projects shall be approved by the executive committee of the medical staff before records can be studied.

16. Subject to the discretion of the chief executive officer, former members of the medical staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.

17. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the medical records committee.

18. In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner or his designee and an entry shall be made in the chart within a reasonable time.

19. It shall be the responsibility of all staff members to secure autopsies whenever possible. All autopsies shall be performed by the hospital pathologist, or by a practitioner delegated this responsibility. Provisional anatomic diagnoses shall be recorded on the medical record within 24 hours and the complete protocol should be made part of the record within 3 months. Autopsy reports will be completed within the following time frames: Gross = 15 days; Microbiology = 30 days; and Toxicology = 6 months. (Added 5/98)

20. All medical records must be completed in all required details within thirty (30) days of discharge of a patient. It will be the responsibility of each member of the Medical Staff to complete their portion of the chart within this thirty (30) day period. Physicians whose charts remain incomplete after twenty (20) days will be notified that they have ten (10) days to complete the charts. Any
chart not completed within this thirty (30) day period will result in the accrual of a delinquency when the incomplete medical record is found on the 1st or 3rd Friday of a month. (The timing for OR and Cath Lab report completion, as described in item 7, supercedes the medical record timing in order to determine whether documentation is complete or not.) The offending physician(s) will be notified of their deficiencies by the Medical Records Office. Three such delinquencies and the offending physician will be presented to the Medical Executive Committee for consideration of disciplinary action which can include expulsion from the medical staff. (Revised 8/03)

Any physician with greater than 25 outstanding medical records delinquencies on the Medical Executive Committee Delinquency Report will be automatically suspended until all records are complete. An automatic suspension will result in: a) the practitioner will not be allowed to schedule procedures, perform consults, admit or assign patients to observation, or accept transfer of a case unless authorized by the Senior Vice President, Medical/Academic Affairs or designee; b) all current cases under the care of the involved practitioner who are in the hospital will not be affected by this automatic suspension. The automatic suspension will remain in effect until delinquent medical records are completed. The physician must notify Medical Records when they have completed all charts. If the physician remains on suspension for longer than two (2) weeks, another delinquency is accrued and the physician will be so informed. (Revised 8/03)

When a physician reaches his/her third suspension within a 12-month period, a letter will be sent to the physician notifying him/her of pending presentation to the Medical Executive Committee. The Medical Executive Committee will consider disciplinary action that can include expulsion from the medical staff. (Revised 8/03)

21. A medical record, authenticated by the practitioner responsible for its clinical accuracy, shall be generated for each patient who visits the Emergency Department.

C. GENERAL CONDUCT OF CARE

1. A general consent form, signed by or on behalf of every patient admitted to the hospital, should be obtained at the time of admission. The attending physician should be made aware if consent was not obtained.

2. Surgical consent should be obtained prior according to the hospital’s Informed Consent Policy (Rev. 7/07) except in those situations in which the patient's life is in jeopardy and consent cannot be obtained because of the patient's clinical condition. In emergencies involving a minor or unconscious patient in whom consent for surgery cannot be immediately obtained from parents, guardian or next of kin, the circumstances should be fully documented on the patient's medical record.

3. Every hospital patient shall be on the service of a member of the medical staff, and shall be visited at least once daily by the attending practitioner or by his designee.

4. All DNR orders will be reviewed with the patient/patient representative prior to performance of a surgical procedure or renal dialysis. A note of the content of the discussion and decision regarding the DNR order will be made by the physician in the Progress Notes. (Added 5/98)
5. All orders shall be in writing unless there is an emergency situation requiring rapid patient interventions. Verbal/telephone orders should be signed/countersigned, dated and timed by the attending/consulting physician within 24 hours.

a. Physician Assistant
   - Write admitting orders after direct communication with the supervising physician
   - May execute a written or oral order for a medical regimen or may relay a written or oral order for a medical regimen to be executed by a health care practitioner. A medical regimen is defined in regulation as a therapeutic, corrective or diagnostic measure performed or ordered by a physician, or performed or ordered by a physician assistant acting within the physician assistant’s scope of practice, and according to the written agreement between the supervising physician and the PA.
   - The supervising physician shall countersign the patient record within a reasonable time not to exceed 10 days.
   - Write prescriptions for signature
   - On orders from the supervising physician, arrange consults for social service, other providers and physicians

b. Nurse Practitioner
   - May function within their defined scope of practice denoted by specific privileging
   - Works under the direction of a physician licensed to practice medicine in the Pa Commonwealth
   - The supervising physician shall countersign the patient record within a reasonable time not to exceed 10 days

c. Imaging technologists may accept verbal orders only in their area of expertise. Pharmacists may transcribe verbal orders pertaining to medications. Respiratory therapists may transcribe oral orders pertaining to respiratory treatments. The ordering practitioner should countersign, date and time the verbal order within 24 hours. (Rev. 7/07)

6. The practitioner's orders must be legible and complete in order to be executed.

7. When patients go to surgery, all previous orders are cancelled.
8. When a patient is transferred in or out of a special care unit, all previous orders are cancelled. Transfer orders are to be written by the physician or the patient's present orders can be reviewed by the nurse and a verbal order obtained for transfer. Transfer of service should not be considered complete until there is a written or verbal telephone order from the receiving physician acknowledging patient acceptance by the receiving physician. (Added Mar. 04)

9. The consultant can write orders unless the attending physician does not want the consultant to do so. The attending physician should designate the specific problem or area that he desires the consultant to address. If it is necessary that the consultant re-evaluate the patient, this request should also be ordered by the attending physician or his designee.

10. (a) All orders for narcotics and controlled substances must be dated and signed by the practitioner on the physician's order sheet. The practitioner's D.E.A. number is on file with the chief executive officer of the hospital and the hospital pharmacy. If a change in the status of the practitioner's D.E.A. number occurs, the chief executive officer of the hospital or his designee should be notified immediately.

(b) For the Automatic Stop Order Policy refer to the Pharmacy and Therapeutics Committee Manual, Policy 2.40.

11. Any elective surgical admission to the hospital preferably should have pre-admission testing. If this is not possible, orders for laboratory testing and x-rays must be available in the Admitting Department at the time of admission.

12. Orders for repetitive laboratory studies must be accompanied by a specific order stating the number of such daily or repetitive tests desired.

13. Reports from laboratories outside the hospital are acceptable in lieu of tests performed in the hospital if the work is done in an accredited laboratory and if the test is recent enough to be pertinent to the individual case. All laboratory reports, including outside lab reports, are made part of the medical record.

14. Except in life threatening emergencies, the preoperative diagnosis and required laboratory tests must be recorded on the patient's medical record prior to any surgical procedure. If not recorded, the operation shall be cancelled. In any emergency the practitioner shall make at least a comprehensive progress note regarding the patient's condition prior to induction of anesthesia and start of the surgery.

15. The anesthesiologist or anesthetist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic assessment and (added 6/06) follow-up of the patient's condition.

16. All tissues removed at the operation, other than those exempted, shall be sent to the hospital pathologist who shall make such examination as he may consider necessary to arrive at a tissue
diagnosis. His authenticated report shall be made a part of the patient's medical record. The list of exempted tissues will be kept in the Department of Medical Affairs.

17. All infections of clean surgical cases shall be reported to the infection control committee.

18. Refer to Administrative Policy on Conflict of Conscience (Rev. 6/06).

A. Any practitioner or employee of the Hospital may refuse to participate, free from discrimination, in the performing of a tubal ligation on grounds of religious views, morals, etc.

19. Refer to Obstetric Department Abortion Policy (Rev. 6/06).

20. Specific regulations have been adopted in connection with the operation of specific care units such as recovery room, intensive care unit, etc. Practitioners managing patients in these areas shall familiarize themselves with these regulations and conform to them.

21. In all cases, where a female patient is admitted, supposed and believed to be pregnant and the attending staff practitioner's examination indicates that a criminal miscarriage was intended to be or was procured, such patient or her representative if she is incapacitated, shall certify to the hospital in writing if the facts so warrant, that no employee of the hospital or attending practitioner was directly or indirectly responsible for the criminal miscarriage.

22. Surgery and cancer therapy treatment of patients at St. Luke's Hospital shall not be started prior to the review of the pertinent pathology slides read elsewhere, except when the life and/or safety of the patient would be imperiled by a delay in such slide review.


24. Any member of the Medical Staff who has reason to suspect drug diversion (theft for purposes of self-administration, selling or other use) from the hospital by an employee or member of the Medical Staff is required to report such information immediately to his or her chief of service.

The chief of service will then notify Physician Health Committee, the Vice President of Medical Affairs and the Assistant Vice President, Department of Pharmacy Services, who will assist in follow-up of the incident including advising as to the appropriate agencies and/or departments to be notified.

D. OTHER SERVICES AND DEPARTMENTS

1. Medical staff shall be responsible for the proper professional instruction of interns and residents and shall participate in the instruction of nurses and para-medical personnel.
2. Surgeons shall be in the operating room and ready to commence operation at the time scheduled.

3. Duties or responsibilities of a chief of service shall be performed or exercised in his absence by his designated agent unless otherwise specified.

4. Medical staff dues shall be as determined from time to time by the medical staff. Dues shall be paid by active, provisional and associate staff members of the staff. Notice of dues shall be mailed to all members by August 1. Delinquent members shall be notified again on October 1 and December 1. Failure to pay dues by January 1 shall be interpreted as resignation from the staff. Reinstatement of members shall be made on application, the procedure being the same as in the case of original appointment.

5. Disaster Assignments:

(a) All practitioners who are members of the active, provisional, associate or courtesy medical staffs shall respond to a call to participate in the care of patients whenever the disaster plan is put into operation. Each practitioner shall perform such duties as are assigned to him by the chairman of the disaster committee or his designate. All practitioners specifically agree to relinquish direction of the professional care of their patients, service or private, to members of the medical staff appointed by the director of the emergency operation and to permit transfer or discharge of their patients in preparation for admission of disaster casualties.

(b) Policies concerning patient care will be a joint responsibility of the chairman of the disaster committee and the chief executive officer of the hospital.

E. GENERAL PRINCIPLES OF PATIENT, PRACTITIONER AND HOSPITAL RELATIONSHIPS

1. St. Luke's Hospital, it’s Medical Staff, and its Employees will give considerate and respectful care to all patients without discrimination as to race, color, sex, sexual preference, religion, national origin, or ability of payment.

2. The patient has the right to obtain from his/her physician complete current information concerning his/her diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his/her behalf. He/she has the right to know, by name, the physician responsible for coordinating his/her care, the names of all other physicians directly participating in his/her care, and the names and functions of the health care persons having direct contact with the patient.

3. The patient has the right to receive from his/her physician information necessary to give informed consent according to the hospital’s Informed Consent Policy (Rev. 7/07). Except in emergencies, such
information for informed consent should include but not necessarily be limited to the specific
procedure and/or treatment, the medically significant risks involved, and the probable duration of
incapacitation. Where medically significant alternatives for care or treatment exist, or when the
patient requests information concerning medical alternatives or possible complications, the patient
has the right to information. The patient also has the right to know the name of the person
responsible for the procedures and/or treatment.

4. The patient may refuse any drugs, treatment, or procedure to the extent permitted by law and will
be informed by his/her physician of the medical consequences of his/her action. The patient shall
be responsible for his/her actions if he/she refuses treatment or does not follow his/her physician's
instructions. The patient is responsible for following hospital rules and regulations affecting patient
care and conduct.

5. The patient has by law a right to privacy. This means that his/her medical care program including
case discussion, consultation, examination and treatment are confidential and should not be
divulged to those not directly involved in his/her care or those involved in the monitoring of its
quality without the patient's permission. This also means that he/she may refuse to talk with or see
anyone not officially connected with the hospital or persons officially connected with the hospital
but who are not officially connected with his/her care.

6. All communications and records pertaining to a patient's care should be treated as confidential
except as otherwise provided by law or third-party contractual arrangements.

7. The hospital and its employees will endeavor to make responsible response, within their capacity,
to patient's reasonable request for service. The patient's physician will provide evaluation service,
and/or referral as indicated by the urgency of each case. When medically permissible, a patient
may be transferred to another facility only after he/she or his/her next of kin or other legal
representative has received complete information and explanation concerning the need for and the
alternatives to such transfer. No transfer shall be made unless the facility to which the patient is to
be transferred has notified the physician and the hospital that it will accept the patient for transfer.

8. The hospital will not engage in or perform clinical investigation affecting a patient's care or
treatment without his/her consent or in event the patient is unable to give informed consent a
legally responsible representative. The patient or legally responsible person may at any time refuse
to continue in any such program to which he/she has previously given informed consent.

9. The patient shall have access, upon request, to all information contained in his/her medical records,
unless access is specifically restricted by the attending physician for medical reasons or is
prohibited by law.

10. The patient who does not speak English should have access to the Language Line or an interpreter
with the consent of the patient (rev. 11/06).

11. The patient has the right to obtain consultation with another physician at his/her request.
12. Patient Accounts and Case Management (Rev. 6/06) will provide the patient with full information and counseling on the availability of known financial resources for his/her health care.

13. The patient will be informed upon discharge, by his/her physician, of his/her continuing health care requirements following discharge and the means for meeting them.

14. Patients are entitled to prompt, courteous service. Any patient not receiving such service is asked to report the facts to the Hospital Administration. It will appreciate having such information as well as suggestions for improvement of service.

15. The hospital has adopted procedures to ensure effective and fair investigation of violations of patients' rights and to ensure their enforcement. These procedures include:
   a. Formal written complaints shall be addressed to the President, St. Luke's Quakertown Hospital, 1021 Park Avenue Quakertown, PA 18951.
   b. Formal written complaints are recorded and investigated.
   c. Complaint records and case dispositions are kept for two years and made available to the Pennsylvania Department of Health on request.
   d. Investigation and resolution, when possible, for formal complaints shall be timely; and
   e. Disciplinary and remedial education procedures will be initiated for members of the hospital and medical staff who consistently cause patient relationship problems.
   f. A response, in writing, will be sent to the individual making the complaint.

F. MEDICAL STAFF DISRUPTIVE PHYSICIAN GUIDELINES

Definition: Disruptive conduct by a physician is behavior which adversely impacts on the quality of patient care and includes: verbal and/or physical abuse of colleagues, hospital personnel or patients, sexual harassment, and threatening or intimidating behavior exhibited during interactions with colleagues or hospital personnel, or patients.

Process:
1. All complaints against members of the medical staff must be handled by the medical staff.
2. Any medical staff member, employee or agent of the hospital, or patient may file a complaint against a physician regarding disruptive conduct.
3. Complaints will be submitted to the medical staff president or department chair wherein the
physician holds privileges who will notify the vice president, medical/academic affairs, or equivalent. If complaints are submitted directly to the CEO, he/she will notify the medical staff president or Vice President Medical Affairs.

4. Complaints must be in writing and must include documentation of the disruptive conduct, which will include:

   a. the date and time of the behavior in question;

   b. the circumstances which precipitated the situation;

   c. whether the behavior involved a patient and, if so, the patient's name;

   d. a description of the behavior limited to factual, objective and observed acts as much as possible;

   e. the consequences, if any, of the disruptive behavior as it relates to patient care and/or hospital operations; and

   f. a record of any action taken to remedy the situation including date, time, place, action, and name(s) of those intervening.

   g. corroboration by another individual if possible.

5. The medical staff president, in collaboration with the chair of the department wherein the physician holds privileges, will conduct an investigation which will include, but not be limited to, an interview with the involved physician.

6. Single minor incidents of disruptive conduct, warranting a discussion with the involved physician, will be handled by the medical staff president. A single copy of the incident and decision documentation will be kept and placed in the physician's confidential credentials file. The physician should have an opportunity to present a written response to the charges placed in that physician's file. The physician should be entitled to review his file periodically until documentation is removed. If no further incidents are reported within two years, the documentation will be removed from the physician's file and destroyed.

7. If there appears to be a pattern of disruptive behavior or if the behavior in question suggests impairment (medical, psychological, or substance abuse problem), the medical staff president will contact the Medical Staff Health Committee. The Medical Staff Health Committee may arrange for the physician to be evaluated by a professional with appropriate expertise to determine whether the physician is impaired.*

8. If the physician refuses to be evaluated and the Medical Staff Health Committee has reason to believe there is significant evidence of impairment, the Medical Staff Health Committee should report its findings to the Medical Executive Committee. The Medical Executive Committee will
then determine the need to report to the State Board of Medicine or the State Board of Osteopathic Medicine.

9. If the involved physician is determined not to be impaired, the president of the medical staff will meet with the physician to discuss the inappropriate behavior, emphasizing that if the behavior continues, more formal action will be taken (i.e., initiation of the disciplinary process as delineated in the Medical Staff By-Laws). This meeting will be documented and a follow-up letter to the physician, which will be part of the physician's permanent record, will emphasize that the physician is expected to behave professionally and cooperatively. One copy only of the letter to the physician will be kept and placed in the physician's confidential credentials file.

10. Additional incidents within two years will result in initiation of a corrective action proceeding pursuant to the Medical Staff By-Laws. When patient safety is in jeopardy, summary suspension procedures, as outlined in the Medical Staff By-Laws, may be indicated pending this process.

* The Physician's Health Programs of the Educational and Scientific Trust of the Pennsylvania Medical Society is a resource available to hospitals and physicians regarding impairment. Informal, confidential consultative services may be obtained without necessitating a formal referral. The address and phone numbers are as follows:

Physicians' Health Programs  
777 East Park Drive, P.O. Box 8820  
Harrisburg, PA 17105-8820  
Direct Line: (717) 558-7750  
Message Line: (717) 558-7817  
Toll Free Line: 1-800-228-7823

G. MEDICAL EDUCATION

1. As required by their department, all new members added to the staff shall either have obtained board certification or be encouraged to pursue board certification.

2. The practitioner will explain to his patient any professional relationship he has with any other practitioner involved in their care.

3. The Hospital shall sponsor a program of continuing education for all staff members designed to keep them informed of pertinent new developments in the diagnostic and therapeutic aspects of patient care and to refresh them in various aspects of their basic medical education. The programs sponsored by the various clinical departments, shall be relevant to the patient care provided in the Hospital, and shall be related to quality assessment activities.

H. COMPLAINT POLICY (Added 10/01)
1. Physician complaints are to be evaluated by the Chief of the Department involved or the Senior Vice President of Medical and Academic Affairs. Complaints arising outside of the hospital not involving hospital referral or care should be referred to the individual physician involved.

2. Complaints involving the hospital should be evaluated for quality of care issues as well as physician disruptive behavior issues. If the complaint falls within the scope of these parameters, it should be referred to the appropriate management as outlined in the Rules and Regulations and By-Laws. For complaints arising outside of these parameters, the complaint should be passed onto the physician involved and discussion with the physician and the Chief of the Department or President of the Medical Staff is strongly advised but not required. Such complaints arising within the hospital may be evaluated and taken into consideration during the process of recredentialing.

Approved: St. Luke's Quakertown Hospital Medical Staff – September 13, 2008
Approved: St. Luke's Quakertown Hospital Board of Trustees – September 25, 2008