Article I – Definitions

1.1 **Board of Directors:** “Board means the Board of Directors which, as established by State Law, is the governing authority of the West Virginia University Hospitals, Inc., and its Medical and Dental Staff.

1.2 **Quality and Patient Safety Committee:** “Quality and Patient Safety” means the committee of the Board that is responsible for the discussion of matters of medical and practice pertaining to efficient and effective patient care. It is the committee delegated authority by the governing body to render initial appointment, reappointment, and renewal or modification of clinical privileges.

1.3 **Dentist:** “Dentist” means a person with the academic degree of DDS and/or DMD and licensed to practice Dentistry in accordance with the laws of the State of West Virginia and the rules and regulations promulgated by the Board of Dentistry.

1.4 **Hospital:** “Hospital” shall mean any Hospital or entity subject to the authority of the Board of Directors of the West Virginia University Hospitals, Inc. (hereinafter “WVUH”).

1.5 **President:** “President” means the duly appointed President of West Virginia University Hospitals, Inc. or his/her designee.

1.6 **Credentialing Policy:** “Credentialing Policy” means the procedures as approved by the Board relating to appointment and reappointment to the Medical Staff, granting clinical privileges, and hearing and appeals. WVUH does not delegate credentialing activities.

1.7 **Executive Committee:** “Executive Committee” means the Medical Executive Committee of the Medical Staff who has been delegated the primary authority over activities related to the functions of self-governance of the Medical Staff and over activities related to the functions of performance improvement of the professional services provided by individuals with clinical privileges including the credentialing of Medical Staff and Allied Health Professionals.
1.8 **Medical Staff:** “Medical Staff” means the physicians, dentists, and podiatrists who meet the standards and requirements set forth in these Bylaws and who have been appointed by the Board to WVUH’s Medical Staff. The Medical Staff is an operational extension of the Board.

1.9 **Physician:** “Physician” means a person with the academic degree of MD and/or DO and is licensed to practice medicine in accordance with the laws of the State of West Virginia and the rules and regulations promulgated by the Board of Medicine.

1.10 **Podiatrist:** “Podiatrist” means a person with the academic degree of DPM and licensed to practice podiatric medicine in accordance with the laws of the State of West Virginia and the rules and regulations promulgated by the Board of Medicine.

1.11 **School of Medicine:** “School of Medicine” means West Virginia University School of Medicine.

1.12 **Allied Health Professional:** “Allied Health Professional” means a person, other than a licensed physician or dentist, whose professional activities in the Hospital require that his authority to care for patients in the Hospital be processed through Medical Staff channels, and who is qualified to render patient care either under the supervision of a physician or dentist on the Medical Staff or independently.

1.13 **Privileges:** “Privileges” or “Clinical Privileges” means that permission granted by the Board to a physician, dentist, or allied health professional to render specified health care services in the Hospital.

1.14 **Secretary:** That person responsible for documenting the attendance, activities, discussions and decisions which take place at the meeting of any committee set forth in these Bylaws and communicating such information to other committees.

1.15 **Organizational Manual:** “Organizational Manual” means that portion of these Bylaws as approved by the Board addressing the organizational structure and hierarchy for governance of the Medical Staff.

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ARTICLE II – Categories of the Medical Staff

2.1 **Consistency with WVUH Mission:** The Board shall make an appointment to the Medical Staff only where such appointment is consistent with the mission, purposes, and the current and long-range strategic plans of WVUH and the applicant satisfies all of the relevant qualifications and conditions set forth in the Credentialing Policy.
2.2 **Active Staff:**

2.2.1 **Nature of Active Staff Category:** The Active Staff category is the corps of physician, dentists and podiatrists on the Medical Staff who are benefits eligible faculty members of WVU at the Morgantown campus. Active Staff are eligible to vote and hold office. Eligibility for appointment to the Active Staff shall be determined in accordance with the policies and procedures set forth in the Credentialing Policy.

2.2.2 **Rights and Responsibilities of Active Staff Appointees:** Each Active Staff appointee shall:
   a. Admit and attend patients;
   b. Attend staff and Department meetings;
   c. Assume all Medical Staff functions and responsibilities as may be assigned including, where appropriate, care for unassigned patients, emergency service care, consultation and teaching assignments;
   d. Participate in the fulfillment of WVUH’s commitment to medical education and research;
   e. Actively participate in quality improvement and peer review activities;
   f. Serve on Committees and accept responsibilities as assigned; attend meetings as provided for in these Bylaws and have the right to vote and hold office on the Medical Staff.
   g. Comply with these Medical Staff Bylaws, the Rules and Regulations of the Medical Staff and conditions set forth in the Credentialing Policy.

2.2.3 **Failure to Comply with Responsibilities:** Failure to comply with any of the above requirements shall in and of itself be grounds for reduction and/or revocation of clinical privileges or for recommendation of termination of appointment to the Medical Staff.

2.3 **Consulting Staff:** (Considered Courtesy and Adjunct Faculty Appointments in the SoM):

2.3.1 **Nature of Consulting Staff Category:** The Consulting Staff category is a corps of physicians and dentists on the Medical Staff who are faculty members of WVU and may see and attend patients at WVUH. Consulting staff is not eligible to vote or to hold office. Eligibility for appointment to the Consulting Staff shall be determined in accordance with the policies and procedures set forth in the Credentialing Policy.

2.3.2 **Rights and Responsibilities of Consulting Staff Appointees:** Each Consulting Staff appointee:
   a. May admit and attend patients;
   b. May attend staff or Department meetings;
   c. Assume Medical Staff functions and responsibilities as may be assigned including, where appropriate, care for unassigned patients, emergency service care, consultation and teaching assignments;
   d. May participate in the fulfillment of WVUH’s commitment to medical education and research;
   e. May serve on Committees and accept responsibilities as assigned; and
   f. Shall comply with these Medical Staff Bylaws, the Rules and Regulations of the Medical Staff and conditions set forth in the Credentialing Policy.

2.3.3 **Failure to Comply with Responsibilities:** Failure to comply with any of the above requirements shall in and of itself be grounds for reduction and/or revocation of
2.4 **Locum Tenens**

2.4.1 **Nature of Locum Tenens Category:** The Locum Tenens Staff category is a corps of physicians on the Medical Staff who are faculty members of WVU or have an executed contractual arrangement with WVU and may see and attend to patients at WVUH. Locum Tenens Staff can also be individuals who are recognized as an allied health member of the Allied Health Staff and identified as such in the Medical Staff Bylaws. Locum Tenens staff is not eligible to vote or to hold office. Eligibility for appointment to the Locum Tenens Staff shall be determined in accordance with the policies and procedures set forth in the Credentialing Policy.

2.4.2 **Rights and Responsibilities of Locum Tenens Staff Appointees:** Each Locum Tenens Staff appointee shall:
   a. Admit and attend patients;
   b. Attend staff or Department meetings;
   c. Assume Medical Staff functions and responsibilities as may be assigned including, where appropriate, care for unassigned patients, emergency service care, consultation and teaching assignments;
   d. Participate in the fulfillment of WVUH’s commitment to medical education and research;
   e. Serve on committees and accept responsibilities as assigned; and
   f. Comply with these Medical Staff Bylaws, the Rules and Regulations of the Medical Staff and conditions set forth in the Credentialing Policy.

2.4.3 **Failure to Comply with Responsibilities:** Failure to comply with any of the above requirements shall in and of itself be grounds for reduction and/or revocation of clinical privileges or for recommendation of termination of appointment to the Medical or Allied Health Staff.

2.5 **Physician Emeritus**

2.5.1 **Nature of Physician Emeritus:** Retired or Emeritus applicants who have a faculty appointment with the School of Medicine may be granted appointment to the Medical Staff with no clinical privileges and shall not admit or attend to patients at WVUH. The appointee shall not be permitted to independently engage in the practice of medicine, dentistry, podiatry or relevant allied health professional field at WVUH. The appointee may be permitted by a peer physician, dentist, podiatrist or allied health professional with privileges at WVUH to speak with or interview patients, be present for physical examinations, or be present in the operating room during a procedure. The primary purpose of such activity should be in pursuit of research or scholarship efforts. The appointee shall not write, dictate or otherwise cause entry to be made in the medical record.

2.5.2 **Rights and Responsibilities of Physician Emeritus Appointees:** Each Physician Emeritus appointee shall:
   a. Have the right to attend staff and Department meetings and grand rounds;
   b. Provide lectures to students, residents and fellows;
   c. Abide by the policies of WVUH and the Medical Staff;
   d. Accept committee assignments and other reasonable duties assigned by the Board and Medical Staff;
   e. Shall not be required to maintain an active license in his/her respective field; and
f. Keep WVUH informed of new developments relevant to appointment and application.

2.5.3 Retired or Emeritus applicants will be exempt from the Focused and Ongoing Professional Practice Evaluations (FPPE and OPPE). A quality file will otherwise be maintained.

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ARTICLE III – Common Responsibilities of Appointees to the Medical Staff

3.1 Ethical Conduct: Each person who provides care to patients in the Hospital shall be governed by and shall conduct him or herself in accordance with the generally accepted ethical standards applicable to his/her profession.

3.2 Quality of Care: Each person who provides care to patients in the Hospital shall provide his/her patients with care at the appropriate level of quality and efficiency.

3.3 Medical Records: Each person who provides care to patients in the Hospital shall prepare and complete in an accurate and timely manner such medical and other records as may be required by the Hospital for such patients.

3.4 Maintain Licensure: Each person to whom these Bylaws apply shall continuously maintain his/her license to practice his/her profession in good standing in West Virginia. Those providers whose primary practice location is outside of the State of West Virginia must maintain his/her current licensure of that jurisdiction. Additionally, he/she must obtain licensure in West Virginia within six (6) months of his/her initial appointment. Failure to obtain West Virginia licensure within the allotted time frame shall result in an automatic review by the Committee, which could result in the termination of his/her privileges.

3.5 Responsibility to Notify: Each person to whom these Bylaws apply shall promptly notify the President or his/her designee of (a) the investigation, reprimand revocation, suspension, restriction or other limitation of his/her professional license by any State licensing body; (b) his/her loss of staff appointment or clinical privileges, voluntarily or involuntarily, at any hospital or other health care institution; (c) the commencement of a formal investigation or the filing of charges by the Department of Health and Human Service, or any law enforcement agency or health regulatory agency of the United States or the State of West Virginia; (d) the filing of a suit against the appointee alleging professional liability on his/her part; or (e) the loss or impending loss of his/her professional liability insurance.

3.6 Clinical Privileges: Each person who provides care to patients in the Hospital shall limit his/her professional practice in the Hospital to the particular clinical privileges granted to him/her by the Board.

3.7 Insurance: Each person to whom these Bylaws apply shall continuously maintain no less than $1,500,000 in insurance per occurrence or more as the Board may require.
3.8 **Faculty Appointment:** Appointee of the Medical Staff shall maintain faculty status at the West Virginia University School of Medicine or Dentistry.

3.9 **Board Certification:** Appointees to the Medical Staff shall maintain certification in their specialty or subspecialty whichever is related to their clinical practice, prior to the expiration of a time-limited board and in accordance with the policies of the respective board and Credentialing Policy 2.1.2.

Clinical Department Chairs are appointed in accordance with the policies and guidelines of West Virginia University and the Bylaws of the West Virginia University School of Medicine (WVUSOM). Board certification must be maintained as a condition of continued appointment in the position of Chair.

3.10 **Teaching:** Each person to whom these Bylaws apply shall actively engage in clinical teaching of residents and students.

3.11 **Failure to Comply:** Failure to comply with any of the above responsibilities may in and of itself be grounds for reduction and/or revocation of clinical privileges or recommendation for termination.

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### WEST VIRGINIA UNIVERSITY HOSPITALS

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ARTICLE IV – Supervised Patient Care Providers

4.1 **Supervised Patient Care Providers:** Generally, the Medical Staff shall be empowered to regulate the practice of the following categories of supervised patient care providers whose practice shall be governed by these Bylaws and Rules and Regulations and who, in practicing at the Hospital, shall agree to so abide. Supervised patient care providers shall be entitled to the procedural or other fair hearing rights specified in these Bylaws for Medical Staff appointees or applicants.

4.1.1 **Residents:** Residents are permitted to practice under the auspices of their training programs by the State of West Virginia and, as trainees, will render patient care under the direction and supervision of their respective Program Directors and Medical Staff members. In matters of professional competence, ethics and scope of practice they will be responsible to their respective Program Director and Clinical members.

4.1.2 **Allied Health Professionals**

4.1.2.1 **Independent Allied Health Professionals:** Independent Allied Health Professional status shall include:
- Geneticists
- Clinical Pharmacists
- Clinical Social Workers
- Certified Nurse Midwives
- Optometrists
- Psychologists
- Radiation Physicists
• Advanced Practice Registered Nurses
• Physician Assistants
• Audiologist
• Speech-Language Pathologist
• Clinical Educators
• Physical Therapist
• Occupational Therapist
• Clinical Dietitian

or members of other classes of healthcare professionals (1) who have faculty appointments in a School within the Health Sciences Center (Medicine/Dentistry/Nursing/Pharmacy) or are employed by or have a professional services agreement with University Health Associates of WVUH; (2) who have been licensed or certified by their respective licensing or certifying agencies, and (3) who desire to independently provide professional services in the Hospital. The Medical Executive Committee and the Department(s) of the Medical Staff to which he/she has been or may be assigned shall evaluate each individual. The appropriate Department(s) shall report to the Medical Executive Committee which shall recommend, through the President to the Board, the clinical privileges, if any, which the applicant shall be permitted to exercise in the Hospital.

a) Discretion of the Board – Appointment as an Independent Allied Health Professional is at the discretion of the Board. The appointment of any independent Allied Health Professional may be terminated at will by the Board subject only to the due process provisions of these Bylaws.

b) Rights and Responsibilities of Independent Allied Health Professionals – Independent Allied Health Professionals are not appointees to the Medical Staff and are therefore not entitled to vote or hold office on the Medical Staff. Clinical privileges shall not include the privilege to independently admit patients to the Hospital. They shall, however, bear the responsibilities set forth in Article III other than Section 3.8 which is limited to appointees of the Medical Staff.

c) Supervision – Any activities permitted by the Board to be performed in the Hospital by any Independent Allied Health Professional shall be performed only under the direct and immediate supervision of the Independent Allied Health Professional’s employer. However, “direct and immediate supervision” shall not require the actual physical presence of the employer. Should any WVUH health care employee who is licensed or certified by the State of West Virginia have any question regarding the clinical competence or authority of any Independent Allied Health Professional, either to act or to issue instructions outside the physical presence of the Independent Allied Health Professional’s employer in a particular instance, such employee has the right to require that the individual employer validate, either immediately or later, the order of the Independent Allied Health Professional. Any act or instruction of the Independent Allied Health Professional shall be delayed until such time as the WVUH employee can be reasonably certain that the act is within the scope of the Independent Allied Health Professional’s activities as permitted by the Board. At all times, the employing physician shall remain responsible for all acts of any of his/her Independent Allied Health Professional within the hospital.

d) Insurance – Each Independent Allied Health Professional shall maintain, as condition of appointment and reappointment as an Independent Allied Health Professional, professional liability insurance in amounts required by the Board which covers all professional activities in the Hospital and shall keep WVUH supplied with evidence of such coverage.
4.1.2.2 **Clinical Assistants**: Clinical Assistants status shall include:

- Certified Registered Nurse Anesthetist
- Anesthesia Assistant
- Genetics Counselor
- Registered Dental Hygienist
- Licensed Social Worker
- Neuromonitorist

or other health care professionals who (1) are approved by the Board; (2) licensed or certified by their respective licensing or certifying agencies; and (3) provide services as employees of, and are subject to the direct and immediate supervision of, physicians, podiatrists or dentists who are presently appointed to the Medical Staff.

To the extent the Board determines to permit such Clinical Assistants to act in the Hospital, the Medical Executive Committee shall recommend to the Board the scope of each such individual’s activities within the Hospital. No such individual shall be permitted to provide medical services in the Hospital as a Clinical Assistant until the Medical Executive Committee has received, on a form provided by the Board, sufficient information about the qualifications of that individual to permit the Medical Executive Committee to recommend to the Board the scope of activities the individual will be permitted to undertake in the Hospital. The form shall be prepared by the individual’s employer and signed by both the employer and the individual. The Chair of the applicable Department shall make a recommendation to the Medical Executive Committee, which in turn shall recommend to the Board, a written delineation of the scope of activities each Clinical Assistant shall be permitted to undertake in the Hospital. The Clinical Assistant may act in the Hospital pursuant to the delineation as approved by the Board only so long as he/she remains an employee of a physician or dentist currently appointed to the Medical Staff.

a) Discretion of the Board – appointment as a Clinical Assistant is at the discretion of the Board. The appointment of any Clinical Assistant may be terminated at will by the Board subject only to the due process provisions of these Bylaws.

b) Rights and Responsibilities of Clinical Assistants – Clinical Assistants are not appointees to the Medical Staff and shall not be entitled to vote or responsibilities set forth in Article V.

c) Supervision – Any activities permitted by the Board to be performed in the Hospital by a Clinical Assistant shall be performed only under the direct and immediate supervision of the Clinical Assistant’s employer. However, “direct and immediate supervision” shall not require the actual physical presence of the employer. Should any WVUH health care employee who is licensed and certified by the State of West Virginia have any question regarding the clinical competence or authority of any Clinical Assistant either to act or to issue instructions outside the physical presence of the Clinical Assistant’s employer in a particular instance, such employee has the right to require that the individual employer validate, either immediately or later, the order of the Clinical Assistant. Any act or instruction of the Clinical Assistant shall be delayed until such time as the WVUH employee can be reasonably certain that the act is within the scope of the Clinical Assistant’s activities as permitted by the Board. At all times the employing physician shall remain responsible for all acts of any of his/her Clinical Assistants within the Hospital.

d) Conformity with Regulations – The number of Clinical Assistants acting as employees of one physician, as well as the acts they may undertake, shall be consistent with applicable State statutes and regulations, the Rules and Regulations of the Medical Staff and the policies of the Board.
e) Insurance – It shall be the responsibility of the physician employing the Clinical Assistant to ensure that a policy of insurance covers the Clinical Assistant in amounts required by the Board that covers all activities in the Hospital. He shall furnish evidence of such to WVUH so that it can be ascertained that such professional liability insurance covers the activities of the Clinical Assistant in the Hospital and such Clinical Assistant shall act in the Hospital only while such coverage is in effect.

f) Indemnity – Notwithstanding any insurance carried by the Clinical Assistant or his/her employer, the employer shall indemnify, defend, and hold WVUH harmless from all claims, loss, damage or injury of any kind or character (including, without limitation, WVUH’s attorney’s fees and costs of defense) to any person or property arising from the performance of services by the Clinical Assistant or caused by or arising from any act or omission of the Clinical Assistant. Where the State of West Virginia or subdivision insures the employer thereof, applicable State Law or policy may limit such indemnity.

g) Individuals with clinical privileges who are not members of the Medical Staff are afforded a fair hearing and appeal process. (See Credentialing Policy, Section 4.5).

4.1.3 Students: It is recognized that students render patient care under the direction and supervision of Medical Staff appointees and Hospital employees. In matters of professional competence, ethics and performance, they will be responsible to the Dean of the School of Medicine.

ARTICLE V – Clinical Departments

5.1 Department Designation: The Medical Staff shall be divided into Departments conforming to the designated Clinical Academic Departments of the School of Medicine and Dentistry. All appointees of the Medical Staff shall have an appointment to one or more of these Departments.

5.1.1 Departments:
- Anesthesiology
- Behavioral Medicine & Psychiatry
- Cardiovascular and Thoracic Surgery
- Community Practice
- Dentistry
- Emergency Medicine
- Family Medicine
- Internal Medicine
- Neurology
- Neurosurgery
- Obstetrics & Gynecology
- Ophthalmology
- Orthopedics
The Board, by its action, may create, eliminate, subdivide, or combine Departments, provided however, that the Departments remain consistent with the designated Clinical Academic Departments of the Schools of Medicine and Dentistry.

5.1.2 Functions of Departments:

a) Each Clinical Department shall make recommendations to the Medical Executive Committee for the assignment of clinical privileges within the Department and each of its sections. Such criteria shall be consistent with and subject to the Bylaws, Policies, and Rules and Regulations of the Medical Staff and Hospital. These criteria shall be effective when approved by the Board. Clinical privileges shall be based upon demonstrated competence, training and experience within the specialties covered by the Department.

b) Each Department or section shall monitor and evaluate medical care in all major clinical activities of the Department. The monitoring and evaluation must at least include:
   1. The identification and collection of information about important aspects of patient care provided in the Department;
   2. The identification of the indicators used to monitor the quality and appropriateness of the important aspects of care; and
   3. The periodic assessments of patient care information to evaluate the quality and appropriateness of care; to identify opportunities to improve care; and to identify important problems in patient care.

c) Each Department shall conduct, participate in, and make recommendations regarding the need for continuing medical education programs.

d) Each Department shall establish such Departmental Committees or other mechanisms as are necessary and desirable to properly perform the functions of the Department.

e) Each Department shall perform other functions as determined by the Medical Executive Committee and the Board.

f) All documents generated for use in peer review and in evaluating and improving the quality of healthcare, reducing morbidity and mortality and establishing and enforcing guidelines designed to keep the cost of healthcare within reasonable bounds. These documents are not to be copied or reproduced and the contents are not to be distributed to anyone outside the peer review process.

5.2 Clinical Chairs:

5.2.1 Clinical Chairs: Each Department shall be led by a Clinical Chair who shall be appointed by and serve at the pleasure of the Vice President and Executive Dean of the School of Medicine (for physician Chairpersons) or Dentistry (for Dental Chairpersons).

5.2.2 Responsibilities of Clinical Chairs: Each Chair shall:
   a) Be responsible for the clinical and administrative activities within the Department;
   b) Monitor and evaluate the quality and appropriateness of patient care provided within the Department;
   c) Monitor the professional performance of all individuals who have delineated clinical privileges in the Department, and report thereon to the Medical Executive
Committee as part of the reappointment process and at such times as may be indicated;

d) Develop and implement Departmental programs, in cooperation with the Hospital and consistent with other provisions of these Bylaws, for credentials review and clinical privileges, delineation, orientation and continuing medical education, utilization review, concurrent monitoring of practice, and continuous monitoring of quality indicators and performance improvement;

e) Be responsible for the integration of the Department/Service into the primary functions of the Hospital;

f) Be responsible for the coordination and integration for the interdepartmental and intradepartmental services;

g) Be responsible for the development and implementation of policies and procedures that guide and support the provision of services;

h) Assess and recommend to Hospital leadership off-site sources for needed patient care services not provided by the Department or organization;

i) Recommend the sufficient number of qualified and competent persons to provide care or services;

j) Recommend the criteria for clinical privileges in the Department;

k) Make recommendations to the Medical Executive Committee regarding the qualifications and competence of Department personnel who are not licensed independent practitioners and who provide patient care services in the Department;

l) Assist the Hospital, in accordance with these Bylaws, with respect to the granting of Locum Tenens privileges within the Department, and with the evaluation of requests for temporary privileges;

m) Appoint ad hoc committees or working groups as necessary to carry out quality improvement activities and Department functions;

n) Be responsible for implementation within the Department of actions taken by the Board of Directors and Medical Executive Committee;

o) Recommend and report to Hospital management, when necessary, matters affecting patient care in the Department, including personnel, space and other resources, supplies, special regulations, standing orders and techniques.

p) Be responsible within the Department of the Hospital for the enforcement of the Medical Staff Bylaws, Policies, and Rules and Regulations;

q) If appropriate, delegate duties to a vice chair of the Department.

5.3 Department Meetings:

5.3.1 Regular Meetings: Departments may, by resolution, provide the time and frequency for conducting standing meetings without notice. Other meeting notices shall be distributed to all members. Such meetings shall occur monthly but in no event less than ten (10) times per year and shall address any appropriate matter pertaining to quality improvement issues including:

a) Morbidity and mortality including detailed consideration of selected deaths;

b) Nosocomial infections and other complications;

c) Efficiency of diagnosis and results of treatment;

d) Risk management issues; and

e) Any other issues of an analytical nature relative to patient care in the Hospital as may be reported.

5.3.2 Special Meetings:

a) A special meeting of any Department may be called at the request of the Chairperson, or by one-third of the Department, but in no event, not less than two (2) members.
b) Written or oral notice stating the place, day and hour of any meeting not held pursuant to resolution shall be given to each Department member not less than three (3) days before the time for such meetings.

5.3.3 Minutes of Meetings: Minutes shall be kept of each Departmental and Sectional Departmental Committee meetings.

5.3.4 Approval of Departmental Policies, Rules and Regulations: All Departmental policies, rules and regulations and changes therein shall be submitted in writing to the Chair of the Department.

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ARTICLE VI – Officers

6.1 Officers: Officers of the Medical Staff shall be the Chief of Staff and the Vice Chief of Staff. One person may not hold more than one such office at a time.

6.2 Election and Term of Officers:
   a) The election of the Vice Chief of Staff shall occur by secret ballot at the beginning of June, by a majority of active members of the WVUH Medical Staff who have cast a vote, from a slate of candidates offered by the Nominating Committee. Provision for write-in votes shall be made. Terms of office shall begin on the 1st of July, and expire two (2) years later on the 30th of June with the Vice Chief of Staff succeeding to the Chief of Staff in ordinary course.

6.3 Qualifications of Officers: To be eligible to serve as a medical staff officer, individuals must:
   a) have been members in good standing of the Active staff of the hospital for the last three (3) years prior to their candidacy and remain so during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved;
   b) have demonstrated excellent clinical experience, leadership skills, communication skills, energy and vision;
   c) support the delivery of programs and services meeting the needs of rapidly changing health care delivery system and the Hospital’s mission of “patient first” and quality care to the citizens of West Virginia and surrounding areas;
   d) have no past or pending adverse recommendations concerning staff appointment or clinical privileges;
   e) not have an employment or other contractual arrangement with another hospital or health care system that is not affiliated with WVUHS;
   f) maintain an active clinical practice at WVUH, using WVUH as their primary Hospital;
   g) have served actively on at least one Medical Staff Standing committee;
   h) be willing to discharge faithfully the duties and responsibilities of the position to which the individual is elected;
   i) be knowledgeable concerning the duties of the office; and
6.4 **Duties of the Chief of Staff:** shall include:

a) Administer the Medical Staff, in accordance with the terms of these Medical Staff Bylaws and the Medical Staff Rules and Regulations in cooperation with Hospital Administration;

b) Assist as necessary in the processes of supervision, control and appraisal necessary to work towards the delivery of quality and efficient medical care in the Hospital, including but not limited to, processes for credentials review and for delineation of clinical privileges, continuing education programs, utilization review, concurrent monitoring of practice, and continuous monitoring of quality indicators and performance improvement;

c) Call, set the agenda for, and preside at all Medical Staff and Medical Executive Committee meetings;

d) Serve as an *ex-officio* member of all other Medical Staff Standing Committees;

e) Serve on the Nominating Committee and fill staff Committee vacancies, except for the Medical Executive Committee;

f) Communicate and represent Medical Staff opinions, policies, concerns, needs and grievances to the Medical Executive Committee, Hospital Administration and the Board of Trustees;

h) Be Chairperson of the Medical Executive Committee;

i) Be responsible for the functioning of the clinical organization of the Hospital and maintain supervision over the clinical work in all Departments;

j) Perform other duties as may be assigned by the Board, the President of WVUH or the Medical Executive Committee;

k) Sit on the Board of Directors of WVUH as a voting member;

l) Enforce the Rules and Regulations contained in these Medical Staff Bylaws and the Medical Staff Rules and Regulations and implement sanctions for noncompliance, and present to the Medical Executive Committee cases where disciplinary action may be recommended to the Board; and

m) Recommend to the President or designee temporary suspension of Medical Staff privileges when appropriate.

6.5 **Duties of the Vice Chief of Staff:** shall include:

a) In the absence of the Chief of Staff, the Vice Chief of Staff shall assume all his/her duties and authority;

b) Perform such duties of supervision as may be assigned to him/her by the Chief of Staff;

c) Be present at all Medical Staff and Medical Executive Committee meetings;

d) Serve as a voting member of the Medical Executive Committee; and

e) Serve on the Nominating Committee.

6.6 **Removal of Officers:** An officer may be removed from office:

a) Immediately by the President or designee if his/her medical license is limited, suspended, or revoked. The President or designee for good cause may suspend an officer temporarily from office. Good cause includes, but is not limited to, violation of any of the provisions of these Bylaws.

b) An officer may be removed if 70% of the members of the Active category of the Medical Staff are in favor of removal, and the Medical Executive Committee and the Board concur with respect to removal of the officer. Grounds for removal shall include, but not be limited to, inability or unwillingness to perform the duties
6.7 Vacancies in Office:
   a) Temporary Vacancy – If the Chief of Staff is temporarily unable to fulfill the responsibilities of the office, the Vice Chief of Staff or a past Chief of Staff, at the request of the Nominating Committee, will assume these responsibilities until the current Chief of Staff is able to resume those duties. See b.(i)
   b) Permanent Vacancy – If, for any reason, the Chief of Staff is unable to complete the elected term of office, the Vice Chief of Staff or a past Chief of Staff, at the request of the Nominating Committee, will assume the office of Chief of Staff and assume the duties of the Chief of Staff and shall serve out the remaining term as Chief of Staff and, if appropriate, his/her own subsequent term if the vacancy is permanent. Permanent vacancy in the office of Vice Chief of Staff shall be filled by special election, held within thirty (30) days of said permanent vacancy being determined, to complete the remaining term. Such election shall be held according to this Article VI, 6.2 of these Bylaws.
      (i) In the event that the Vice Chief of Staff has served less than one (1) year in that position, any Chief of Staff vacancy will be filled by the immediate past Chief of Staff, with the Vice Chief of Staff succeeding to the position on reaching one (1) year of service. Should the immediate past Chief of Staff be unable to serve, the prior Chief of Staff will serve. If neither of the past two (2) Chiefs of Staff is able to serve, the Vice Chief will fill the vacancy.
   c) Once a Vice Chief of Staff fills a Chief of Staff vacancy, he or she will serve the remainder of that term and also, subsequently, the term for which he or she was originally elected.
   d) If unforeseen circumstances occur, they will be adjudicated at a joint meeting of the MEC and the Nominating Committee.

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ARTICLE VII – Standing Committees of the Medical Staff

7.1 Standing Committees of the Medical Staff and Functions

7.1.1. Appointment and/or reappointment of the Chairpersons of each such committee will be made by the Nominating Committee. The appointment and/or reappointment of the members of such committee will be made by the Nominating Committee in conjunction with the designated Chairperson of said committee. Quarterly reports shall be made to the Medical Executive Committee by the Chairs of the Standing Committees. Committee members may be removed by a two-thirds (2/3) vote of the Medical Executive Committee. The Chief of Staff, Vice Chief of Staff, and the Vice
President of Clinical Programs shall be non-voting, ex-officio members of all committees, unless otherwise indicated.

7.1.2. Unless otherwise stated, Standing Committees will include a broad representation of the Medical Staff; however, committees will consist of an appropriate number of individuals.

7.1.3. Each Standing Committee may, with the approval of the Chief of Staff, form subcommittees, task forces, or ad hoc committees as appropriate to carry out the charge of the Standing Committee. All such groups will be considered committees of the Medical Staff and will terminate upon the conclusion of the designated task.

7.1.4. Membership on Medical Staff Standing Committees shall be for a period of two (2) years and may be renewable.

7.1.5. Duties Generally:
   a) All Standing Committees appointed under this Article will report and make recommendations to the Medical Executive Committee.
   b) The Chairperson of each Committee shall appoint a Secretary to keep minutes of each meeting.
   c) Each Committee will keep a record of the minutes of each of its meetings, including an attendance roster. A copy of the minutes, approved by the membership and signed by the committee Chair, shall be kept on file for seven (7) years.
   d) Unless otherwise stated, meetings of all Standing Committees shall be held at a minimum semi-annually, but each Committee may by resolution provide the time and frequency of regular meetings.
   e) Special meetings may be called by, or at the request of, the Chairperson, Chief of Staff or by one-third (1/3) of the Committee membership, but not less than two (2) members.
   f) Written or oral notice stating the place, day, and hour of any Special meeting shall be provided to each Committee member not less than three (3) days before the time of such meeting.
   g) Quorum shall consist of a minimum of two (2) voting members of the Standing Committee.
   h) Meetings may be held by telephonic means. Telephonic participation shall be considered attendance under Section 9.1.1.10 of these Bylaws. All other provisions of Article IX shall apply to telephonic meetings.

7.2 Medical Executive Committee:

7.2.1 Composition: The Medical Executive Committee shall consist of the Chief of Staff as Chairperson, the Vice Chief of Staff, the Chairs of the Clinical Departments, the Dean of the School of Dentistry or his/her permanent designee, and four (4) faculty members at large elected by the Medical Staff. In the event that the Clinical Chair is not a member of the medical Staff, he or she may designate a member of the Medical Staff of his or her Clinical Department to accompany the Chair as a voting member. If one of the Clinical Chairs is removed or resigns from his/her position, the Interim Chair shall complete the remainder of the term. A resident from an ACGME accredited residency program, elected by a vote of the residents in all ACGME programs, shall be a voting member. The President of the Hospital or his/her permanent designee, Vice President & Executive Dean for Health Sciences, Chief Medical Officer, Vice President of Clinical Programs, the Director of Medical Staff Affairs, the Vice President for Nursing, Director for Quality Outcomes, Vice Dean for Medical Education, DIO for General Medical
Education, Director for Advanced Practice Professionals and the General Counsel, shall be ex-officio, non-voting members of the Medical Executive Committee. The President of the Hospital or his/her designee shall serve as Secretary for the Committee. No individual who was a member of the Medical Executive Committee within the last two (2) years who failed, while a member, to attend at least fifty percent (50%) of the regularly scheduled meetings shall be eligible for election to the Committee. A Medical Staff member is not ineligible for nomination/election to the Medical Executive Committee solely because of his or her professional discipline or specialty.

7.2.2 Duties of the Medical Executive Committee shall include:

a) To receive, review and act upon requests from all Committees and Departments of the Medical Staff, including making a recommendation for or against their recommendations;

b) To provide liaison between the Medical Staff and Clinical Departments and between the Medical Staff and Hospital Administration and the Board;

c) To resolve disputes between and among Departments of the Medical Staff;

d) To represent and to act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;

e) To coordinate the activities and general policies of the Committees and Clinical Departments as they pertain to the care of the patient and credentialing, and to integrate the findings and activities of the Committees and Departments into the credentialing process;

f) To recommend action to the Hospital Administrator and/or the Board on matters relating to Medical Staff appointment, reappointment, staff category, clinical privileges, Department functioning, and corrective actions to be taken, and make recommendations of a medico-administrative nature;

g) Report to the Board and to the Medical Staff on the overall quality and efficiency of care rendered to patients in the Hospital by Medical Staff appointees, and to receive and act on reports from Departments, Committees, and Officers of the Medical Staff concerning all continuous quality improvement and risk management activities;

h) To generate, publish and enforce policies of the Medical Staff not otherwise provided for or defined in these Bylaws;

i) To review credentials and actual performance of all applicants for membership or reappointment and to make recommendations to the Board for staff membership and delineation of clinical privileges or remand to the Department Chairperson for further consideration. As a member of the Committee, it is understood that these recommendations are to be made without discrimination on the basis of age, race, gender, religion, national origin, ancestry, disability, marital status, sexual orientation, type of procedure or patient in which the practitioner specializes, or any other characteristic protected by state, federal or local law;

j) To take all reasonable steps to provide professional, ethical conduct and competent clinical behavior on the part of all appointees of the Medical Staff, including the initiation of and/or participation in Medical Staff review or corrective measures when warranted in accordance with these Bylaws;

k) To take action to ensure compliance with accreditation standards;

l) To report the activities of the Medical Executive Committee to the Hospital Board;

m) To foster and encourage self-discipline among appointees to the Medical Staff, promote professional activities, promote medical education and research, promote good community relationships and assist Hospital administrative personnel in long-range planning;

n) To make policy recommendations to the Board of WVUH on matters relating to Medical Staff appointment, reappointment, staff category, departmental functioning, clinical privileges, and corrective actions to be taken with respect to
health care providers, and make recommendations on medico-administrative and
Hospital management matters;
o) To include reports from Medical Staff Committees in the minutes of the Medical
Executive Committee;
p) In cooperation with the Chief of Staff, Vice President of Medical Affairs and the
President of WVUH, formulate, amend and submit to the Board for approval
Medical Staff Rules and Regulations;
q) Present a report of any action it may have taken since the last meeting at each
meeting of the Medical Staff. Special meetings may be called at any time by the
Chief of Staff or on written request to the Chief of Staff from any three (3)
members of the Medical Executive Committee provided that at least forty-eight
(48) hour notice of such special meetings is given in such manner as the Chief of
Staff shall consider appropriate;
r) Assess and make recommendations for selection of products and services for
use in the Hospital based upon the mission and values of the organization,
internal and community needs, alternative products and services, and optional
benefit/value;
s) To periodically review the Medical Staff Bylaws and Rules and Regulations and
draft and recommend to the Hospital Board and/or to the Medical Staff as
appropriate:
1. Changes in Bylaws;
2. Changes in Medical Staff Rules and Regulations;
3. Changes in the Credentialing Policy
t) In addition to all other explicitly enumerated duties and responsibilities, the
Medical Executive Committee and all other Committees of the Medical Staff
reporting directly or indirectly to or through the Medical Executive Committee,
shall have the authority and duty to:
1. Measure, analyze and sustain the performance improvement activities of
both clinical and non-clinical processes and resulting patient outcomes of
Medical Staff members;
2. Gather and review information relating to the care and treatment of
patients;
3. Evaluate and make recommendations for the improvement of the quality
of healthcare rendered at the Hospital;
4. Take any other reasonable actions necessary to ensure effective Medical
Staff governance.

7.2.3 Meetings:
 a) The Medical Executive Committee shall meet on a regular basis, but no less
 often than quarterly.
b) No business shall be transacted at any special meeting except that stated in the
 written request asking for such meeting; and
c) The Committee shall maintain a written record of all its proceedings and actions
 at all meetings.

7.2.4 Quorum: A quorum shall consist of a minimum of four (4) Medical Staff.

7.2.5 Conditions and Mechanism for Removal: The Chief of Staff shall have the
authority to remove a member from the Medical Executive Committee under the
following conditions:
a) Denial, suspension, reduction or revocation of clinical privileges; or
b) Failure to comply with confidentiality of information as defined in these Bylaws.
7.2.6 **Reporting:** The Medical Executive Committee shall report to the Quality and Patient Safety Committee of the Board.

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**ARTICLE VIII – Medical Staff Meetings**

8.1 **Meetings of the Medical Staff**

8.1.1 **Regular Meetings:** Regular meetings of the Medical Staff shall be held semi-annually in the Spring and Fall. The Medical Staff Office shall make an agenda prior to these meetings.

8.1.2 **Special Meetings:** The Chief of Staff or the Medical Executive Committee may call a special meeting of the Medical Staff at any time. Upon receipt of a written request from not less than twenty five percent (25%) of the Active staff, stating the purpose for such a meeting, the Chief of Staff shall set a date, place and time for a special meeting to occur within twenty-one (21) days. Notice shall be given to the Active Staff not less than ten (10) days before the date of such meeting. No business shall be transacted at any special meeting except that slated in the notice requesting the special meeting.

8.1.3 **Minutes:** The Vice Chief of Staff or his/her designee shall prepare minutes of each regular and special meeting. The minutes will be filed and maintained by the Department of Medical Staff Affairs.

**At the top of the first page of all minutes, the following should be stated: “All documents generated for use in peer review and in evaluating and improving the quality of healthcare, reducing morbidity and mortality and establishing and enforcing guidelines designed to keep the cost of healthcare within reasonable bounds. These documents are not to be copied or reproduced and the contents are not to be provided to anyone outside the peer review process.”**

8.1.4 **Quorum:** A quorum shall consist of a majority of those members of the Active Staff present in person or by written proxy at any regular or special meeting.

8.1.5 **Agenda for Meetings:** The agenda for the semi-annual meetings shall be:  
   a) Call to order;  
   b) Acceptance of the minutes of the last meeting;  
   c) Update, Vice President and Executive Dean, School of Medicine, or designee;  
   d) Update, Dean, School of Dentistry, or designee;  
   e) Update, President, WVUH, or designee;  
   f) Old Business;  
   g) New Business; and
8.1.6 **Agenda for Special Meetings:** The agenda at any special meeting shall be:
   a) Reading of the notice calling the meeting;
   b) Transaction of the business for which the meeting was called; and
   c) Adjournment

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ARTICLE IX – Rules and Regulations of the Medical Staff and Medical Staff Policies

**9.1 Standards:** The Medical Executive Committee shall promulgate and the Board of Directors shall approve such Rules and Regulations and Medical Staff Policies, not in conflict with these Bylaws. Rules and Regulations and Medical Staff Policies shall set forth appropriate standards of practice for each physician and dentist in the Hospital and shall act as an aid in evaluating performance under and compliance with these standards. They shall have the same force and effect as the Bylaws.

**9.2 Amendment:** The Medical Executive Committee shall have the power to adopt amendments to the Rules and Regulations and Medical Staff Policies as are in the Committee’s judgment to be technical or legal modifications or clarifications, reorganization, re-numbering or amendments made necessary because of punctuation, spelling or other errors of grammar or expression. These amendments will be communicated to the Medical Staff and the Board by the Chief of Staff at the next regular meeting of each of these respective bodies. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or the Board of Directors at their next meetings. If any or all of these amendments are rejected by any or all of the above entities, then such amendment or amendments shall no longer be operational unless and until such amendment or amendments pass the approval process outlined in Article 10.1 of these Bylaws. The action to amend may be taken by a motion acted upon in the same manner as any other motion before the Medical Executive Committee. After adoption, such amendments shall be communicated by the Secretary of the Medical Executive Committee to the Medical Staff and sent to the Chief of Staff for transmittal to the Hospital President, or designee and Board of Directors.

**9.3 Urgent Amendments:** The Medical Executive Committee and the Board shall have the power to provisionally adopt urgent amendments to the Rules and Regulations that are needed in order to comply with a law or regulation, without providing prior notice of the proposed amendments to the Medical Staff. Notice of all provisionally adopted amendments shall be provided to each member of the Medical Staff as soon as
possible. The Medical Staff shall have 14 days to review and provide comments on the provisional amendments to the Medical Executive Committee. If there is no conflict between the Medical Staff and the Medical Executive Committee, the provisional amendments shall stand. If there is conflict over the provisional amendments, then the process for resolving conflicts set forth below shall be implemented.

9.4 **Conflict Management Process:**

1. When there is a conflict between the Medical Staff and the Medical Executive Committee with regard to:
   a) Proposed amendments to the Medical Staff Rules and Regulations;
   b) A new policy proposed by the Medical Executive Committee; or
   c) Proposed amendments to an existing policy that is under the authority of the Medical Executive Committee,

   a special meeting of the Medical Staff will be called. “Conflict” means that a petition signed by 25% of the voting staff expresses disagreement with the Medical Executive Committee. The agenda for that meeting will be limited to the amendment(s) or policy at issue. The purpose of the meeting is to discuss and strive to resolve the differences that exist with respect to Medical Staff Rules and Regulations or policies.

2. If the differences cannot be resolved at the meeting, the Medical Executive Committee shall forward its recommendations, along with the proposed recommendations pertaining to the Medical Staff Rules and Regulations or policies offered by the voting members of the Medical Staff, to the Board for final action.

3. This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including but not limited to, professional review actions concerning individual members of the Medical Staff.
majority of the votes cast at the meeting. Amendments so adopted shall not be effective unless and until approved by the Board of Directors.

10.2 Clarifications: The Medical Executive Committee shall have the power to adopt such amendments to the Bylaws as are in the Committee’s judgment to be technical or legal modifications or clarifications, reorganization, re-numbering or amendments made necessary because of punctuation, spelling or other errors of grammar or expression. These amendments will be communicated to the Medical Staff and the Board by the Chief of Staff at the next regular meeting of each of these respective bodies. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or the Board of Directors at their next meetings. If any or all of these amendments are rejected by any or all of the above entities, then such amendment or amendments shall no longer be operational unless and until such amendment or amendments pass the approval process outlined in the preceding paragraph. The action to amend may be taken by a motion acted upon in the same manner as any other motion before the Medical Executive committee. After adoption, such amendments shall be communicated by the Secretary of the Medical Executive Committee to the Medical Staff and sent to the Chief of Staff for transmittal to the Hospital President, or designee and Board of Directors.

10.3 The Medical Executive Committee may also present any proposed amendments to the voting staff by written ballot, returned to Medical Staff Affairs by the date indicated by the Medical Executive Committee. Along with the proposed amendments, the Medical Executive Committee may, in its discretion, provide a written report on them either favorably or unfavorably. To be adopted, an amendment must receive a majority of the votes cast, so long as the amendment is voted on by at least 25% of the staff eligible to vote.

ARTICLE XI – General Information- Credentialing Policy

The following information sets forth the general principles of the Credentialing Policy.

11.1 Qualifications for Appointment, Reappointment and Clinical Privileges: To be eligible for initial appointment or reappointment to the Medical Staff, or granted clinical privileges, an applicant must meet qualifications, standards and requirements set forth in the Credentialing Policy by Federal and State law and in such policies as adopted from time to time by the Board of Directors.

11.2 Automatic Relinquishment of Appointment and/or Privileges:
1. Appointment and clinical privileges will be automatically relinquished if an individual:
   a) Fails to do any of the following:
      i. Timely complete medical records;
      ii. Satisfy threshold eligibility criteria; or
      iii. Provide requested information; or
   b) Is convicted or pleads guilty or no contest to any felony.
2. Automatic relinquishment shall take effect immediately and shall continue until the matter is resolved, if applicable.

11.3 Precautionary Suspension or Restriction:
1. Whenever, in their opinion, failure to take action may result in imminent danger to the health and/or safety of any individual, or may interfere with the orderly operation of the Hospital, the Quality and Patient Safety Committee or any two of the following: the Chief of Staff, the President, or designee, the Vice President of Medical Affairs or the Chairperson of the Board is authorized to suspend or restrict all or any portion of an individual's clinical privileges pending an investigation.
2. A precautionary suspension is effective immediately and will remain in effect unless it is modified by the President, or designee or Medical Executive Committee.
3. The Medical Executive Committee will review the reasons for the suspension within a reasonable time not to exceed 14 days.

11.4 Recommendations Following Investigation:
Following an investigation, the Medical Executive Committee may recommend suspension or revocation of appointment or clinical privileges based on concerns about:
   a) Clinical competence or practice;
   b) Violation of ethical standards or the Bylaws, Policies, Rules and Regulations of the Hospital or Medical Staff; or
   c) Conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff.

11.5 Hearing and Appeal Process:
1. The hearing will begin no sooner than 30 days after the notice of the hearing, unless an earlier date is agreed upon by the parties.
2. The Hearing Panel will consist of at least three members or there will be a Hearing Officer.
3. The hearing process will be conducted in an informal manner; formal rules of evidence or procedure will not apply.
4. A stenographic reporter will be present to make a record of the hearing.
5. Both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer:
   a) To call and examine witnesses to the extent they are available and willing to testify;
   b) To introduce exhibits;
   c) To cross-examine any witness on any matter relevant to the issues;
d) To have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and

e) To submit a written statement at the close of the hearing.

6. The personal presence of the affected individual is mandatory. If the individual who requested the hearing does not testify, he or she may be called and questioned.

7. The Hearing Panel (or Hearing Officer) may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

8. The affected individual or the Medical Executive Committee may request an appeal of the recommendations of the Hearing Panel (or Hearing Officer) to the Board.

ARTICLE XII – Authority of Interpretation

Full authority for the interpretation of these Bylaws rests exclusively with the Board of Directors. Any request for interpretation shall be reduced to writing and given to the Medical Executive Committee for consideration and recommendation to the Board.

ARTICLE XIII – Adoption

These Bylaws shall be adopted at a meeting of the Active Staff. A simple majority vote of the Active Staff present will constitute adoption. The adopted Bylaws will then be presented to the Board of Directors for approval. If the Board rejects any Bylaw, the Board will inform the Chief of Staff of its specific objection or objections. These objections will then be addressed as outlined in Article X.
AMENDMENT 1 – Content and Completion of Medical Records

1. **Medical History and Physical Examinations**
   
   (a) A medical history and physical examination must be completed and documented for each patient no more than 30 days before, or 24 hours after admission or registration, but prior to surgery or a procedure requiring the use of moderate sedation, deep sedation, or general anesthesia, including procedures done in the operating room, procedural lab, or performed with imaging guidance. Minimally invasive radiological procedures that do not require sedation are exempt. The medical history and physical examination must be completed and documented by a physician, an oral-maxillofacial surgeon, or other qualified licensed individual who has been granted these privileges and is a member of the Medical Staff of West Virginia University Hospitals.

   (b) An updated examination of the patient, including any changes in the patient’s condition, must be completed and documented within 24 hours after admission or registration (when the medical history and physical examination are completed within 30 days before admission or registration), but prior to surgery, or a procedure requiring the use of moderate sedation, deep sedation, or general anesthesia, including procedures done in the operating room, procedural lab, or performed with imaging guidance. Minimally invasive radiological procedures that do not require sedation are exempt. The updated examination of the patient, including any changes in the patient’s condition, must be completed and documented by a physician, an oral-maxillofacial surgeon, or other qualified licensed individual who has been granted these privileges and is a member of the Medical Staff of West Virginia University Hospitals.

   (c) A medical history and physical examination may be performed by a Certified Registered Nurse Anesthetist (CRNA), Advanced Practice Registered Nurse (APRN), Physician Assistant (PA), or Certified Nurse Midwife (CNM); however, a physician, an oral-maxillofacial surgeon, or other qualified licensed individual who has been granted these privileges and is a member of the Medical Staff of West Virginia University Hospitals must confirm the findings, conclusions and assessments of risk prior to all operative procedures and image guided interventional procedures, excluding those procedures in which the CRNA, APRN, PA, or CNM have been credentialed to perform independently.

   (d) Dentists will only be responsible for the part of a patient’s medical history and physical examination that relates to dentistry.

   (e) The minimum standard for a medical history and physical examination is documentation of a chief complaint; HPI; chronic medical illnesses; major surgical procedures; all medications; medication allergies; examination of heart, lung and affected body organ; and an assessment/plan. Previous H&P’s may be referenced if incorporated into the current episode of care.
f) A physician, an oromaxillofacial surgeon, Certified Registered Nurse Anesthetist, Advanced Practice Registered Nurse, Physician Assistant, or Certified Nurse Midwife can perform a medical screening exam sufficient to reasonably identify an emergency medical condition within the meaning of EMTALA.

2. Procedure and Operative Notes:
   a) An operative or other high-risk procedure report is required before the patient is transferred to the next level of care.
   b) The operative or other high-risk procedure report includes the following information:
      i. The name(s) of the licensed independent practitioner(s) who performed the procedure and his or her assistants;
      ii. The name of the procedure performed;
      iii. Type of anesthesia;
      iv. A description of the procedure;
      v. Findings of the procedure;
      vi. Any estimated blood loss;
      vii. Any specimen(s) removed; and
      viii. The postoperative diagnosis.
   c) When a full operative or other high-risk procedure report cannot be entered immediately into the patient’s medical record after the operation or procedure, a note is entered in the medical record before the patient is transferred to the next level of care. This note includes:
      i. The name(s) of the primary surgeon(s) and his or her assistant(s);
      ii. The name of the procedure performed;
      iii. Type of Anesthesia;
      iv. A description of each procedure finding;
      v. Any estimated blood loss;
      vi. Any specimen(s) removed; and
      vii. The postoperative diagnosis.

3. Discharge Note
   a) The discharge note must include discharge disposition, the reason for the hospital stay and any significant finds, procedures performed and care, treatment and services provided during the hospital stay, follow-up instructions, diet, activity and medications, and be signed and dated by the responsible physician. Furthermore, upon discharge, the physician shall discuss with the patient the reason for discharge and any anticipated need for continued care, treatment and services after discharge. Additionally, if transfer is warranted, the physician shall discuss with the patient the reason for transfer and any alternative, and must include consideration of nearest facility that adequately meets the patient care needs.
   b) Signed, dated and time stamped discharge summaries should include the patient’s discharge diagnosis, discharge medications, a brief summary of the hospitalization, and condition at discharge, follow-up plans, and activity allowed at discharge.
   c) All admissions, except normal OB and newborns, must have a signed, dated and time stamped discharge or death summary entered into their medical record within 12 hours.
   d) Signed, dated and time stamped Necroscopy reports must be completed within sixty (60) days.
   e) A complete list of discharge medications must be provided to the patient at the time of discharge. “Continue medications” is never appropriate.
4. **Cancer Staging:** Signed, dated and time stamped cancer staging documentation must be completed within thirty (30) days of the completion of the staging process.

5. **Verbal Orders:**
   a) All verbal orders must be signed, dated and time stamped by the ordering practitioner within forty-eight (48) hours after order is given.
   b) Verbal orders may only be given in times of urgent situations when immediate written or technical accommodations are not readily available.

6. **Legible Documentation:** All written documentation within a patient’s medical record must be legible, clear and concise to all staff in order to facilitate the quality of care that is required within the institution.

7. **Outpatient Encounters:**
   a) All encounters for patient office visits must be completed and closed by the treating practitioner within forty-eight (48) hours from the end of the visit.
   b) After forty-eight (48) hours, the encounter will have a deficiency assigned in the system, appearing in their open chart folder.
   c) All ambulatory encounters must be accompanied by accurate documentation of patient information that corresponds with the level of service provided.

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**AMENDMENT 2 – Reporting Adverse Actions**

a. The Committee must report any professional review action that adversely affects the clinical privileges of a practitioner or dentist for a period longer than thirty (30) days. It is the duty for the Authorized Representative of the Committee to report adverse actions taken against clinical privileges of a practitioner, or dentist to the applicable licensing agency within fifteen (15) days of the date the adverse professional review action was taken. Any revisions in adverse professional review actions are to be reported in like manner. Before a report is submitted by the Authorized Representative, it shall be reviewed by the Chief of the Medical Staff and the Chief of the Service in which the affected practitioner or dentist has the majority of his or her privileges. The Chief of Staff and Chief of Service shall attest to the accuracy of the report on behalf of the Medical Staff. The affected practitioner or dentist is to receive a copy of the report for information only.

b. Voluntary surrender or reduction of clinical privileges is to be reported as described above when, at the time of surrender or reduction of privileges, the affected practitioner or dentist is under investigation by the medical staff for possible incompetence or improper professional conduct or if surrender or reduction is to avoid an investigation.
c. The process involving an investigation is set forth in Articles 4.2.2 through 4.4 of the Credentialing Policy.

d. Confidentiality of this report shall be maintained in accordance with guidelines currently in effect for practitioners' and dentists' credentials files.