# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. GENERAL</strong></td>
<td>1</td>
</tr>
<tr>
<td>1.A. DEFINITIONS</td>
<td>1</td>
</tr>
<tr>
<td>1.B. TIME LIMITS</td>
<td>1</td>
</tr>
<tr>
<td>1.C. DELEGATION OF FUNCTIONS</td>
<td>1</td>
</tr>
<tr>
<td><strong>2. CLINICAL SECTIONS</strong></td>
<td>2</td>
</tr>
<tr>
<td>2.A. LIST OF SECTIONS</td>
<td>2</td>
</tr>
<tr>
<td>2.B. FUNCTIONS AND RESPONSIBILITIES OF</td>
<td>3</td>
</tr>
<tr>
<td>DEPARTMENTS AND DIVISIONS</td>
<td></td>
</tr>
</tbody>
</table>
3. MEDICAL STAFF COMMITTEES

3.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

3.B. MEETINGS, REPORTS AND RECOMMENDATIONS

3.C. BYLAWS COMMITTEE

3.D. CANCER COMMITTEE

3.E. CODE COMMITTEE

3.F. CREDENTIALS COMMITTEE

3.G. ETHICS COMMITTEE

3.H. INFECTION CONTROL COMMITTEE

3.I. MEDICAL STAFF EXECUTIVE COMMITTEE

3.J. MEDICAL STAFF QUALITY AND PERFORMANCE REVIEW COMMITTEE
<table>
<thead>
<tr>
<th>3.K.</th>
<th>PEDIATRIC CODE COMMITTEE</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.L.</td>
<td>PERIOPERATIVE ADMINISTRATION COMMITTEE</td>
<td>11</td>
</tr>
<tr>
<td>3.M.</td>
<td>PHARMACY AND THERAPEUTICS COMMITTEE</td>
<td>12</td>
</tr>
<tr>
<td>3.N.</td>
<td>PROFESSIONAL STANDARDS COMMITTEE</td>
<td>13</td>
</tr>
<tr>
<td>3.O.</td>
<td>SEDATION COMMITTEE</td>
<td>14</td>
</tr>
<tr>
<td>3.P.</td>
<td>TISSUE REVIEW COMMITTEE</td>
<td>15</td>
</tr>
<tr>
<td>3.Q.</td>
<td>TRANSFUSION COMMITTEE</td>
<td>16</td>
</tr>
<tr>
<td>3.R.</td>
<td>TRAUMA PEER REVIEW COMMITTEE</td>
<td>17</td>
</tr>
<tr>
<td>3.S.</td>
<td>MEDICAL STAFF COUNCIL</td>
<td>17</td>
</tr>
<tr>
<td>4.</td>
<td>AMENDMENTS</td>
<td>18</td>
</tr>
<tr>
<td>5.</td>
<td>ADOPTION</td>
<td>18</td>
</tr>
</tbody>
</table>
ARTICLE 1

GENERAL

1.A. DEFINITIONS

The definitions that apply to terms used in all the Medical Staff documents are set forth in the Credentials Policy.

1.B. TIME LIMITS

Time limits referred to in this Manual are advisory only and are not mandatory, unless it is expressly stated.

1.C. DELEGATION OF FUNCTIONS

When a function is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chairman, may delegate performance of the function to one or more qualified designees.
ARTICLE 2

CLINICAL SECTIONS

2.A. LIST OF SECTIONS

The following clinical sections are established for the Hospital:

- Anesthesia Section (including but not necessarily limited to Anesthesia, Cardiovascular Anesthesia, Pain Management and Pediatric Anesthesia)
- Cardiology Section
- Cardiovascular Surgery Section
- Dermatology Section
- Emergency Medicine Section (including but not necessarily limited to General Emergency Medicine, Pediatric Emergency Medicine, Medical Toxicology, Aeromedical Transport, and Emergency Medical Sections)
- Family Practice Section
- Gastroenterology Section
- Hematology/Oncology Section (including but not necessarily limited to Bone Marrow Transplant)
- Infectious Diseases Section
- Internal Medicine Section (including but not necessarily limited to Allergy/Immunology, Clinical Pharmacology (physician only), Geriatrics, Occupational Medicine and Rheumatology)
- Medical & Molecular Genetics Section
- Nephrology Section
- Neurology Section
- Neurosurgery Section
- Obstetrics and Gynecology Section (including but not necessarily limited to General Obstetrics/Gynecology, Gynecological Oncology, Gynecology, Infertility, Maternal Fetal Medicine, Reproductive Endocrinology and Urogynecology)
- Ophthalmology Section (including but not necessarily limited to Adult Ophthalmology, Neuro-Ophthalmology and Pediatric Ophthalmology)
- Oral & Maxillofacial Surgery and Dentistry Section (including but not necessarily limited to Adult Dentistry, Oral Medicine/TMD, Oral Surgery Orthodontics and Pediatric Dentistry)
- Orthopaedics Section (including but not necessarily limited to Orthopaedic
Surgery, Pediatric Orthopaedics and Sports Medicine

- Otolaryngology and Head & Neck Surgery Section (including but not necessarily limited to Audiology and Speech, Facial Plastics, Head and Neck and Pediatric Otolaryngology)
- Pathology and Laboratory Sections (including but not necessarily limited to Blood Banking/Transfusion Medicine, Chemical Pathology, Cytopathology, Dermatopathology, Forensic Pathology, Hematology, Medical Microbiology, Necropsy, Neuropathology, Pediatric Pathology and Surgical Pathology)
- Pediatrics, General Section
- Pediatrics, Specialty Sections
- Pediatric Surgery
- Physical Medicine and Rehabilitation Section
- Plastic Surgery Section
- Psychiatry Section (including but not necessarily limited to Adult Psychiatry and Child and Adolescent)
- Pulmonology & Critical Care Medicine Section
- Radiation Oncology Section
- Radiology Section (including but not necessarily limited to Abdominal Imaging, Adult Radiology, Breast Imaging, Chest Radiology, Emergency Room Radiology, General Radiology, Musculoskeletal Radiology, Neuradiology, Nuclear Medicine, Pediatric Radiology and Vascular/Interventional Radiology)
- Surgery Section (including but not necessarily limited to General Surgery, Transplant Surgery and Trauma Surgery)
- Urology Section (including but not necessarily limited to Adult Urology and Pediatric Urology)
- Vascular Surgery

2.B. FUNCTIONS AND RESPONSIBILITIES OF DEPARTMENTS AND DIVISIONS

The functions and responsibilities of sections, sub-sections, section chairmen and sub-section chairmen are set forth in Article 4 of the Medical Staff Bylaws.
ARTICLE 3

MEDICAL STAFF COMMITTEES

3.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

(1) This Article outlines the Medical Staff committees of Indiana University Health that carry out peer review and other performance improvement functions that are delegated to the Medical Staff by the Board.

(2) Procedures for the appointment of committee chairmen and physician members of the committees are set forth in Article 5 of the Medical Staff Bylaws.

(3) Unless otherwise provided, all Hospital and administrative representatives on the committees shall be appointed by the Chief Executive Officer or designee.

3.B. MEETINGS, REPORTS AND RECOMMENDATIONS

Unless otherwise indicated, each committee described in this Manual will meet as necessary and will maintain a permanent record of its findings, proceedings, and actions. Each committee will make a timely written report after each meeting to the Medical Staff Executive Committee ("MSEC") and to other committees and individuals as may be indicated in this Manual.

3.C. BYLAWS COMMITTEE

3.C.1. Composition:

The Bylaws Committee shall be composed of an appropriate number of Active Members of the Medical Staff.
3.C.2. Duties:

The Bylaws Committee shall:

(a) meet as needed, at least annually, to review, draft and recommend corrections, changes and amendments to the Medical Staff Bylaws, Rules and Regulations, manuals and other applicable Medical Staff policies;

(b) ensure that the Bylaws and related documents reflect the current practice and structure of the Medical Staff and comply with changes which are required by state or federal law, Joint Commission ("JC") accreditation standards, and Centers for Medicare & Medicaid Services ("CMS") Conditions of Participation; and

(c) recommend changes and amendments as appropriate to the MSEC per Article 8 of the Medical Staff Bylaws.

3.D. CANCER COMMITTEE

3.D.1. Composition:

(a) The Cancer Committee shall be multidisciplinary with required members as appropriate to the institution to maintain accreditation by the American College of Surgeons, Commission on Cancer,

(b) The breast center services shall be multidisciplinary with required members as appropriate to the institution to maintain accreditation by the National Accreditation Program for Breast Center. The Breast Program Leadership will report to the Cancer Committee.

(c) The majority of the members of the Cancer Committee shall consist of members of the Active Staff and shall include both adult and pediatric representatives.
3.D.2. Duties:

The Cancer Committee provides:

(a) program leadership with duties as described in the Standards of the Commission on Cancer;

(s).

3.D.3. Meetings:

The Cancer Committee shall meet at least quarterly or at the call of the chair. Subcommittees will meet as needed for the completion of cancer committee and Breast Program Leadership activities.

3.E. CODE COMMITTEE

3.E.1. Composition:

(a) The Code Committee shall be a multidisciplinary committee that consists of members from sections who participate in critical care roles.

(b) Other members shall include a representative from Nursing, Respiratory Therapy and Pharmacy from critical care departments.

3.E.2. Duties:

The Code Committee shall:
(a) recommend policies and procedures related to cardiopulmonary resuscitation and the
calling of codes in the Hospital;

(b) recommend standards for code responses with a mechanism for systematic, ongoing
monitoring to provide improved patient care to cardiac arrest victims, and develop a
methodology for the collection, collation, and analysis of performance and outcomes data
of cardiopulmonary resuscitation in the Hospital;

(c) review personnel roles, procedures, and practices for code responses;

(d) identify educational needs of staff involved in cardiopulmonary resuscitation events and
coordinate basic and advanced life support teaching and testing; and

(e) recommend standardized equipment and medications for code responses.

3.E.3. Meetings:

The Code Committee shall meet at least quarterly or at the call of the chairman.

3.F. CREDENTIALS COMMITTEE

3.F.1. Composition:

The Credentials Committee shall consist of an appropriate number of members of the Active Staff
representing the major clinical sections. Particular consideration is to be given to Past Presidents
of the Medical Staff, past section chairmen, and other physicians knowledgeable in the
credentialing and quality improvement processes.

3.F.2. Duties:
The Credentials Committee shall:

(a) in accordance with the Credentials Policy, review the credentials of all applicants for Medical Staff and Allied Health Professionals appointment, reappointment, and clinical privileges, conduct a thorough review of the applications, interview such applicants as may be necessary, and make written reports of its findings and recommendations;

(b) review, as may be requested, all information available regarding the current clinical competence and behavior of persons currently appointed to the Medical Staff or Allied Health Professionals and, as a result of such review, make a written report of its findings and recommendations; and

(c) review and make recommendations regarding appropriate threshold eligibility criteria for clinical privileges within the Hospital, including specifically as set forth in Section 4.A.4 ("Clinical Privileges for New Procedures") and Section 4.A.5 ("Clinical Privileges That Cross Specialty Lines") of the Credentials Policy.

3.F.3. Meetings:

The Credentials Committee shall meet monthly or at the call of the chairman.
3.G. ETHICS COMMITTEE

3.G.1. Composition:

The Ethics Committee shall be a multidisciplinary committee and shall consist of an appropriate number of members of the Active Staff. At least one representative each from Nursing, Social Services, Clergy, Legal, and Administration shall also serve on the committee. The chairman may appoint individuals to temporary ad hoc positions on the committee when it is determined that their expertise may be necessary or of assistance for a particular issue.

3.G.2. Duties:

The Ethics Committee shall:

(a) serve as a resource for the Medical Staff, Hospital staff, and the community in regard to ethics information and education;

(b) facilitate communication and aid in conflict resolution between concerned parties by assisting in the identification of options available to the patient, the patient's family, and the physician;

(c) be responsible for ongoing internal education of committee members and for the development of educational programs for the Hospital, patients and their families, and the community;

(d) be responsible for the review and development of policies for the Hospital in the area of ethical principles and their application and for the revision of these policies as needed; and
(c) be responsible for developing procedures for responding to requests for consultations and be available for case consultation upon request of any member of the patient's health care team, the patient, or the patient's family.

3.G.3. Meetings:

The Ethics Committee shall meet at least quarterly or at the call of the chairman.

3.H. INFECTION CONTROL COMMITTEE

3.H.1. Composition:

The Infection Control Committee shall consist of an appropriate number of members of the Active Staff, representing the medical and surgical sections. The individual employed by the Hospital for management of the infection control program, such as an infection control nurse, and at least one representative each from Nursing Sections and Hospital administration shall also serve on the committee. The chairman may appoint individuals to temporary ad hoc positions on the committee when it is determined that their expertise may be necessary or of assistance for a particular issue.

3.H.2. Duties:

The Infection Control Committee shall:

(a) develop and maintain a Hospitalwide infection control program and maintain surveillance over the program;

(b) develop a system for identifying, analyzing, and reporting the incidence and cause of nosocomial infections in the Hospital;
(c) monitor infection surveillance data to uncover epidemics, cluster infections and unusual pathogens, and report such data and educate the Medical Staff and involved Hospital services on appropriate prevention and treatment protocols;

(d) review the surveillance and infection control policies related to all phases of the Hospital's activities and recommend opportunities for improvement to the particular department or section; and

(e) collaborate with the Pharmacy and Therapeutics Committee on the selection of antibiotics and antiviral agents for the Hospital formulary.

3.H.3. Meetings:

The Infection Control Committee shall meet at least six times per year or at the call of the chairman.

3.I. MEDICAL STAFF EXECUTIVE COMMITTEE

The composition and duties of the MSEC are set forth in Section 5.A of the Medical Staff Bylaws.

3.J. MEDICAL STAFF QUALITY AND PERFORMANCE REVIEW COMMITTEE

3.J.1. Composition:

(a) The Medical Staff Quality and Performance Review Committee shall consist of at least six voting members of the Medical Staff, including the Vice President of the Medical Staff or other officer (who shall serve as committee co-chair) along with a standing co-chair and section co-chair and physicians representing the Hospital-based section and Director of Anesthesia. Members appointed to this committee shall be appointed for terms of three to five years to ensure continuity.
(b) Other members shall include the following, who shall serve without a vote: Executive Vice President, Chief Medical Officer, Senior Vice President of Medical Quality, Director of Medical Staff Services, representatives from Legal Services and ad-hoc consulting members may be assigned as needed.

3.J.2. Duties:

The Medical Staff Quality and Performance Review Committee shall:

(a) Review the Senior Vice President of Medical Quality’s organizational improvement activities and the priorities concerning the same: develop an annual plan for performance improvement activities and set priorities concerning the same;

(b) Serve as the clearinghouse for all services gathering and reporting provider quality at either the individual practitioner or service line level;

(c) Encourage interdisciplinary approach to performance improvement activities;

(d) Review findings from patient satisfaction data;

(e) Ensure that identified system improvement opportunities are referred to the proper authorities;

(f) Ensure that identified practitioner improvement opportunities are addresses;

(g) Oversee the ongoing and focused professional practice evaluation processes and ensure that the information is communicated both to the practitioner and to the Credentialing Committee as per policy;

(h) Monitor patient quality and safety through evaluation of physician performance.
3.J.3. Meetings:

The Medical Staff Quality and Performance Review Committee shall meet at least quarterly each year or at the call of the chair. A quorum will be defined as those in attendance at the meeting. Agreement of a decision is a majority consensus of votes case.

3.K. PEDIATRIC CODE COMMITTEE

3.K.1. Composition:

(a) The Pediatric Code Committee shall be a multidisciplinary committee that consists of members involved in pediatric sections who participate in critical care and emergency response roles.

(b) Other members shall include a representative from Nursing, Respiratory Therapy and Pharmacy from critical care and pediatric departments.

3.K.2. Duties:

The Pediatric Code Committee shall:

(a) provide high quality standards for pediatric-specific cardiopulmonary resuscitation and the Children's Acute Response Team at Riley Hospital for Children and Riley Units at Methodist Hospital. Invitation for membership is extended to other Clarian/Indiana Health facilities which provide pediatric services to promote standardization of care;
(b) develop and maintain policies and procedures that are derived from evidence-based literature, supportive of regulatory guidelines and recommendations, and reflective of national standards of care;

(c) analyze aggregate data specific to the pediatric population;

(d) identify opportunities and support initiatives for improved patient outcomes;

(e) address issues that pertain to the operations of cardiopulmonary resuscitation and emergency response activities; and

(f) identify educational needs for staff involved in cardiopulmonary resuscitation events.

3.K.3. Meetings:

The Pediatric Code Committee shall meet at least quarterly or at the call of the chairman.

3.L. PERIOPERATIVE ADMINISTRATION COMMITTEE

3.L.1. Composition:

(a) The Perioperative Administration Committee shall consist of the following: Surgeon in Chief of the Indiana University Medical Center ("IUMC"); Perioperative Medical Directors of University Hospital, Riley Hospital and Methodist Hospital and the Beltways; Chair of the Department of Anesthesia at IUMC; Medical Director of Anesthesia at Methodist Hospital; Section Chief of Anesthesia at University Hospital; Section Chief of Anesthesia at Riley Hospital; and Medical Director of Infection Control for Clarian/Indiana.
(b) Other members shall include the Chief Nursing Officer for Clarian/Indiana Health; Vice President for Perioperative Sections; Perioperative Clinical Directors for University Hospital, Riley Hospital, and Methodist Hospital and the Beltways; Chief Quality Coordinator for Perioperative Sections; and Director of Risk Management and Patient Safety.

(c) The committee shall be cochaired by the Surgeon in Chief of IUMC and the Perioperative Medical Director of Methodist Hospital and the Beltways.

3.L.2. Duties:

The Perioperative Administration Committee shall:

(a) provide high quality standards for Perioperative Sections;

(b) develop and maintain policies and procedures that are derived from evidence-based literature, supportive of regulatory guidelines and recommendations, and reflective of national standards of care;

(c) participate in quality improvement activities and make recommendations based on the same;

(d) address issues that pertain to the operations of Perioperative Sections; and

(e) identify educational needs of physicians and perioperative staff.

3.L.3. Meetings:

The Perioperative Administration Committee shall meet at least quarterly or at the call of the chairman.
3.M. PHARMACY AND THERAPEUTICS COMMITTEE

3.M.1. Composition:

(a) The Pharmacy and Therapeutics Committee shall be composed of an appropriate number of Active Members of the Medical Staff.

(b) Other members shall include the Directors of Pharmacy, Manager, Drug Use Policy, a pharmacist with content expertise, and representatives from Hospital Administration, Nursing Services, Performance Improvement and other disciplines deemed appropriate by the committee chairman.

(c) The majority of the members of the Pharmacy and Therapeutics Committee shall be members of the Active Staff and shall include both adult and pediatric representatives.

3.M.2. Duties:

The Pharmacy and Therapeutics Committee shall:

(a) be responsible for the development and surveillance of all drug utilization policies and practices within the Hospital;

(b) assist in the formulation of policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the Hospital;

(c) advise the Medical Staff and the pharmaceutical department on matters pertaining to the choice of available drugs;
(d) make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

(e) develop and review periodically a formulary or drug list for use in the Hospital;

(f) evaluate clinical data concerning new drugs or preparations requested for use in the Hospital;

(g) recommend education programs for staff regarding drugs and their appropriate therapeutic use;

(h) oversee Drug Specialty Panels;

(i) establish guidelines for pharmaceutical representatives; and

(j) facilitate communication between the committee and the Institutional Review Boards.

3.M.3. Meetings:

The Pharmacy and Therapeutics Committee shall meet at least ten months each year.

3.N. PROFESSIONAL STANDARDS COMMITTEE

3.N.1. Composition:

The Professional Standards Committee shall consist of an appropriate number of members of the Medical Staff, including both adult and pediatric representatives. A physician representative from each IU Health downtown campus will also be appointed.
3.N.2. Duties:

The Professional Standards Committee shall:

(a) provide oversight of peer review activities conducted at the section level through examination of aggregate peer review data, including review of recommendations to adjust practitioner clinical privileges, based on investigations conducted at the section level; and

(b) review investigation of serious complaints and allegations of unethical, unprofessional or incompetent medical practice in conjunction with peer review activities that are conducted by the clinical sections.

With respect to matters involving individual Medical Staff members, the committee may provide such advice, counseling, or referrals as it may deem appropriate. Such advice, counseling or referrals may be confidential; however, in the event that information received by the committee demonstrates that the health or condition of a Medical Staff member may pose an undue risk of harm to patients or colleagues or in the event the committee recommends that action be taken pursuant to Article VI of the Credentials Policy, the committee shall notify and may make appropriate recommendations to the President of the Medical Staff or the MSEC.

The committee shall consider matters relating to the health and well-being of the Medical Staff and shall act as a liaison between impaired physicians and the Indiana State Medical Association-Physician Assistance Committee (“ISMA-PAC”). The committee shall act as a physician advocate as follows:

(a) be available to receive reports of potentially impaired physicians;

(b) refer reports regarding potentially impaired physicians to the ISMA-PAC;
(c) assist in gathering information on potentially impaired physicians and assist the ISMA-PAC in intervention, as appropriate; and

(d) assist the ISMA-PAC in rehabilitation efforts and/or monitoring.

Pursuant to Article I of the Credentials Policy, all activities of the committee shall be activities of a peer review committee under Indiana and federal law.

3.N.3. Meetings:

The Professional Standards Committee shall meet at least quarterly or at the call of the chairman.

3.O. SEDATION COMMITTEE

3.O.1. Composition:

The Sedation Committee shall consist of the appropriate number of physicians and nurses from multidisciplinary sections. Nurse members shall use their expertise in their specific areas of service and convey messages back to their facilities/departments.

3.O.2. Duties:

The Sedation Committee shall:

(a) provide high quality standards for sedation;

(b) develop and maintain policies and procedures that are derived from evidence-based literature and supportive of regulatory guidelines;
(c) monitor deep/moderate sedation processes throughout the organization;

(d) collect and analyze data to determine outcomes and opportunities for improvement and develop action plans, when appropriate;

(e) recommend education programs for staff and physicians in regard to the use of sedation;

(f) enforce competencies regarding deep and moderate sedations; and

(g) discuss and address other issues of sedation concern.

3.O.3. Meetings:

The Sedation Committee shall meet at least quarterly or at the call of the chairman.

3.P. TISSUE REVIEW COMMITTEE

3.P.1. Composition:

The Tissue Review Committee shall consist of an appropriate number of members, the majority of which shall be members of the Active Staff.

3.P.2. Duties:

The Tissue Review Committee shall:
(a) review and evaluate surgery performed in the Hospital when there is a disagreement among the preoperative, postoperative, and pathological diagnoses, or where a question of the acceptability of the procedure has been raised. Written reports shall be maintained reflecting the results of all evaluations performed and actions taken;

(b) establish a process to determine the appropriateness of procedures in which a clinically relevant discrepancy with the potential to change the course of therapy exists between the preoperative (clinical) diagnosis and postoperative (pathological) diagnosis; and

(c) consider the practice related to the review of pathology specimens diagnosed at outside institutions prior to internal clinical interventions.

3.P.3. Meetings:

The Tissue Review Committee shall meet at least quarterly or at the call of the chairman.

3.Q. TRANSFUSION COMMITTEE

3.Q.1. Composition:

(a) The Transfusion Committee shall consist of an appropriate number of members.

(b) Other members shall include the Medical Director of Transfusion Services and representatives from sections which are high-volume users of blood components, including Surgery, Anesthesia, Hemotology/Oncology, and Transplant Services.

(c) The majority of the members of the Transfusion Committee shall consist of members of the Active Staff and shall include both adult and pediatric representatives.

3.Q.2. Duties:
The Transfusion Committee shall:

(a) develop and monitor policies and procedures for the ordering, distribution, handling, use and administration of whole blood and blood components;

(b) review the adequacy of transfusion services for patient needs;

(c) review actual or suspected transfusion reactions and sentinel events related to transfusion practice; and

(d) evaluate blood usage, including the review of the amount of blood requested, the amount of blood used and the amount of blood wasted.

3.Q.3. Meetings:

The Transfusion Committee shall meet at least quarterly or at the call of the chairman.

3R. TRAUMA PEER REVIEW COMMITTEE

3.R.1 Composition

The Trauma Peer Review Committee shall consist of the Trauma Medical Director or designee, physician from the core trauma general surgeons, and physician representatives from: orthopedics, neurosurgery, emergency medicine, anesthesia, and trauma critical care.

3.R.2 Duties

The Trauma Peer Review Committee shall:
(a) perform peer review activities on all trauma related deaths;

(b) develop and maintain policies and procedures;

(c) identify opportunities for patient improvement/outcomes;

(d) identify educational needs of staff and physicians; and,

(e) analyze aggregate data.

3.R.3 Meetings

The Trauma Peer Review Committee will typically meet monthly, but the frequency is determined by the Trauma Medical Director based upon the needs of the Performance Improvement and Patient Safety Committee of the American College of Surgeons Committee on Trauma.

3.S. MEDICAL STAFF COUNCIL

3.S.1. Composition

The Medical Staff Council shall consist of the following persons: Medical Staff officers, section chiefs, medical staff committee co-chairs, chief medical officers, and appropriate representatives of administration.

3.S.2. Duties
The Medical Staff Council is to be used as a forum for education and distribution of information to the medical staff leadership. This includes but is not limited to the activities of the Medical Staff Executive Committee, results and responses to accreditation and regulatory bodies and activities of administration.

3.3 Meetings

The Medical Staff Council will meet at the call of the President of the Medical Staff.
ARTICLE 4

AMENDMENTS

This Manual may be amended in accordance with Article 8 of the Medical Staff Bylaws.
ARTICLE 5

ADOPTION

This Medical Staff Organization Manual is adopted and made effective upon approval of the Medical Staff and the Board, superseding and replacing any and all previous Medical Staff Bylaws and policies pertaining to the subject matter herein.

Adopted by the Medical Staff: February 15, 2011
Approved by the Board: February 24, 2012

Revision by the Medical Staff: December 4, 2012
Approved by the Board: December 13, 2012