

**TUESDAY, FEBRUARY 8, 2022**  
**WEXNER MEDICAL CENTER BOARD MEETING**

Leslie H. Wexner  
Abigail S. Wexner  
Erin P. Hoeflinger  
Hiroyuki Fujita  
Alan A. Stockmeister  
John W. Zeiger  
Carly G. Sobol  
Stephen D. Steinour  
Robert H. Schottenstein  
W.G. Jurgensen  
Cindy Hilsheimer  
Amy Chronis  
Gary R. Heminger (ex officio, voting)  
Kristina M. Johnson (ex officio, voting)  
Melissa L. Gilliam (ex officio, voting)  
Michael Papadakis (ex officio, voting)  
Mark Larmore and Andrew Thomas (ex officio, voting)

Location: Watch via livestream at <https://livestream.com/wosu/osubotfeb2022> 1:00-3:00pm

**Public Session**

1. Approval of November 2021 Wexner Medical Center Board Meeting Minutes
2. Interim Co-Leaders' Report – Mr. Mark Larmore, Dr. Andrew Thomas 1:00-1:05pm
3. James Cancer Hospital Report – Dr. William Farrar 1:05-1:10pm
4. Wexner Medical Center Financial Report – Mr. Mark Larmore 1:10-1:15pm
5. Recommend for Approval to Increase Professional Services and Construction Contracts – Mr. Frank Aucremanne 1:15-1:20pm
6. Recommend for Approval: Acquisition of Real Property – Mr. Frank Aucremanne
7. Quality & Professional Affairs Committee Items for Approval – Mr. Alan Stockmeister, Dr. Andrew Thomas, Dr. David Cohn 1:20-1:25pm
  - Ratification of Committee Appointments FY2022-2023
  - Delegation of Oversight and Management of the Food & Dietetic Services for the Wexner Medical Center and the James Cancer Hospital
  - Approval of Amendments to the Bylaws and Rules & Regulations of the Medical Staff of University Hospitals and the James Cancer Hospital

**Executive Session**

1:25-3:00pm

## **SUMMARY OF ACTIONS TAKEN**

*November 16, 2021 - Wexner Medical Center Board Meeting*

### **Members Present:**

Leslie H. Wexner  
Abigail S. Wexner  
Erin P. Hoeflinger  
Hiroyuki Fujita  
Alan A. Stockmeister  
John W. Zeiger

Carly G. Sobol  
Robert H. Schottenstein  
Cindy Hilsheimer  
Gary R. Heminger (ex officio)  
Kristina M. Johnson (ex officio)  
Melissa L. Gilliam (ex officio)

Michael Papadakis (ex officio)  
Mark Larmore (ex officio)  
Andrew Thomas (ex officio)

### **Members Present via Zoom:**

Stephen D. Steinour

Amy Chronis

### **Members Absent:**

W.G. "Jerry" Jurgensen

## **PUBLIC SESSION**

The Wexner Medical Center Board convened for its 40th meeting on Tuesday, November 16, 2021, in person at the Longaberger Alumni House on the Columbus campus and virtually over Zoom. Board Secretary Jessica A. Eveland called the meeting to order at 1:01 p.m.

### ***Item for Action***

1. Approval of Minutes: No changes were requested to the August 17, 2021, meeting minutes; therefore, a formal vote was not required, and the minutes were considered approved.

### ***Items for Discussion***

2. Interim Co-Leaders' Report: Mark Larmore, CFO, and Andrew Thomas, Chief Clinical Officer, were named interim co-leaders of the Wexner Medical Center following the resignation of former Chancellor and Executive Vice President Hal Paz. Mr. Larmore and Dr. Thomas will serve as co-members of the Wexner Medical Center Board for the interim period, sharing one vote between them and alternating their votes at each meeting. For this meeting, Mr. Larmore will serve as the voting member.

In honor of Veterans Day, Mr. Larmore began this report by expressing gratitude for all of the servicemen and women who have served and currently serve our country, including the 500 veterans and active-duty service members across the medical center. He also announced that the Robert F. Wolfe and Edgar T. Wolfe Foundation awarded a \$5 million gift to endow the chief clinical officer position at the medical center. Dr. Thomas is the first designee in this endowed position, the Wolfe Foundation Chief Clinical Officer Chair. Upon his retirement, the chair will be funded in perpetuity and renamed the Wolfe Foundation Dr. Andrew M. Thomas Chief Clinical Officer Chair.

Dr. Thomas thanked the Jay and Jeanie Schottenstein Foundation for a \$10 million gift to the College of Medicine to support mental health and resilience programs across the medical center and, especially, directed to support the student body. He also spoke about the 12th Annual Faces of Resilience event, which was hosted in September by Dr. Lee Shackelford and Ms. Patti Shorr. The event honored Governor



Mike DeWine, First Lady Fran DeWine and Nationwide Children's Hospital CEO Tim Robinson. It raised more than \$420,000 to benefit Ohio State's Department of Psychiatry and Behavioral Health and Harding Hospital. Additionally, Dr. Thomas highlighted the medical center's new TALK suicide prevention program as well as the good news that both the University Hospitals and Ross Heart Hospital nursing teams won a prestigious international award from the Magnet program of the American Nurses Credentialing Center. It was a \$75,000 prize and a unanimous vote by the awards committee – the first time ever– to recognize the nursing teams' creation of a remote glucose monitoring system during the COVID-19 pandemic. Additionally, he shared that the medical center set a record in terms of NIH funding last year with \$195 million in grants, and the College of Medicine's research funding topped \$300 million.

Mr. Larmore noted that Fifth Third Bank selected the medical center as one of nine centers to receive a grant of \$20 million to continue developing the PACT program on the Near East Side. PACT was established in 2010 with the City of Columbus and other Near East stakeholders. This is a great example of how the medical center can work with community partners to address health disparities. Additionally, five of our health sciences graduate programs received 2021 Health Professions HEED awards, which stands for Higher Education Excellence in Diversity, and the health system was selected by Becker's Hospital Review as one of the 10 most-trusted health system brands.

Finally, the group watched a pre-recorded performance of the "To the Builders" poem by Dr. Antoinette Pusateri, a current fellow at the medical center, in celebration of the new inpatient hospital tower being constructed on the Columbus campus.

3. Leading the Way: Military Medicine: Amy Moore, Professor and Chair of the Department of Plastic and Reconstructive Surgery, shared a presentation on Ohio State's plastic surgery efforts related to wounded veterans. Ohio has the fourth-largest veteran community in the United States. As such, the medical center is working to expand its Military Medicine Program, which will serve the needs of our nation's servicemen and women through integrated efforts designed to augment the range and quality of care available to our injured service members, enhance the capability of our military providers, foster meaningful research collaboration, and provide a community space for our military personnel and patients.

(See Attachment X for background information, page XX)

4. New Albany Ambulatory Update: Jay Anderson, Chief Operating Officer, gave an update on the medical center's newest ambulatory site, Outpatient Care New Albany, which opened in late July. The 250,000-square-foot facility offers comprehensive health care in a convenient, community setting, and it will serve as the model for the medical center's next ambulatory locations. The facility features more than 200 patient exam rooms, more than 50 clinic procedure rooms, a mammography unit, a surgery and endoscopy unit, and more. There are more than 130 providers there supported by 350-plus staff, and less than three months after opening the facility had already seen more than 40,000 patient visits.

(See Attachment X for background information, page XX)

5. James Cancer Hospital Report: William Farrar, CEO of the James Cancer Hospital, shared a variety of updates, including the hiring of the James' new CFO Ryan Goerlitz, who previously served as Associate Vice President of Finance in the College of Medicine. He also discussed the impact that COVID-19 has had on cancer screening rates and prevention efforts. Data from multiple journals indicates that, nationally, there has been a decrease of 56% to 85% in breast, colon, prostate and lung cancer screenings. To mitigate these declines, the James has invested significantly in its marketing efforts, targeting both the community and referring providers. Additionally, the James has worked to provide expanded access through the development of six new mammography screening locations around the central Ohio area. He also discussed the work of the Center for Cancer Health Equity at the OSUCCC-James to educate the community on the importance of screening and prevention. In the past five years, the center has hosted more than 600 events that reached 27,000 people.



Dr. Farrar also shared that Ohio has the fourth-highest level of radon in the nation. Radon exposure is the second-leading cause of lung cancer and the primary cause among non-smokers. Dr. David Carbone, director of the OSUCCC-James Thoracic Oncology Center, spearheaded the work to raise awareness of radon exposure to state leaders in order to create a statewide radon awareness month. Known as the Annie Cacciato Act, the new legislation, signed by Governor Mike DeWine in July, designated January as Radon Awareness Month in Ohio.

Additionally, Dr. Farrar shared that the OSUCCC-James recently added an additional member to the James Cancer Network – an affiliation with Mercy Health-Springfield. This affiliation will enhance cancer care services for patients throughout Clark and Champaign counties. With seven affiliations overall, the James Cancer Network is enhancing and expanding the scope of oncology care and research throughout the region and state. Also, the James has received national recognition for excellence in patient care after receiving the Press Ganey Guardian of Excellence in Patient Experience Award for the sixth time, as well as two Pinnacle of Excellence Awards.

(See Attachment X for background information, page XX)

- 6. Wexner Medical Center Financial Report: Mr. Larmore shared the medical center’s first quarter financial results, ending September 30. The health system – which includes the seven hospitals – saw an excess of revenue over expenses of \$79.6 million, which was approximately \$17 million more than anticipated. This was a 27.9% improvement over the same time last year. The combined Wexner Medical Center results, consisting of the health system, College of Medicine and OSU Physicians, showed \$89.2 million excess of revenue over expenses, which was approximately \$19 million more than anticipated, and a 26.8% improvement year-over-year. This shows 10.6% growth in revenue and 9.3% growth in expenses.

(See Attachment X for background information, page XX)

**Items for Action**

- 7. Resolution No. 2022-47, Recommend Approval to Enter Into Construction Contracts:

**APPROVAL TO ENTER INTO CONSTRUCTION CONTRACTS  
WMC Loading Dock Expansion and Renovation**

Synopsis: Authorization to enter into construction contracts, as detailed in the attached materials, is proposed.

WHEREAS in accordance with the attached materials, the University desires to enter into construction contracts for the following project:

	Construction Approval Requested	Total Requested	
WMC Loading Dock Expansion and Renovation	\$15.1M	\$15.1M	Auxiliary Funds

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves and proposes that the construction contracts for the project listed above be recommended to the University Board of Trustees for approval.

(See Attachment X for background information, page XX)

8. Resolution No. 2022-48, Ratification of Committee Appointments FY2022-2023:

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves that the ratification of appointments to the Quality and Professional Affairs Committee for FY2022-2023 are as follows:

Quality and Professional Affairs Committee

Alan A. Stockmeister, Chair  
Erin P. Hoeflinger  
Carly G. Sobol  
Melissa L. Gilliam  
Michael Papadakis  
Jay M. Anderson  
**MARK E. LARMORE**  
Andrew M. Thomas  
David E. Cohn  
Elizabeth Seely  
Scott A. Holliday  
Iahn Gonsenhauser  
Jacalyn Buck  
Kristopher M. Kipp  
Lisa Keder  
Alison R. Walker  
Abigail S. Wexner (ex officio)

**Action:** Upon the motion of Mr. Zeiger, seconded by Mr. Stockmeister, the board approved the foregoing motions by unanimous roll call vote with the following members present and voting: Mr. Wexner, Mrs. Wexner, Mrs. Hoeflinger, Dr. Fujita, Mr. Stockmeister, Mr. Zeiger, Ms. Sobol, Mr. Schottenstein, Ms. Hilsheimer, Ms. Chronis, Mr. Heminger, Dr. Johnson, Mr. Larmore, Dr. Gilliam and Mr. Papadakis. Mr. Steinour was not present.

**EXECUTIVE SESSION**

It was moved by Mrs. Wexner, and seconded by Mr. Heminger, that the board recess into executive session to consider business-sensitive trade secrets and quality matters required to be kept confidential by federal and state statutes, to consult with legal counsel regarding pending or imminent litigation, and to discuss personnel matters involving the appointment, employment and compensation of public officials, which are required to be kept confidential under Ohio law.

A roll call vote was taken, and the board voted to go into executive session with the following members present and voting: Mr. Wexner, Mrs. Wexner, Mrs. Hoeflinger, Dr. Fujita, Mr. Stockmeister, Mr. Zeiger, Ms. Sobol, Mr. Schottenstein, Ms. Hilsheimer, Ms. Chronis, Mr. Heminger, Dr. Johnson, Mr. Larmore, Dr. Gilliam and Mr. Papadakis. Mr. Steinour was not present.

The board entered executive session at 2:05 p.m. and adjourned at 5:36 p.m.



# Wexner Medical Center Board Report

The Arthur G. James Cancer Hospital and  
Richard J. Solove Research Institute

William Farrar, MD  
Chief Executive Officer  
February 8, 2022

## The James



**THE OHIO STATE UNIVERSITY**

WEXNER MEDICAL CENTER

Creating a Cancer-free World.  
One Person, One Discovery at a Time.

Since a “war on cancer” was declared half a century ago with the signing of the National Cancer Act of 1971, scientists and clinicians at the OSUCCC – James have made big gains against a formidable foe.

## 50 Years of the National Cancer Act: Cancer Pioneers at Ohio State

- **Dr. Arthur G. James** – Opened the first freestanding cancer hospital in the Midwest
- **Dr. Bertha Bouroncle** – Discovered hairy cell leukemia
- **Dr. Clara Bloomfield** – Revolutionized treatment for patients with acute myeloid leukemia and acute lymphoblastic leukemia
- **Dr. John Byrd** – World expert on chronic lymphocytic leukemia
- **Dr. Electra Paskett** – National expert on cancer health disparities
- **Dr. Albert de la Chapelle, Dr. Arnab Chakravarti, and more....**



## Top 50 Change Makers (2021): Congratulations to Dr. Electra Paskett



- **National Cancer Institute, Division of Cancer Prevention**
- **Commemoration of the 50<sup>th</sup> Anniversary of the National Cancer Act**
- **The champions and change makers of cancer prevention, early detection and symptom science**

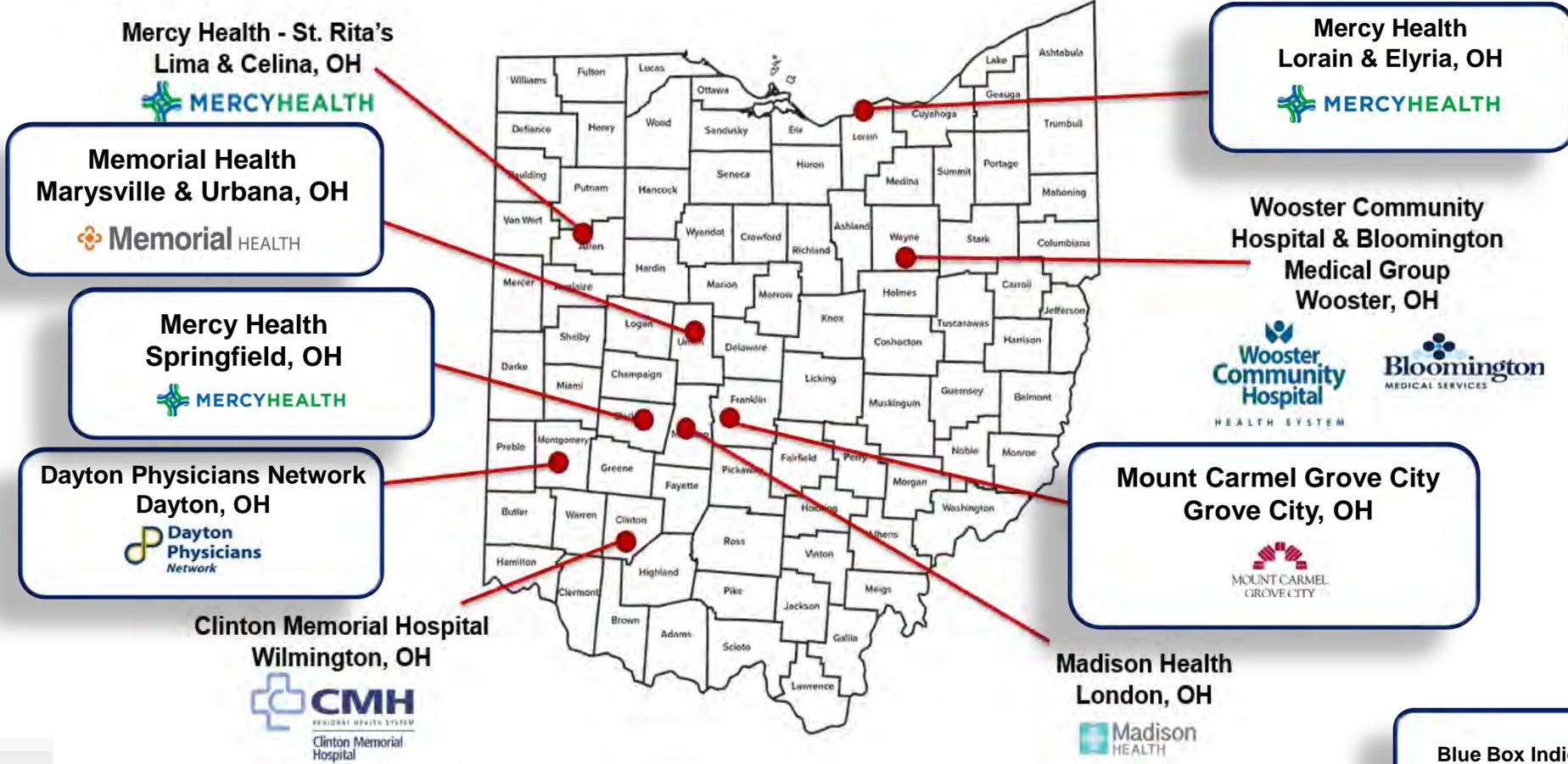
### **Electra D. Paskett, Ph.D.**

Marion N. Rowley Professor of Cancer Research  
Associate Director for Population Sciences and Community Outreach  
Founding Director of the Center for Cancer Health Equity at the OSUCCC – James



# The OSUCCC-James has expanded evidence-based cancer care and research to optimize care and survival rates for patients across Ohio.

## James Cancer Network 9 locations across Ohio



Blue Box Indicates New Relationships Between CYs 2019-2021

# **New Network Relationship:** We are proud to welcome the Dayton Physicians Network into the James Cancer Network family.



Enhance access to innovative and subspecialized care for cancer patients in the Dayton region



Create clinical rotations for OSU hematology / oncology fellows



Collaborate on clinical research

## 3 Goals of Partnership

*Note: This JCN affiliation is limited to medical oncology.*

# The dramatic progress that has been made in treating cancer over the past three decades has predominantly come from scientific research.

## Clinical trials:

- Provide options for people with cancer, while allowing physicians to improve the way they prevent, diagnose and treat cancer.
- Show the effectiveness of new cancer treatments.
- Give participants access to the latest advances available in the nation.
- Benefit future generations.

## The OSUCCC-James:

- Has **more than 600 open clinical trials** at any given time, with some of the world's latest discoveries available to clinical trial patients.
- **325 cancer researchers** dedicated to understanding what makes each patient's cancer grow, move, metastasize or reoccur.

## Patients at the OSUCCC – James who have successfully completed a clinical trial at OSU.



# The OSU Wexner Medical Center Outpatient Care West Campus will enhance access to vital cancer services for patients across central Ohio.



Looking southeast at the project site shows the current progress of the site in perspective with the 640 space parking garage in the background.

- Construction is progressing on schedule for Spring '23; Proton Center ready to “go-live” for Fall '23.
- FLASH: We have successfully commissioned our FLASH Mobetron device and have started to conduct investigations on small animal model systems.
- Varian has awarded us over \$2 million in funding for FLASH.
- One of five programs nationally to be currently under consideration for NCI ROBIN Program of Excellence designation (possible \$9 million grant award).

# Our Impact: Reach of Care and Research (FY21)

Inpatient Admissions

14,880

Clinic Visits

252,449



Patient Satisfaction Scores

95th Percentile

Therapeutic Accruals

961



600+ Clinical Trials

325 Cancer Researchers



Engagement on Social Media



518,616

\$19M

Raised by our Pelotonia Community

1.78 million  
Digital Pathology Tumor Sections Scanned (January 2021)

\$76,498,529

Total Peer-reviewed Cancer-focused Funding, with Emphasis from NCI

60,000 Patients Enrolled in Total Cancer Care®





**Thank You!**

The James





# **Wexner Medical Center Financial Report Public Session**

*February 8, 2022*

# The Ohio State University Health System

## Consolidated Statement of Operations

For the YTD ended: December 31, 2021

(in thousands)

<b>OSUHS</b>						
	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
<b>OPERATING STATEMENT</b>						
Total Operating Revenue	\$ 1,890,370	\$ 1,843,279	\$ 47,091	2.6%	\$ 1,747,280	8.2%
<b>Operating Expenses</b>						
Salaries and Benefits	809,343	804,339	(5,004)	-0.6%	751,230	-7.7%
Resident/Purchases Physician Services	65,356	64,718	(638)	-1.0%	62,634	-4.3%
Supplies	210,387	202,245	(8,142)	-4.0%	201,819	-4.2%
Drugs and Pharmaceuticals	258,752	244,994	(13,758)	-5.6%	232,952	-11.1%
Services	187,384	193,794	6,410	3.3%	162,400	-15.4%
Depreciation	98,612	98,614	2	0.0%	86,535	-14.0%
Interest	18,856	13,759	(5,097)	-37.0%	14,993	-25.8%
Shared/University Overhead	37,553	37,352	(201)	-0.5%	36,202	-3.7%
<b>Total Expense</b>	<b>1,686,243</b>	<b>1,659,815</b>	<b>(26,427)</b>	<b>-1.6%</b>	<b>1,548,765</b>	<b>-8.9%</b>
Gain (Loss) from Operations (pre MCI)	204,127	183,463	20,664	11.3%	198,516	2.8%
Medical Center Investments	(97,706)	(97,706)	-	0.0%	(91,982)	-6.2%
Income from Investments	14,721	8,798	5,923	67.3%	12,262	20.1%
Other Gains (Losses)	12,949	12,446	503	---	11,592	---
<b>Excess of Revenue over Expense</b>	<b>\$ 134,091</b>	<b>\$ 107,001</b>	<b>\$ 27,090</b>	<b>25.3%</b>	<b>\$ 130,387</b>	<b>2.8%</b>
<b>Margin Percentage</b>	<b>7.1%</b>	<b>5.8%</b>	<b>1.3%</b>	<b>22.2%</b>	<b>7.5%</b>	<b>-0.4%</b>

# The Ohio State University Wexner Medical Center

## Combined Statement of Operations

For the YTD ended: December 31, 2021

(in thousands)

	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
<b>OPERATING STATEMENT</b>						
Total Revenue	\$ 2,426,108	\$ 2,350,363	\$ 75,745	3.2%	\$ 2,229,284	8.8%
Operating Expenses						
Salaries and Benefits	1,297,614	1,282,511	(15,103)	-1.2%	1,185,658	-9.4%
Resident/Purchases Physician Services	65,356	64,718	(638)	-1.0%	62,634	-4.3%
Supplies	233,389	229,374	(4,015)	-1.8%	225,347	-3.6%
Drugs and Pharmaceuticals	263,864	249,618	(14,246)	-5.7%	237,611	-11.0%
Services	255,281	254,782	(500)	-0.2%	215,152	-18.7%
Depreciation	103,262	108,607	5,345	4.9%	97,313	-6.1%
Interest/Debt	18,972	13,906	(5,066)	-36.4%	15,119	-25.5%
Other Operating Expense	21,255	28,620	7,366	25.7%	29,314	27.5%
Medical Center Investments	1,844	999	(845)	-85%	14,167	87.0%
Total Expense	2,260,836	2,233,135	(27,702)	-1.2%	2,082,315	-8.6%
Excess of Revenue over Expense	\$ 165,272	\$ 117,228	\$ 48,043	41.0%	\$ 146,970	12.5%
<b>Financial Metrics</b>						
Integrated Margin Percentage	6.8%	5.0%	1.8%	36.6%	6.6%	0.2%
Adjusted Admissions	63,906	67,827	(3,920)	-5.8%	64,816	-1.4%
Operating Revenue per AA	\$ 29,580	\$ 27,176	\$ 2,404	8.8%	\$ 26,957	9.7%
Total Expense per AA	\$ 26,386	\$ 24,471	\$ (1,915)	-7.8%	\$ 23,895	-10.4%
This statement does not conform to Generally Accepted Accounting Principles. Different accounting methods are used in each of these entities and no eliminating entries are included.						

# The Ohio State University Wexner Medical Center

*Combined Balance Sheet  
As of: December 31, 2021  
(in thousands)*

	Dec 2021	June 2021	Change
<b>Cash</b>	\$ 1,658,820	\$ 1,747,406	\$ (88,586)
<b>Net Patient Receivables</b>	466,190	463,625	2,564
<b>Other Current Assets</b>	663,220	686,640	(23,419)
<b>Assets Limited as to Use</b>	1,151,871	511,090	640,781
<b>Property, Plant &amp; Equipment - Net</b>	2,336,975	2,097,748	239,227
<b>Other Assets</b>	583,942	527,245	56,697
<b>Total Assets</b>	<b>\$ 6,861,019</b>	<b>\$ 6,033,755</b>	<b>\$ 827,264</b>
<b>Current Liabilities</b>	\$ 805,033	\$ 847,443	\$ (42,410)
<b>Other Liabilities</b>	214,920	204,138	10,782
<b>Long-Term Debt</b>	1,269,738	602,438	667,300
<b>Net Assets - Unrestricted</b>	3,774,861	3,598,760	176,102
<b>Net Assets - Restricted</b>	796,467	780,977	15,490
<b>Liabilities and Net Assets</b>	<b>\$ 6,861,019</b>	<b>\$ 6,033,755</b>	<b>\$ 827,264</b>

This Balance sheet is not intended to conform to Generally Accepted Accounting Principles. Different accounting methods are used in each of these entities and no eliminating entries are included.

**Thank You**

[Wexnermedical.osu.edu](http://Wexnermedical.osu.edu)

**RECOMMEND APPROVAL TO INCREASE PROFESSIONAL SERVICES  
AND CONSTRUCTION CONTRACTS**

**APPROVAL TO INCREASE PROFESSIONAL SERVICES AND CONSTRUCTION CONTRACTS  
WMC Loading Dock Expansion and Renovation**

Synopsis: Authorization to increase professional services and construction contracts, as detailed in the attached materials, is proposed.

WHEREAS in accordance with the attached materials, the university desires to increase professional services and construction contracts for the following project:

	Prof. Serv. Approval Requested	Construction Approval Requested	Total Requested	
East Hospital Dock Expansion	\$0.6M	\$4.9M	\$5.5M	Auxiliary Funds

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves and proposes that the professional services and construction contracts for the project listed above be recommended to the University Board of Trustees for approval, and;

BE IT FURTHER RESOLVED, That the Wexner Medical Center Board hereby recommends that the President and/or Senior Vice President for Business and Finance be authorized to increase professional services and construction contracts for the project listed above in accordance with established university and State of Ohio procedures, with all actions to be reported to the Board at the appropriate time.

# Project Data Sheet for Board of Trustees Approval

## East Hospital Dock Expansion

OSU-210249 (Request ID: EAS210001)

Project Location: OSU East Hospital Loading Dock

- approval requested and amount**

increase professional services	\$0.6M
increase construction w/contingency	\$4.9M
- project budget**

professional services	\$0.6M
construction w/contingency	\$4.9M
<b>total project budget</b>	<b>\$5.5M</b>

- project funding**
  - university debt
  - fundraising
  - university funds
  - auxiliary funds
  - state funds

- project schedule**

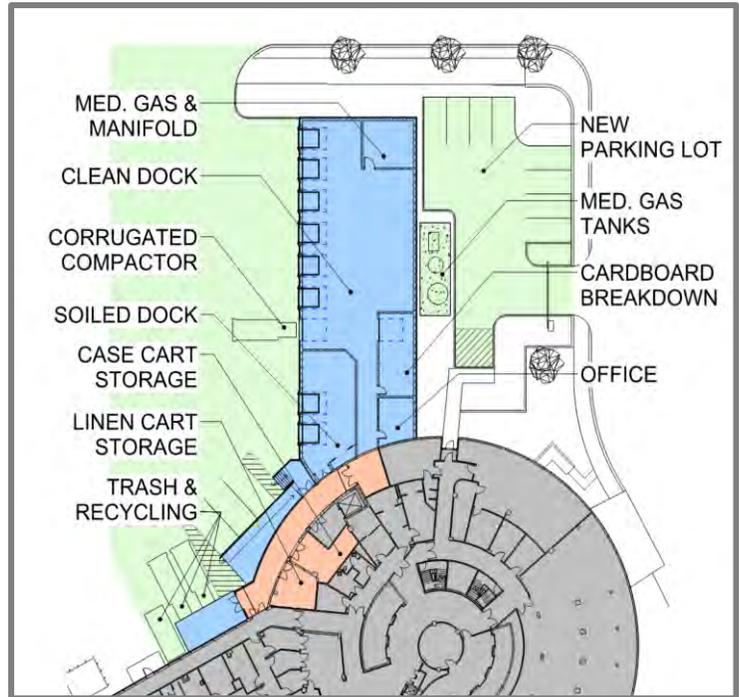
BoT prof svcs/con approval	02/22
design	05/21 – 10/22
construction	01/23 – 04/24
facility opening	06/24

- project delivery method**
  - general contracting
  - design/build
  - construction manager at risk

- planning framework**
  - o this project is included in the FY21 and FY22 Capital Investment Plans and will be included in the FY23 plan
  - o this project is based on a study that was completed in January 2020. the total project cost was updated in September 2021 during the design process

- project scope**
  - o this project will add nine new bays, approximately 6,000 sf, to the existing three for a total of twelve
  - o the upgrade will meet the offsite central sterile requirements to provide an enclosed space for cart delivery and pick up
  - o the three existing dock bays will remain operational during construction

- approval requested**
  - o approval is requested to increase professional services and construction contracts



- project team**

University project manager:	Ben Trick
AE/design architect:	Davis Wince
CM at Risk:	

**RECOMMEND FOR APPROVAL  
ACQUISITION OF REAL PROPERTY**

AT LEONARD AVENUE  
FRANKLIN COUNTY, OHIO

Synopsis: Authorization to acquire property located adjacent to Outpatient Care East, on Leonard Avenue, City of Columbus, Franklin County, Ohio, for the development of parking facilities, is proposed.

WHEREAS The Ohio State University seeks to acquire approximately 5 acres of unimproved real property located at Outpatient Care East, on Leonard Avenue in the City of Columbus, Ohio; and

WHEREAS the ground will be developed into parking facilities for the Outpatient Care East facility:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves and proposes that the purchase of said property be recommended to the University Board of Trustees for approval; and

BE IT FURTHER RESOLVED, That the Wexner Medical Center Board hereby recommends that the President and/or Senior Vice President for Business and Finance shall be authorized to take any action required to effect the purchase of this property upon terms and conditions deemed to be in the best interest of the university.

**APPROVAL FOR ACQUISITION OF REAL PROPERTY  
LEONARD AVENUE  
COLUMBUS, FRANKLIN COUNTY, OHIO  
BOARD BACKGROUND**

**Background**

The Ohio State University seeks to acquire approximately 5 acres of land from the State of Ohio Department of Transportation (ODOT) located on the Near East Side of Columbus and adjacent to Outpatient Care East for the purpose of expanding parking options in support of the medical operations.

**Location and Description**

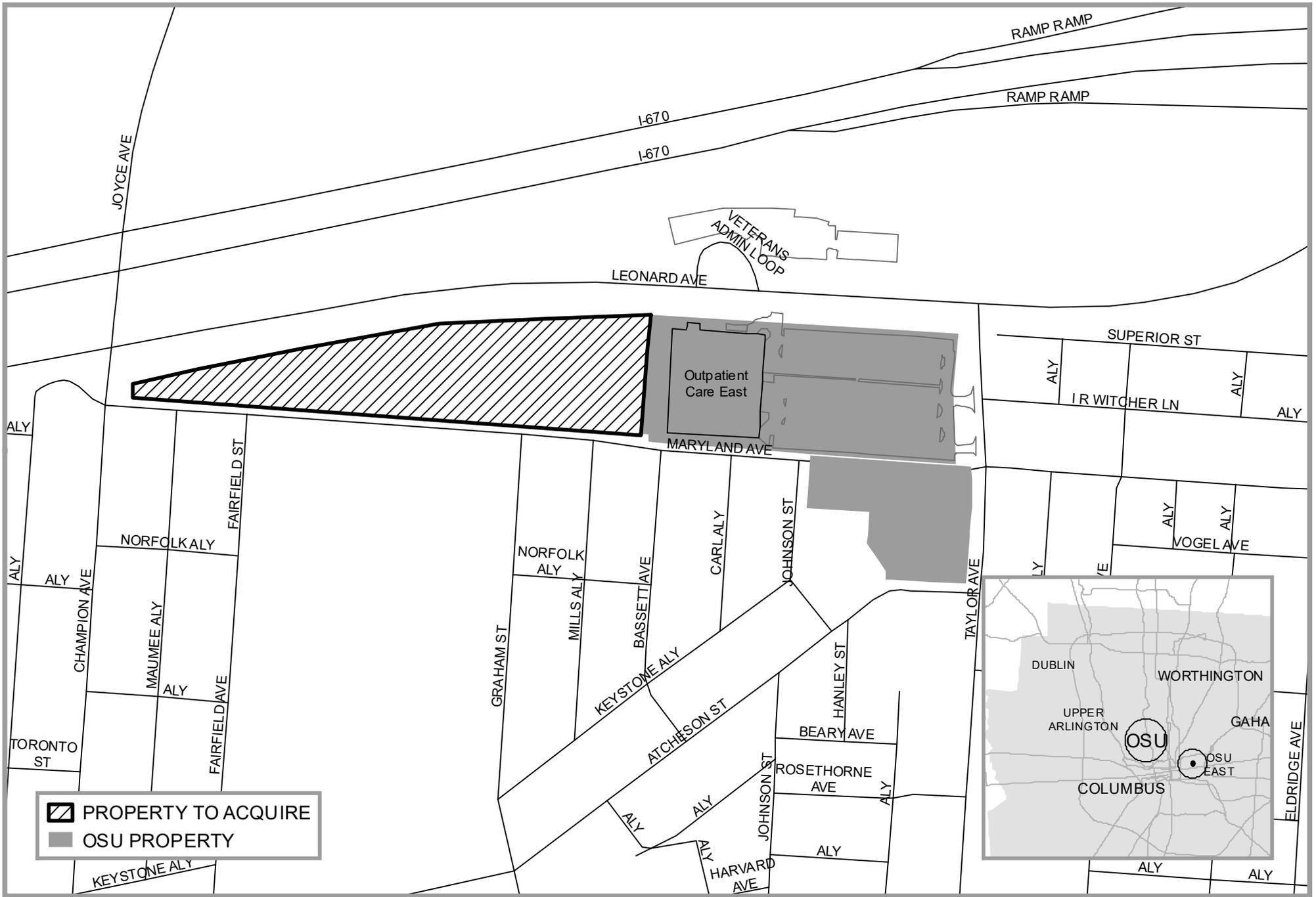
The affected property is located on the west side of Outpatient Care East. The site is identified as Franklin County parcel number 010-047041 and adjacent tract. It is located within the City of Columbus and is zoned M2, Manufacturing.

**Property History**

The property is titled to the State of Ohio, Department of Transportation and will be acquired in the name of the State of Ohio for the use and benefit of The Ohio State University.

**Acquisition of Property**

Planning, Architecture and Real Estate, together with the Wexner Medical Center, recommend that the +/- 5 acres be acquired under terms and conditions that are deemed to be in the best interest of the university. The source of funding for the acquisition is the Wexner Medical Center. OSU will perform due diligence to support the subject price.



 PROPERTY TO ACQUIRE  
 OSU PROPERTY

ODOT PROPERTY ACQUISITION  
 PID 010-047041 AND ADJACENT TRACT  
 COLUMBUS, FRANKLIN COUNTY, OHIO 43203

**RATIFICATION OF COMMITTEE APPOINTMENTS FY2022-2023**

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves that the ratification of appointments to the Quality and Professional Affairs Committee for FY2022-2023 are as follows:

**Quality and Professional Affairs Committee**

Alan A. Stockmeister, Chair  
Erin P. Hoeflinger  
Carly G. Sobol  
Melissa L. Gilliam  
Michael Papadakis  
Jay M. Anderson  
Mark E. Larmore  
Andrew M. Thomas  
David E. Cohn  
Elizabeth Seely  
Scott A. Holliday  
Iahn Gonsenhauser  
Jacalyn Buck  
Kristopher M. Kipp  
Lisa Keder  
**PAUL MONK**  
Abigail S. Wexner (ex officio)

**FOOD AND DIETETIC SERVICES**

**OHIO STATE UNIVERSITY HOSPITALS d/b/a OSU WEXNER MEDICAL CENTER**

Synopsis: Approval of the oversight and management of the Food and Dietetic Services for the hospitals at the Ohio State University Hospitals d/b/a OSU Wexner Medical Center, including: Ohio State University Hospital, Ohio State Richard M. Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital, is proposed.

WHEREAS the mission of the Ohio State University Hospitals is to improve people's lives through the provision of high-quality patient care; and

WHEREAS the Food and Dietetic Services for the Ohio State University Hospital, Ohio State Richard M. Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital must have a full-time employee who serves as the Director of the Food and Dietetic Services; and

WHEREAS the Director of the Food and Dietetic Services is responsible for the daily management of the dietary services, and must be qualified by experience or training; and

WHEREAS on November 10, 2021, the University Hospital Medical Staff Administration Committee granted the authority and delegated the responsibility to the Director of the Food and Dietetic Services for: the daily management of the food and dietetic services, the implementation of training programs for the dietary staff, and the establishment and maintenance of policies and procedures addressing safety practices for food handling; and

WHEREAS the University Hospital Medical Staff Administration Committee's delegation of oversight of the Food and Dietetic Services to the Director of the Food and Dietetic Services is contingent on final approval by the Wexner Medical Center Board; and

WHEREAS on November 23, 2021, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board delegate the oversight and management of the Food and Dietetic Services to the Director of Food and Dietetic Services:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby delegates the oversight and management of the Food and Dietetic Services to the Director of Food and Dietetic Services for University Hospital, Ohio State Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital.

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**FOOD AND DIETETIC SERVICES**

THE OHIO STATE UNIVERSITY COMPREHENSIVE CANCER CENTER  
ARTHUR G. JAMES CANCER HOSPITAL AND  
RICHARD J. SOLOVE RESEARCH INSTITUTE

Synopsis: Approval of the oversight and management of the Food and Dietetic Services for the Ohio State Comprehensive Cancer Center — James Cancer Hospital and Solove Research Institute, is proposed.

WHEREAS the mission of The James is to eradicate cancer from individuals' lives by generating knowledge and integrating groundbreaking research with excellence in education and patient-centered care; and

WHEREAS the Food Services Director must have a full-time employee who serves as the Director of the Food and Dietetic Services at The James; and

WHEREAS the Director of the Food and Dietetic Services is responsible for the daily management of the dietary services, and must be qualified by experience or training; and

WHEREAS on November 19, 2021, The James Medical Staff Administration Committee granted the authority and delegated the responsibility to the Director of the Food and Dietetic Services for: the daily management of the food and dietetic services, the implementation of training programs for the dietary staff, and the establishment and maintenance of policies and procedures addressing safety practices for food handling; and

WHEREAS The James Medical Staff Administration Committee's delegation of oversight of the Food and Dietetic Services to the Director of the Food and Dietetic Services is contingent on final approval by the Wexner Medical Center Board; and

WHEREAS on November 23, 2021, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board delegate the oversight and management of the Food and Dietetic Services to the Director of Food and Dietetic Services:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby delegates the oversight and management of the Food and Dietetic Services to the Director of Food and Dietetic Services for The James.

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		<b>Proposed Bylaws and Rules &amp; Regs Changes</b>	
<b>Agenda Item</b>	<b>Topic</b>	<b>Background</b>	<b>For Review/Proposed Change</b>
1	Amend language to comply with JC Standard	Joint Commission Standard:	3335-111-07 Categories of the Medical Staff - Page 32
		MS.06.01.134 All temporary privileges are granted by the chief executive officer or authorized designee.	(J.) Temporary privileges:
			(a) Temporary privileges may be extended to a doctor of medicine, osteopathic medicine, dental surgery, psychologist, podiatry or to a licensed health care professional upon completion of an application prescribed by the medical staff administrative committee, upon recommendation of the chief of the clinical department. <del>and approval by the chief medical officer. All temporary privileges are granted by the chief executive officer or authorized designee. The chief medical officer has been delegated responsibility by the Wexner medical center board to grant approval of temporary privileges.</del> The temporary privileges granted shall be consistent with the applicant's training and experience and with clinical department guidelines. Prior to granting temporary privileges, primary source verification of licensure and current competence shall be required. Temporary privileges shall be limited to situations which fulfill an important patient-care need, and shall be granted for a period not to exceed one hundred twenty days.
2	OP Visit note completion and closure of open encounters	OSUP Policy:	<b>Rules &amp; Regs 84-10 Medical Records-Deadlines and sanctions.</b> - Pages 10 & 11
			A. (2) Deadlines and Sanctions
		I. Timeliness of Documentation Standards.	(e.) <del>Office visit encounters shall be closed within ten days of the patient's visit. Outpatient visit notes and letters to referring physicians, when appropriate, shall be completed within three days of the patient's visit.</del>
		1. A procedure note shall be entered in the record immediately upon completion of the procedure.	(f.) All entries not previously defined must be signed within ten <del>business</del> days of completion.
		2. All ambulatory visit notes and letters to referring physicians shall be written, dictated, or electronically created within 3 days of the patient's visit and the encounter closed within one week.	(g). Queries by clinical documentation specialists requesting clarification of a patient's diagnoses and procedures will be resolved within five business days of confirmed notification of request.
		3. OSUP shall follow the Health System's documentation standards for in-patient services. These standards can be located on OneSource under Medical Information Management within the Medical Staff Rules and Regulations or in the E-documentation guidelines.	<del>(h.) Office visit encounters shall be closed within one week of the patient's visit.</del>

**AMENDMENTS TO THE *BYLAWS AND RULES AND REGULATIONS*  
OF THE MEDICAL STAFF OF THE OHIO STATE UNIVERSITY HOSPITALS**

Synopsis: The amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals are recommended for approval.

WHEREAS a summary of the proposed amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals is attached; and

WHEREAS the proposed amendments are also attached; and

WHEREAS the proposed 2021 amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals were approved by a joint University Hospitals and James Medical Staff Bylaws Committee on September 29, 2021; and

WHEREAS the proposed 2021 amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals were approved by the University Hospitals Medical Staff Administrative Committee on October 13, 2021; and

WHEREAS the proposed 2021 amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals were approved by vote of the University Hospitals Medical Staff on November 18, 2021; and

WHEREAS on December 8, 2021, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals.



**University Hospital Bylaws and Rules & Regulations  
Summary<sup>1</sup> of Proposed Changes for Review/Vote**

1. **Background:** This bylaws change is proposed to comply with Joint Commission Standard MS.06.01.13 EP4. The redline language is taken directly from the JC standard.

**3335-43-07 Categories of the medical staff**

2) Temporary privileges:

(a) Temporary privileges may be extended to a doctor of medicine, osteopathic medicine, dental surgery, psychologist, podiatry or to a licensed health care professional upon completion of an application prescribed by the medical staff administrative committee, upon recommendation of the chief of the clinical department, and approval by the chief medical officer. All temporary privileges are granted by the chief executive officer or authorized designee. The chief medical officer has been delegated responsibility by the Wexner medical center board to grant approval of temporary privileges. The temporary privileges granted shall be consistent with the applicant's training and experience and with clinical department guidelines. Prior to granting temporary privileges, primary source verification of licensure and current competence shall be required. Temporary privileges shall be limited to situations which fulfill an important patient-care need, and shall be granted for a period not to exceed one hundred twenty days.

2. **Background:** These proposed rules and regulation changes are to clarify deadlines for outpatient visits and to ensure that the ambulatory policy implemented by OSUP aligns with the Rules & Regulations. Other deadlines defined in this section (operative notes, discharges, progress notes, etc.) are not affected, but work will continue to review, clarify and simplify the language and associated sanctions.

**84-12 Medical Records**

(2) Deadlines and sanctions.

- e. Office visit encounters shall be closed within ten days of the patient's visit. Outpatient visit notes and letters to referring physicians, when appropriate, shall be completed within three days of the patient's visit.
- f. All entries not previously defined must be signed within ten ~~business~~ days of completion.
- g. Queries by clinical documentation specialists requesting clarification of a patient's diagnoses and procedures will be resolved within five business days of confirmed notification of request.
- h. ~~Office visit encounters shall be closed within one week of the patient's visit.~~

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<sup>1</sup> The full text of the effected bylaw and medical staff rule are included in the following pages with proposed revisions included.



### **3335-43-07 Categories of the medical staff.**

The medical staff of the Ohio state university hospitals shall be divided into seven categories: physician scholar medical staff; attending medical staff; courtesy A medical staff; courtesy B medical staff; community affiliate medical staff; consulting medical staff; and limited staff. Medical staff members who do not wish to obtain any clinical privileges shall be exempt from the requirements of medical malpractice liability insurance, DEA registration, demonstration of recent active clinical practice during the last two years and specific annual education requirements as outlined in the list maintained in the chief medical officer's office, but are otherwise subject to the provisions of these bylaws.

#### (A) Physician scholar medical staff.

(1) Qualifications: The physician scholar medical staff shall be composed of those faculty members of the colleges of medicine and dentistry who are recognized for outstanding reputation, notable scientific and professional contributions, and high professional stature. This medical staff category includes but is not limited to emeritus faculty members. Nominations may be made to the chair of the credentialing committee who shall present the candidate to the medical staff administrative committee for approval.

(2) Prerogatives: Members of the physician scholar medical staff shall have access to the Ohio state university hospitals and shall be given notice of all medical staff activities and meetings. Members of the physician scholar medical staff shall enjoy all rights of an attending medical staff member except physician scholar members shall not possess clinical privileges.

(3) Physician scholar medical staff must have either a full license or an emeritus registration by the State Medical Board of Ohio.

#### (B) Attending medical staff.

(1) Qualifications: The attending medical staff shall consist of those faculty members of the colleges of medicine and dentistry to whom clinical teaching responsibilities are assigned in the Ohio state university hospitals and who satisfy the requirements and qualifications for membership set forth in rule 3335-43-04 of the Administrative Code. The assignment of teaching responsibility is the prerogative of the chief of the clinical department or the chief's designee.

#### (2) Prerogatives:

An attending medical staff member may:

(a) Admit patients consistent with their clinical privileges and the balanced teaching and patient care responsibilities of the Ohio state university hospitals. When, in the judgment of the chief of the clinical department, a balanced teaching program is jeopardized, following consultation with the dean of the college of medicine and the Ohio state university hospitals' chief executive officer, and with the concurrence of a majority of the medical staff administrative committee, the chief of the clinical department may restrict an attending medical staff member's ability to admit patients. Imposition of



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such restrictions shall not entitle the attending medical staff member to a hearing or appeal pursuant to rule 3335-43-06 of the Administrative Code.

(b) Be free to exercise such clinical privileges as are granted pursuant to these bylaws.

(c) Vote on all matters presented at general and special meetings of the medical staff and of the department and committees of which he or she is a member unless otherwise provided by resolution of the medical staff, clinical department, or committee and approved by the medical staff administrative committee.

(d) Hold office in the medical staff organization and in the clinical department and committees of which he or she is a member, unless otherwise provided by resolution of the medical staff, clinical department, or committee and approved by the medical staff administrative committee.

(3) Responsibilities:

Each member of the attending medical staff with clinical privileges shall:

(a) Meet the basic responsibilities set forth in rules 3335-43-02 and 3335-43-03 of the Administrative Code.

(b) Retain responsibility within the member's area of professional competence for the continuous care and supervision of each patient in the Ohio state university hospitals for whom the member is providing care, or arrange a suitable alternative for such care and supervision.

(c) Actively participate in such quality evaluation and monitoring activities as required by the medical staff, and discharge such medical staff functions as may be required from time to time.

(d) Satisfy the requirements set forth in rule 3335-43-11 of the Administrative Code for attendance at staff and departmental meetings and meetings of those committees of which he or she is a member and for payment of membership dues.

(e) Supervise members of the limited staff in the provision of patient care in accordance with accreditation standards and policies and procedures of approved clinical training programs. It is the responsibility of the attending physician to authorize each member of the limited staff to perform only those services which the limited staff member is competent to perform under supervision.

(f) Supervise other licensed healthcare professionals as necessary in accordance with accreditation standards and state law. It is the responsibility of the attending physician to authorize each licensed healthcare professional to perform only those services which the licensed healthcare professional is privileged to perform.

(g) Take call as assigned by the chief of the clinical department.

(C) Courtesy A medical staff.

(1) Qualifications: The courtesy A medical staff shall consist of those faculty members of the colleges of medicine and dentistry who do not qualify for attending medical staff appointment. This



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category includes community physicians who routinely admit patients to the Ohio state university hospitals and who actively participate in teaching programs.

### (2) Prerogatives:

The courtesy A medical staff may:

- (a) Exercise such clinical privileges as are granted pursuant to these bylaws.
- (b) Admit, consistent with their clinical privileges, patients who complement the clinical teaching program.
- (c) Attend meetings as a member of the medical staff and the clinical department of which he or she is a member and any medical staff or the Ohio state university hospitals education programs. The courtesy A medical staff member may vote for and be eligible to hold a position on the medical staff administrative committee reserved for the representative of the courtesy A or community affiliate medical staff as set forth in paragraph (D) of rule 3335-43-09 and paragraph (C) of rule 3335-43-10 of the Administrative Code. Members of the courtesy A medical staff may serve on non-elected medical staff committees as provided by these bylaws.

(3) Responsibilities: Each member of the courtesy A medical staff with clinical privileges shall be required to discharge the basic responsibilities specified in paragraph (B)(3) of this rule.

### (D) Courtesy B medical staff.

(1) Qualifications: The courtesy B medical staff shall consist of those faculty members of the colleges of medicine and dentistry who do not qualify for attending medical staff appointment. This category is comprised of referring physicians who desire to be associated with the Ohio state university hospitals to refer and follow patients. Courtesy B medical staff members shall not possess clinical privileges, shall not be eligible to vote on medical staff policies, rules and regulations, or bylaws, and shall not be eligible to hold office.

### (2) Prerogatives:

Courtesy B medical staff members may:

- (a) Have access to the Ohio state university hospitals and shall be given notice of all medical staff activities and meetings.
- (b) Attend meetings as a member of the medical staff and the clinical departments of which he or she is a member and any medical staff or the Ohio state university hospitals education programs.
- (3) The grant of courtesy B medical staff appointment to physicians is a courtesy only, and may be terminated by the Wexner medical center board upon recommendation of the medical staff administrative committee without the right to a hearing or appeal.

### (E) Limited staff.



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Limited staff are not considered full members of the medical staff, do not have delineated clinical privileges and do not have the right to vote in general medical staff elections. Except where expressly stated, members of the limited staff are bound by the terms of these bylaws, the rules and regulations of the medical staff, and the limited staff agreement.

### (1) Qualifications:

(a) The limited staff shall consist of doctors of medicine, osteopathic medicine, dentists and practitioners of podiatry or psychology who are accepted in good standing by a program director into a post-doctoral graduate medical education program and appointed to the limited staff in accordance with these bylaws.

(b) The limited staff shall maintain compliance with the requirements of state law, including regulations adopted by the Ohio state university Wexner medical center board, or the limited staff member's respective licensing board.

(c) Members of the limited staff shall possess a valid training certificate or an unrestricted Ohio license from the applicable state board based on eligibility criteria defined by that state board. All members of the limited staff shall be required to successfully obtain an Ohio training certificate prior to beginning training within a program.

### (2) Responsibilities:

Each member of the limited staff shall:

(a) Be responsible to respond to all questions and to complete all forms as may be required by the credentials committee.

(b) Participate fully in the teaching programs, conferences, and seminars of the clinical department in which he or she is appointed in accordance with accreditation standards and policies and procedures of the graduate medical education committee and approved clinical training programs.

(c) Participate in the care of all patients assigned to the limited staff member under the appropriate supervision of a designated member of the attending or courtesy A medical staff in accordance with accreditation standards and policies and procedures of the clinical training programs. The clinical activities of the limited staff shall be determined by the program director appropriate for the level of education and training. Limited staff shall be permitted to perform only those services that they are authorized to perform by the member of the attending or courtesy A medical staff based on the competence of the limited staff to perform such services. The limited staff may admit or discharge patients only when acting on behalf of the attending or courtesy A medical staff. The limited staff member shall follow all rules and regulations of the service to which the limited staff member is assigned, as well as the general rules of the Ohio state university hospitals pertaining to limited staff. Specifically, a limited staff member shall consult with the attending or courtesy A member of the medical staff responsible for the care of the patient before the limited staff member undertakes a procedure or treatment that carries a significant, material-risk to the patient unless the consultation would cause a delay that would jeopardize the life or health of the patient.

(d) Serve as a member of various medical staff committees in accordance with established committee composition as described in these bylaws and/or the rules and regulations of the medical



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staff. The limited staff member shall not be eligible to vote or hold elected office in the medical staff organization but may vote on committees to which the limited staff member is assigned.

(e) Be expected to make regular satisfactory professional progress including anticipated certification by the respective specialty or sub-specialty program of post-doctoral training in which the limited staff member is enrolled. Evaluation of professional growth and appropriate humanistic qualities shall be made on a regular schedule by the clinical departmental chief, program director, teaching faculty or evaluation committee in accordance with accreditation standards and policies and procedures of the approved training programs.

(f) Appeal by a member of the limited staff of probation, lack of promotion, suspension or termination for failure to meet expectations for professional growth or failure to display appropriate humanistic qualities or failure to successfully complete any other competency as required by the accreditation standards of an approved training program will be conducted and limited in accordance with written guidelines established by the respective department or training program and approved by the program director and the Ohio state university hospitals graduate medical education committee as delineated in the limited staff agreement and by the graduate medical education policies.

Alleged misconduct by a member of the limited staff, for reasons other than failure to meet expectations of professional growth as outlined above, shall be handled in accordance with rules 3335-43-05 and 3335-43-06 of the Administrative Code.

(3) Failure to meet reasonable expectations.

Termination of employment from the limited staff member's residency or fellowship training program shall result in automatic termination of the limited staff member's appointment pursuant to these bylaws.

(4) Temporary appointments.

(a) Limited staff members who are Ohio state university faculty may be granted an early commencement or an extension of appointment upon the recommendation of the chief of the clinical department, with prior concurrence of the associate dean for graduate medical education, when it is necessary for the limited staff member to begin his or her training program prior to or extend his or her training program beyond a regular appointment period. These appointments shall not exceed sixty days.

(b) Temporary appointments may be granted upon the recommendation of the chief of the clinical department, with prior concurrence of the medical directors, for limited staff members who are not Ohio state university faculty but who, pursuant to education affiliate agreements approved by the university, need to satisfy approved graduate medical education clinical rotation requirements. These appointments shall not exceed a total of one hundred twenty days in any given post-graduate year. In such cases, the mandatory requirement for a faculty appointment may be waived. All other requirements for limited staff member appointment must be satisfied.

(5) Supervision.

Limited staff members shall be under the supervision of an attending or courtesy A medical staff member. Limited staff members shall have no privileges as such but shall be able to care for patients under the supervision and responsibility of their attending or courtesy A medical staff member. The



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care they extend will be governed by these bylaws and the general rules and regulations of each clinical department. The practice of care shall be limited by the scope of privileges of their attending or courtesy A medical staff member. Any concerns or problems that arise in the limited staff member's performance should be directed to the attending or courtesy A medical staff member or the director of the training program.

(a) Limited staff members may write admission, discharge and other orders for the care of patients under the supervision of the attending or courtesy A medical staff member.

(b) All records of limited staff member cases must document involvement of the attending or courtesy A medical staff member in the supervision of the patient's care to include co-signature of the admission order, history and physical operative report, and discharge summary.

(F) Community affiliate medical staff.

This is a closed medical staff category that was created as a one-time grandfathering category for medical staff members of the Ohio state university hospitals east prior to July 1, 2007.

(1) Qualifications: Community affiliate medical staff shall consist of those doctors of medicine, osteopathic medicine, dentists and practitioners of podiatry or psychology who:

(a) Do not qualify for an attending medical staff appointment; and

(b) Are community affiliate members seeking reappointment; and

(c) Satisfy the requirements and qualifications set forth in rule 3335-43-04 of the Administrative Code and are already appointed to the community affiliate medical staff pursuant to these bylaws.

A community affiliate medical staff member shall meet and maintain the same standards for quality patient care applicable to all members of the medical staff. Community affiliate medical staff members shall be subject to these bylaws and the rules and regulations of the medical staff except as provided in this paragraph. The community affiliate medical staff member shall not be required to obtain appointment to the faculty of the Ohio state university. The community affiliate medical staff member shall not be subject to the requirement for board certification within the community affiliate medical staff member's respective area of practice if that requirement was waived when he or she became a member of the Ohio state university east medical staff. Teaching and research accomplishments shall not be required in determining the qualifications of applicants to this category of the medical staff.

To optimize the clinical organization, resource utilization, and planning of the hospitals, the chief of the clinical department may require that the applicant for community affiliate medical staff membership to identify categories of diagnosis, extent of anticipated patient activity, and service areas to be utilized and may prepare a statement of participation for the applicant which will be made a part of the application for appointment.

(2) Prerogatives:

A community affiliate medical staff member may:



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(a) Admit patients consistent with the limitations of bed and service allocations established by the medical directors and approved by the medical staff administrative committee, and the Wexner medical center board. If, in the judgment of the medical directors, a balanced teaching program is jeopardized, following consultation with the chief of the clinical department, and with the concurrence of a majority of the medical staff administrative committee, the medical director may restrict admissions of members of the community affiliate medical staff. Patients admitted under the care of the community affiliate medical staff will not be required to participate in the educational mission of the Ohio state university hospitals. Ordinarily, no coverage by the limited medical staff will be afforded, with the exception of emergency medical services.

(b) Exercise the clinical privileges granted, have access to all medical records, and be entitled to utilize the facilities of the Ohio state university hospitals incidental to the clinical privileges granted pursuant to these bylaws.

(c) Attend teaching and educational conferences approved by the Ohio state university, attend medical staff social functions, and participate as providers in the Ohio state university or the Ohio state university hospitals affiliated health plans.

### (3) Responsibilities:

Each member of the community affiliate medical staff shall:

(a) Participate in the management of and represent the interests of the clinical department for which he or she is granted clinical privileges. The community affiliate medical staff member shall comply with all provisions of these bylaws and rules and regulations of the medical staff, unless expressly exempted under this rule. The community affiliate medical staff member shall comply with all the Ohio state university hospitals' policies and accreditation standards, and shall be subject to the same quality evaluation, monitoring, and resource management requirements as other members of the medical staff.

(b) Be responsible within the member's area of professional competence for the continuous care and supervision of each patient in the Ohio state university hospitals for whom the member is providing care, or arrange a suitable alternative for such care and supervision.

(c) Not be eligible to vote on medical staff policies, rules and regulations, or bylaws or to hold office. Members of the community affiliate medical staff may serve on non-elected medical staff committees as provided by these bylaws.

(d) Be subject to payment of medical staff dues or assessments as approved by the medical staff.

### (G) Temporary medical staff appointment.

(1) External peer review. When peer review activities are being conducted by someone other than a current member of the medical staff, the chief medical officer may admit a practitioner to the medical staff for a limited period of time. Such membership is solely for the purpose of conducting peer review in a particular evaluation and this temporary membership automatically expires upon the member's completion of duties in connection with such peer review. Such appointment does not include clinical privileges, and is for a limited purpose.



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(2) Proctoring. Temporary privileges may be extended to visiting medical faculty for special clinical or educational activities as provided by the Ohio state medical or dental board. When medical staff members require proctoring for the purposes of gaining experience to become credentialed to perform a procedure, a visiting physician may apply for temporary privileges per the prescribed medical staff proctoring policy.

(H) Consulting medical staff.

(1) Qualifications. The consulting medical staff shall consist of those faculty members of the colleges of medicine and dentistry who:

(a) Satisfy the requirements and qualifications for membership set forth in rule 3335-43-04 of the Administrative Code.

(b) Are consultants of recognized professional ability and expertise who provide a service not readily available from the attending medical staff. These practitioners provide services at the Ohio state university hospitals only at the request of attending or courtesy A members of the medical staff.

(c) Demonstrate participation on the active medical staff at another accredited hospital requiring performance improvement/quality assessment activities similar to those of the Ohio state university hospitals. The practitioner shall also hold at such other hospital the same privileges, without restriction, that he/she is requesting at the Ohio state university hospitals. An exception to this qualification may be made by the Wexner medical center board provided the practitioner is otherwise qualified by education, training and experience to provide the requested service.

(2) Prerogatives:

Consulting medical staff members may:

(a) Exercise the clinical privileges granted for consultation purposes on an occasional basis when requested by an attending or courtesy A medical staff member.

(b) Have access to all medical records and be entitled to utilize the facilities of the Ohio state university hospitals incidental to the clinical privileges granted pursuant to these bylaws.

(c) Not admit patients to the Ohio state university hospitals.

(d) Not vote on medical staff policies, rules and regulations, or bylaws, and may not hold office.

(e) Must actively participate in such quality evaluation and monitoring activities as required by the medical staff and as outlined in the medical staff policy entitled "Consulting medical staff member policy."

(f) Attend medical staff meetings, but shall not be entitled to vote at such meetings or hold office.

(g) Attend department meetings, but shall not be entitled to vote at such meetings or serve as chief of a clinical department.



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(h) Serve as a non-voting member of a medical staff committee; provided, however, that he/she may not serve as a committee chair or as a member of the medical staff administrative committee.

(3) Responsibilities.

Each member of the consulting medical staff shall:

(a) Meet the basic responsibilities set forth in rules 3335-43-02 and 3335-43-03 of the Administrative Code.

(b) Be exempt from all medical staff dues.

(l) Clinical privileges.

(1) Delineation of clinical privileges:

(a) Every person practicing at the Ohio state university hospitals by virtue of medical staff membership, faculty appointment, contract or under authority granted in these bylaws shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically applied for and granted to the staff member or other licensed health care professional by the Ohio state university Wexner medical center board after recommendation from the medical staff administrative committee.

Each clinical department shall develop specific clinical criteria and standards for the evaluation of clinical privileges with emphasis on invasive or therapeutic procedures or treatment which present significant risk to the patient or for which specific professional training or experience is required. Such criteria and standards are subject to the approval of the medical staff administrative committee and the Wexner medical center board.

(b) Requests for the exercise and delineation of clinical privileges must be made as part of each application for appointment or reappointment to the medical staff on the forms prescribed by the medical staff administrative committee. Every person in an administrative position who desires clinical privileges shall be subject to the same procedure as all other applicants. Requests for clinical privileges must be submitted to the chief of the clinical department in which the clinical privileges will be exercised. Clinical privileges requested other than during appointment or reappointment to the medical staff shall be submitted to the chief of the clinical department and such request must include documentation of relevant training or experience supportive of the request.

(c) The chief of the clinical department shall review each applicant's request for clinical privileges and shall make a recommendation regarding clinical privileges to the chief medical officer. Requests for clinical privileges shall be evaluated based upon the applicant's education, training, experience, demonstrated competence, references, and other relevant information, including the direct observation and review of records of the applicant's performance by the clinical department in which the clinical privileges are exercised. Whenever possible the review should be of primary source information. The applicant shall have the burden of establishing the applicant's qualifications and competency in clinical privileges requested and shall have the burden of production of adequate information for the proper evaluation of qualifications.

(d) The applicant's request for clinical privileges and the recommendation of the chief of the clinical department shall be forwarded to the credentials committee and shall be processed in the same



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manner as applications for appointment and reappointment pursuant to rule 3335-43-04 of the Administrative Code.

(e) Medical staff members who are granted new or initial privileges are subject to FPPE, which is a six-month period of focused monitoring and evaluation of practitioners' professional performance. Following FPPE medical staff members with clinical privileges are subject to ongoing professional practice evaluation (OPPE), which information is factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of renewal. FPPE and OPPE are fully detailed in medical staff policies that were approved by the medical staff administrative committee and the Wexner medical center board.

(f) Upon resignation, termination or expiration of the medical staff member's faculty appointment or employment with the university for any reason, such medical staff appointment and clinical privileges of the medical staff member shall automatically expire.

(g) Medical staff members authorize the Ohio state university hospitals and clinics to share credentialing, quality and peer review information pertaining to the medical staff member's clinical competence and/or professional conduct. Such information may be shared at initial appointment and/or reappointment and at any time during the medical staff member's medical staff appointment to the medical staff of the Ohio state university hospitals.

(h) Medical staff members authorize the Ohio state university hospitals to release information, in good faith and without malice, to managed care organizations, regulating agencies, accreditation bodies and other health care entities for the purposes of evaluating the medical staff member's qualifications pursuant to a request for appointment, clinical privileges, participation or other credentialing or quality matters.

### (2) Temporary privileges:

(a) Temporary privileges may be extended to a doctor of medicine, osteopathic medicine, dental surgery, psychologist, podiatry or to a licensed health care professional upon completion of an application prescribed by the medical staff administrative committee, upon recommendation of the chief of the clinical department, ~~and approval by the chief medical officer. All temporary privileges are granted by the chief executive officer or authorized designee. The chief medical officer has been delegated responsibility by the Wexner medical center board to grant approval of temporary privileges.~~ The temporary privileges granted shall be consistent with the applicant's training and experience and with clinical department guidelines. Prior to granting temporary privileges, primary source verification of licensure and current competence shall be required. Temporary privileges shall be limited to situations which fulfill an important patient-care need, and shall be granted for a period not to exceed one hundred twenty days.

(b) Temporary privileges may be extended to visiting medical faculty or for special activity as provided by the Ohio state medical or dental board.

(c) Temporary privileges granted for locum tenens may be exercised for a maximum of ninety days, consecutive or not, any time during the twenty-four month period following the date they are granted.

(d) Practitioners granted temporary privileges will be restricted to the specific delineations for which the temporary privileges are granted. The practitioner will be under the supervision of the chair of the clinical department while exercising any temporary privileges granted.



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(e) Special privileges. Upon receipt of a written request for specific temporary privileges and the approval of the clinical department chief and the chief medical officer, an appropriately licensed practitioner of documented competence, who is not an applicant for medical staff membership, may be granted special privileges for the care of one or more specific patients. Such privileges shall be exercised in accordance with the conditions specified in these bylaws.

(f) Practitioners exercising temporary privileges shall abide by these medical staff bylaws, rules and regulations, and hospital and medical staff policies.

(g) The temporary and special privileges must be in conformity with accrediting bodies' standards and the rules and regulations of the professional boards of Ohio.

(3) Expedited privileges.

If the Wexner medical center board is not scheduled to convene in a timeframe that permits the timely consideration of the recommendation of a complete application by the medical staff administrative committee, applicants may be granted expedited privileges by the quality and professional affairs committee of the Wexner medical center board. Certain restrictions apply to the appointment and granting of clinical privileges via the expedited process. These include but are not limited to: an involuntary termination of medical staff membership at another hospital, involuntary termination of medical staff membership at another hospital, involuntary limitation, or reduction, denial or loss of clinical privileges, a history of professional liability actions resulting in a final judgment against the applicant or a challenge by a state licensing board.

(4) Podiatric privileges:

(a) Practitioners of podiatry may admit patients to the Ohio state university hospitals if such patients are being admitted solely to receive care that a podiatrist may provide without medical assistance, pursuant to the scope of the professional license of the podiatrist. Practitioners of podiatry must, in all other circumstances, co-admit patients with a member of the medical staff who is a doctor of medicine or osteopathic medicine. A member of the medical staff who is a doctor of medicine or osteopathy shall be responsible for any medical problems that the patient has while an inpatient of the Ohio state university hospitals.

(b) A member of the medical staff who is a doctor of medicine or osteopathy:

(i) Shall be responsible for any medical problems that the patient has while an inpatient of the Ohio state university hospitals; and

(ii) Shall confirm the findings, conclusions and assessment of risk prior to high-risk diagnosis or therapeutic interventions defined by the medical staff.

(c) Practitioners of podiatry shall be responsible for the podiatric care of the patient including the podiatric history and physical examination and all appropriate elements of the patient's record.

(d) The podiatrist shall be responsible to the chief of the department of orthopaedics.

(5) Psychology privileges.



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(a) Psychologists shall be granted clinical privileges based upon their training, experience and demonstrated competence and judgment consistent with their license to practice. Psychologists shall not prescribe drugs, or perform surgical procedures, or in any other way practice outside the area of their approved clinical privileges or expertise, unless otherwise authorized by law.

(b) Psychologists may not admit patients to the Ohio state university hospitals, but may diagnose and treat a patient's psychological illness as part of the patient's comprehensive care while hospitalized. All patients admitted for psychological care shall receive the same medical appraisal as all other hospitalized patients. A member of the medical staff who is a doctor of medicine or osteopathic medicine shall admit the patient and shall be responsible for the history and physical and any medical care that may be required during the hospitalization, and shall determine the appropriateness of any psychological therapy based on the total health status of the patient. Psychologists may provide consultation within their area of expertise on the care of patients within the Ohio state university hospitals.

In outpatient settings, psychologists shall diagnose and treat their patients' psychological illness. Psychologists shall ensure that their patients receive referral for appropriate medical care.

(c) Psychologists shall be responsible to the chief of the clinical department in which they are appointed.

### (6) Dental privileges.

(a) Practitioners of dentistry, who have not been granted clinical privileges as oral and maxillofacial surgeons, may admit patients to the Ohio state university hospitals if such patients are being admitted solely to receive care which a dentist may provide without medical assistance, pursuant to the scope of the professional license of the dentist. Practitioners of dentistry must, in all other circumstances co-admit patients with a member of the medical staff who is a doctor of medicine or osteopathic medicine. A member of the medical staff who is a doctor of medicine or osteopathy shall be responsible for any medical problems that the patient has while an inpatient of the Ohio state university hospitals.

(b) A member of the medical staff who is a doctor of medicine or osteopathy:

(i) Shall be responsible for any medical problems that the patient has while an inpatient of the Ohio state university hospitals; and

(ii) Shall confirm the findings, conclusions and assessment of risk prior to high-risk diagnosis or therapeutic interventions defined by the medical staff.

(c) Practitioners of dentistry shall be responsible for the dental care of the patient including the dental history and physical examination and all appropriate elements of the patient's record.

### (7) Oral and maxillofacial surgical privileges.

All patients admitted to the Ohio state university hospitals for oral and maxillofacial surgical care shall receive the same medical appraisal as all other hospitalized patients. Qualified oral and maxillofacial surgeons shall admit patients, shall be responsible for the plan of care for the patients, shall perform the medical history and physical examination, if they have such privileges, in order to assess the medical, surgical, and anesthetic risks of the proposed operative and other procedure(s),



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and shall be responsible for the medical care that may be required at the time of admission or that may arise during hospitalization.

(8) Other licensed health care professionals.

(a) Clinical privileges may be exercised by licensed health care professionals who are duly licensed in the state of Ohio, and who are either:

(i) Members of the faculty of the Ohio state university, or

(ii) Employees of the Ohio state university whose employment involves the exercise of clinical privileges, or

(iii) Employees or members of the medical staff.

(b) A licensed health care professional as used herein, shall not be eligible for medical staff membership but shall be eligible to exercise those clinical privileges granted pursuant to these bylaws and in accordance with applicable Ohio state law. If granted such privileges under this rule and in accordance with applicable Ohio state law, other licensed health care professionals may perform all or part of the medical history and physical examination of a patient. Licensed health care professionals with privileges are subject to FPPE and OPPE.

(c) Licensed health care professionals shall apply and re-apply for clinical privileges on forms prescribed by the medical staff administrative committee and shall be processed in the same manner as provided in rule 3335-43-04 of the Administrative Code subject to the provisions of paragraph (G)(8) of this rule.

(d) Licensed health care professionals are not members of the medical staff, but may write admitting orders for patients of the Ohio state university hospitals when granted such privileges under this rule and in accordance with applicable Ohio state law. If such privileges are granted, the patient will be admitted under the medical supervision of the responsible medical staff member. Licensed health care professionals and shall not be eligible to hold office, to vote on medical staff affairs, or serve on standing committees of the medical staff unless specifically authorized by the medical staff administrative committee.

(e) Each licensed health care professional shall be individually assigned to a clinical department and shall be sponsored by one or more members of the medical staff. The licensed health care professional's clinical privileges are contingent upon the sponsoring medical staff member's privileges. In the event that the sponsoring medical staff member loses privileges or resigns, the licensed health care professionals whom he or she has sponsored shall be placed on administrative hold until another sponsoring medical staff member is assigned. The new sponsoring medical staff member must be assigned in less than thirty days.

(f) Licensed health care professionals must comply with all limitations and restrictions imposed by their respective licenses, certifications, or legal credentials as required by Ohio law, and may only exercise those clinical privileges granted in accordance with provisions relating to their respective professions.

(g) Only applicants who can document the following shall be qualified for clinical privileges as a licensed health care professional:



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- (i) Current license, certification, or other legal credential required by Ohio law.
- (ii) Certificate of authority, standard care agreement, or utilization plan.
- (iii) Education, training, professional background and experience, and professional competence.
- (iv) Patient care quality indicators definition for initial appointment. This data will be in a format determined by the licensed health care professional subcommittee and the quality management department.
- (v) Adherence to the ethics of the profession for which an individual holds a license, certification, or other legal credential required by Ohio law.
- (vi) Evidence of required immunization.
- (vii) Evidence of good personal and professional reputation as established by peer recommendations.
- (viii) Satisfactory physical and mental health to perform requested clinical privileges.
- (xi) Ability to work with members of the medical staff and the Ohio state university hospitals employees.
- (h) The applicant shall have the burden to produce documentation with sufficient adequacy to assure the medical staff and the Ohio state university hospitals that any patient cared for by the licensed health care professional seeking clinical privileges shall be given quality care, and that the efficient operation of the Ohio state university hospitals will not be disrupted by the applicant's care of patients in the Ohio state university hospitals.
- (i) By applying for clinical privileges as a licensed health care professional, the applicant agrees to the following terms and conditions:
  - (i) The applicant has read the bylaws and rules and regulations of the medical staff of the Ohio state university hospitals and agrees to abide by all applicable terms of such bylaws and any applicable rules and regulations, including any subsequent amendments thereto, and any applicable Ohio state university hospitals policies that the Ohio state university hospitals may from time to time put into effect.
  - (ii) The applicant releases from liability all individuals and organizations who provide information to the Ohio state university hospitals regarding the applicant and all members of the medical staff, the Ohio state university hospitals staff, the Ohio state university Wexner medical center board and the Ohio state university board of trustees for all acts in connection with investigating and evaluating the applicant.
  - (iii) The applicant shall not deceive a patient as to the identity of any practitioner providing treatment or service in the Ohio state university hospitals.
  - (iv) The applicant shall not make any statement or take any action that might cause a patient to believe that the licensed health care professional is a member of the medical staff.



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(v) The applicant shall not perform any patient care in the Ohio state university hospitals that is not permitted under the applicant's license, certification, or other legal credential required under Ohio law.

(vi) The applicant shall obtain and continue to maintain professional liability insurance in such amounts required by the medical staff.

(j) Licensed health care professionals shall be subject to quality review and corrective action as outlined in this paragraph for violation of these bylaws, their certificate of authority, standard of care agreement, utilization plan, or the provisions of their licensure, including professional ethics. Review may be requested by any member of the medical staff, a chief of the clinical department, or by the chief quality officer or his or her designee. All requests shall be in writing and shall be submitted to the chief quality officer. The chief quality officer shall appoint a three-person committee to review and make recommendations concerning appropriate action. The committee shall consist of at least one licensed health care professional and one medical staff member. The committee shall make a written recommendation to the chief quality officer, who may accept, reject, or modify the recommendation. The chief quality officer forwards his or her recommendation to the chief medical officer for final determination.

(k) Appeal process.

(i) A licensed health care professional may submit a notice of appeal to the chairperson of the quality and professional affairs committee within thirty days of receipt of written notice of any adverse corrective action pursuant to these bylaws.

(ii) If an appeal is not so requested within the thirty-day period, the licensed health care professional shall be deemed to have waived the right to appeal and to have conclusively accepted the decision of the chief medical officer.

(iii) The appellate review shall be conducted by the chief of staff, the chair of the licensed health care professionals subcommittee and one medical staff member from the same discipline as the licensed health care professional under review. The licensed health care professional under review shall have the opportunity to present any additional information deemed relevant to the review and appeal of the decision.

(iv) The affected licensed health care professional shall have access to the reports and records, including transcripts, if any, of the hearing committee and of the medical staff administrative committee and all other material, favorable or unfavorable, that has been considered by the chief quality officer. The licensed health care professional shall submit a written statement indicating those factual and procedural matters with which the member disagrees, specifying the reasons for such disagreement. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the review committee no later than seven days following the date of the licensed health care professional's notice of appeal.

(v) New or additional matters shall only be considered on appeal at the sole discretion of the quality and professional affairs committee.

(vi) Within thirty days following submission of the written statement by the licensed health care professional, the chief of staff shall make a final recommendation to the chair of the quality and



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professional affairs committee of the Wexner medical center board. The quality and professional affairs committee of the Wexner medical center board shall determine whether the adverse decision will stand or be modified and shall recommend to the Ohio state university Wexner medical center board that the adverse decision be affirmed, modified or rejected, or to refer the matter back to the review committee for further review and recommendation. Such referral to the review committee may include a request for further investigation.

(vii) Any final decision by the Wexner medical center board shall be communicated by the chief quality officer and by certified return receipt mail to the last known address of the licensed health care professional as determined by university records. The chief quality officer shall also notify in writing the executive vice president for health sciences, the dean of the college of medicine, the chief executive officer of the Ohio state university hospitals and the vice president for health services and the chief of the applicable clinical department or departments. The chief medical officer shall take immediate steps to implement the final decision.

### (9) Emergency privileges.

In case of an emergency, any member of the medical staff to the degree permitted by the member's license or certification and regardless of department or medical staff status shall be permitted to do everything possible to save the life of a patient using every facility of the Ohio state university hospitals necessary, including the calling for any consultation necessary or desirable. After the emergency situation resolves, the patient shall be assigned to an appropriate member of the medical staff. For the purposes of this paragraph, an "emergency" is defined as a condition which would result in serious permanent harm to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

### (10) Disaster privileges.

Disaster privileges may be granted in order to provide voluntary services during a local, state, or national disaster in accordance with hospital/medical staff policy and only when the following two conditions are present: the emergency management plan has been activated and the hospital is unable to meet immediate patient needs. Such privileges may be granted by the chief medical officer or his or her designee to fully licensed or certified, qualified individuals who at the time of the disaster are not members of the medical staff. These privileges will be limited in scope and will terminate once the disaster situation subsides or at the discretion of the chief medical officer.

### (11) Telemedicine.

Telemedicine involves the use of electronic communication or other communication technologies to provide or support clinical care at a distance. Diagnosis and treatment of a patient may now be performed via telemedicine link.

(a) A member of the medical staff who wants to render care via telemedicine must so indicate on his or her application for clinical privileges.

(b) A member of the medical staff may request to exercise via telemedicine the same clinical privileges he or she has already been granted. The credentials committee, the chief of the clinical service, the chief medical officer, the medical staff administrative committee, and the Wexner medical center board shall have the prerogative of requiring documentation or making a



determination of the appropriateness for the exercise of a particular specialty/sub-specialty via telemedicine.

(Board approval dates: 6/7/2002, 9/6/2002, 5/30/2003, 6/4/2004, 5/6/2005, 11/4/2005, 2/2/2007, 2/1/2008, 9/19/2008, 9/18/2009, 5/14/2010, 4/8/2011, 8/31/2012, 2/1/2013, 11/07/2014, 11/6/2015, 4/6/2018)

## **84-12 Medical records**

(A) Each member of the medical staff shall conform to the medical information management department policies, including the following:

1. Medical record contents.

The attending medical staff member shall be ultimately responsible for the preparation of a complete medical record of each patient. The medical record may contain information collected and maintained by members of the medical staff, limited staff, other licensed healthcare professionals, medical students or providers who participate in the care of the patient in an electronic or paper form. This record shall include the following elements as it applies to the patient encounter:

- a. Identification and demographic data including the patient's race and ethnicity.
- b. The patient's language and communication needs.
- c. Emergency care provided to the patient prior to arrival, if any.
- d. The legal status of patients receiving mental health services.
- e. Evidence of known advance directives.
- f. Statement of present complaint.
- g. History and physical examination.
- h. Any patient generated information.
- i. Provisional diagnosis.
- j. Documentation of informed consent when required.
- k. Any and all orders related to the patient's care.
- l. Special reports, as those from:
  - i. The clinical laboratory, including examination of tissues and autopsy findings, when applicable.
  - ii. Signed and dated reports of nuclear medicine interpretations, consultations, and procedures.
  - iii. The radiology department.
  - iv. Consultants.
- m. Medical and surgical treatments.
- n. Progress notes.
- o. Pre-sedation or pre-anesthesia assessment and plans of care for patients receiving anesthesia.
- p. An intra-operative anesthesia record.
- q. Postoperative documentation records, including the patient's vital signs and level of consciousness; medications, including IV fluids, blood and blood components; any unusual events or postoperative complications; and management of such events.
- r. Postoperative documentation of the patient's discharge from the post-sedation or post-anesthesia care area by the responsible licensed independent practitioner or according to discharge criteria.



- s. A post-anesthesia follow-up report written within forty-eight hours after surgery.
  - t. Reassessments and revisions of the treatment plan.
  - u. Every dose of medication administered and any adverse drug reaction.
  - v. Every medication dispensed to an inpatient at discharge.
  - w. Summary and final diagnosis as verified by the attending medical staff member's signature.
  - x. Discharge disposition, condition of patient at discharge, and instructions given at that time and the plan for follow up care.
  - y. Any referrals and communications made to external or internal providers and to community agencies.
  - z. Any records of communication with the patient made by telephone or email or patient electronic portal.
2. Deadlines and sanctions.
- a. A procedure note shall be entered in the record by the responsible attending medical staff member or the medical staff member's designee, who is appropriately credentialed by the hospital, immediately upon completion of an invasive procedure. Procedure notes must be written for any surgical or medical procedures, irrespective of their repetitive nature, which involve material risk to the patient. Notes for procedures completed in the operating rooms must be finalized in the operating room information system by the attending surgeon. For any formal operative procedures, a note shall include preoperative and postoperative diagnoses, procedure(s) performed and description of each procedure, surgeon(s), resident(s), anesthesiologist(s), surgical service, type of anesthesia (general or local), complications, estimated blood loss, any pertinent information not included on the O.R./anesthesia record, preliminary surgical findings, and specimens removed and disposition of each specimen. Where a formal operative report is appropriate, the report must be completed immediately following the procedure. The operative/procedure report must be signed by the attending medical staff member. Any operative/procedure report not completed or any procedure note for procedures completed in the operating rooms not completed in the operating room information system by ten a.m. the day following the procedure shall be deemed delinquent and the attending medical staff member responsible shall lose operating/procedure room and medical staff privileges the following day. The operating rooms and procedure rooms will not cancel cases scheduled before the suspension occurred.  
  
Effective with the suspension, the attending medical staff member will lose all privileges to schedule elective and add-on cases. The attending medical staff member will only be allowed to schedule emergency cases until all delinquent operative/procedure reports are completed. All emergency cases scheduled by suspended medical staff members are subject to the review of the medical director and will be reported to the suspended medical staff members' chief of the clinical department and the medical director by the operating room staff. Affected medical staff members shall receive telephone calls from the medical information management department indicating the delinquent operative/procedure reports.
  - b. Progress notes must provide a pertinent chronological report of the patient's course in the hospital and reflect any change in condition, or results of treatment. In the event that the patient's condition has not changed, and no diagnostic studies have been done, a progress note must be completed by the attending medical staff member or his or her designated member of the limited medical staff or practitioner with



appropriate privileges at least once every day.

Each medical student or other licensed health care professional progress note in the medical records should be signed or counter-signed by a member of the attending, courtesy, or limited staff.

- c. Medical staff members with more than twenty-five verbal orders that remain unsigned greater than twenty-one days after the date of order will be subject to corrective action including administrative suspension which may include suspension of admitting and operating room scheduling privileges until the orders are signed. Medical staff members shall be notified electronically prior to suspension for unsigned verbal orders.
  - d. Birth certificates must be signed by the medical staff member who delivers the baby within one week of completion of the certificate. Fetal death certificates and death certificates must be signed and the cause of death must be recorded by the medical staff member with a permanent Ohio license within twenty-four hours of death.
  - e. ~~Office visit encounters shall be closed within ten days of the patient's visit. Outpatient visit notes and letters to referring physicians, when appropriate, shall be completed within three days of the patient's visit.~~
  - f. All entries not previously defined must be signed within ten ~~business~~ days of completion.
  - g. Queries by clinical documentation specialists requesting clarification of a patient's diagnoses and procedures will be resolved within five business days of confirmed notification of request.
  - h. ~~Office visit encounters shall be closed within one week of the patient's visit.~~
3. Discharges.
- a. Patients may not be discharged without a written or electronically entered discharge order from the appropriately credentialed, responsible medical staff member, limited staff member, or other licensed healthcare professional.
  - b. At the time of discharge, the appropriately credentialed attending medical staff member, limited staff member, or other licensed healthcare professional is responsible for verifying the principal diagnosis, secondary diagnoses, the principal procedure, if any, and any other significant invasive procedures that were performed during the hospitalization. If a principal diagnosis has not yet been determined, then a "provisional" principal diagnosis should be used instead.
  - c. The discharge summary must be available to any facility receiving the patient before the patient arrives at the facility. Similarly, the discharge summary must be available to the care provider before the patient arrives at any outpatient care visit subsequent to discharge. The discharge summary should be available within forty-eight hours of discharge for all patients. The discharge summary should be signed by the



responsible medical staff member within forty-eight hours of availability.

- d. The discharge summary must contain the following elements:
    - i. hospital course including reason for hospitalization and significant findings upon admission;
    - ii. principal and secondary diagnoses or provisional diagnoses;
    - iii. relevant diagnostic test results;
    - iv. procedures performed and care, treatment and services provided;
    - v. condition at discharge;
    - vi. medication list and medication instructions;
    - vii. plan for follow up of tests and studies for which results are pending at discharge;
    - viii. coordination and planning for follow-up testing and appointments;
    - ix. plans for follow up care and communication, and the instructions provided to the patient.
  - e. A complete summary is required on all patients who expire, regardless of length of stay.
  - f. All medical records must be completed by the attending medical staff member or, when applicable, the limited staff member or other licensed healthcare professional within twenty-one days of discharge of the patient.
  - g. Attending medical staff members shall be notified prior to suspension for all incomplete records. After notification, attending medical staff members shall have their admitting and operative scheduling privileges suspended until all records are completed. Attending medical staff members shall receive electronic notification of delinquent records. If an attempt is made by the attending medical staff member, or the attending medical staff member's designee, who is appropriately credentialed by the hospital, when applicable, to complete the record, and the record is not available, electronically for completion, the record shall not be counted against the attending medical staff member. Medical staff members who are suspended for a period of longer than one hundred twenty consecutive days are required to appear before the practitioner evaluation committee.
  - h. Records which are incomplete, more than twenty-one days after discharge or the patient's visit are defined as delinquent.
4. Confidentiality.

Access to medical records is limited to use in the treatment of patients, research, and teaching. All medical staff members are required to maintain the confidentiality of medical records. Improper use or disclosure of patient information is subject to disciplinary action.

5. Ownership.

Medical records of hospital-sponsored care including pathological examinations, slides, radiological films, photographic records, cardiographic records, laboratory reports, statistical evaluations, etc. are the property of the hospital and shall not be removed from the hospital's jurisdiction and safekeeping except in accordance with a court order, subpoena, or statute.



6. Records storage and security.

In general, medical records shall be maintained by the hospital. Records on microfilms, paper, electronic tape recordings, magnetic media, optical disks, and such other acceptable storage techniques shall be used to maintain patient records for twenty-one years for minors and ten years for adults. In the case of readmission of the patient, all records or copies thereof from the past ten/twenty-one years shall be available for the use of the attending medical staff member or other health care providers.

7. Informed consent documentation.

- a. Where informed consent is required for a special procedure (such as surgical operation), documentation that such consent has been obtained must be made in the hospital record prior to the initiation of the procedure. Such documentation shall be in compliance with the hospital's policy and procedure manual section 03-27.
- b. In the case of limb amputation, a limb disposition form, in duplicate, must be signed prior to the operation.

8. Sterilization consent.

Prior to the performance of an operative procedure for the expressed purpose of sterilization of a (male or female) patient, the attending medical staff member shall be responsible for the completion of the legal forms provided by the hospital and signed by the patient. Patients who are enrolled in the Medicaid program must have their forms signed at least thirty days prior to the procedure. Informed consent must also be obtained from one of the parents or the guardian of an unmarried minor.

9. Criteria changes.

The medical information management department shall define the criteria for record completion subject to the approval of the medical staff.

10. Entries and authentication.

- a. Entries in the medical record can only be made by staff recommended by the medical information management department subject to the approval of the medical staff.
- b. All entries must be legible and complete and must be authenticated, timed and dated promptly by the person, identified by name and discipline, who is responsible for ordering, providing, or evaluating the service furnished.
- c. The electronic signature of medical record documents requires a signing password. At the time the password is issued, the individual is required to sign a statement that she/he will be the only person using the password. This statement will be maintained in the department responsible for the electronic signature system.
- d. Signature stamps may not be used in the medical record.

(Board approval dates: 9/6/2002, 3/5/2003, 6/4/2004, 5/6/2005, 11/4/2005, 2/2/2007, 11/2/2007, 6/6/2008, 9/18/2009, 4/8/2011, 8/31/2012, 4/6/2016, 9/2/2016, 4/6/2018, 5/31/2019)

**AMENDMENTS TO THE *BYLAWS AND RULES AND REGULATIONS*  
OF THE MEDICAL STAFF OF THE ARTHUR G. JAMES CANCER HOSPITAL  
AND RICHARD J. SOLOVE RESEARCH INSTITUTE**

Synopsis: The amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute are recommended for approval.

WHEREAS a summary of the proposed amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of the James Cancer Hospital is attached; and

WHEREAS the proposed amendments are also attached; and

WHEREAS the proposed 2021 amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of the James Cancer Hospital were approved by a joint University Hospitals and James Medical Staff Bylaws Committee on September 29, 2021; and

WHEREAS the proposed 2021 amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of the James Cancer Hospital were approved by the James Cancer Hospital Medical Staff Administrative Committee on October 15, 2021; and

WHEREAS the proposed 2021 amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of the James Cancer Hospital were approved by vote of the James Cancer Hospital Medical Staff on November 18, 2021; and

WHEREAS on December 8, 2021, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of the James Cancer Hospital:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of the Medical Staff of The Arthur G. James Cancer Hospital and Richard J. Solove Research Institute.



**Chapter 3335-111 - Bylaws of the Medical Staff of the  
Arthur G. James Cancer Hospital and Richard J. Solove Research Institute**

Updated May 18, 2021

**3335-111-01 Medical staff name.**

The board of trustees of the Ohio state university, by official action, established "the Arthur G. James cancer hospital and Richard J. Solove research institute (CHRI)." Hereinafter, the abbreviation "CHRI" shall mean the Arthur G. James cancer hospital and Richard J. Solove research institute; the term "medical staff" shall refer to the medical staff of the cancer hospital and research institute. "The medical staff of the Arthur G. James cancer hospital and Richard J. Solove research institute" shall be the name of the hospital's medical staff organization. In accordance with rules 3335-109-01 to 3335-109-20 and 3335-104-07 of the Administrative Code, the Ohio state university Wexner medical center board (herein called "Wexner medical center board") has delegated to the medical staff of the CHRI the responsibility to prepare and recommend adoption of these bylaws.

(Board approval dates: 9/1/1993, 2/5/1999, 9/6/2002, 2/6/2004, 11/4/2005, 2/11/2011, 11/7/2014)

**3335-111-02 Purpose.**

The purpose of the self-governing, democratically organized medical staff, which is accountable to the Ohio state medical center board for the quality of care provided to the patients of the CHRI shall be:

- (A) To maintain exemplary standards of medical care for all patients at the CHRI. To assure continuity of care and treatment for the individual patient throughout the course of his or her illness, and to assure ongoing support and care for cancer survivors. To commit to being responsive to the needs of all CHRI patients and to communicate compassionately and effectively concerning matters of patient care.
- (B) To support and encourage research, with an emphasis on the prevention and treatment of cancer; to actively encourage patients to participate in clinical trials and other research, and to foster research programs to enhance and advance the educational and patient care programs.
- (C) To support educational programs for health care and other professionals, patients and families, and the community, with an emphasis on cancer-related education; to elevate and advance the educational standards of our professions, including pre and post medical or osteopathic students, nursing students, students of the allied medical professions, and students of other health professional colleges.
- (D) To provide a means to identify and review medical problems, assure adherence to regulatory and accreditation standards, review and revise policies and procedures; and to provide a means for establishing and maintaining standards of professional, medical and educational performance, evaluation and discipline within the medical staff, and harmonious cooperation and understanding among the units comprising the CHRI.
- (E) To govern medical staff credentialed practitioners and these Bylaws are not intended to and shall not create any contractual rights between the Ohio state university Wexner medical center and any practitioner. Any and all contracts of affiliation, association or employment shall control contractual and financial relationships between the Ohio state university Wexner medical center and such practitioners.

(Board approval dates: 9/1/1993, 12/6/1996, 9/1/1999, 12/3/1999, 6/2/2000, 11/4/2005, 9/18/2009, 10/29/2011, 4/8/2011, 4/6/2018)

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**3335-111-03 Patients.**

- (A) The continuous care and treatment of individual patients is the medical responsibility of the member of the attending, associate attending, clinical attending or community associate attending medical staff to whose care the patient is treated at or transferred to the CHRI, and to an allied health professional being granted clinical privileges under these bylaws.
- (B) There shall be only one category or classification of patients in the CHRI, and those patients are the patients of the medical staff under whose care they are treated. Patients treated at the CHRI who, prior to treatment, have not requested or selected a member of the medical staff to attend them shall be assigned for their care and treatment to a member of the medical staff for their care and treatment.
- (C) All patients treated at the CHRI should cooperate in, and, whenever applicable, participate in an approved cancer related protocol and knowingly participate in the teaching program of the college of medicine. Should a patient, or on the behalf of the patient, the patient's representative, refuse to participate or cooperate in the teaching program of the CHRI or the college of medicine, the medical staff member responsible for the care and treatment of the patient will encourage participation in the Ohio state university's teaching programs, but will simultaneously inform patients, or when appropriate, the patients representative, of their right to refuse participation.
- (D) Students, including pre and post medical or osteopathic, but not limited thereto, shall be under the direction and control of the members of the medical staff to whom the patient is assigned for treatment within the CHRI. The CHRI respects the patient's right to participate in decisions about his or her care, treatment and services, and further respects the patient's rights to refuse care, treatment and services, in accordance with law and regulation.

(Board approval dates: 9/1/1993, 12/6/1996, 12/3/1999, 9/6/2002, 2/6/2004, 11/4/2005, 9/18/2009, 4/8/2011)

**3335-111-04 Membership.**

- (A) Qualifications.
  - (1) Membership on the medical staff of the CHRI is a privilege extended to doctors of medicine, osteopathic medicine, dentistry, and to practitioners of psychology and podiatry who consistently meet the qualifications, standards, and requirements set forth in the bylaws, rules and regulations of the medical staff, and the board of trustees of the Ohio state university. Membership on the medical staff is available on an equal opportunity basis without regard to race, color, creed, religion, sexual orientation, national origin, gender, age, handicap, genetic information or veteran/military status. Doctors of medicine, osteopathic medicine, dentistry, and practitioners of psychology and podiatry in faculty and administrative positions who desire medical staff membership shall be subject to the same policies and procedures as all other applicants for the medical staff.
  - (2) All members of the medical staff of the CHRI, except physician scholar medical staff, shall be members of the faculty of the Ohio state university college of medicine, or in the case of dentists, of the Ohio state university college of dentistry, and shall be duly licensed or certified to practice in the state of Ohio. Members of the limited staff shall possess a valid training certificate, or an unrestricted license from the applicable state board based on the eligibility criteria defined by that board. All members of the medical staff and limited staff and licensed health care professionals with clinical privileges shall comply with provisions of state law and the regulations of the respective state medical board or other state licensing board if applicable. Only those physicians, dentists, and practitioners of psychology and podiatry who can document their education, training, experience, competence, adherence to the ethics of

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their profession, dedication to educational and research goals and ability to work with others with sufficient adequacy to assure the Wexner medical center board and the board of trustees of the Ohio state university that any patient treated by them at the CHRI will be given high quality medical care provided at CHRI, shall be qualified for eligibility for membership on the medical staff of the CHRI. CHRI medical staff members shall also hold appointments to the medical staff of the Ohio state university hospitals for consulting purposes. Loss of such appointment shall result in immediate termination of membership on the CHRI medical staff and immediate termination of clinical privileges as of the effective date of the Ohio state university hospitals appointment termination. This consequence does not apply to an individual's suspension for completion of medical records. If the medical staff member regains an appointment to the Ohio state university hospitals medical staff, the affected medical staff member shall be eligible to apply for CHRI medical staff membership at that time. All applicants for membership, clinical privileges, and members of the medical staff must provide basic health information to fully demonstrate that the applicant or member has, and maintains, the ability to perform requested clinical privileges. The director of medical affairs of the CHRI, the medical director of credentialing, the department chairperson, the credentialing committee, the medical staff administrative committee, the quality and professional affairs committee of the Ohio state university Wexner medical center board, or the Ohio state university Wexner medical center board may initiate and request a physical or mental health evaluation of an applicant or member. Such request shall be in writing to the applicant.

- (3) All members of the medical staff and licensed health care professionals will comply with medical staff and the CHRI policies regarding employee and medical staff health and safety, provision of uncompensated care, and will comply with appropriate administrative directives and policies which, if not followed, could adversely impact overall patient care or may adversely impact the ability of the CHRI employees or staff to effectively and efficiently fulfill their responsibilities. All members of the medical staff and licensed health care professionals shall agree to comply with bylaws, rules and regulations, and policies and procedures adopted by the medical staff administrative committee and the Wexner medical center board, including but not limited to policies on professionalism, behaviors that undermine a culture of safety, annual education and training (list approved by the medical staff administrative committee and maintained in the chief medical officer's office), conflict of interest, HIPAA compliance and access and communication guidelines. Medical staff members and licensed health care professionals must also comply with the university integrity program requirements including but not limited to billing, self-referral, ethical conduct and annual education. Medical staff members and licensed health care professionals with clinical privileges must immediately disclose to the chief medical officer and the department chairperson the occurrence of any of the following events: a licensure action in any state, any malpractice claims filed in any state or an arrest by law enforcement.
- (4) All members of the medical staff and credentialed providers must maintain continuous uninterrupted enrollment with all governmental healthcare programs. This includes any federal and state government programs.
  - (a) It shall be the duty of all medical staff members and credentialed providers to promptly inform the chief medical officer and the corporate credentialing office of any investigation, action taken, or the initiation of any process which could lead to an action taken by any governmental program.
  - (b) Exclusion of any medical staff member or credentialed provider from participation in any federal or state government program or suspension from participation, in whole or in part, in any federal or state government reimbursement program, shall result in immediate lapse of membership on the medical staff of the CHRI and the immediate lapse of clinical privileges at the CHRI as of the effective date of the exclusion or

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suspension. Medical staff members may submit a request to resign their medical staff membership to the Chief Medical Officer in lieu of automatic termination. The resignation in lieu of automatic termination shall be discussed at the next credentialing committee and medical staff administrative committee in order to provide recommendations to the Quality and Professional Affairs Committee of the Wexner Medical Center Board. A final determination should be decided by the Quality and Professional Affairs Committee at its next regular meeting.

- (c) If the medical staff member's or credentialed provider's participation in all governmental programs is fully reinstated, the affected medical staff member or credentialed provider shall be eligible to apply for membership and clinical privileges at that time.

(5) Board certification.

An applicant for membership shall at the time of appointment or reappointment, be board certified in his or her specialty. This board certification must be approved by the American board of medical specialties, or other applicable certifying boards for doctors of osteopathy, podiatry, psychology, and dentistry. All applicants must be certified within the specific areas for which they have requested clinical privileges. Applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last five years will be eligible for medical staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within five years from the date of completion of their residency or fellowship training. Applicants must maintain board certification and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirement. Recertification will be assessed at reappointment. Failure to meet or maintain board certification shall result in termination of membership on the medical staff of the CHRI. Waiver of these eligibility criteria is as follows:

- (a) A request for a waiver will only be considered if the applicant provides information sufficient to satisfy his or her burden to demonstrate that his or her qualifications are equivalent to or exceed the criterion in question and that there are exceptional circumstances that warrant a waiver. The clinical department chief must endorse the request for waiver in writing to the credentialing committee.
- (b) The credentialing committee may consider supporting documentation submitted by the prospective applicant, any relevant information from third parties, input from the relevant clinical department chiefs, and the best interests of the hospital and the communities it serves. The credentialing committee will forward its recommendation, including the basis for such, to the medical staff administrative committee.
- (c) The medical staff administrative committee will review the recommendation of the credentialing committee and make a recommendation to the Wexner medical center board regarding whether to grant or deny the request for a waiver and the basis for its recommendation.
- (d) The Wexner medical center board determination regarding whether to grant a waiver is final. A determination not to grant a waiver is not a denial of appointment or clinical privileges and does not give rise to a right to a hearing. The prospective applicant who requested the waiver is not entitled to a hearing. A determination to grant a waiver in a particular case is not intended to set a precedent for any other applicant. A determination to grant a waiver does not mean that an appointment will be granted.

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Waivers of threshold eligibility criteria will not be granted routinely. No applicant is entitled to a waiver or to a hearing if a waiver is not granted.

- (6) All applicants must demonstrate recent clinical activity in their primary area of practice during the last two years to satisfy minimum threshold criteria for privileges within their clinical departments.
- (8) Resignation, termination or non-reappointment to the faculty of the Ohio state university shall result in immediate termination of membership on the medical staff of the CHRI for attending, associate attending and clinical attending staff members.
- (9) Any staff member whose membership has been terminated pursuant to paragraph (A)(4), (A)(5) or (A)(7) of this rule shall not be entitled to request a hearing and appeal in accordance with rule 3335-111-06 of the Administrative Code. Any allied health professional whose clinical privileges have been terminated pursuant to paragraph (A)(4) of this rule may not request an appeal in accordance with paragraph (F)(6)(i) of rule 3335-111-07 of the Administrative Code.
- (10) No applicant shall be entitled to medical staff membership and or clinical privileges merely by the virtue of fulfilling the above qualifications or holding a previous appointment to the medical staff.

(B) Application for membership.

Initial application for all categories of medical staff membership shall be made by the applicant to the clinical department chief or designee on forms prescribed by the medical staff administrative committee, stating the qualifications and references of the applicant and giving an account of the applicant's current licensure, relevant professional training and experience, current competence and ability to perform the clinical privileges requested. All applications for appointment must specify the clinical privileges requested. Applications may be made only if the qualifications are fulfilled as outlined in paragraph (A) of this rule. See paragraph (E)(1) of rule 3335-111-07 of the Administrative Code for exceptions to signature requirements. The application shall include written statements by the applicant that commit the applicant to abide by the bylaws, rules and regulations and policies and procedures of the medical staff, the Wexner medical center board, and the board of trustees of the Ohio state university. The applicant shall produce a government issued photo identification to verify his/her identity pursuant to hospital/medical staff policy. The applicant for medical staff membership shall agree that membership requires participation in and cooperation with the peer review processes of evaluating credentials, medical staff membership and clinical privileges, and that a condition for membership requires mutual covenants between all members of the medical staff to release one another from civil liability in these review processes as long as the peer review is not conducted in bad faith, with malice, or without reasonable effort to ascertain the accuracy of information being disclosed or relied upon. A separate record shall be maintained for each applicant requesting appointment to the medical staff.

(C) Terms of appointment.

Initial appointment to the medical staff, except for the honorary category, shall be for a period not to exceed twenty-four months. An appointment or grant of privileges for a period of less than twenty-four months shall not be deemed an adverse action. During the first six months of the initial appointment, except medical staff appointments without clinical privileges, appointees shall be subject to focused professional practice evaluation (FPPE) in order to evaluate the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privilege at the organization pursuant to these bylaws. FPPE requires the evaluation by the clinical department chief with oversight by the credentials committee and the medical staff administrative committee.

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The provisional appointee identifies the primary hospital. Following the six month FPPE period, the clinical department chief may: (1) recommend the initial appointee to transition to ongoing professional practice evaluation (OPPE), which is described later in these bylaws to the medical staff administrative committee; (2) extend the FPPE period, which is not considered an adverse action, for an additional six months not to exceed a total of twelve months for purposes of further monitoring and evaluation; or (3) terminate the initial appointee's medical staff membership and clinical privileges. In the event that the medical staff administrative committee recommends that an adverse action be taken against an initial appointee, the initial appointee shall be entitled to the provisions of due process as outlined in these bylaws.

(D) Professional ethics.

The code of ethics as adopted, or as may be amended, by the American medical association, the American dental association, the American osteopathic association, the American psychological association, the American college of surgeons, or the American podiatric medical association shall usually govern the professional ethical conduct of the respective members of the medical staff.

(E) Procedure for appointment.

(1) The completed and signed application for membership of all categories of the medical staff as defined in rule 3335-111-07 of the Administrative Code, shall be presented to the clinical department chief or designee. The applicant shall include in the application a signed statement indicating the following:

- (a) If the applicant should be appointed to a category of the CHRI medical staff, the applicant agrees to be governed by the bylaws, rules and regulations of the medical staff, the Wexner medical center board, and the board of the trustees of the Ohio state university.
- (b) The applicant consents to be interviewed in regard to the application.
- (c) The applicant authorizes the CHRI to consult with members of the medical staffs of other hospitals with which the applicant has been or has attempted to be associated, and with others who may have information bearing on the applicant's competence, character and ethical qualifications.
- (d) The applicant consents to the CHRI's inspection of all records and documents that may be material to the evaluation of the applicant's professional qualifications and competence to carry out the clinical and educational privileges which the applicant is seeking as well as the applicant's professional and ethical qualifications for medical staff membership.
- (e) The applicant releases from any liability:
  - (i) All representatives of the CHRI for acts performed in connections with evaluating the applicant's credentials or releasing information to other institutions for the purpose of evaluating the applicant's credentials in compliance with these bylaws performed in good faith and without malice; and
  - (ii) All third parties who provide information, including otherwise privileged and confidential information, to members of the medical staff, the CHRI staff, the medical center board members, and members of the Ohio state university board of trustees concerning the applicant's credentials performed in good faith and without malice.

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- (f) The applicant has an affirmative duty to disclose any prior termination, voluntary or involuntary, current loss, restriction, denial, or the voluntary or involuntary relinquishment of any of the following: professional licensure, board certification, DEA registration, membership in any professional organization or medical staff membership or privileges at any other hospital or health care facility.
  - (g) The applicant further agrees to disclose to the director of medical affairs or the medical director of credentialing the initiation of any process which could lead to such loss or restriction of the applicant's professional licensure, board certification, DEA registration, membership in any professional organization or medical staff membership or privileges at any other hospital or health care facility.
  - (h) The applicant agrees that acceptance of an appointment to any category of the CHRI medical staff authorizes the CHRI to conduct any appropriate health assessment including, but not limited to, drug or alcohol screens on a practitioner before granting of privileges and at any time during the normal pursuit of medical staff duties, based upon reasonable cause as determined by the chief of the practitioner's clinical department or the director of medical affairs of the CHRI or their authorized designees.
- (2) The purpose of the health assessment shall be to ensure that the applicant or appointee to the CHRI medical staff is able to fully perform and discharge the clinical, educational, administrative and research responsibilities which the applicant or appointee would or is permitted to exercise by reason of medical staff appointment. If, at the time of the initial request for a health assessment, and at any time an appointee refuses to participate as needed in a health assessment, including, but not limited to, a drug or alcohol screening, this shall result in automatic lapse of membership, privileges, and prerogatives until remedied by compliance with the requested health assessment. Upon request of the medical staff administrative committee or the Wexner medical center board, the applicant or appointee will provide documentation of their physical/mental status with sufficient adequacy to demonstrate that any patient treated by the applicant or appointee will receive efficient and quality care at a professionally recognized level of quality and efficiency. The conditions of this paragraph shall be deemed continuing and may be applicable to issues of continued good standing as an appointee to the medical staff.
- (3) An application for membership on the medical staff shall be considered complete when all the information requested on the application form is provided, the applicant signs the application and the information is verified. A completed application must contain:
- (a) Peer recommendations from at least three individuals with first hand knowledge about the applicant's clinical and professional skills within the last year;
  - (b) Evidence of required immunizations;
  - (c) Evidence of current professional medical malpractice liability coverage required for the exercise of clinical privileges;
  - (d) Satisfaction of ECFMG requirements, if applicable. If an individual receives a conceded eminence certificate or a clinical research faculty certificate from the state medical board of Ohio, the requirement for ECFMG certification may be waived at the discretion\_of the Wexner medical center board.
  - (e) Verification by primary source documentation of:

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- (i) Current and previous state licensure, and
  - (ii) Faculty appointment, when applicable.
- (f) DEA registrations, when required for the exercise of requested clinical privileges;
  - (g) Graduation from an accredited professional school, when applicable;
  - (h) Successful completion or record of post professional graduate medical education;
  - (i) Board certification or, active candidacy for board certification or applicant qualifies for a waiver pursuant to paragraph (A)(5) of this rule.
  - (j) Information from the national practitioner data bank and other JCAHO approved sources;
  - (k) Verification that the applicant has not been excluded from any federally funded health care program; and
  - (l) Complete disclosure by the applicant of all past and current claims, suits, verdicts, and settlements, if any.
  - (m) Completion of criminal history check by the Ohio state university medical center security department.
  - (n) Completion of the Ohio state university medical center drug testing.
  - (o) Verification of completion of annual educational requirements approved by the medical staff administrative committee and maintained in the chief medical officer's office.
  - (p) Demonstration of recent active clinical practice during the last two years required for exercise of clinical privileges.
  - (q) Attestation of current Ohio automated Rx reporting system ("OARRS") account for all applicants who have a DEA registration.
- (4) The clinical department chief shall be responsible for investigating and verifying the character, qualifications and professional standing of the applicants by making inquiry of the primary source of such information and shall within thirty days of receipt of the completed application, submit a report of those findings along with a recommendation on medical staff membership and clinical privileges to the applicant's respective CHRI department chairperson and/or division director. Licensed allied health professional applicants will have their clinical department chief's report submitted to the subcommittee of the credentials committee charged with review of applications for associates to the medical staff.
- (5) The department chairperson and/or division director shall receive all initial signed and verified applications from the appropriate clinical department chief and shall make a recommendation to the medical director of credentialing on each application. The medical director of credentialing shall make an initial determination as to whether the application is complete. The credentials committee, the medical staff administrative committee, the quality and professional affairs committee, and the Wexner medical center board have the right to render an application incomplete, and therefore not able to be processed, if the need arises for additional or clarifying information. The medical director of credentialing shall forward all completed applications to the credentials committee.

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- (6) The applicants shall have the burden of producing information for an adequate evaluation of his/her qualifications for membership and for the clinical privileges requested. If the applicant fails to complete the prescribed forms or fails to provide the information requested within sixty days of receipt of the signed application, processing of the application shall cease and the application shall be deemed to have been voluntarily withdrawn, action which is not subject to hearing or appeal pursuant to rule 3335-111-06 of the Administrative Code.
- (7) If the clinical department chief does not submit a report and recommendation on a timely basis, the completed application shall be forwarded to the medical director of credentialing for presentation to the credentials committee on the same basis as other applicants.
- (8) Completed applications shall be acted upon as follows:
  - (a) By the credentials committee within thirty days after receipt of a completed application from the medical director of credentialing;
  - (b) By the medical staff administrative committee within thirty days after receipt of a completed application and the report of the recommendation of the credentials committee;
  - (c) By the quality and professional affairs committee of the Wexner medical center board;
  - (d) By the Wexner medical center board within one hundred twenty days after receipt of a completed application and the report and recommendation of the medical staff administrative committee; and
  - (e) By the Wexner medical center board, or a subcommittee of the Wexner medical center board if eligible for expedited credentialing, within one hundred twenty days after receipt of a completed application and the report and recommendation of the medical staff administrative committee.
- (9) These time periods are deemed guidelines only and do not periods. These periods may be stayed or altered pending receipt and verification of further information requested from the applicant, or if the application is deemed incomplete at any time. If the procedural rights create any right to have an application processed within these precise specified in rule 3335-111-06 of the Administrative Code are activated, the time requirements provided therein govern the continued processing of the application.
- (10) The credentials committee shall review the application, evaluate and verify the supporting documentation, references, licensure, the clinical department chief's report and recommendation, and other relevant information. The credentials committee shall examine the character, professional competence, professional conduct, qualifications, and ethical standing of the applicant and shall determine, through information contained in the personal references and from other sources available, whether the applicant established and met all of the necessary qualifications for the category of the medical staff and clinical privileges requested.
- (11) The credentials committee shall, within thirty days from receipt of a completed application, make a recommendation to the medical director of credentialing that the application be accepted, rejected or modified. The medical director of credentialing shall forward the recommendation of the credentials committee to the medical staff administrative committee. The credentials committee or the medical director of credentialing may recommend to the

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medical staff administrative committee that certain applications for appointment be reviewed in executive session.

- (12) The recommendation of the medical staff administrative committee regarding an appointment decision shall be made within thirty days of receipt of the credentials committee recommendation and shall be communicated by the medical director of credentialing, along with the recommendation of the director of medical affairs, to the quality and professional affairs committee of the Wexner medical center board, and thereafter to the Wexner medical center board. When the Wexner medical center board has acted, the chair of the Wexner medical center board shall instruct the director of medical affairs to transmit the final decision to the clinical department chief, the applicant, and the respective department chairperson and/or division director.
  - (13) At any time, the medical staff administrative committee first recommends non-appointment of an initial applicant for any category of the medical staff or recommends denial of any clinical privileges requested by the applicant, the medical staff administrative committee shall require the medical director of credentialing to notify the applicant by certified return receipt mail that applicant may request an evidentiary hearing as provided in paragraph (D) of rule 3335-111-06 of the Administrative Code. The applicant shall be notified of the requirement to request a hearing as provided by paragraph (B) of rule 3335-111-06 of the Administrative Code. If a hearing is properly requested, the applicant shall be subject to the rights and responsibilities of rule 3335-111-06 of the Administrative Code. If an applicant fails to properly request a hearing, the medical staff administrative committee shall accept, reject, or modify the application for appointment to membership and clinical privileges.
  - (14) The director of medical affairs, who may make a separate recommendation to the Wexner medical center board, shall directly communicate the final recommendation of the medical staff administrative committee to the Wexner medical center board. When the Wexner medical center board has acted, the director of medical affairs will transmit the final decision to the clinical department chief, the applicant, the respective department chairperson and/or division director, and the Ohio state university board of trustees.
- (F) Procedure for reappointment.
- (1) Reappointment for all categories of the medical staff shall be for a period not to exceed twenty-four months. An appointment or grant of privileges for a period of less than twenty-four months shall not be deemed an adverse action. At least ninety days prior to the end of the medical staff member' or licensed allied health professional's appointment period, the clinical department chief shall provide each individual with an application for reappointment to the medical staff on forms prescribed by the medical staff administrative committee.
  - (2) The reappointment application shall include all information necessary to update and evaluate the qualification of the applicant. The clinical department chief shall review the information available on each applicant for reappointment and shall make recommendations regarding reappointment to the medical staff and for granting of privileges for the ensuing appointment period. The clinical department chief's recommendation shall be transmitted in writing along with the signed and completed reappointment forms to the appropriate department chairperson and/or division director at least forty-five days prior to the end of the individual's appointment. The terms of paragraphs (A), (B), (C), (D), (E)(1), and (E)(2) of this rule shall apply to all applicants for reappointment. Only completed applications for reappointment shall be considered by the credentials committee.
  - (3) An application for reappointment is complete when all the information requested on the reappointment application is provided, the reappointment form is signed by the applicant,

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and the information is verified, and no need for additional or clarifying information is identified. A completed reappointment application must contain:

- (a) Evidence of current professional medical malpractice liability insurance required for the exercise of clinical privileges;
  - (b) Verification by primary source documentation of state licensure;
  - (c) DEA registration when required for clinical privileges as requested;
  - (d) Successful completion or record of any additional post graduate medical or professional education not submitted since initial or last appointment;
  - (e) Board certification, recertification, or continued active candidacy for certification or applicant qualifies for a waiver pursuant to paragraph (A)(5) of this rule.
  - (f) Information from the national practitioner data bank;
  - (g) Verification that the applicant has not been excluded from any federally funded health care program;
  - (h) Specific requests for any changes in clinical privileges sought at reappointment with supporting documentation as required by credentialing guidelines;
  - (i) Specific requests for any changes in medical staff category;
  - (j) A summary of the member's clinical activity during the previous appointment period;
  - (k) Verification of completion of any annual education requirements approved by the medical staff administrative committee and maintained in the chief medical officer's office;
  - (l) Complete disclosure by individuals of claims, suits, verdicts and settlements, if any since last appointment; and
  - (m) Continuing medical education and applicable continuing professional education activities: documentation of category one CME that, at least in part, relates to the individual medical staff member's specialty or subspecialty area and is consistent with the licensing requirements of the applicable Ohio state licensing board shall be required.
  - (n) Attending physicians only: submit information summarizing clinical research activities with each application.
  - (o) Attestation of current OARRS account for all applicants who have a DEA registration.
- (4) The applicant for reappointment shall be required to submit any reasonable evidence of current ability to perform the clinical privileges requested. The clinical department chief shall review and evaluate the reappointment application and the supporting documentation. The clinical department chief shall evaluate all matters relevant to recommendation, including: the applicant's professional competence; clinical judgment; clinical or technical skills; ethical conduct; participation in medical staff affairs, if applicable; compliance with the bylaws, rules and regulations of the medical staff, the Wexner medical center board, and the board of trustees of the Ohio state university; cooperation with the CHRI hospitals personnel and the use of the CHRI hospital's facilities for patients; relations with other physicians other health

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professionals or other staff; maintenance of a professional attitude toward patients; and the responsibility to the CHRI and the public.

- (5) The clinical department chief shall submit a report of those findings along with a recommendation on reappointment to the applicant's respective CHRI department chairperson and/or division director. Licensed allied health professional applicants will have their clinical department chief's report submitted to the subcommittee of the credentials committee charged with review of application for associates to the medical staff. The department chairperson and/or division director shall review the reappointment application and forward to the medical director of credentialing with a recommendation for reappointment. The medical director of credentialing shall forward the reappointment forms and the recommendations of the clinical department chief and department chairperson and/or division director to the credentials committee. The credentials committee shall review the request for reappointment in the same manner, and with the same authority, as an original application for medical staff membership. The credentials committee shall review all aspects of the reappointment application including source verification of the member's quality assurance record for continuing membership qualifications and for continuing clinical privileges. The credentials committee shall review each member's performance-based profile to ensure that all medical staff members deliver the same level of quality of care with similar delineated clinical privileges across all clinical departments and across all categories of medical staff membership.
- (6) The credentials committee shall forward its recommendations to the medical director of credentialing at least thirty days prior to the end of the period of appointment for the individual. The medical director of credentialing shall transmit the completed reappointment application and recommendation of the credentials committee to the medical staff administrative committee.
- (7) Failure of the member to submit a reappointment application shall be deemed a voluntary resignation from the medical staff and shall result in automatic termination of membership and all clinical privileges at the end of the medical staff member's current appointment period, action which shall not be subject to a hearing or appeal pursuant to rule 3335-111-06 of the Administrative Code. A request for reappointment subsequently received from a member who has been automatically terminated shall be processed as a new appointment.
- (8) Failure of the clinical department chief to act in a timely manner on an application for reappointment shall be the same as provided in paragraph (E)(7) of this rule.
- (9) The medical staff administrative committee shall review each request for reappointment in the same manner and with the same authority as an original application for appointment to the medical staff and shall accept, reject, or modify the request for reappointment in the same manner and with the same authority as an original application. The recommendation of the medical staff administrative committee regarding reappointment shall be communicated by the medical director of credentialing, along with the recommendation of the director of medical affairs, to the quality and professional affairs committee of the Wexner medical center board, and thereafter to the Wexner medical center board. When the Wexner medical center board has acted, the chair of the Wexner medical center board shall instruct the director of medical affairs to transmit the final decision to the clinical department chief, the applicant, and the department chairperson and/or division director.
- (10) When the decision of the medical staff administrative committee results in a decision of non-reappointment or reduction, suspension, or revocation of clinical privileges, the medical staff administrative committee shall instruct the medical director of credentialing to give written notice to the affected member of the decision, the stated reason for the decision, and the member's right to a hearing pursuant to rule 3335-111-06 of the Administrative Code. This

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notification and an opportunity to exhaust the appeal process shall occur prior to an adverse decision unless the provisions outlined in paragraph (C) of rule 3335-111-06 of the Administrative Code apply. The notice by the medical director of credentialing shall be sent certified return receipt mail to the affected member's last known address as determined by the Ohio state university records.

- (11) If the affected member of the medical staff does not make a written request for a hearing to the director of medical affairs within thirty-one days after receipt of the adverse decision, it shall be deemed a waiver of the right to any hearing or appeal as provided in rule 3335-111-06 of the Administrative Code to which the staff member might otherwise have been entitled on the matter. If a timely, written request for hearing is made, the procedures set forth in rule 3335-111-06 of the Administrative Code shall apply.
- (G) Resumption of clinical activities following a leave of absence:
- (1) A member of the medical staff or credentialed provider shall request a leave of absence in writing for good cause shown such as medical reasons, educational and research reasons or military service to the chief of clinical service and the director of medical affairs. Such leave of absence shall be granted at the discretion of the chief of the clinical service and the director of medical affairs provided, however, such leave shall not extend beyond the term of the member's or credentialed provider's current appointment. A member of the medical staff or credentialed provider who is experiencing health problems that may impair his or her ability to care for patients has the duty to disclose such impairment to his or her chief of clinical department and the director of medical affairs and the member or credentialed provider shall be placed on immediate medical leave of absence until such time the member or credentialed provider can demonstrate to the satisfaction of the director of medical affairs that the impairment has been sufficiently resolved and can request for reinstatement of clinical activities. During any leave of absence, the member or credentialed provider shall not exercise his or her clinical privileges, and medical staff responsibilities and prerogatives shall be inactive.
  - (2) The member or credentialed provider must submit a written request for the reinstatement of clinical privileges to the chief of the clinical service. The chief of the clinical service shall forward his recommendation to the credentialing committee which, after review and consideration of all relevant information, shall forward its recommendation to the medical staff administrative committee and the quality and professional affairs committee of the Wexner medical center board. The credentials committee, the director of medical affairs, the medical director of credentialing, the chief of the clinical service or the medical staff administrative committee shall have the authority to require any documentation, including advice and consultation from the member's or credentialed provider's treating physician or the committee for practitioner health that might have a bearing on the medical staff member's or credentialed provider's ability to carry out the clinical and educational responsibilities for which the medical staff is seeking privileges. Upon return from a leave of absence for medical reasons the medical staff member or credentialed provider must demonstrate his or her ability to exercise his or her clinical privileges upon return to clinical activity.
  - (3) All members or credentialed providers of the medical staff who take a leave of absence for medical or non-medical reasons must be in good standing on the medical staff upon resumption of clinical activities. No member shall be granted leave of absence in excess of his or her current appointment and the usual procedure for appointment and reappointment, including deadlines for submission of application as set forth in this rule will apply irrespective of the nature of the leave. Absence extending beyond his or her current term of failure to request reinstatement of clinical privileges shall be deemed a voluntary resignation from the medical staff and of clinical privileges, and in such event, the member or credentialed provider shall not be entitled to a hearing or appeal.

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(Board approval dates: 9/1/1993, 3/3/1995, 4/3/1996, 12/6/1996, 9/1/1999, 12/3/1999, 6/2/2000, 4/5/2002, 2/6/2004, 11/4/2005, 8/6/2007, 2/6/2009, 9/18/2009, 5/14/2010, 10/29/2011, 4/8/2011, 8/31/2012, 2/1/2013, 6/6/2014, 11/7/2014, 11/6/2015, 9/2/2016, 4/6/2018)

**3335-111-05 Peer review and corrective action**

(A) Informal peer review.

- (1) All medical staff members agree to cooperate in informal peer review activities that are solely intended to improve the quality of medical care provided to patients at the CHRI.
- (2) Information indicating a need for informal review, including patient complaints, disagreements, questions of clinical competence, inappropriate conduct and variations in clinical practice identified by the clinical departments or divisions and medical staff committees shall be referred to the chair of the practitioner evaluation committee.
- (3) The practitioner evaluation committee chair or his or her designee may obtain information or opinions from medical staff members or credentialed providers as well as external peer review consultants pursuant to criteria outlined in these bylaws. The information or opinions from the informal peer review may be presented to the practitioner evaluation committee or another designated peer review committee.
- (4) Following the assessment by the practitioner evaluation committee chair or his or her designee, the practitioner evaluation committee may make recommendations for educational actions of additional training, sharing of comparative data or monitoring or provide other forms of guidance to the medical staff member to assist him or her in improving the quality of patient care. Such actions are not regarded as adverse, do not require reporting to any governmental or other agency, and do not invoke a right to any hearing.
- (5) At the conclusion of the evaluation, the practitioner evaluation committee chair or his or her designee submits a report to the applicable clinical department chief and the director of medical affairs. The clinical department chief and the director of medical affairs shall evaluate the matter to determine the appropriate course of action. They shall make an initial written determination on whether:
  - (a) The matter warrants no further action;
  - (b) Informal resolution under this paragraph is appropriate. The clinical department chief and the director of medical affairs shall determine whether to include documentation of the informal resolution in the medical staff member's file. If documentation is included in the member's file, the affected member shall have an opportunity to review it and may make a written response which shall also be placed in the file. Informal review under this paragraph is not a procedural prerequisite to the initiation of formal peer review under paragraph (B) of this rule; or
  - (c) Formal peer review under paragraph (B) of this rule is warranted. In cases where the clinical department chief and director of medical affairs cannot agree, the matter shall be submitted and determined as set forth in paragraph (B) of this rule.

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- (B) Formal peer review.
- (1) Formal peer review may be requested in more serious situations or where informal review has not resolved an issue or whenever the activities or professional conduct of a member of the medical staff of the CHRI:
    - (a) Violates the standards or aims of the medical staff or standards of professional conduct;
    - (b) Is considered to be disruptive to the operation of the CHRI;
    - (c) Violates the bylaws, rules and regulations of the medical staff, the Wexner medical center board, or the board of trustees of the Ohio state university;
    - (d) Violates state or federal law; or
    - (e) Is detrimental to patient safety or to the delivery of patient care within the CHRI.
  - (2) Formal peer review may be initiated by the clinical department chief, the department chairperson and/or division director, the director of medical affairs, any member of the medical staff, the chief executive officer of the CHRI, the dean of the college of medicine, any member of the Wexner medical center board, or the vice president for health services. All requests for formal peer review shall be in writing, shall be submitted to the director of medical affairs, and shall be supported by reference to the specific activities or conduct which constitute grounds for the requested action.
  - (3) The director of medical affairs shall promptly notify the affected member of the medical staff, in a confidential manner, that a request for formal peer review has been made, and inform the member of the specific activities or conduct which constitute grounds for the requested action. The director of medical affairs shall verify the facts related to the request for formal peer review, and within thirty days, make a written determination. If the director of medical affairs decides that no further action is warranted, the director of medical affairs shall notify the person(s) who filed the request for formal peer review and the member accused, in writing, that no further action would be taken.
  - (4) Whenever the director of medical affairs determines that formal peer review is warranted and that a reduction, suspension or revocation of clinical privileges could result, the director of medical affairs shall refer the request for formal peer review to the formal peer review committee. The affected member of the medical staff shall be notified of the referral to the formal peer review committee, and be informed that these medical staff bylaws shall govern all further proceedings. The executive vice president for health sciences or designee shall exercise any or all duties or responsibilities assigned to the director of medical affairs under these rules for implementing corrective action and appellate procedure only if:
    - (a) The director of medical affairs is the medical staff member charged;
    - (b) The director of medical affairs is responsible for having the charges brought against another medical staff member; or
    - (c) There is an obvious conflict of interest.
  - (5) The formal peer review committee shall investigate every request and shall report in writing its findings and recommendations for action to the appropriate clinical department chief and notice given to the division director. In making its recommendation the formal peer review committee may consider as appropriate, relevant literature and clinical practice guidelines,

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all the opinions and views expressed throughout the review process, and any information or explanations provided by the member under review. Prior to making its report, the medical staff member against whom the action has been requested shall be afforded an opportunity for an interview with the formal peer review committee. At such interview, the medical staff member shall be informed of the specific activities alleged to constitute grounds for formal peer review, and shall be afforded the opportunity to discuss, explain or refute the allegations against the medical staff member. The medical staff member may furnish written or oral information to the formal peer review committee at this time. However, such interview shall not constitute a hearing, but shall be investigative in nature. The medical staff member shall not be represented by an attorney at this interview. The written findings and recommendations for action is expected to be submitted within 90 days, unless an extension is deemed necessary by the committee.

- (6) Upon receipt of the written report from the formal peer review committee, the appropriate clinical department chief shall make his or her own written determination and forward that determination along with the findings and recommendations of the formal peer review committee to the director of medical affairs, or if required by paragraph (B)(3) of this rule, to the executive vice president for health sciences or designee.
- (7) Following receipt of the recommendation from the clinical department chief and the report from the formal peer review committee, the director of medical affairs, or the executive vice president for health sciences or designee, shall approve or modify the determination of the clinical department chief. Following receipt of the report of the clinical department chief, the director of medical affairs or executive vice president for health sciences or designee shall decide whether the grounds for the requested corrective action are such as should result in a reduction, suspension or revocation of clinical privileges. If the director of medical affairs, or executive vice president for health sciences or designee, decides the grounds are not substantiated, the director of medical affairs will notify the formal peer review committee; clinical department chief and if applicable, the academic department chairperson; division director; person(s) who filed the complaint and the affected medical staff member, in writing, that no further action will be taken.

In the event the director of medical affairs or executive vice president for health sciences or designee finds the grounds for the requested corrective action are substantiated, the director of medical affairs shall promptly notify the affected medical staff member of that decision and of the affected medical staff member's right to request a hearing before the medical staff administrative committee pursuant to rule 3335-111-06 of the Administrative Code. The written notice shall also include a statement that the medical staff member's failure to request a hearing in the timeframe prescribed in rule 3335-111-06 of the Administrative Code shall constitute a waiver of rights to a hearing and to an appeal on the matter; a statement that the affected medical staff member shall have the procedural rights found in rule 3335-111-06 of the Administrative Code; and a copy of the rule 3335-111-06 of the Administrative Code. This notification and an opportunity to exhaust the administrative hearing and appeal process shall occur prior to the imposition of the proposed corrective action unless the emergency provisions outlined in paragraph (D) of this rule apply. This written notice by the director of medical affairs shall be sent certified return receipt mail to the affected medical staff member's last known address as determined by university records.

- (8) If the affected member of the medical staff does not make a written request for a hearing to the director of medical affairs within thirty-one days after receipt of the adverse decision, it shall be deemed a waiver of the right to any review by the medical staff administrative committee to which the staff member might otherwise have been entitled on the matter.
- (9) If a timely, written request for hearing is made, the procedures set forth in rule 3335-111-06 of the Administrative Code shall apply.

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(C) Composition of the formal peer review committee.

- (1) When the determination that formal peer review is warranted is made, the clinical department chief shall select three members of the medical staff to serve on a formal peer review committee.
- (2) Whenever the questions raised concern the clinical competence of the member under review, the clinical department chief shall select members of the medical staff to serve on the formal peer review committee who shall have similar levels of training and qualifications as the member who is subject to formal peer review.
- (3) An external review consultant may serve as a member of the formal peer review whenever:
  - (a) A determination is made by the clinical department chief and the director of medical affairs that the clinical expertise needed to conduct the review is not available on the medical staff;
  - (b) The objectivity of the review may be compromised due to economic considerations;  
or
  - (c) Whenever the director of medical affairs determines that an external review is otherwise advisable.

If an external reviewer is recommended, the clinical department chief shall make a written recommendation to the director of medical affairs for selection of an external reviewer. The director of medical affairs shall make the final selection of an external reviewer.

(D) Summary suspension.

- (1) Notwithstanding the provisions of this rule, a member of the medical staff shall have all or any portion of clinical privileges immediately suspended or appointment terminated by the chief executive officer or department chairperson and/or division director, whenever such action must be taken when there is imminent danger to patients or to the patient care operations. Such summary suspension shall become effective immediately upon imposition and the chief executive officer will subsequently notify the medical staff member in writing of the suspension. Such notice shall be by certified return receipt mail to the affected medical staff member's last known address as determined by university records.
- (2) A medical staff member whose privileges have been summarily suspended or whose appointment has been terminated shall be entitled to appeal the suspension pursuant to rule 3335-111-06 of the Administrative Code. If the affected member of the medical staff does not make a written request for a hearing to the chief executive officer within thirty-one days after receipt of the adverse decision, it shall be deemed a waiver of the affected member's right to any review by the medical staff administrative committee of which the member might otherwise been entitled. If a timely, written request for a hearing is made, the procedures set forth in rule 3335-111-06 of the Administrative Code shall apply.
- (3) Immediately upon the imposition of a summary suspension, the chief executive officer in consultation with the appropriate department chairperson and/or division director, shall have the authority to provide for alternative medical coverage for the patients of the suspended medical staff member who remain in the hospital at the time of suspension. The wishes of the patient shall be considered in the selection of such alternative medical coverage. While a summary suspension is in effect, the member of the medical staff is ineligible for

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reappointment to the medical staff. Medical staff and hospital administrative duties and prerogatives are suspended during the summary suspension.

(E) Automatic suspension and termination.

- (1) Notwithstanding the provisions of this rule, a temporary lapse of a medical staff member's admitting privileges, effective until medical records are completed, may be imposed automatically by the chief executive officer after a warning, in writing, of delinquency for failure to complete medical records as defined by the rules and regulations of the medical staff.
- (2) Action by the state boards of licensure revoking or suspending a medical staff member's licensure or placing the member on probation shall automatically impose the same restrictions to that member's CHRI medical staff privileges.
- (3) Failure to maintain the minimum required type and amount of professional liability insurance with an approved insurer, shall result in immediate and automatic suspension of a medical staff member's appointment and privileges until such time as proof of appropriate insurance coverage is furnished. In the event such proof is not provided within ten days of notice of such suspension, the medical staff member or credentialed provider shall be deemed to no longer comply with medical staff requirements under 3335-111-04 and automatically relinquish his or her appointment and privileges.
- (4) Upon exclusion, debarment, or other prohibition from participation in any state or federal health care reimbursement program, or a federal procurement or non-procurement program, the medical staff member's appointment and privileges shall immediately and automatically terminate, unless resignation in lieu of automatic termination is permitted pursuant to rule 3335-43-04(A)(4).
- (5) If a medical staff member pleads guilty to or is found guilty of a felony which involves violence or abuse upon a person, conversion, embezzlement, or misappropriation of property; fraud, bribery, evidence tampering, or perjury; or a drug offense, the medical staff member's appointment and privileges shall be immediately and automatically terminated.
- (6) Whenever a medical staff member's drug enforcement administration (DEA) or other controlled substances number is revoked, he or she shall be immediately and automatically divested of his or her right to prescribe medications covered by the number.
- (7) When a medical staff member's DEA or other controlled substances number is suspended or restricted in any manner, his or her right to prescribe medications covered by the number is similarly automatically suspended or restricted during the term of the suspension or restriction.
- (8) No medical staff member shall be entitled to the procedural rights set forth in rule 3335-111-06 of the Administrative Code as a result of an automatic suspension or termination. As soon as practicable after the imposition of an automatic suspension, the medical staff administrative committee shall convene to determine if further corrective action is necessary. Any further action with respect to an automatic suspension must be taken in accordance with this rule.

(Board approval dates: 9/1/1993, 5/2/1997, 9/1/1999, 10/1/1999, 12/3/1999, 4/5/2002, 9/6/2002, 2/6/2004, 11/4/2005, 2/6/2009, 9/18/2009, 10/29/2011, 4/8/2011, 11/7/2014, 11/6/2015, 4/6/2018)

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**3335-111-06 Hearing and appellate review procedure.**

- (A) Right to hearing before the medical staff administrative committee and to appellate review.
- (1) When a member of the medical staff has exhausted remedies under paragraph (F) of rule 3335-111-04 of the Administrative Code on reappointments; or under rule 3335-111-05 of the Administrative Code for corrective action; or who has been summarily suspended under paragraph (D) of rule 3335-111-05 of the Administrative Code, the staff member shall be entitled to an adjudicatory hearing.
  - (2) A medical staff member shall not be entitled to a hearing under the following circumstances:
    - (a) Denial of the Wexner medical center board to grant a waiver of board certification for a medical staff member.
    - (b) Termination of a medical staff member because of exclusion from participation in any government reimbursement program.
    - (c) Voluntary withdrawal of a medical staff application.
    - (d) Failure to submit a reappointment application.
    - (e) A leave of absences extending beyond current appointment or failure to request reinstatement of clinical privileges following a leave of absence.
    - (f) Actions or recommendations resulting from an informal peer review.
    - (g) Termination of courtesy B medical staff appointments upon approval by the Wexner medical center board.
  - (3) All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this rule to assure that the affected medical staff member is accorded all rights to which the member is entitled.
- (B) Request for hearing.
- (1) The request for a hearing shall be submitted in writing by the affected medical staff member to the chief executive officer within thirty days of notifications by the chief executive officer of the intended action. The chief executive officer shall forward the request to the medical staff administrative committee along with instructions to convene a hearing.
  - (2) The failure of a medical staff member to request a hearing to which the member is entitled by these bylaws within the time and in the manner herein provided, shall be deemed a waiver of the member's right to any review by the medical staff administrative committee to which the member might otherwise been entitled. The chief executive officer shall then implement the decision and that action shall become and remain effective against the medical staff member in the same manner as a final decision of the Wexner medical center board as provided for in paragraph (E) of this rule. The chief executive officer shall promptly inform the affected medical staff member that the proposed decision, which had entitled the medical staff member to a hearing, has now become final.

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(C) Notice of hearing.

- (1) After receipt of a timely request for hearing by the chief executive officer from a medical staff member entitled to such hearing, the medical staff administrative committee shall be notified of the request for hearing by the chief executive officer, and shall at the next scheduled meeting take the following action:
  - (a) Instruct the director of medical affairs and chief of staff to jointly appoint within seven days a hearing committee, consisting of three to five members of the medical staff who are not members of the medical staff administrative committee, are not direct competitors, do not have a conflict of interest, and who have not previously participated in the peer review of the matter under consideration.
  - (b) Instruct the hearing committee to schedule and arrange for a hearing which hearing shall be conducted not less than thirty nor more than sixty days from the date of the receipt of the request for a hearing by the chief executive officer. However, an initial hearing or meeting for a medical staff member who is under summary suspension, which is then in effect, shall be held as soon as arrangements may be reasonably made.
- (2) The medical staff member shall be given at least ten days prior notice of the scheduled hearing, provided that the medical staff member may waive this notice in writing. Notice shall be by certified return receipt mail to the staff member at the staff member's last known address as reflected by university records. The notice of hearing shall state in concise language the acts or omissions with which the medical staff member is charged; a list of representative medical records or documents being used; names of potential witnesses to be called; and any other reason or evidence that may be considered by the hearing committee during the hearing.

(D) Conduct of hearing.

- (1) The hearing committee shall select a chairperson from the committee to preside over the hearing. The chairperson may require a representative for the individual and for the medical staff administrative committee (or the Wexner medical center board) to participate in a pre-hearing conference. At the pre-hearing conference, the chairperson shall resolve all procedural questions, including any objections to exhibits or witnesses, the role of legal counsel, and determine the time to be allotted to each witness's testimony and cross-examination. The hearing committee shall have benefit of Ohio state university legal counsel. The hearing committee may grant continuances, recesses, and the chairperson may excuse a member of the hearing committee from attendance temporarily for good cause, provided that there shall be at no time less than two members of the hearing committee present unless the affected staff member waives this requirement.

All members of the hearing committee must be present to deliberate and vote. No member may vote by proxy. The person who has taken the action from which the affected staff member has requested the hearing shall not participate in the deliberation or voting of the hearing committee. The hearing shall be a de novo hearing, although evidence of the prior recommendations and decisions may be presented.

- (2) An accurate record of the hearing shall be kept. The record shall be done by the use of a professional stenographer. This record shall be available to the affected member of the medical staff upon request at the affected member's expense.
- (3) The personal presence of the medical staff member for whom the hearing has been scheduled shall be required. A medical staff member who fails without good cause to appear

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and proceed at such hearing shall be deemed to have waived the right to appear and to have a hearing before the medical staff administrative committee in the same manner as provided in paragraph (B) of this rule, and to have accepted the adverse recommendation or decision involved and the same shall therein become and remain in effect as provided in paragraph (B) of this rule. The hearing committee may, at its own discretion, proceed with the hearing without the medical staff member and impose a sanction.

- (4) Postponements of hearings beyond the time set forth in this chapter shall be made only with the approval of the medical staff administrative committee. Granting of such postponement shall be only for good cause shown.
- (5) The hearing need not be conducted strictly according to the rules of law related to the examination of witnesses or presentation of evidence. Any relevant matters upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action. The member of the medical staff for whom the hearing is being held shall, prior to, or during the hearing, be entitled to submit memoranda concerning any issues of procedure or of fact and such memoranda shall become a part of the hearing record.
- (6) The affected medical staff member shall have the following rights: to be represented by an attorney at law and to call and examine witnesses; to introduce evidence; to cross-examine any witnesses on any matter relevant to the issue of the hearing; and to challenge any witness and to rebut any evidence. If the medical staff member does not testify in his/her own behalf, the member may be called and examined as if under cross-examination.
- (7) The hearing committee shall request the person who has taken the action from which the affected medical staff member has requested the hearing to present evidence to the hearing committee in support of the adverse recommendation. The hearing committee may proceed to hear evidence and testimony from either party in whatever order the hearing committee deems appropriate. The hearing committee may call its own witnesses, may recall any party's witnesses, and may question witnesses as it deems appropriate. All parties shall be responsible to secure the attendance of their own witnesses. All witnesses and evidence received by the hearing committee shall be open to challenge and cross-examination by the parties. Witnesses shall not be placed under oath. At the close of the evidence the hearing committee may request each party to make summary statements, either oral or written.
- (8) The hearing committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. The hearing committee shall make its best effort to expeditiously determine the issues presented. The hearing committee may limit its proceedings when sufficient material has been received. The parties may be required to provide evidence in oral or written form. Upon conclusion of the presentation of evidence the hearing shall be closed. The hearing committee may there upon, at a time convenient to itself, conduct its deliberations outside the presence of the medical staff member for whom the hearing was convened.
- (9) Within sixty days after its appointment, unless otherwise extended by the medical staff administrative committee, the hearing committee shall forward its written report and recommendation together with the transcript of the hearing and all other documentation presented by the parties to the medical staff administrative committee. The affected member shall be notified of the recommendation of the hearing committee including a statement of the basis for the recommendation. The medical staff administrative committee shall accept, reject, or modify the recommendation of the hearing committee. The medical staff administrative committee may conduct further hearings as it deems necessary or may

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remand the matter back to the hearing committee for further action as directed. The medical staff administrative committee may impose a greater or lesser sanction than that recommended by the hearing committee.

- (10) Within fourteen days after the conclusion of the taking of all evidence and of all hearings, the medical staff administrative committee shall make a written report of its findings and its recommendation and shall forward the same together with the hearings record and all other documentation to the chairperson of the Wexner medical center board. Notice of that decision shall be sent certified return receipt mail to the affected medical staff member at the member's last known address as determined by university records by the director.
  - (11) The decision and record of the medical staff administrative committee shall be transmitted to the quality and professional affairs committee of the Wexner medical center board, which shall, subject to the affected member's right to appeal and implementation of paragraph (E) of this rule, consider the matter at its next scheduled meeting, or at a special meeting to be held no less than thirty days following receipt of the transmittal. The quality and professional affairs committee of the Wexner medical center board may accept, reject, or modify the decision of the medical staff administrative committee.
  - (12) The recommendation of the quality and professional affairs committee of the Wexner medical center board shall be promptly considered by the Wexner medical center board at its next scheduled meeting. The Wexner medical center board may accept, reject, or modify the recommendation of the quality and professional affairs committee of the Wexner medical center board.
  - (13) A copy of the Wexner medical center board decision shall be sent by certified return receipt mail to the affected medical staff member at the member's last known address as determined by university records.
- (E) Appeal process.
- (1) Within thirty days after receipt of a notice by an affected medical staff member of the action of the medical staff administrative committee the staff member may, by written notice to the chairperson of the Wexner medical center board, request an appeal. Such appeal shall only be held on the record before the medical staff administrative committee.
  - (2) If an appeal is not requested within the thirty-day period, the affected medical staff member shall be deemed to have waived the right to an appeal, and to have accepted such adverse decision.
  - (3) The appeal shall be conducted by the quality and professional affairs committee of the Wexner medical center board.
  - (4) The affected medical staff member shall have access to the reports and records, including transcripts, if any, of the medical staff administrative committee and all other material, favorable or unfavorable, that have been considered by that committee. The member shall then submit a written factual statement specifying those factual and procedural matters with which the member disagrees, and the reasons for such disagreement. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the quality and professional affairs committee of the Wexner medical center board no later than seven days following the date of the affected member's notice of appeal.

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- (5) New or additional matters not raised during the hearing procedure or in the medical staff administrative committee hearings shall only be introduced on appeal at the sole discretion of the quality and professional affairs committee of the Wexner medical center board.
- (6) Within fourteen days following submission of the written statement by the affected medical staff member, the quality and professional affairs committee shall recommend to the Wexner medical center board that the adverse decision be affirmed, modified or rejected, or to refer the matter back to the medical staff administrative committee for further review and recommendation. Such referral to the medical staff administrative committee may include a request for further investigation.
- (7) Any final decision by the Wexner medical center board shall be communicated by the chief executive officer by certified return receipt mail to the affected medical staff member at the member's last known address as determined by university records. The chief executive officer shall also notify in writing the executive vice president for health sciences, the dean of the college of medicine, the chief medical officer of OSU medical center, the vice president for health services, the director of medical affairs, chief of staff, the department chairperson and/or division director, clinical department chief and the academic department chairperson and the person(s) who initiated the request for formal peer review. The chief executive officer shall take immediate steps to implement the final decision.

(Board approval dates: 9/1/1993, 4/5/2002, 9/6/2002, 2/6/2004, 11/4/2005, 2/6/2009, 9/18/2009, 10/29/2010, 4/8/2011, 11/7/2014, 11/6/2015, 4/6/2018)

**3335-111-07 Categories of the medical staff.**

The medical staff of the CHRI shall be divided into honorary, physician scholar, attending, associate attending, clinical attending, consulting medical staff and limited designations. All medical staff members with admitting privileges may admit patients in accordance with state law and criteria for standards of care established by the medical staff. Medical staff members who do not wish to obtain any clinical privileges shall be exempt from the requirements of medical malpractice liability insurance, DEA registration, demonstration of recent active clinical practice during the last two years and specific annual education requirements as outlined in the list maintained in the chief medical officer's office, but are otherwise subject to the provisions of these bylaws.

**(A) Honorary staff.**

The honorary staff will be composed of those individuals who are recognized for outstanding reputation, notable scientific and professional contributions, and high professional stature in an oncology field of interest. The honorary staff designation is awarded by the Wexner medical center board on the recommendation of the chief executive officer of the CHRI, executive vice president for health sciences, department chairperson and/or division director, or the credentials committee after approval by the medical staff administrative committee. This is a lifetime appointment. Honorary staff are not entitled to patient care privileges.

**(B) Physician scholar medical staff.**

- (1) **Qualifications:** The physician scholar medical staff shall be composed of those faculty members of the colleges of medicine and dentistry who are recognized for outstanding reputation, notable scientific and professional contributions, and high professional stature. This medical staff category includes but is not limited to emeritus faculty members. Nominations may be made to the chair of the credentialing committee who shall present the candidate to the medical staff administrative committee for approval.

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- (2) Prerogatives: Members of the physician scholar medical staff shall have access to the CHRI and shall be given notice of all medical staff activities and meetings. Members of the physician scholar medical staff shall enjoy all rights of an attending medical staff member except physician scholar members shall not possess clinical privileges.
  - (3) Physician scholar medical staff must have either a full license or an emeritus registration by the State Medical Board of Ohio.
- (C) Attending medical staff.
- (1) Qualifications:

The attending staff shall consist of those regular faculty members of the colleges of medicine and dentistry who are licensed or certified in the state of Ohio, whose practice is at least seventy-five percent oncology and with a proven career commitment to oncology as demonstrated by the majority of the following:

Training, current board certification (as specified in paragraph (A)(5) of rule 3335-111-04 of the Administrative Code), publications, grant funding, other funding and experience (as deemed appropriate by the chief executive officer and the department chairperson and/or division director); and who satisfy the requirements and qualifications for membership set forth in rule 3335-111-04 of the Administrative Code.
  - (2) Prerogatives:

Attending staff members may:

    - (a) Admit patients consistent with the balanced teaching and patient care responsibilities of the CHRI. When, in the judgment of the director of medical affairs, a balanced teaching program is jeopardized, following consultation with the chief executive officer, the clinical department chief and with the concurrence of a majority of the medical staff administrative committee, the director of medical affairs may restrict admissions. Imposition of such restrictions shall not entitle the attending staffmember to a hearing or appeal pursuant to rule 3335-111-06 of the Administrative Code.
    - (b) Be free to exercise such clinical privileges as are granted pursuant to these bylaws.
    - (c) Vote on all matters presented at general and special meetings of the medical staff and committees of which he or she is a member unless otherwise provided by resolution of the medical staff, clinical department or committee and approved by the medical staff administrative committee.
    - (d) Hold office in the medical staff organization, clinical departments and committees of which they are a member, unless otherwise provided by resolution of the medical staff, clinical department or committee and approved by the medical staff administrative committee.
  - (3) Responsibilities:

An attending staff member shall:

    - (a) Meet the basic responsibilities set forth in rules 3335-111-02 and 3335-111-03 of the Administrative Code.

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- (b) Retain responsibility within the member's area of professional competence for the continuous care and supervision of each patient in the CHRI for whom he or she is providing care, or arrange a suitable alternative for such care and supervision.
- (c) Actively participate in such quality evaluation and monitoring activities as required by the medical staff, and discharge such staff functions as may be required from timeto time.
- (d) Satisfy the requirements set forth in rule 3335-111-13 of the Administrative Code for attendance at medical staff meetings and meetings of those committees of which they are a member.
- (e) Supervise members of the limited staff in the provision of patient care in accordance with accreditation standards and policies and procedures of approved clinical training programs. It is the responsibility of the attending physician to authorize each member of the limited staff to perform only those services that the limited staff member is competent to perform under supervision.
- (f) Supervise other licensed allied health professionals as necessary in accordance with accreditation standards and state law. It is the responsibility of the attending physician to authorize each licensed allied health professional to perform only those services which the licensed allied health professional is privileged to perform.
- (g) Take call as assigned by the clinical department chief.

(D) Associate attending staff.

(1) Qualifications:

The associate attending staff shall consist of those regular faculty members of the colleges of medicine and dentistry who do not qualify for attending staff appointment.

(2) Prerogatives:

The associate attending staff may:

- (a) Admit patients consistent with the balanced teaching and patient care responsibilities of the institution. When, in the judgment of the director of medical affairs, a balanced teaching program is jeopardized, following consultation with the chief executive officer, the clinical department chief and with the concurrence of a majority of the medical staff administrative committee, the director of medical affairs may restrict admissions. Imposition of such restrictions shall not entitle the associate attending staff member to a hearing or appeal pursuant to rule 3335-111-06 of the Administrative Code.
- (b) Be free to exercise such clinical privileges as are granted pursuant to the bylaws.
- (c) Vote on all matters presented at general and special meetings of the medical staff and at committees of which he or she is a member unless otherwise prohibited by these bylaws or by resolution approved by the medical staff administrative committee.
- (d) The associate attending staff member may not vote on amendments to the bylaws.

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(3) Responsibilities:

Associate attending staff members shall:

- (a) Meet the basic responsibilities set forth in rules 3335-111-02 and 3335-111-03 of the Administrative Code.
- (b) Retain responsibility within the member's care area of professional competence for the continuous care and supervision of each patient in the CHRI for whom the member is providing care, or arrange a suitable alternative for such care and supervision including the supervision of interns, residents and fellows assigned to their service.
- (c) Actively participate in such quality evaluation and monitoring activities as required by the staff and discharge such staff functions as may be required from time to time.
- (d) Satisfy the requirements set forth in rule 3335-111-13 of the Administrative Code for attendance at medical staff meetings and meetings of those committees of which they are a member.

(E) Clinical attending staff.

(1) Qualifications:

The clinical attending staff shall consist of those clinical faculty members of the colleges of medicine and dentistry who have training, expertise, and experience in oncology, as determined by the chief executive officer in consultation with the department chairperson and/or division director and who satisfy the requirements and qualifications for membership set forth in rule 3335-111-04 of the Administrative Code.

(2) Prerogatives:

The clinical attending staff may:

- (a) Admit patients which complement the research and clinical teaching program. At times when hospital beds or other resources are in short supply, patient admissions of clinical staff shall be subordinate to those of attending or associate attending staff.
- (b) Be free to exercise such clinical privileges as are granted pursuant to these bylaws.
- (c) Attend meetings as non-voting members of the medical staff and any medical staff or hospital education programs. The clinical attending staff may not hold elected office in the medical staff organization.

(3) Responsibilities:

- (a) Meet the basic responsibilities set forth in rules 3335-111-02 and 3335-111-03 of the Administrative Code.
- (b) Retain responsibility within the member's area of professional competence for the continuous care and supervision of each patient in the CHRI for whom the member is providing care, or arrange a suitable alternative for such care and supervision including the supervision of interns, residents and fellows assigned to their service.

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- (c) Actively participate in such quality evaluation and monitoring activities as required by the staff and discharge such staff functions as may be required from time to time.
- (d) Satisfy the requirements set forth in rule 3335-111-13 of the Administrative Code for attendance at medical staff meetings and meetings of those committees of which they are a member.
- (e) Supervise members of the limited staff in the provision of patient care in accordance with accreditation standards and policies and procedures of approved clinical training programs. It is the responsibility of the attending physician to authorize each member of the limited staff to perform only those services which the limited staff member is competent to perform under supervision.
- (f) Supervise other licensed allied health professionals as necessary in accordance with accreditation standards and state law. It is the responsibility of the attending physician to authorize each licensed allied health professional to perform only those services which the licensed allied health professional is privileged to perform.

(F) Consulting medical staff.

(1) Qualifications.

The consulting medical staff shall consist of those faculty members of the colleges of medicine and dentistry who:

- (a) Satisfy the requirements and qualifications for membership set forth in rule 3335-111-04 of the Administrative Code.
- (b) Are consultants of recognized professional ability and expertise who provide a service not readily available from the attending medical staff. These practitioners provide services to James patients only at the request of attending or associate attending members of the medical staff.
- (c) Demonstrate participation on the active medical staff at another accredited hospital requiring performance improvement/quality assessment activities similar to those of the hospitals of the Ohio state university. The practitioner shall also hold at such other hospital the same privileges, without restriction, that he/she is requesting at the James cancer hospital. An exception to this qualification may be made by the Wexner medical center board provided the practitioner is otherwise qualified by education, training and experience to provide the requested service.

(2) Prerogatives:

Consulting medical staff members may:

- (a) Exercise the clinical privileges granted for consultation purposes on an occasional basis when requested by an attending or associate attending medical staff member.
- (b) Have access to all medical records and be entitled to utilize the facilities of the Ohio state university hospitals and James cancer hospital incidental to the clinical privileges granted pursuant to these bylaws.
- (c) Not admit patients to the Ohio state university hospitals or James cancer hospital.

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- (d) Not vote on medical staff policies, rules and regulations, or bylaws, and may not hold office.
- (e) Must actively participate in such quality evaluation and monitoring activities as required by the medical staff and as outlined in the medical staff policy entitled "consulting medical staff member policy."
- (f) Attend medical staff meetings, but shall not be entitled to vote at such meetings or hold office.
- (g) Attend department meetings, but shall not be entitled to vote at such meetings or serve as clinical department chief.
- (h) Serve as a non-voting member of a medical staff committee; provided, however, that he/she may not serve as a committee chair or as a member of the medical staff administrative committee.

(3) Responsibilities.

Each member of the consulting medical staff shall:

- (a) Meet the basic responsibilities set forth in rules 3335-111-02 and 3335-111-03 of the Administrative Code.
- (b) Be exempt from all medical staff dues.

(G) Limited staff.

Limited staff are not considered members of the medical staff, do not have delineated clinical privileges, and do not have the right to vote in general medical staff elections. Except where expressly stated, limited staff are bound by the terms of these bylaws, rules and regulations of the medical staff and the limited staff agreement.

(1) Qualifications:

The limited staff shall consist of doctors of medicine, osteopathic physicians, dentists and practitioners of podiatry or psychology who are accepted in good standing by a program director into a postdoctoral graduate medical education program and appointed to the limited staff in accordance with these bylaws. The limited staff shall maintain compliance with the requirements of state law, including regulations adopted by the Ohio state medical board, or the limited staff member's respective licensing board.

Members of the limited staff shall possess a valid training certificate or an unrestricted Ohio license from the applicable state board based on eligibility criteria defined by that state board. All members of the limited staff shall be required to successfully obtain an Ohio training certificate prior to beginning training within a program.

(2) Responsibilities:

The limited staff shall:

- (a) Be responsible to respond to all questions and complete all forms as may be required by the credentials committee.

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- (b) Participate fully in the teaching programs, conferences, and seminars of the clinical department in which he or she is appointed in accordance with accreditation standards and policies and procedures of the graduate medical education committee and approved clinical training programs.
- (c) Participate in the care of all patients assigned to the limited staff member under the appropriate supervision of a designated member of the attending medical staff in accordance with accreditation standards and policies and procedures of the clinical training programs. The clinical activities of the limited staff shall be determined by the program director appropriate for the level of education and training. Limited staff shall be permitted to perform only those services that they are authorized to perform by the member of the attending medical staff based on the competence of the limited staff to perform such services. The limited staff may admit or discharge patients only when acting on behalf of the attending, associate attending or clinical attending medical staff. The limited staff member shall follow all rules and regulations of the service to which he or she is assigned, as well as the general rules of the CHRI pertaining to limited staff.
- (d) Serve as full members of the various medical staff committees in accordance with established committee composition as described in these bylaws and/or rules and regulations of the medical staff. The limited staff member shall not be eligible to vote or hold elected office in the medical staff organization, but may vote on committees to which the limited staff member is assigned.
- (e) Be expected to make regular satisfactory professional progress including anticipated certification by the respective specialty or subspecialty program of post-doctoral training in which the limited staff member is enrolled. Evaluation of professional growth and appropriate humanistic qualities shall be made on a regular schedule by the clinical department chief, program director, teaching faculty or evaluation committee in accordance with accreditation standards and policies and procedures of the approved training programs.
- (f) Appeal by a member of the limited staff of probation, lack of promotion, suspension or termination for failure to meet expectations for professional growth or failure to display appropriate humanistic qualities or failure to successfully complete any other competency as required by the accreditation standards of an approved training program will be conducted and limited in accordance with written guidelines established by the respective academic department or training program and approved by the program director and the Ohio state university's graduate medical education committee as delineated in the limited staff agreement and by the graduate medical education policies.

Alleged misconduct by a member of the limited staff, for reasons other than failure to meet expectations of professional growth as outlined above, shall be handled in accordance with rules 3335-111-05 and 3335-111-06 of the Administrative Code.

(3) Failure to meet reasonable expectations:

Termination of employment from the limited staff member's residency or fellowship training program shall result in automatic termination of the limited staff member's appointment pursuant to these bylaws.

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(4) Temporary appointments:

- (a) Limited staff members who are Ohio state university faculty may be granted an early commencement or an extension of appointment upon the recommendation of the chief of the clinical department, with prior concurrence of the associate dean for graduate medical education, when it is necessary for the limited staff member to begin his or her training program prior to or extend his or her training program beyond a regular appointment period. The appointment shall not exceed sixty days.
- (b) Temporary appointments may be granted upon the recommendation of the chief of the clinical department, with prior concurrence of the associate dean for graduate medical education, for limited staff members who are not Ohio state university faculty but who, pursuant to education affiliate agreements approved by the university, need to satisfy approved graduate medical education clinical rotation requirements. These appointments shall not exceed a total of one hundred twenty days in any given post-graduate year. In such cases, the mandatory requirement for a faculty appointment may be waived. All other requirements for limited staff member appointment must be satisfied.

(5) Supervision:

Limited staff members shall be under the supervision of an attending, associate attending or clinical attending medical staff member. Limited staff members shall have no privileges as such but shall be able to care for patients under the supervision and responsibility of their attending, associate attending or clinical attending medical staff member. The care they extend will be governed by these bylaws and the general rules and regulations of each clinical department. The practice of care shall be limited by the scope of privileges of their attending, associate attending or clinical attending medical staff member. Any concerns or problems that arise in the limited staff member's performance should be directed to the attending, associate attending or clinical attending medical staff member or the director of the training program.

- (a) Limited staff members may write admission, discharge or other orders for the care of patients under the supervision of the attending, associate attending or clinical attending medical staff member.
- (b) All records of limited staff member cases must document involvement of the attending, associate attending or clinical attending medical staff member in the supervision of the patient's care to include co-signature of the admission order, history and physical, operative report, and discharge summary.

(H) Associates to the medical staff.

(1) Qualifications:

Licensed health care professionals are those professionals who possess a license, certificate or other legal credential required by Ohio law to provide direct patient care in a hospital setting, but who are not acting as licensed independent practitioners.

(2) Due process:

Licensed health care professionals are subject to corrective action for violation of these rules, their certificate of authority, standard care agreement, utilization plan or the provisions of their licensure, including professional ethics. Corrective action may be requested by any member of the medical staff, the clinical department chief, the chairperson of an academic

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department, the section chief, the medical director of credentialing or the director of medical affairs. All requests shall be in writing and be submitted to the director of medical affairs.

The director of medical affairs shall appoint a three-person committee to review the situation and recommend appropriate corrective action, including termination or suspension of clinical privileges. The committee shall consist of at least one licensed health care professional licensed in the same field as the individual being reviewed, if available, and one medical staff member. The committee shall make a written recommendation to the director of medical affairs, who may accept, reject or modify the recommendation. The decision of the director of medical affairs shall be final.

(I) Temporary medical staff appointment.

- (1) External peer review. When peer review activities are being conducted by someone other than a current member of the medical staff, the chief medical officer or director of medical affairs may admit a practitioner to the medical staff for a limited period of time. Such membership is solely for the purpose of conducting peer review in a particular evaluation and this temporary membership automatically expires upon the member's completion of duties in connection with such peer review. Such appointment does not include clinical privileges, and is for a limited purpose.
- (2) Proctoring. Temporary privileges may be extended to visiting physician or visiting medical faculty for special clinical or educational activities as permitted by the Ohio state medical or dental board. When medical staff members require proctoring for the purposes of gaining experience to become credentialed to perform a procedure, a visiting medical faculty or visiting physician may apply for temporary privileges pursuant to the medical staff proctoring policy.

(J) Clinical privileges.

- (1) Delineation of clinical privileges:
  - (a) Every person practicing at the CHRI by virtue of medical staff membership, faculty appointment, contract or under authority granted in these bylaws shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically applied for and granted to the staff member or other licensed allied health professional by the Wexner medical center board after recommendation from the medical staff administrative committee.
  - (b) Each clinical department and CHRI department and/or division shall develop specific clinical criteria and standards for the evaluation of privileges with emphasis on invasive or therapeutic procedures or treatment which represent significant risk to the patient or for which specific professional training or experience is required. Such criteria and standards are subject to the approval of the medical staff administrative committee and the Wexner medical center board.
  - (c) Requests for the exercise and delineation of clinical privileges must be made as part of each application for appointment or reappointment to the medical staff on the forms prescribed by the medical staff administrative committee. Every person in an administrative position who desires clinical privileges shall be subject to the same procedure as all other applicants. Requests for clinical privileges must be submitted to the chief of the clinical department in which the clinical privileges will be exercised. Clinical privileges requested other than during appointment or reappointment to the medical staff shall be submitted to the chief of the clinical department and such

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request must include documentation of relevant training or experience supportive of the request.

- (d) The chief of the clinical department shall review each applicant's request for clinical privileges and shall make a recommendation regarding clinical privileges to the medical director of credentialing. Requests for clinical privileges shall be evaluated based upon the applicant's education, training, experience, demonstrated competence, references, and other relevant information including the direct observation and review of records of the applicant's performance by the clinical department in which the clinical privileges are exercised. Whenever possible, the review should be of primary source information. The applicant shall have the burden of establishing qualifications and competence in the clinical privileges requested and shall have the burden of production of adequate information for the proper evaluation of qualifications.
  - (e) The applicant's request for clinical privileges and the recommendation of the clinical department chief shall be forwarded to the credentials committee and shall be processed in the same manner as applications for appointment and reappointment pursuant to rule 3335-111-04 of the Administrative Code.
  - (f) Medical staff members who are granted new or initial privileges are subject to FPPE, which is a six-month period of focused monitoring and evaluation of practitioner's professional performance. Following FPPE medical staff members with clinical privileges are subject to ongoing professional practice evaluation (OPPE), which information is factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of renewal. FPPE and OPPE are fully detailed in medical staff policies that were approved by the medical staff administrative committee and the Wexner medical center board.
  - (g) Upon resignation, termination or expiration of the medical staff member's faculty appointment or employment with the university for any reason, such medical staff appointment and clinical privileges of the medical staff member shall automatically expire.
  - (h) Medical staff members authorize the CHRI and clinics to share amongst themselves credentialing, quality and peer review information pertaining to the medical staff member's clinical competence and/or professional conduct. Such information may be shared at initial appointment and/or reappointment and at any time during the medical staff member's medical staff appointment to the medical staff of the CHRI.
  - (i) Medical staff members authorize the CHRI to release, in good faith and without malice, information to managed care organizations, regulating agencies, accreditation bodies and other health care entities for the purposes of evaluating the medical staff member's qualifications pursuant to a request for appointment, clinical privileges, participation or other credentialing or quality matters.
- (2) Temporary and special privileges:
- (a) Temporary privileges may be extended to a doctor of medicine, osteopathic medicine, dental surgery, psychologist, podiatry or to a licensed allied health professional upon completion of an application prescribed by the medical staff administrative committee, upon recommendation of the chief of the clinical department, ~~and approval by the chief medical officer. The chief medical officer has been delegated responsibility by the Wexner medical center board to grant approval of temporary privileges. All temporary privileges are granted by the chief executive officer or authorized designee.~~ The temporary privileges granted shall be

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consistent with the applicant's training and experience and with clinical department guidelines. Prior to granting temporary privileges, primary source verification of licensure and current competence shall be required. Temporary privileges shall be limited to situations which fulfill an important patient care need and shall not be granted for a period not to exceed one hundred twenty days.

- (b) Temporary privileges may be extended to visiting medical faculty or for special activity as provided by the Ohio state medical or dental boards.
  - (c) Temporary privileges granted for locum tenens may be exercised for a maximum of one hundred twenty days, consecutive or not, any time during the twenty-four month period following the date they are granted.
  - (d) Practitioners granted temporary privileges will be restricted to the specific delineations for which the temporary privileges are granted. The practitioner will be under the supervision of the chair of the clinical department while exercising any temporary privileges granted.
  - (e) Practitioners exercising temporary privileges shall abide by these medical staff bylaws, rules and regulations, and hospital and medical staff policies.
  - (f) Special privileges -- upon receipt of a written request for specific temporary clinical privileges and the approval of the clinical department chief, the chairperson of the academic department and the director of medical affairs, an appropriately licensed or certified practitioner of documented competence, who is not an applicant for medical staff membership, may be granted special clinical privileges for the care of one or more specific patients. Such privileges shall be exercised in accordance with the conditions specified in rule 3335-111-04 of the Administrative Code.
  - (g) The temporary and special privileges must also be in conformity with accrediting bodies' standards and the rules and regulations of professional boards of Ohio.
- (3) Expedited privileges:

If the Wexner medical center board is not scheduled to convene in a timeframe that permits the timely consideration of the recommendation of a complete application by the medical staff administrative committee, eligible applicants may be granted expedited privileges by the quality and professional affairs committee of the Wexner medical center board. Certain restrictions apply to the appointment and granting of clinical privileges via the expedited process. These include but are not limited to: an involuntary termination of medical staff membership at another hospital, involuntary limitation, or reduction, denial or loss of clinical privileges, a history of professional liability actions resulting in a final judgment against the applicant, or a challenge by a state licensing board.

- (4) Podiatric privileges:

(a) Practitioners of podiatry may admit patients to the CHRI if such patients are being admitted solely to receive care that a podiatrist may provide without medical assistance, pursuant to the scope of the professional license of the podiatrist. Practitioners of podiatry must, in all other circumstances co-admit patients with a member of the medical staff who is a doctor of medicine or osteopathic medicine. A member of the medical staff who is a doctor of medicine or osteopathy shall:

- (i) Be responsible for any medical problems that the patient has while an inpatient of the CHRI; and

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- (ii) Shall confirm the findings, conclusions and assessment of risk prior to high-risk diagnosis or therapeutic interventions defined by the medical staff.
  - (b) Practitioners of podiatry shall be responsible for the podiatric care of the patient including the podiatric history and physical examination and all appropriate elements of the patient's record.
  - (c) The podiatrist shall be responsible to the chief of the department of orthopaedics.
- (5) Psychology privileges:
  - (a) Psychologists shall be granted clinical privileges based upon their training, experience and demonstrated competence and judgment consistent with their license to practice. Psychologists shall not prescribe drugs, or perform surgical procedures, or in any other way practice outside the area of their approved clinical privileges or expertise unless otherwise authorized by law.
  - (b) Psychologists may not admit patients to the CHRI, but may diagnose and treat a patient's psychological illness as part of the patient's comprehensive care while hospitalized. All patients admitted for psychological care shall receive the same medical appraisal as all other hospitalized patients. A member of the medical staff who is a doctor of medicine or osteopathic medicine shall admit the patient and shall be responsible for the history and physical and any medical care that may be required during the hospitalization, and shall determine the appropriateness of any psychological therapy based on the total health status of the patient. Psychologists may provide consultation within their area of expertise on the care of patients within the CHRI. In ambulatory settings, psychologists shall diagnose and treat their patient's psychological illness. Psychologists shall ensure that their patients receive referral for appropriate medical care.
  - (c) Psychologists shall be responsible to the chief of the clinical department in which they are appointed.
- (6) Dental privileges:
  - (a) Practitioners of dentistry, who have not been granted clinical privileges as oral and maxillofacial surgeons, may admit patients to the CHRI if such patients are being admitted solely to receive care which a dentist may provide without medical assistance, pursuant to the scope of the professional license of the dentist. Practitioners of dentistry must, in all other circumstances, co-admit patients with a member of the medical staff who is a doctor of medicine or osteopathic medicine.
  - (b) A member of the medical staff who is a doctor of medicine or osteopathy:
    - (i) Shall be responsible for any medical problems that the patient has while an inpatient of the CHRI; and
    - (ii) Shall confirm the findings, conclusions and assessment of risk prior to high-risk diagnoses or therapeutic interventions defined by the medical staff.
  - (c) Practitioners of dentistry shall be responsible for the dental care of the patient including the dental history and physical examination and all appropriate elements of the patient's record.

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(7) Oral and maxillofacial surgical privileges:

All patients admitted to the CHRI for oral and maxillofacial surgical care shall receive the same medical appraisal as all other hospitalized patients. Qualified oral and maxillofacial surgeons shall admit patients, shall be responsible for the plan of care for the patients, shall perform the medical history and physical examination, if they have such privileges, in order to assess the medical, surgical, and anesthetic risks of the proposed operative and other procedure(s), and shall be responsible for the medical care that may be required at the time of admission or that may arise during hospitalization.

(8) Licensed allied health professionals:

- (a) Clinical privileges may be exercised by licensed allied health professionals who are duly licensed in the state of Ohio and who are either:
  - (i) Members of the faculty of the Ohio state university, or
  - (ii) Employees of the Ohio state university whose employment involves the exercise of clinical privileges, or
  - (iii) Employees of members of the medical staff.
- (b) A licensed allied health professional as used herein, shall not be eligible for medical staff membership but shall be eligible to exercise those clinical privileges granted pursuant to these bylaws and in accordance with applicable Ohio state law. If granted such privileges under this rule and in accordance with applicable Ohio state law, other licensed allied health professionals may perform all or part of the medical history and physical examination of the patient. Licensed health care professionals with privileges are subject to FPPE and OPPE.
- (c) Licensed allied health professionals shall apply and re-apply for clinical privileges on forms prescribed by the medical staff administrative committee and shall be processed in the same manner as provided in rule 3335-111-04 of the Administrative Code.
- (d) Licensed allied health professionals are not members of the medical staff, but may write admitting orders for; patients of the CHRI when granted such privileges under this rule and in accordance with applicable Ohio state law. If such privileges are granted, the patient will be admitted under the medical supervision of the responsible medical staff member. Licensed allied health professionals are not members of the medical staff and shall not be eligible to hold office, to vote on medical staff affairs, or to serve on standing committees of the medical staff unless specifically authorized by the medical staff administrative committee.
- (e) Each licensed allied health professional shall be individually assigned to a clinical department and shall be supervised by or collaborate with one or more members of the medical staff as required by Ohio law. The licensed health care professional's clinical privileges are contingent upon the collaborating/supervising medical staff member's privileges. In the event that the collaborating/supervising medical staff member loses privileges or resigns, the licensed allied health care professionals whom he or she has supervised shall be placed on administrative hold until another collaborating/ supervising medical staff member is assigned. The new collaborating/supervising medical staff member shall be assigned in less than thirty days.

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- (f) Licensed allied health professionals must comply with all limitations and restrictions imposed by their respective licenses, certifications, or legal credentials as required by Ohio law, and may only exercise those clinical privileges granted in accordance with provisions relating to their respective professions.
- (g) Only applicants who can document the following shall be qualified for clinical privileges as a licensed allied health professional:
  - (i) Current license, certification, or other legal credential required by Ohio law;
  - (ii) Certificate of authority, standard care arrangement/agreement, or utilization plan;
  - (iii) Education, training, professional background and experience, and professional competence;
  - (iv) Patient care quality indicators definition for initial appointment. This data will be in a format determined by the licensed allied health professional subcommittee and the quality management department of the Ohio state university medical center;
  - (v) Adherence to the ethics of the profession for which an individual holds a license, certification, or other legal credential required by Ohio law;
  - (vi) Evidence of required immunization;
  - (vii) Evidence of good personal and professional reputation as established by peer recommendations;
  - (viii) Satisfactory physical and mental health to perform requested clinical privileges; and
  - (ix) Ability to work with members of the medical staff and the CHRI employees.
- (h) The applicant shall have the burden to produce documentation with sufficient adequacy to assure the medical staff and the CHRI that any patient cared for by the licensed allied health professional seeking clinical privileges shall be given quality care, and that the efficient operation of the CHRI will not be disrupted by the applicant's care of patients in the CHRI.
- (i) By applying for clinical privileges as a licensed allied health professional, the applicant agrees to the following terms and conditions:
  - (i) The applicant has read the bylaws and rules and regulations of the medical staff of the CHRI and agrees to abide by all applicable terms of such bylaws and any applicable rules and regulations, including any subsequent amendments thereto, and any applicable CHRI policies that the CHRI may from time to time put into effect;
  - (ii) The applicant releases from liability all individuals and organizations who provide information to the CHRI regarding the applicant and all members of the medical staff, the CHRI staff and the Wexner medical center board and the Ohio state university board of trustees for all acts in connection with investigating and evaluating the applicant;

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- (iii) The applicant shall not deceive a patient as to the identity of any practitioner providing treatment or service in the CHRI;
  - (iv) The applicant shall not make any statement or take any action that might cause a patient to believe that the licensed allied health professional is a member of the medical staff; and
  - (v) The applicant shall obtain and continue to maintain professional liability insurance in such amounts required by the medical staff.
- (j) Licensed allied health care professionals shall be subject to quality review and corrective action as outlined in this paragraph for violation of these bylaws, their certificate of authority, standard of care agreement, utilization plan, or the provisions of their licensure, including professional ethics. Review may be requested by any member of the medical staff, a chief of the clinical department, or by the medical director of quality or the chief quality officer. All requests shall be in writing and shall be submitted to the chief quality officer. The chief quality officer, unless delegated to the medical director of quality, shall appoint a three-person committee to review and make recommendations concerning appropriate action. The committee shall consist of at least one licensed allied health care professional and one medical staff member. The committee shall make a written recommendation to the chief quality officer, unless delegated to the medical director of quality, who may accept, reject, or modify the recommendation. The chief quality officer, unless delegated to the medical director of quality shall forward his or her recommendation to the director of medical affairs for final determination.
- (k) Appeal process.
- (i) A licensed allied health care professional may submit a notice of appeal to the chairperson of the quality and professional affairs committee within thirty days of receipt of written notice of any adverse corrective action pursuant to these bylaws.
  - (ii) If an appeal is not so requested within the thirty-day period, the licensed allied health care professional shall be deemed to have waived the right to appeal and to have conclusively accepted the decision of the director of medical affairs.
  - (iii) The appellate review shall be conducted by the chief of staff, the chair of the licensed health care professionals subcommittee and one medical staff member from the same discipline as the licensed allied health care professional under review. The licensed allied health care professional under review shall have the opportunity to present any additional information deemed relevant to the review and appeal of the decision.
  - (iv) The affected licensed allied health care professional shall have access to the reports and records, including transcripts, if any, of the hearing committee and of the medical staff administrative committee and all other material, favorable or unfavorable, that has been considered by the chief quality officer. The licensed allied health care professional shall submit a written statement indicating those factual and procedural matters with which the member disagrees, specifying the reasons for such disagreement. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the review

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committee no later than seven days following the date of the licensed allied health care professional's notice of appeal.

- (v) New or additional matters shall only be considered on appeal at the sole discretion of the quality and professional affairs committee.
- (vi) Within thirty days following submission of the written statement by the licensed allied health care professional, the chief of staff shall make a final recommendation to the chair of the quality and professional affairs committee of the Wexner medical center board. The quality and professional affairs committee of the Wexner medical center board shall determine whether the adverse decision will stand or be modified and shall recommend to the Ohio state university Wexner medical center board that the adverse decision be affirmed, modified or rejected, or to refer the matter back to the review committee for further review and recommendation. Such referral to the review committee may include a request for further investigation.
- (vii) Any final decision by the Wexner medical center board shall be communicated by the chief quality officer and by certified return receipt mail to the last known address of the licensed allied health care professional as determined by university records. The chief quality officer shall also notify in writing the senior vice president for health sciences, the dean of the college of medicine, the chief executive officer of the CHRI and the vice president for health services and the chief of the applicable clinical department or departments. The chief quality officer, unless delegated to the medical director of quality, shall take immediate steps to implement the final decision.

(9) Emergency privileges:

In the case of an emergency, any member of the medical staff to the degree permitted by the member's license or certification and regardless of department or medical staff status shall be permitted to do everything possible to save the life of a patient using every facility of the CHRI necessary, including the calling for any consultation necessary or desirable. After the emergency situation resolves, the patient shall be assigned to an appropriate member of the medical staff. For the purposes of this paragraph, an "emergency" is defined as a condition that would result in serious permanent harm to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

(10) Disaster privileges:

Disaster privileges may be granted in order to provide voluntary services during a local, state or national disaster in accordance with hospital/medical staff policy and only when the following two conditions are present: the emergency management plan has been activated and the hospital is unable to meet immediate patient needs. Such privileges may be granted by the director of medical affairs or the medical director of credentialing to fully licensed or certified, qualified individuals who at the time of the disaster are not members of the medical staff. These privileges will be limited in scope and will terminate once the disaster situation subsides or at the discretion of the director of medical affairs temporary privileges are granted thereafter.

(11) Telemedicine:

Telemedicine involves the use of electronic communication or other communication technologies to provide or support clinical care at a distance. Diagnosis and treatment of a patient may now be performed via telemedicine link.

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- (a) A member of the medical staff who wishes to utilize electronic technologies (telemedicine) to render care must so indicate on the application for clinical privileges form.
- (b) A member of the medical staff may request to exercise via telemedicine the same clinical privileges he or she has already been granted. The credentials committee, the chief of the clinical service, medical director of credentialing, the director of medical affairs or the medical staff administrative committee, and the Wexner medical center board shall have the prerogative of requiring documentation or making a determination of the appropriateness of the exercise of a particular specialty/subspecialty via telemedicine.

(Board approval dates: 9/1/1993, 3/3/1995, 4/3/1996, 12/6/1996, 9/1/1999, 12/3/1999, 6/2/2000, 4/5/2002, 9/6/2002, 2/6/2004, 11/4/2005, 7/7/2006, 8/6/2006, 2/6/2009, 9/18/2009, 5/14/2010, 10/29/2011, 4/8/2011, 8/31/2012, 2/1/2013, 11/7/2014, 11/6/2015, 4/6/2018, 5/18/2021)

**3335-111-08 Organization of the CHRI medical staff.**

(A) The chief executive officer.

(1) Method of appointment:

The chief executive officer shall be appointed by the board of trustees of the Ohio state university upon recommendation of the president, executive vice president for health sciences, and the vice president for health services following consultation with the medical center board in accordance with university bylaws, rules and regulations. The chief executive officer shall be a member of the attending medical staff of the CHRI.

(2) Responsibilities:

The chief executive officer shall be responsible for the conduct of teaching, research, and CHRI service activities of the facility, including continuing compliance with all appropriate quality assurance standards, ethical codes, or other monitoring or regulatory requirements. The chief executive officer shall be a member of all committees of the CHRI.

(B) The director of medical affairs (physician-in-chief/chief medical officer of the James cancer hospital).

(1) Method of appointment:

The director of medical affairs shall be appointed by the executive vice president for health sciences upon recommendation by the chief executive officer of the James Cancer Hospital. The director of medical affairs is the physician-in-chief and shall be the chief medical officer of the CHRI and must be a member of the attending medical staff of the CHRI.

(2) Responsibilities:

The director of medical affairs shall report to the chief executive officer and the Wexner medical center board for the quality of patient care provided in the CHRI. The director of medical affairs shall assist the chief executive officer in the administration of medical affairs including quality assurance and credentialing. In addition, the director of medical affairs determines initial medical staff category appointments, reappointments and any changes in categories of the medical staff.

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- (C) The chief medical officer of the Ohio state university medical center.

The chief medical officer of the Ohio state university medical center is the senior medical officer for the medical center with the responsibility and authority for all health and medical care delivered at the medical center. The chief medical officer is responsible for overall quality improvement and clinical leadership throughout the medical center, physician alignment, patient safety and medical staff development. The appointment, scope of authority, and responsibilities of the chief medical officer shall be as outlined in the Ohio state medical center board bylaws. The director of medical affairs will work collaboratively with the chief medical officer and medical directors of each hospital of the medical center for the: coordination and supervision of patient care and clinical activities; responsibility for the clinical organization of his or her respective hospital; and to establish priorities, jointly with the chief executive officer or executive director of his or her respective hospital, for capital medical equipment, clinical space, and the establishment of new clinical programs, or the revision of existing clinical programs.

- (D) The chief quality officer of the Ohio state university medical center.

The chief quality and patient safety officer of the Ohio state university medical center is referred to herein these bylaws as the chief quality officer. The chief quality officer reports to the chief medical officer. The chief quality officer works collaboratively with clinical leadership of the medical center, including medical director of quality for the CHRI, director of medical affairs for the CHRI, nursing leadership and hospital administration. The chief quality officer provides leadership in the development and measurement of the medical center's approach to quality, patient safety and reduction of adverse events. The chief quality officer communicates and implements strategic, operational and programmatic plans and policies to promote a culture where patient safety is an important priority for medical and hospital staff.

- (E) Medical director of credentialing.

The medical director of credentialing for the James cancer hospital oversees the process for the credentialing of practitioners applying for membership and/or clinical privileges at the James cancer hospital. The medical director of credentialing shall provide guidance on specific practitioner application or privileging concerns as raised pursuant to these bylaws and shall recommend practitioners for membership and/or privileges at the James cancer hospital and facilitate the process for approving such membership and granting of clinical privileges.

- (F) Medical director, James surgical services.

The medical director, James surgical services has oversight of all James designated perioperative services and procedural suites. Working collaboratively with the administrator of perioperative services, the medical director, James surgical services facilitates the timely sharing of OR resources (including personnel and equipment) across the medical center in order to maximize the efficiency of OR services. The medical director, James surgical services works with clinical service lines and clinical leadership to coordinate OR services in a manner that enhances the quality of care and safety of services for patients. The medical director, James surgical services reports to the director of medical affairs of the James.

- (G) Professional assignments.

Each member of the attending, associate attending, clinical, limited, physician scholar and honorary staff shall be assigned to a CHRI division and/or department by the chief executive officer upon the recommendation of the appropriate academic department chairperson and the credentials committee.

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Appointment to a specific department and/or division is based on the clinical specialty of the applicant for medical staff membership. Each department and/or division is headed by a department chairperson or division director who has the responsibility to oversee all research and clinical activities conducted by members of the department and/or division. Specifically, the department chairperson or division director shall be responsible for the following: the development and implementation of policies and procedures that guide and support the provision of service; recommendations re: staffing needs and clinical privileges for all members appointed to the department and/or division; the orientation and continuing surveillance of the professional performance of all department and/or division members; recommendation for space and other resources needed.

(H) Clinical department chief.

- (1) Qualifications and responsibilities of the chief of the clinical department. The academic department chair shall ordinarily serve also as the chief of the clinical department. Each clinical department chief shall be qualified by education and experience appropriate to the discharge of the responsibilities of the position. Each clinical department chief must be board certified by an appropriate specialty board or must establish comparable competence. The chief of the clinical department must be a medical staff member at the Ohio state university hospitals. Such qualifications shall be judged by the respective dean of the colleges of medicine or dentistry. Qualifications for chief of the clinical department generally shall include recognized clinical competence, sound judgment and well-developed administrative skills.
- (2) Procedure for appointment. Appointment or reappointment of chief of the clinical department shall be made by the dean of the respective colleges of medicine or dentistry in consultation with elected representatives of the medical staff and the chief medical officer of the Ohio state university medical center.
- (3) Term of appointment of the chief of the clinical department. The term of the appointment of the chief of the clinical department shall be concurrent with the chief's academic appointment but shall be no longer than four years. Prior to the end of said four-year term, a review shall be conducted by the dean of the college of medicine and such review shall serve as the basis for the recommendation for reappointment pursuant to paragraph (D)(2) of this rule.
- (4) Duties of the chief of the clinical department:

Each clinical department chief is responsible for the following:

- (a) Clinically related activities of the department;
- (b) Administratively related activities of the department, unless otherwise provided by the hospital;
- (c) Continuing surveillance of the professional performance of all practitioners in the department who have delineated clinical privileges;
- (d) Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department;
- (e) Recommending clinical privileges for each practitioner of the department based on relevant training and experience, current appraised competence, health status that does not present a risk to patients, and evidence of satisfactory performance with existing privileges;

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- (f) Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the hospital;
- (g) The integration of the department or service into the primary functions of the hospital, developing services that complement the medical center's mission and plan for clinical program development;
- (h) The coordination and integration of interdepartmental and intradepartmental services;
- (i) The development and implementation of policies and procedures that guide and support the provision of care, treatment, and services. This includes the development, implementation, enforcement and updating of departmental policies and procedures that are consistent with the hospital's mission. The clinical department chief shall make such policies and procedures available to the medical staff;
- (j) The recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services, including call coverage for continuous high quality and safe care;
- (k) The determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;
- (l) The continuous assessment and improvement of the quality of care, treatment, and services;
- (m) The maintenance of quality control programs, as appropriate;
- (n) The orientation and continuing education of all persons in the department or service;
- (o) Recommending space and other resources needed by the department or service; and
- (p) Hold regular clinical department meetings and ensure open lines of communication are maintained in the clinical department. The agenda for the meetings shall include, but not be limited to, a discussion of the clinical activities of the department and communication of the decisions of the medical staff administrative committee. Minutes of the departmental meetings, including a record of attendance, shall be kept in the clinical department.

(Board approval dates: 9/1/1993, 3/3/1995, 12/6/1996, 12/3/1999, 4/5/2002, 9/6/2002, 2/6/2004, 11/4/2005, 7/7/2006, 2/6/2009, 9/18/2009, 5/14/2010, 2/11/2011, 4/8/2011, 8/31/2012, 2/01/2013, 6/6/2014, 11/6/2015, 4/6/2018)

**3335-111-09 Elected officers of the medical staff of the CHRI.**

- (A) Chief of staff.

The chief of staff shall:

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- (1) Serve on those committees of the Ohio state medical center board as appointed by the chairperson of the medical center board.
  - (2) Be a vice chairperson of the medical staff administrative committee and serve as liaison between university administration, CHRI administration, and the medical staff in all matters of mutual concern within the CHRI.
  - (3) Call, preside, and be responsible for the agenda of all general staff meetings.
  - (4) Make medical staff committee appointments jointly with the director of medical affairs and chief of staff-elect for approval by the CHRI medical staff administrative committee.
  - (5) Be a spokesperson for the medical staff in its external professional and public relations.
  - (6) Serve as chairperson of the nominating committee of the medical staff.
- (B) Chief of staff-elect.

The chief of staff-elect shall:

- (1) Serve on those committees of the Ohio state medical center board as appointed by the chairperson of the medical center board.
  - (2) Serve as the chairperson of the bylaws committee of the CHRI.
  - (3) Carry out all the duties of the chief of staff when the chief of staff is unable to do so.
  - (4) Oversee the inclusion of changes in the bylaws, rules and regulations of the medical staff.
  - (5) Assist the Chief of Staff with duties outlined above in section (A) 1-6.
- (C) Delegates at-large.

Up to two additional at-large member(s) may be appointed to the medical staff administrative committee at the recommendation of the chief executive officer of the CHRI, subject to the approval of the medical staff administrative committee and subject to review and renewal every two years.

- (D) Qualifications of officers.
- (1) Officers must be members of the attending staff at the time of their nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.
  - (2) The chief executive officer and director of medical affairs, chiefs of the clinical departments, and division directors are not eligible to serve as chief of staff or chief of staff-elect unless they are replaced in their CHRI administrative role during the period of their term of office.

- (E) Election of officers.
- (1) All officers (other than at-large officers) will be elected by a majority of those voting by written or electronic ballot after the April meeting of the medical staff. If one candidate does not achieve a majority vote, there will be an election on a second ballot between the two receiving the greatest number of votes.

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- (2) The nominating committee will be composed of five members. The chief of staff and the chief of staff-elect will serve on the committee and the chief of staff will be its chairperson. The chief of staff will appoint the three other members of the committee.
  - (3) Nominations for officers will be accepted from the floor at the March meeting.
  - (4) The committee's nominees will be submitted by electronic or written ballot to all voting members of the medical staff no later than May.
  - (5) Candidates for the office of chief of staff-elect will be listed and each attending staff member may vote for one.
  - (6) Automatic removal shall be for failure to meet those responsibilities assigned within these bylaws, failure to comply with medical staff rules and regulations, policies and procedures of the medical staff, for conduct or statements that damage the reputation of the CHRI, its goal and missions, or programs, or an automatic termination or suspension of clinical privileges that lasts more than thirty days.
- (F) Term of office.
- (1) The chief of staff and chief of staff-elect will each serve two years in office beginning on the first of July. The chief of staff-elect will be elected in the odd years. The chief of staff may not be elected chief of staff-elect within one year of the end of the chief of staff's term in office.
  - (2) The at-large representatives shall serve two years, beginning on the first of July. The delegate at large may succeed themselves for three successive terms (six years, total), if so elected. They may not serve again without a period of two years out of office as a delegate at large. The delegate at large may be elected chief of staff-elect at any time if they are members of the attending staff.
- (G) Vacancies in office.
- (1) Vacancies in the office of chief of staff during the chief's term will be automatically succeeded and performed by the chief of staff-elect. When the unexpired term is one year or less, the new chief of staff will continue in office until the completion of the expected term in that office. When the unexpired term is more than one year, the new chief of staff will serve out the remaining term only.
  - (2) Vacancies in the office of chief of staff-elect shall be filled by a special election held within sixty days of establishing the vacancy by the nominating and election process set forth in paragraph (F) of this rule. The nominating committee will make nominations and a special meeting of the voting members of the medical staff will be called to add nominations and elect the replacement. The new chief of staff-elect will become chief of staff at the end of the term of the incumbent.
  - (3) Vacancies in the at-large representatives' positions will be filled by appointment by the chief executive officer.

(Board approval dates: 9/1/1993, 3/3/1995, 12/6/1996, 9/1/1999, 4/5/2002, 9/6/2002, 2/6/2004, 11/4/2005, 2/6/2009, 9/18/2009, 2/11/2011, 4/8/2011, 6/6/2014, 9/2/2016, 4/6/2018, 5/18/2021)

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**3335-111-10 Administration of the medical staff of the CHRI.**

Medical staff committees.

- (A) Appointments: Appointments to all medical staff committees except the medical staff administrative committee (MSAC) and the nominating committee will be made jointly by the chief of staff, chief of staff-elect, and the director of medical affairs with medical staff administrative committee ratification. Unless otherwise provided by the bylaws, all appointments to medical staff committees are for two years and may be renewed. The chairperson shall control the committee agenda, attendance of staff and guests and conduct the proceedings. A simple majority of appointed voting members shall constitute a quorum. All committee members appointed or elected to serve on a medical staff committee are expected to participate fully in the activities of those committees. The chief of staff, director of medical affairs and the chief executive officer of the CHRI may serve on any medical staff committee as an ex-officio member without vote.
- (B) The medical staff as a whole and each committee provided for by these medical staff bylaws is hereby designated as a peer review committee in accordance with the laws of the state of Ohio. The medical staff through its committees shall be responsible for evaluating, maintaining and monitoring the quality and utilization of patient care services provided by CHRI.
- (C) Medical staff administrative committee:
  - (1) Composition:
    - (a) Voting membership includes: chief of staff, chief of staff-elect, immediate past chief of staff, clinical department chief or division director of medical oncology, radiation oncology, anatomic pathology and molecular pathology; department chairperson or division director of hematology, gynecologic oncology, otolaryngology/head and neck, hospital medicine, human genetics, infectious diseases, surgical oncology, thoracic surgery, neurological oncology, orthopaedic oncology/sarcoma pulmonary, critical care, sleep medicine, and urology; medical director of James emergency services; clinical department chiefs of anesthesia, physical medicine and rehabilitation, plastic surgery, psychiatry, and radiology; CHRI medical director of quality, CHRI medical director of credentialing, CHRI chief executive officer, CHRI director of medical affairs, director of the division of palliative medicine, chairperson of the cancer subcommittee, CCC director for clinical research, CCC director for cancer control, and medical director of the James surgical services. Up to two additional at-large member(s) may be appointed to the MSAC at the recommendation of the chief executive officer of the CHRI, subject to the approval of the medical staff administrative committee and subject to review and renewal on a yearly basis. If a division director is a member by leadership position, he or she will also fulfill the role of division director appointment. The director of medical affairs shall be the chairperson and the chief of staff shall be the vice-chairperson.
    - (b) Ex-officio non-voting membership includes: the CHRI executive director, the CHRI chief nursing officer, the CHRI executive director of patient services, the medical director of university hospital and/or the chief medical officer of the medical center, the dean of the Ohio state university college of medicine and the executive vice president for health sciences.
    - (c) Any member of the committee who anticipates absence from a meeting of the committee may appoint a temporary substitute as a representative at the meeting. The temporary substitute will have all the rights of the absent member. The chief executive officer may invite any member of staff as the chief executive officer's representative at a meeting or to attend any meeting with the chief executive officer.

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- (d) All members of the committee shall attend, either in person or by proxy, a minimum of two-thirds of all committee meetings.
  - (e) Any members may be removed from the medical staff administrative committee at the recommendation of the dean of the college of medicine, the director of medical affairs or the executive vice president for health sciences and subject to the review and approval of the medical staff administrative committee. A replacement will be appointed as outlined above to maintain the medical staff administrative committee's composition as stated in this paragraph.
- (2) Duties:
- (a) To represent and to act on behalf of the medical staff, subject to such limitations as may be imposed by this chapter, and the bylaws or rules of the Ohio state university.
  - (b) To have primary authority for activities related to self-governance of the medical staff. Action approved by the medical staff administrative committee can be reviewed by the quality and professional affairs committee pursuant to rule 3335-43-13 of the Administrative Code.
  - (c) To receive and act upon commission and committee reports. To delegate appropriate staff business to committees while retaining the right of executive responsibility and authority over all medical staff committees. This shall include but is not limited to review of and action upon medical staff appointments and reappointments whenever timely action is necessary.
  - (d) To approve and implement policies of the medical staff.
  - (e) To recommend action to the chief executive officer on matters of medico-administrative nature.
  - (f) To fulfill the medical staff's accountability to the Wexner medical center board for medical care rendered to patients in the CHRI, and for professional conduct and activities of the medical staff, including recommendations concerning;
    - (i) Medical staff structure;
    - (ii) The mechanism to review credentials and to delineate clinical privileges;
    - (iii) The mechanism by which medical staff membership may be terminated or suspended;
    - (iv) Participation in the CHRI's performance improvement, quality and patient safety activities; and
    - (v) Corrective action and hearing procedures applicable to medical staff members and other licensed allied health professionals granted clinical privileges.
  - (g) To ensure the medical staff is kept abreast of the accreditation process and informed of the accreditation status of the CHRI.
  - (h) To review and act on medical staff appointments and reappointments.

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- (i) To report to the medical staff all actions affecting the medical staff.
- (j) To inform the medical staff of all changes in committees, and the creation or elimination of such committees as circumstances shall require.
- (k) To create committees (for which membership is subsequently appointed pursuant to rule 3335-111-10 of the Administrative Code) to meet the needs of the medical staff and comply with the requirements of accrediting agencies.
- (l) To establish and maintain rules and regulations governing the medical staff.
- (m) To oversee functions related to performance improvement of professional services provided by individuals with clinical privileges.
- (n) To perform other functions as are appropriate.

(3) Meetings:

The committee shall meet monthly and keep detailed minutes, which shall be distributed to each committee member before or at the next meeting of the committee.

(4) Voting:

At a properly constituted meeting, voting shall be by a simple majority of members present except in the case of termination or non-reappointment of medical staff membership or permanent suspension of clinical privileges, wherein two-thirds of members present shall be required.

(D) Credentialing committee of the hospitals of the Ohio state university:

(1) Composition:

The credentialing responsibilities of the medical staff are delegated to the credentialing committee of the hospitals of the Ohio state university, the composition of which shall include representation from the medical staff of each hospital.

The chief medical officer of the medical center shall appoint the credentialing committee of the hospitals of the Ohio state university. The director of medical affairs and medical director of credentialing shall make recommendation to the chief medical officer for representation on the credentialing committee of the hospitals of the Ohio state university.

The credentialing committee of the hospitals of the Ohio state university shall meet at the call of its chair, whom shall be appointed by the chief medical officer of the medical center.

(2) Duties:

- (a) To review all applications for medical staff and licensed allied health professional appointment and reappointment, as well as all requests for delineation, renewal, or amendment of clinical privileges in the manner provided in these medical staff bylaws, including applicable time limits. During its evaluation, the credentialing committee of the hospitals of the Ohio state university will take into consideration the appropriateness of the setting where the requested privileges are to be conducted;
- (b) To review biennially all applications for reappointment or renewal of clinical privileges;

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- (c) To review all requests for changes in medical staff membership;
  - (d) To assure, through the chairperson of the committee, that all records of peer review activity taken by the committee, including committee minutes, are maintained in the strictest of confidence in accordance with the laws of the state of Ohio. The committee may conduct investigations and interview applicants as needed to discharge its duties. The committee may refer issues and receive issues as appropriate from other medical staff committees;
  - (e) To make recommendations to the medical staff administrative committee through the medical director of credentialing regarding appointment applications and initial requests for clinical privileges. Such recommendations shall include the name, status, department (division and/or department), medical school and year of graduation, residency and fellowships, medical-related employment since graduation, board certification and recertification, licensure status as well as all other relevant information concerning the applicant's current competence, experience, qualifications, and ability to perform the clinical privileges requested;
  - (f) To recommend to the medical staff administrative committee that certain applications for appointment be reviewed in executive session;
  - (g) The committee, after review and investigation, may make recommendations to the director of medical affairs, chief of staff, or the chief of a clinical department, regarding the restriction or limitation of any medical staff member's clinical privileges, noncompliance with the credentialing process, or any other matter related to its responsibilities;
  - (h) To review requests made for clinical privileges by other licensed allied health professionals as set forth in this chapter.
  - (i) To recommend eligibility criteria for the granting of medical staff membership and privileges.
  - (j) To develop, recommend, and consistently implement policy and procedures for all credentialing and privileging activities.
  - (k) To review, and where appropriate take action on, reports that are referred to it from other medical staff committees and medical staff members.
  - (l) To perform such other functions as requested by the medical staff administrative committee, quality and professional affairs committee or Wexner medical center board.
- (3) Licensed health care professionals subcommittee:
- (a) This subcommittee shall consist of other licensed health care professionals who have been appointed in accordance with paragraph (A)(3) of rule 3335-111-09 of the Administrative Code. This subcommittee shall be chaired by a director of nursing.
  - (b) Duties:
    - (i) To review, within thirty days of receipt, all completed applications as may be referred by the credentialing committee of the hospitals of the Ohio state university;

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- (ii) To review and investigate the character, qualifications and professional competence of the applicant;
- (iii) To review the applicant's patient care quality indicator definitions on initial granting of clinical privileges and the performance based profile at the time of renewal;
- (iv) To verify the accuracy of the information contained in the application; and
- (v) To forward, following review of the application, a written recommendation for clinical privileges to the credentialing committee of the hospitals of the Ohio state university for review at its next regularly scheduled meeting.
- (vi) To develop relevant policies and procedures regarding the scope of service and scope of practice to be granted to each licensed allied health care professional specialty. These policies and procedures shall be ratified by the credentialing committee, and medical staff administrative committee and be approved by the Wexner medical center board.

(E) Medical staff bylaws committee:

(1) Composition.

The committee shall be composed of at least four members of the attending staff pursuant to paragraph (A)(3) of rule 3335-111-09 of the Administrative Code. The chairperson shall always be the chief of staff-elect.

(2) Duties.

To review and recommend amendments to the medical staff administrative committee as necessary to maintain bylaws that reflect the structure and functions of the medical staff but not less than every two years. This committee will recommend changes to the medical staff administrative committee.

(F) Committee for practitioner health.

(1) Composition:

The committee shall consist of medical staff members appointed in accordance with paragraph (A)(3) of rule 3335-111-09 of the Administrative Code.

(2) Duties:

- (a) To consider issues of licensed independent practitioner health or impairment whenever a self-referral or referral is requested by an affected member or another member or committee of the medical staff, CHRI hospital staff, or any other individual.
- (b) To provide appropriate counsel, referral, and monitoring until the rehabilitation is complete and periodically thereafter, if required, to enable the medical staff member to obtain appropriate diagnosis and treatment, and to provide appropriate standards of care.

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- (c) To consult regularly with the chief of staff, medical director of credentialing and director of medical affairs of the CHRI.
- (d) To advise credentials and/or other appropriate medical staff committees on the credibility of a complaint, allegation or concern, including those affecting the quality and safety of patient care.
- (e) It will be the responsibility of the chairperson of the committee to assure that all proceedings and records, including the identity of the person referring the case, are handled and maintained in the strictest of confidence in accordance with the laws of the state of Ohio.
- (f) To educate CHRI hospital and the medical staff about illness and impairment recognition issues, including at risk criteria specific to licensed independent practitioners.

(G) Cancer subcommittee:

(1) Composition:

Required to be included as members of the cancer subcommittee are physician representatives from surgery, medical oncology, radiology, radiation oncology, anesthesia, plastic surgery, urology, otolaryngology/head and neck, hematology, gynecologic oncology, thoracic surgery, orthopaedic oncology, neurological oncology, emergency medicine, palliative medicine and pathology, the cancer liaison physician and non-physician representatives from the cancer registry, administration, nursing, social services, and quality assurance. Other disciplines should be included as appropriate for the institution. The chairperson is appointed at the recommendation of the chief executive officer of the CHRI and the director of medical affairs, subject to the approval of the medical staff administrative committee and subject to review and renewal on a yearly basis.

(2) Duties:

- (a) Develop and evaluate the annual goals and objectives for the clinical, educational, and programmatic activities related to cancer.
- (b) Promote a coordinated, multidisciplinary approach to patient management.
- (c) Ensure that educational and consultative cancer conferences cover all major site and related issues.
- (d) Ensure that an active supportive care system is in place for patients, families, and staff.
- (e) Monitor quality management and improvement through completion of quality management studies that focus on quality, access to care, and outcomes.
- (f) Promote clinical research.
- (g) Supervise the cancer registry and ensure accurate and timely abstracting, staging, and follow-up reporting.
- (h) Perform quality control of registry data.
- (i) Encourage data usage and regular reporting.

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- (j) Ensure content of the annual report meets requirements.
  - (k) Publishes the annual report by November first of the following year.
  - (l) Upholds medical ethical standards.
  - (m) Serve as cancer committee for commission on cancer program of the American college of surgeons.
- (3) Meetings:
- (a) The subcommittee shall meet in collaboration with the medical staff administrative committee as a policy-advisory and administrative body with documentation of activities and specialties in attendance.
  - (b) Any member anticipating an absence from the meeting should designate a representative to attend in their place.
- (H) Ethics committee.
- (1) Composition.  

The committee is a joint committee and shall consist of members of the medical staff, nursing, hospital administration, and other persons representing both the CHRI and UH who, by reason of training, vocation, or interest, may make a contribution. Appointments will be made as provided by in this chapter. The chairperson shall be a physician who is a clinically active member of the medical staff of UH or the CHRI.
  - (2) Duties
    - (a) To make recommendations for the review and development of guidelines or policies regarding ethical issues.
    - (b) To provide ethical guidelines and information in response to requests from members of the medical staff, patients, patient's family or other representative, and staff members of the CHRI.
    - (c) To provide a support mechanism for primary decision makers at the CHRI.
    - (d) To provide educational resources on ethics to all health care providers at the CHRI.
    - (e) To provide and enhance interaction between CHRI administration and staff, departmental ethics committees, pastoral care services, and members of the medical staff.
- (I) Practitioner evaluation committee.
- (1) Composition.  

This multi-disciplinary peer review committee is composed of clinically-active practitioners. If additional expertise is needed, the practitioner evaluation committee may request the assistance from any medical staff member or recommend to the director of medical affairs an external review.

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(2) Duties:

- (a) To meet regularly and keep minutes, which describe issues, opportunities to improve patient care, recommendations and actions to the chief quality officer, unless delegated to the medical director of quality and the chair of the clinical department, responsible parties, and expected completion dates. The minutes are maintained in the quality and patient safety office.
- (b) To ensure that ongoing and systematic monitoring, evaluation and process improvement is performed in each clinical department.
- (c) To develop and utilize objective criteria in practitioner peer review activities.
- (d) To ensure that the medical staff peer review process is effective.
- (e) To maintain confidentiality of its proceedings. These issues are not to be handled outside of the practitioner evaluation committee by any individual, clinical department, division, or committee.

(J) Professionalism consultation committee.

(1) Composition.

This multi-disciplinary peer review committee is composed of clinically-active practitioners and other individuals with expertise in professionalism.

(2) Duties.

- (a) Receive and review validity of complaints regarding concerns about professionalism of credentialed practitioners;
- (b) Treat, counsel and coach practitioners in a firm, fair and equitable manner;
- (c) Maintain confidentiality of the individual who files a report unless the person who submitted the report authorizes disclosure or disclosure is necessary to fulfill the institution's legal responsibility;
- (d) Ensure that all activities be treated as confidential and protected under applicable peer review and quality improvement standards in the Ohio Revised Code;
- (e) Forward all recommendations to the clinical department chief, director of medical affairs or his/her designee and, if applicable, to the chief nursing officer.

(Board approval dates: 9/1/1993, 3/3/1995, 12/6/1996, 9/1/1999, 10/1/1999, 12/3/1999, 4/5/2002, 9/6/2002, 2/6/2004, 11/4/2005, 7/7/2006, 2/6/2009, 9/18/2009, 5/14/2010, 2/11/2011, 4/8/2011, 8/31/2012, 2/1/2013, 11/7/2014, 11/6/2015, 9/2/2016, 4/6/2018, 5/18/2021)

**3335-111-11 History and physical.**

(A) History and physical examination.

- (1) A history and physical appropriate to the patient and/or the procedure to be completed shall be documented in the medical record of all patients either:

- (a) Admitted to the hospital
  - (b) Undergoing outpatient/ambulatory procedures
  - (b) Undergoing outpatient/ambulatory surgery
  - (d) In a hospital-based ambulatory clinic
- (2) For patients admitted to the hospital, the history and physical examination shall include at a minimum:
- (a) Date of admission
  - (b) Chief complaint and/or indication for procedure
  - (c) History of present illness
  - (d) Past medical and surgical history
  - (e) Relevant past social and family history
  - (f) Medications and allergies
  - (g) Review of systems
  - (h) Physical examinations
  - (i) Test results
  - (j) Assessment or impression
  - (k) Plan of care
- (3) For patients undergoing outpatient/ambulatory procedures or outpatients/ambulatory surgery, the history and physical examination shall include at a minimum:
- (a) Indication for procedure/surgery
  - (b) Relevant medical or surgical history
  - (c) Medications and allergies or reference to current listing in the electronic medical record
  - (d) Focused review of systems, as appropriate
  - (e) Pre-procedure assessment and physical examination
  - (f) Assessment/impression and treatment plan
- (4) For patients seen in a hospital-based ambulatory clinic, the history and physical shall include at a minimum:
- (a) Chief complaint
  - (b) History of present illness

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- (c) Medications and allergies
  - (d) Problem-focused physical examination
  - (e) Assessment or impression
  - (f) Plan of care
- (B) Deadlines and sanctions
- (1) A history and physical examination must be performed by a member of the medical staff, his/her designee or other licensed healthcare professional, who is appropriately credentialed by the hospital, and be signed, dated and timed.
  - (2) Patients admitted to the hospital: If the history and physical is performed by the medical staff member's designee or other licensed healthcare professional who is appropriately credentialed by the hospital, the history and physical must be countersigned by the responsible medical staff member.
  - (3) The complete history and physical examination shall be dictated, written or updated no later than twenty-four hours after admission for all inpatients.
  - (4) Admitted patients or patients undergoing a procedure or surgery, the history and physical examination may be performed or updated up to thirty days prior to admission, or the procedure/surgery. If completed before admission or the procedure, there must be a notation documenting an examination for any changes in the patient's condition since the history and physical was completed. The updated examination must be completed and documented in the patient's medical record within twenty-four hours after admission, or before the procedure/surgery, whichever occurs first. It must be performed by a member of the medical staff, his/her designee, or other licensed health care professional who is appropriately credentialed by the hospital, and be signed, dated and timed. In the event the history and physical update is performed by the medical staff member's designee or other licensed health care professional who is appropriately credentialed by the hospital, it shall be countersigned, dated and timed by the responsible medical staff member.
    - (a) For patients undergoing an outpatient procedure or surgery, regardless of whether the treatment, procedure or surgery is high or low risk, a history and physical examination must be performed by a member of the medical staff, his/her designee, or other licensed health care professional who is appropriately credentialed by the hospital and must be signed or countersigned when required, timed and dated.
    - (b) If a licensed health care professional is appropriately credentialed by the hospital to perform a procedure or surgery independently, a history and physical performed by the licensed health care professional prior to the procedure or surgery is not required to be countersigned.
  - (5) Hospital-based ambulatory clinic: If a history and physical examination is performed by a licensed health care professional who is appropriately credentialed by the hospital to see patients independently, the history and physical is not required to be countersigned.
  - (6) When the history and physical examination including the results of indicated laboratory studies and x-rays is not recorded in the medical record before the times stated for a procedure or surgery, the procedure or surgery cannot proceed until the history and physical is signed or countersigned, when required, by the responsible medical staff member, and

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indicated test results are entered into the medical record. In cases where such a delay would likely cause harm to the patient, this condition shall be entered into the medical record by the responsible medical staff member, his/her designee, or other licensed health care professional who is appropriately credentialed by the hospital, and the procedure or surgery may begin. When there is disagreement concerning the urgency of the procedure, it shall be adjudicated by the medical director or the medical director's designee.

- (7) Ambulatory patients must have a history and physical at the initial visit.
- (8) For psychology, psychiatric and substance abuse ambulatory sites, if no other acute or medical condition is present on the initial visit, a history and physical examination may be performed either:
  - (a) Within the past six months prior to the initial visit,
  - (b) At the initial visit, or
  - (c) Within thirty days following the initial visit.

(Board approval dates: 5/14/2010, 6/6/2014, 11/7/2014, 11/6/2015)

**3335-111-12 Amendments and adoption.**

- (A) Medical staff responsibility.

The medical staff bylaws committee shall have the initial responsibility to formulate, review at least biennially, and recommend to the quality and professional affairs committee of the Wexner medical center board any medical staff bylaws, rules, regulations, policies, procedures, and amendments as needed. Amendments to the bylaws shall be effective when approved by the university board of trustees. Amendments to the rules and regulations shall be effective when approved by the Wexner medical center board.

Such responsibility shall be exercised in good faith, in a timely manner and in accordance with applicable laws and regulatory standards. This applies as well to the review, adoption, and amendment of the related rules, policies, and protocols developed to implement the various sections of these bylaws.

The organized medical staff shall also have the ability to propose amendments to the medical staff bylaws, rules and regulations and policies and procedures and propose them directly to the quality and professional affairs committee of the Wexner medical center board.

If the voting members of the organized medical staff propose to adopt amendments to the bylaws, rules and regulations or policies, they must first communicate the proposal to the medical staff administrative committee. When the medical staff administrative committee proposes to adopt amendments to the bylaws, rules and regulations or policies, it communicates the proposal to the organized medical staff.

Conflict between the organized medical staff and the medical staff administrative committee will be managed by allowing communication directly from the medical staff to the quality and professional affairs committee of the Wexner medical center board on issues including, but not limited to: amendments to the bylaws and the adoption of new rules and regulations or policies. Medical staff members may communicate with the quality and professional affairs committee of the Wexner medical center board by submitting their communication in writing to the chief of staff, who shall then

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communicate on their behalf to the quality and professional affairs committee of the Wexner medical center board at its next regularly scheduled meeting for final determination.

In cases of urgent need to update the medical staff bylaws or rules and regulations in order to comply with law, statute, federal regulation, or accreditation standard, the medical staff administrative committee and the quality and professional affairs committee of the Wexner medical center board may provisionally approve an urgent amendment without prior notification to the medical staff. The medical staff shall be immediately notified by the medical staff administrative committee. The medical staff shall have the opportunity for review of and vote on the provisional amendment. If the medical staff votes in favor of the provisional amendment it shall stand. If there is conflict over the provisional amendment, process for resolving conflict between the organized medical staff and the medical staff administrative committee shall be implemented.

(B) Methods of adoption and amendment to these bylaws.

Proposed amendments to these bylaws may be originated by the medical staff bylaws committee, medical staff administrative committee or by a petition signed by twenty-five percent (25%) of attending medical staff members.

Each attending medical staff member will be eligible to vote on the proposed amendment via printed or secure electronic ballot in a manner determined by the medical staff administrative committee. All attending medical staff members shall receive at least thirty days advance notice of the changes to be adopted:

- (1) The medical staff receives a simple majority of the votes cast by those members eligible to vote.
- (2) Amendments so adopted shall be effective when approved by the university board of trustees.

(C) Methods of adoption and amendment to medical staff rules, regulations and policies.

The medical staff may adopt additional rules, regulations and policies as necessary to carry out its functions and meet its responsibilities under these bylaws.

Proposed amendments to the rules, regulations and policies may be originated by the medical staff bylaws committee or the medical staff administrative committee.

The medical staff administrative committee shall vote on the proposed language changes at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by the medical staff administrative committee, rules and regulations may be adopted, amended or repealed, in whole or in part and such changes shall be effective when approved by the organized medical staff, and the Wexner medical center board. Policies and procedures will become effective upon approval of the medical staff administrative committee.

In addition to the process described above, the organized medical staff itself may recommend directly to the quality and professional affairs committee of the Wexner medical center board an amendment to any rules, regulation, or policy by submitting a petition signed by twenty-five per cent of the members of the attending medical staff category. Upon presentation of such petition, the adoption process outlined above will be followed.

(D) The medical staff administrative committee may adopt such amendments to these bylaws, rules, regulations, and policies that are, in the committee's judgment, administrative, technical or legal modifications or clarifications. Such modifications may include reorganization or renumbering, punctuation, spelling, or other errors of grammar or expression. Such amendments need not be

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approved by the entire Wexner medical center board but must be approved by the vice president of health services. Neither the organized medical staff nor the Wexner medical center board may unilaterally amend the medical staff bylaws or rules and regulations.

The medical staff bylaws, rules and regulations, Wexner medical center board bylaws, and relevant policies shall not conflict. The medical staff bylaws committee shall assure that there is no conflict.

(Board approval dates: 9/1/1993, 3/3/1995, 12/3/1999, 9/6/2002, 2/6/2004, 9/18/2009, 5/14/2010, 2/11/2011, 4/8/2011, 11/7/2014)

**3335-111-13 Meetings and dues.**

(A) Meetings.

The medical staff of the CHRI shall conduct scheduled meetings semi-annually. Notice of the meetings will be sent to all medical staff at least two weeks prior to the meeting. Attendance is encouraged, but shall not be a requirement for continued medical staff membership and clinical privileges. Special or electronic meetings may be called at the option of the medical staff administrative committee.

(B) Dues. The medical staff, by two-thirds vote of those in attendance at a regularly scheduled meeting, may establish dues. Payment of dues is a requirement for continued medical staff membership except honorary, clinical, and limited staff.

(Board approval date: 4/8/2011)

**3335-111-14 Rules of construction.**

(A) "Shall" as used herein is to be construed as mandatory.

(B) These bylaws should be construed to be gender neutral.

(Board approval dates: 9/1/1993, 12/6/1996, 9/1/1999, 9/6/2002, 5/14/2010, 4/8/2011)



**MEDICAL STAFF RULES AND REGULATIONS**

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as of May 18, 2021**

**01 Ethical pledge.**

- (A) Each member of the medical staff and health care providers with clinical privileges shall pledge adherence to standard medical ethics, including:
- (1) Refraining from fee splitting or other inducements relating to patient referral;
  - (2) Providing for continuity of patient care;
  - (3) Refraining from delegating the responsibility for diagnosis or care of hospitalized patients to a medical or dental practitioner or other licensed healthcare professional who is not qualified to undertake this responsibility or who is not adequately supervised;
  - (4) Seeking consultation whenever necessary; and
  - (5) Never substituting physicians without the patient's knowledge or appropriate consent.

(Board approval dates: 7/7/2006, 8/31/2012, 4/6/2016)

**02 Admission procedures.**

- (A) Except in an emergency, in the interest of assignment to the appropriate service, no patient shall be admitted to the hospital until after a provisional diagnosis has been stated by the patient's attending physician a member of the attending staff, limited staff member or other licensed healthcare professional who is appropriately credentialed by the hospital and under the supervision of the responsible medical staff member. The request for admission shall also include the following information:
- (1) Any facts essential for the protection of the general hospital population against unnecessary exposure to infectious and other communicable diseases.
  - (2) Any information which will warn responsible hospital personnel of any tendency of any patient to commit suicide or to injure others because of mental disturbance.
  - (3) Any information concerning physical condition or personality idiosyncrasy which might be objectionable to other patients who might be occupying the same or adjoining rooms.
- (B) It shall be the responsibility of the attending physician to notify hospital or medical staff personnel of the existence of mental or substance disorders and to order such precautionary measures as may be necessary to assure protection of the patient and the protection of others whenever a patient might be a source of danger. The attending physician is responsible to provide a comprehensive plan of care, including emergency care.

(Board approval dates: 9/18/2009, 4/6/2016)

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**03 Attending assignment.**

(A) All patients entering the Arthur G. James cancer hospital and Richard J. Solove research institute (CHRI) who have not requested the services of a member of the medical staff to be responsible for their care and treatment while a patient therein shall be assigned to a member of the attending staff of the service concerned with the treatment of the disease, injury, or condition which necessitated the admission of the patient to the CHRI. This shall also apply to the transfer of patients within the services of the CHRI.

(B) Alternative attending medical staff member coverage.

Each division shall have a plan for medical coverage. Each member of the medical staff shall designate on his or her medical staff application one or more members of the attending or limited medical staff who have accepted this responsibility and who shall be called to attend his or her patients if the responsible attending medical staff member is not available, the director of medical affairs, section chiefs, department chair or his designee shall have authority to contact any member of the medical staff and arrange for coverage should the attending medical staff member and the alternate be unavailable.

(C) In the case of a medical or psychiatric emergency involving a patient, visitor or CHRI staff member in an inpatient or outpatient setting, any individual who is a member of the medical staff or who has been delineated privileges is permitted to do everything possible to save the life or prevent serious harm regardless of the individual's staff status or clinical privileges.

(Board approval dates: 11/4/2005, 2/11/2011, 4/6/2016)

**04 Consultations.**

(A) Consultation requirements.

When a patient care problem is identified that requires intervention during the hospital stay that is outside the medical staff member's area of training and experience, it is the responsibility of the medical staff member or his or her designee (with appropriate credentials) to obtain consultation by the appropriate specialist. The consultation may be ordered by the responsible medical practitioner, a member of the limited staff, or another licensed healthcare professional with appropriate clinical privileges as designated in these rules and regulations. If a consultation is ordered prior to 10:00 a.m., the consult shall occur on the same business day. If a consultation is ordered after 10:00 a.m., the consult shall occur within twenty-four hours. Each patient is continuously assessed and his or her plan for care if modified as necessary.

(B) Responsibility to monitor consultations.

It is the duty of the medical staff, through its clinical section chief and the medical staff administrative committee, to assure that members of the staff comply in the matter of requesting consultations as needed.

(C) Consultation contents.

A satisfactory consultation shall be rendered within one day of the request and shall include examination of the patient, examination of the medical record, and a written opinion signed by the consultant that is made a part of such record. If operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the operation.

(Board approval dates: 11/4/2005, 7/7/2006, 2/6/2009, 9/18/2009, 4/8/2011, 4/6/2016)

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**05 Order writing privileges.**

(A) Definition of "patient orders".

- (1) A patient order(s) is a prescription for care or treatment of patients. An order can be given verbally, electronically or in writing to qualified personnel identified by category in paragraph (C) of this rule and shall be authenticated by the licensed medical practitioner, a member of the limited staff, or another licensed healthcare professional with appropriate clinical privileges. Patient orders may be given initially, renewed, discontinued or cancelled. Throughout these rules and regulations, the word "written" and its grammatical derivatives, as used to describe a nonverbal order, refer to both written and electronically entered orders.
- (2) Electronic orders are equivalent and have the same authority as written orders. Electronic orders have been expressly structured to mirror these rules and regulations and all policy guidelines adopted by the medical staff and hospital administration.

(B) Responsible medical practitioner.

All patient care is the responsibility of the attending, associate attending, clinical attending, or community associate attending staff. Coverage may be provided by the limited staff or another licensed healthcare professional with appropriate clinical privileges under supervision. The licensed physician, dentist, podiatrist, or psychologist (under medical doctor supervision) with appropriate clinical privileges responsible for the hospitalization or outpatient care, and treatment of the patient is responsible for all orders for the patient. Attending, associate attending and clinical medical staff may designate members of the limited staff, or other licensed healthcare professionals with appropriate clinical privileges to write or electronically enter orders under their direction. The attending staff member may also designate members of the pre-M.D. medical student group to write or electronically enter orders, but in all cases these orders shall be signed by the physician, dentist, psychologist, podiatrist, or designated limited staff member who has the right to practice medicine, dentistry, psychology, or podiatry and who is responsible for that patient's care prior to the execution of the order. Supervising physicians may delegate to a medical staff member (who is appropriately credentialed) the ability to relay, enter, transcribe or write orders for routine laboratory, radiologic and diagnostic studies under their direction, but, in all cases, the order shall be co-signed by the supervising physician within twenty-four hours of the order being written. Community associate staff coverage may be provided by the limited staff under supervision.

- (C) Telephone and verbal orders may be given by the responsible attending physician, dentist, podiatrist, psychologist, member of the limited medical staff, or other licensed healthcare professionals with appropriate clinical privileges only to health care providers who have been approved in writing by title or category by the director of medical affairs and each chief of the clinical service where they will exercise clinical privileges, and only where said health care provider is exercising responsibilities which have been approved and delineated by job description for employees of the hospital, or by the customary medical staff credentialing process when the provider is not an employee of the hospital. Lists of the approved titles or categories of providers shall be maintained by the director of medical affairs. Verbal orders should be utilized infrequently. The individual giving the verbal or telephone order must verify the complete order by having the person receiving the information record and "read back" the complete order to assure the quality and safety of patient care. The job description or delineated privileges for each provider must indicate each provider's authority to receive telephone or verbal orders, including but not limited to the authority to receive orders for medications. The order is to be recorded and authenticated by approved health care provider to whom it is given as "verbal order by \_\_\_\_\_," or "V.O. or T.O. by \_\_\_\_\_," giving the licensed healthcare practitioner's name and the time of the order, followed by the approved health care provider's signature and date, and read back in its entirety to the ordering physician, dentist, psychologist, podiatrist, designated limited staff member, or other licensed healthcare professionals with appropriate clinical privileges. All verbal orders for DEA schedule II controlled substances, patient seclusion, or patient restraint must be

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authenticated within twenty-four hours by signature of a licensed physician, dentist, podiatrist, psychologist, or designated limited staff member or other licensed healthcare professionals with appropriate clinical privileges. Verbal orders for directives of urgent issues that cannot be addressed by the prescriber's order entry are encouraged to be signed electronically within forty-eight hours, but must be authenticated within twenty-one days by signature by a licensed physician, dentist, podiatrist, psychologist, limited staff member, or other licensed healthcare professionals with appropriate clinical privileges.

(D) Standing orders.

Standing orders for medications are only approved in emergency situations. All other standing orders must be developed, approved, used and monitored in strict compliance with the standing orders medical staff policy approved by the medical staff administrative committee and hospital administration.

(E) Preprinted orders.

Preprinted order forms for patients must be reviewed, dated, timed and signed by a responsible medical practitioner, a limited staff member, or other licensed healthcare professionals with appropriate clinical privileges before becoming effective.

(F) Investigational drug orders.

Evidence of informed patient consent must be available to a nurse or pharmacist before an investigational agent is ordered and administered. Investigational drugs may be ordered only upon authorization of the principal or co-investigator or other delegated physician, dentist, or podiatrist named in FDA forms 1572 or 1573. Registered nurses or pharmacists who are knowledgeable about the investigational agents may administer the drugs to patients.

(G) Change of nursing service.

Level of care is defined as the type and frequency of medical and nursing interventions required to appropriately manage the medical and nursing care requirements of the patient. "Change of level of care" means official and physical movement (transfer) of a patient from an inpatient or observation care unit providing one level of care to another providing a different level of care, with or without change in attending physician, dentist, psychologist or podiatrist or clinical service. Orders effective before transfer must be reviewed, renewed or rewritten upon transfer by signature of a responsible medical practitioner. The new or renewed orders may be written or electronically entered before or when the patient arrives on the receiving unit and may become effective immediately.

In each case of "change of nursing service," it is the responsibility of the receiving nurse to establish the availability of renewed or new written or electronically entered orders. Prior orders will remain in effect until new orders are available. This should be done within eight hours of transfer.

(H) "Transfer of clinical service" means transfer of full patient responsibility from one attending physician, dentist, psychologist or podiatrist to another; the patient may remain on the same unit or a change in patient care area may also occur. Admission of a patient from an emergency service to the hospital as an inpatient involves "transfer of clinical service."

For the purposes of order writing or electronically entering orders, two essentials of "transfer of clinical service" are necessary:

- (1) The initial transfer order must indicate the release of responsibility and control of the patient, pending acceptance by the receiving service. The order may read "transfer (or admit) to Dr., head and neck service."

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- (2) Transfer of service may be completed only by the receiving service writing an order to the effect "accept in transfer (or admission) to Dr., head and neck service."

Orders effective before the transfer must be renewed or rewritten upon transfer by signature of a responsible medical practitioner, a limited staff member, or other licensed healthcare professionals with appropriate clinical privileges. The new or renewed orders may be written or electronically entered before or at the time of transfer, and may become effective immediately. It is the responsibility of the receiving nurse to establish the availability of new or renewed orders. If new orders are unavailable, then the nurse may continue previous orders and immediately notify the responsible medical practitioner, a limited staff member, or other licensed healthcare professionals with appropriate clinical privileges.

- (I) Patient orders and the "covering" medical practitioner.

"Coverage" of patient responsibilities for another physician, dentist or podiatrist for a brief period of time does not constitute or require "transfer of clinical service" unless so desired and agreed upon by the physician, dentist, or podiatrist and patient.

- (J) Hospital discharge/readmission orders.

Hospital discharge from standard inpatient units or day care unit to outpatient status requires appropriate discharge orders. Readmission to any inpatient unit requires new, rewritten/reentered or renewed orders by signature of the responsible medical practitioner, limited staff member, or other licensed healthcare professional with appropriate privileges and under the supervision of the responsible medical staff member.

- (K) Do not resuscitate orders.

The order for do not resuscitate indicating that the patient should not undergo cardiopulmonary resuscitation may be written only by the attending physician or his delegate. Verbal orders for do not resuscitate will not be accepted under any circumstances. The order for do not resuscitate may be rescinded only by the attending physician or delegate and an order must be written to annul said order. Please refer to hospital policy 03-24 do not resuscitate orders for further details.

- (L) Hospital admission/observation orders.

Hospital admission/observation requires an appropriate level of care (ALOC) order designating the patient as inpatient or outpatient (observation). The appropriate level of care (ALOC) order may be written and signed by the attending physician. If the ALOC order for inpatient admission is written by a member of the limited staff or other licensed healthcare practitioner with appropriate clinical privilege, it must be co-signed by the attending physician prior to the patient being discharged from the hospital. Admission to any inpatient unit or placing a patient in observation status requires new, rewritten/reentered or renewed orders by the responsible medical practitioner or limited staff member or other licensed healthcare professional with appropriate privileges and under the supervision of the responsible medical staff member.

(Board approval dates: 4/6/2016, 9/2/2016)

**06 Death procedures.**

- (A) Every member of the medical staff shall be actively interested in securing necropsies in every death on their service. No autopsy shall be performed without written consent, permission, or direction as prescribed by the laws of Ohio.

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- (B) The death of a patient in the hospital within twenty-four hours of admission must be reported to the proper legal authorities under the laws of Ohio.
- (C) When a necropsy is performed, provisional anatomic diagnosis should be recorded in the medical record within three days and the complete protocol should be made a part of the record within sixty days.
- (D) Criteria for autopsy requests include the following:
  - (1) Coroner's cases when the coroner elects not to perform an autopsy. The county coroner has jurisdiction for performing an autopsy when death is the result of violence, casualty, or suicide, or occurs suddenly in a suspicious or unusual manner. Deaths occurring during surgery or within twenty-four hours of admission to the hospital are also coroner's cases, and the decision whether to autopsy is the coroner's responsibility. When the coroner elects not to perform an autopsy, a request of an autopsy shall be made pursuant to paragraph (A) of this rule.
  - (2) Unexpected or unexplained deaths, where apparently due to natural causes or due to those occurring during or following any surgical, medical, or dental diagnostic procedures or therapies.
  - (3) Undiagnosed infectious disease where results may be of value in treating close contacts.
  - (4) All deaths in which the cause of death is not known with certainty on clinical grounds.
  - (5) Cases where there is question of disease related to occupational exposure.
  - (6) Organ donors (to rule out neoplastic or infectious disease).
  - (7) Cases in which autopsy may help to allay the concerns of the family or public regarding the death and to provide assurance to them regarding the same.
  - (8) Deaths in which autopsy may help to explain unknown or unanticipated medical complications to the attending.
  - (9) Deaths of patients who have participated in investigational therapy protocols.
  - (10) Deaths in which there is a need to enhance the education and knowledge of the medical staff and house staff. The attending practitioner shall be notified of the autopsies performed by the pathology department.
- (E) When an autopsy is performed, provisional anatomic diagnosis should be recorded in the medical record within three days and the complete protocol should be made a part of the record within sixty days.

(Board approval dates: 11/4/2005, 4/6/2016)

**07 Emergency preparedness.**

- (A) Emergency care.

Emergency care is considered to be treatment rendered to stabilize the patient prior to transport to the Ohio state university hospital's emergency department or other appropriate facility as the patient's condition dictates.

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(B) Disaster preparedness.

In case of a civil, military, natural emergency or disaster, patients may be discharged from the CHRI, moved to other community hospitals, or moved to other facilities made available for the care and treatment of patients, by the order of the director of medical affairs of the CHRI or the director of medical affairs designated agent, to preserve life and health, to make room for more critically ill or injured patients sent to the hospitals from a disaster area or for the purpose of saving lives and to provide adequate medical care and treatment.

(Board approval dates: 11/4/2005, 2/6/2009, 4/6/2016)

**08 Surgical case review (tissue committees).**

Surgical case review shall be performed on an on-going basis by each department regularly doing surgical procedures in conjunction with the clinical quality management committee. The review shall include indications for surgery and all cases in which there is a major discrepancy between preoperative and postoperative (including pathologic) diagnoses. Discrepancies between the clinical impression and tissue removed during a surgical procedure are identified by pathology and then referred to the appropriate department for review. A screening mechanism based on predetermined criteria may be established for cases involving no specimens. Written records of the evaluations and any action taken shall be maintained in the quality and operations improvement department, and be available to the director of medical affairs, the CHRI section chief, department chairperson or their designees.

(Board approval dates: 11/4/2005, 4/6/2016)

**09 Tissue disposition.**

All tissue and foreign bodies removed during a surgical procedure shall be sent to the pathology laboratory for examination except for the following categories. These exceptions may be invoked by the attending surgeon only when the quality of care is not compromised by the exception when another suitable means of verification of the removal is routinely employed and when there is an authenticated operative or other official report that documents the removal. The categories of specimens that may be exempted from pathological examination are the following:

- (A) Specimens that by their nature or condition do not permit fruitful examination, such as cataract, orthopedic appliance, foreign body, or portion of rib removed only to enhance operative exposure;
- (B) Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements;
- (C) Traumatically injured members that have been amputated and for which examination for either medical or legal reasons is not deemed necessary;
- (D) Foreign bodies (for example bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives.
- (E) Specimens known to rarely if ever show pathological change, and removal of which is highly visible postoperatively.
- (F) Teeth, provided the number including fragments is recorded in the medical record.
- (G) Specimens for gross only examination.

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- (H) Medical devices. Soft tissue accompanying medical devices may be submitted for microscopic examination if deemed appropriate by the pathologist.
- (I) Foreign bodies that are hard and cannot be decalcified. Accompanying soft tissue may be submitted for microscopic examination if deemed appropriate by the pathologist.
- (J) Portions of bone removed from feet for bunions/hammer toes, if microscopic exam deemed unnecessary by pathology.
- (K) Portions of rib removed for operative exposure only and not designated "disposal only." At the pathologist's discretion, marrow samples from such ribs may be submitted for microscopic examination.
- (L) Nasal bone and cartilage removed for deviated septum (does not apply if deviation due to neoplastic or inflammatory process). If soft tissue accompanies nasal bone and cartilage, it may be examined at pathologist's discretion.

(Board approval dates: 11/4/2005, 4/6/2016)

**10 Medical records.**

- (A) Each member of the medical staff shall conform to the following medical information management department policies:
  - (1) Medical record contents.
    - (a) The attending physician is ultimately responsible for the preparation of a complete medical record for each patient. The medical record may contain information collected and maintained by members of the medical staff, limited staff, other licensed healthcare professionals, medical students or providers who participate in the care of the patient. This record shall including the following elements as it applies to the patient encounter:
      - (i) Identification demographic data including the patient's race and ethnicity.
      - (ii) The patient's language and communication needs.
      - (iii) Emergency care provided to the patient prior to arrival, if any.
      - (iv) The legal status of patients receiving mental health services.
      - (v) Evidence of known advance directives.
      - (vi) Statement of present complaint.
      - (vii) History and physical examination.
      - (viii) Any patient generated information.
      - (ix) Provisional diagnosis.
      - (x) Documentation of informed consent when required.
      - (xi) Any and all orders related to the patient's care.

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- (xii) Special reports, as those from:
  - (a) The clinical laboratory, including examination of tissues and autopsy findings, when applicable.
  - (b) Signed and dated reports of nuclear medicine interpretations, consultations, and procedures.
  - (c) The radiology department.
  - (d) Consultants as verified by the attending medical staff member's signature.
- (xiii) Medical and surgical treatments.
- (xiv) Progress notes.
- (xv) Pre-sedation or pre-anesthesia assessment and plans of care for patients receiving anesthesia.
- (xvi) An intra-operative anesthesia record.
- (xvii) Postoperative documentation records, the patient's vital signs and level of consciousness; medications, including IV fluids, blood and blood components; any unusual events or postoperative complications; and management of such events.
- (xviii) Postoperative documentation of the patient's discharge from the post-sedation or post-anesthesia care area by the responsible licensed independent practitioner or according to discharge criteria.
- (xix) A post anesthesia follow-up report written within forty-eight hours after surgery by the individual who administers the anesthesia.
- (xx) All reassessments and any revisions of the treatment plan.
- (xxi) Every dose of medication administered and any adverse drug reaction.
- (xxii) Every medication dispensed to an inpatient at discharge.
- (xxiii) Summary and final diagnosis as verified by the attending physician's signature.
- (xxiv) Discharge disposition, condition of patient at discharge, instructions given at that time and the plan for follow up care.
- (xxv) Any referrals and communications made to external or internal providers and to community agencies.
- (xxvi) Any records of communication with the patient made by telephone or email or patient electronic portal.
- (xxvii) Memorandum copy of the death certificate when applicable.

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- (2) Deadlines and sanctions.
- (a) A procedure note shall be entered in the record by the responsible attending medical staff member or the medical staff member's designee (who is appropriately credentialed) immediately upon completion of an invasive procedure. Procedure notes must be written for any surgical or medical procedures, irrespective of their repetitive nature, which involve material risk to the patient. Notes for procedures performed in the operating rooms must be finalized in the operating room information system by the attending surgeon. For any formal operative procedures, a note shall include pre-operative and post-operative diagnoses, procedure(s) performed and description of each procedure, surgeon(s), resident(s), anesthesiologist(s), surgical service, type of anesthesia (general or local), complications, estimated blood loss, any pertinent information not included on the O.R./anesthesia record, preliminary surgical findings, and specimens removed and disposition of each specimen. Where a formal operative procedure report is appropriate, the report must be completed immediately following the procedure. The operative/procedure report must be signed by the attending medical staff member. Any operative/procedure report not completed or any procedure note for procedures completed in the operating rooms not completed in the operating room information system by 10:00 a.m. the day following the procedure shall be deemed delinquent and the attending medical staff member responsible shall lose operating/procedure room and medical staff privileges the following day. The operating rooms and procedure rooms will not cancel cases scheduled before the suspension occurred. Effective with the suspension, the attending medical staff member will lose all privileges to schedule elective cases. Affected medical staff members shall receive telephone calls from the medical information management department indicating the delinquent operative/procedure reports.
  - (b) Progress notes must provide a pertinent chronological report of the patient's course in the hospital and reflect any change in condition or results of treatment. A progress note must be completed by the attending medical staff member or his or her designated member of the limited medical staff or practitioner with appropriate privileges at least once every day. Each medical student or other licensed health care professional progress note in the medical records should be signed or counter-signed by a member of the attending, courtesy, or limited staff.
  - (c) Medical staff members with more than twenty-five verbal orders that remain unsigned greater than twenty-one days after the date of the order will be subject to corrective action including administrative suspension which may include suspension of admitting and operating room scheduling privileges until the orders are signed. Medical staff members shall be notified electronically prior to suspension for unsigned verbal orders.
  - (d) Birth certificates must be signed by the medical staff member who delivers the baby within one week of completion of the certificate. Fetal death certificates and death certificates must be signed and the cause of death must be recorded by the medical staff member with a permanent Ohio license within twenty-four hours of death.
  - ~~(e) Office visit encounters shall be closed within ten days of the patient's visit.~~
  - ~~(e) Outpatient visit notes and letters to referring physicians, when appropriate, shall be completed within three days of the patient's visit.~~
  - (f) All entries not previously defined must be signed within ten ~~business~~ days of completion.

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- (g) Queries by clinical documentation specialists requesting clarification of a patient's diagnoses and procedures will be resolved within five business days of confirmed notification of request.

~~(h) Office visit encounters shall be closed within one week of the patient's visit.~~

(3) Discharges.

- (a) Patients may not be discharged without a written or electronically entered discharge order from the appropriately credentialed, responsible medical staff member, a limited staff member or other licensed healthcare professional.
- (b) At the time of discharge, the appropriately credentialed attending medical staff member, limited staff member, or other licensed healthcare professional is responsible for certifying the principal diagnosis, secondary diagnosis, the principal procedure, if any, and any other significant invasive procedures that were performed during the hospitalization. If a principal diagnosis has not yet been determined, then a "provisional" principal diagnosis should be used instead.
- (c) The discharge summary must be available to any facility receiving the patient before the patient arrives at the facility. Similarly, the discharge summary must be available to the care provider before the patient arrives at any outpatient care visit subsequent to discharge. The discharge summary should be available within forty-eight hours of discharge for all patients. The discharge summary should be signed by the responsible attending medical staff member within forty-eight hours of availability.
- (d) The discharge summaries must contain the following elements:
  - i. hospital course including reason for hospitalization and significant findings upon admission;
  - ii. principal and secondary diagnoses or provisional diagnosis;
  - iii. relevant diagnostic test results;
  - iv. procedures performed and care, treatment and services provided;
  - v. condition on discharge;
  - vi. medication list and medication instructions;
  - vii. plan for follow-up of tests and studies for which results are pending at discharge;
  - viii. coordination and planning for follow-up testing and physician appointments;
  - ix. plans for follow-up care and communication, and the instructions provided to the patient.
- (e) All medical records must be completed by the attending medical staff member or, when applicable, the limited staff member or other licensed healthcare professional who is appropriately credentialed by the hospital, within twenty-one days of discharge of the patient.

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- (f) Attending medical staff members shall be notified prior to suspension for all incomplete records. After notification, attending medical staff members shall have their admitting and operative scheduling privileges suspended until all records are completed. Attending medical staff members shall receive electronic notification of delinquent records. If an attempt is made by the attending medical staff member, or the attending medical staff member's designee, who is appropriately credentialed by the hospital, when applicable, to complete the record, and the record is not available electronically for completion, the record shall not be counted against the attending medical staff member. Medical staff members who are suspended for a period of longer than one hundred twenty consecutive days are required to appear before the practitioner evaluation committee.
- (g) Records which are incomplete greater than twenty-one days after discharge or the patient's visit are defined as delinquent.

(4) Confidentiality.

Access to medical records is limited to use in the treatment of patients, research, and teaching. All medical staff members are required to maintain the confidentiality of medical records. Improper use or disclosure of patient information is subject to disciplinary action.

(5) Ownership.

Medical records of hospital sponsored care are the property of the hospital and shall not be removed from the hospital's jurisdiction and safekeeping except in accordance with a court order, subpoena, or statute.

(6) Records storage, security, and accessibility.

All patient's records, pathological examinations, slides, radiological films, photographic records, cardiographic records, laboratory reports, statistical evaluations, etc., are the property of the CHRI and shall not be taken from the CHRI except on court order, subpoena or statute duly filed with the medical record administrator or the hospital administration. The hospital administration may, under certain conditions, arrange for copies or reproductions of the above records to be made. Such copies may be removed from the hospital after the medical record administrator or the proper administrative authority has received a written receipt thereof. In the case of readmission of the patient, all previous records or copies thereof shall be available for the use of the attending medical staff member.

In general, medical records shall be maintained by the hospital. Records on microfilms, paper, electronic tape recordings, magnetic media, optical disks, and such other acceptable storage techniques shall be used to maintain patient records for twenty-one years for minors and ten years for adults. In the case of readmission of the patient, all records or copies thereof from the past ten/twenty-one years shall be available for the use of the attending medical staff member or other health care providers.

(7) Informed consent documentation.

- (a) Where informed consent is required for a special procedure (such as surgical operation), documentation that such consent has been obtained must be made in the hospital record prior to the initiation of the procedure.
- (b) In the case of limb amputation, a limb disposition form, in duplicate, must be signed prior to the operation.

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(8) Sterilization consent.

Prior to the performance of an operative procedure for the expressed purpose of sterilization of a (male or female) patient, the attending medical staff member shall be responsible for the completion of the legal forms provided by the hospital and signed by the patient. Patients who are enrolled in the Medicaid program must have their forms signed at least thirty days prior to the procedure. Informed consent must also be obtained from one of the parents or the guardian of an unmarried minor.

(9) Criteria changes.

The medical information management department shall make recommendations for changes in the criteria for record completion with approval of the medical staff.

(10) Entries and authentication.

- (a) Entries in the medical record can only be made by staff recommended by the medical information management department subject to the approval of the medical staff.
- (b) All entries must be legible and complete and must be authenticated, dated and timed promptly by the person, identified by name and credentials, who is responsible for ordering, providing, or evaluating the service furnished.
- (c) The electronic signature of medical record documents requires a signing password. At the time the password is issued, the individual is required to sign a statement that she/he will be the only person using the password. This statement will be maintained in the department responsible for the electronic signature.
- (d) Signature stamps may not be used in the medical record.

(11) Abbreviations.

Abbreviations, acronyms and symbols appearing on the non-approved abbreviations list may not be used in the medical record.

(Board approval dates: 9/18/2009, 4/8/2011, 8/31/2012, 4/6/2016, 9/2/2016, 4/6/2018, 5/31/2019)

**11 Committees.**

In addition to the medical staff committees, the medical staff shall participate in the following hospital and monitoring functions: infection control, clinical quality management, safety, and disaster planning and in other quality leadership council policy groups.

Operating Room Committee

- (A) The operating room committee shall have representation from all clinical departments utilizing the operating room. Representation will include: medical director of the CHRI operating room, the section or division chief, or their designee, of: surgery, gynecologic oncology, urology, otolaryngology, radiation oncology, thoracic surgery, surgical oncology, neurological surgery, orthopedic surgery, anesthesia, and plastic surgery; epidemiology/infection control, the medical director of perioperative services for the Ohio state university, the CHRI medical director of quality, the director of perioperative services of the CHRI operating room, the manager of perioperative services, the director of admitting, the operating room coordinator, and the CHRI director of operations. The committee chair will be a

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CHRI surgeon selected by the nominating committee and shall serve a two-year term beginning on the first of July. The committee shall meet monthly and carry out the following duties:

- (1) Develop written policies and procedures concerning the scope and provision of care in the surgical suite in cooperation with the departments and services concerned, including allocation of operating room resources. Allocation of operating room time will be done by the director of medical affairs and approved by the operating room committee.
  - (2) Monitor quality concerns and consider problems and improvements in operating room functions brought to its attention by any of its members.
  - (3) Monitor medical staff compliance with operating room policies established for patient safety, infection control, access and throughput, and smooth functioning of the operating rooms.
  - (4) Maintain written records of actions taken, and results of those actions, and make these available to each committee member, the vice president of health services, the director of medical affairs, and the executive director of the CHRI.
- (B) Each member of the medical staff shall conform to the policies established by the operating room committee, including the following:

A member of the surgical attending staff and a member of the anesthesiology staff shall be present in person for crucial periods of surgical procedures and anesthetization, shall be familiar with the progress of the procedure, and be immediately available at all times during the procedure.

Pharmacy and Therapeutics Committee (P & T Committee)

The P & T committee shall be appointed in conformity with the medical staff bylaws and have representation from medical staff, nursing, pharmacy department, and the hospital administration. The majority of members shall be members of the medical staff. The committee shall meet at least quarterly and carry out the following duties:

- (A) Review the appropriateness, safety, and effectiveness of the prophylactic empiric and therapeutic use of drugs, including antibiotics, through the analysis of individual or aggregate patterns of drug practice.
- (B) Consider the welfare of patients as well as education, research and economic factors when analyzing the utilization of drugs and related products.
- (C) Advise on the use and control of experimental drugs.
- (D) Develop or approve policies and procedures relating to the selection, distribution, use, handling, and administration of drugs and diagnostic testing materials.
- (E) Review all significant untoward drug reactions.
- (F) Maintain the Formulary of Accepted Drugs with review of proposed additions and deletions and review of use of non-formulary drugs within the institution.
- (G) Maintain written reports of conclusions, recommendations, actions taken, and the results of actions taken, and report these at least quarterly to the medical staff administrative committee.
- (H) Create sub-committees, as follows: pharmacy and therapeutic and drug utilization executive sub-committee; formulary sub-committee; antibiotic usage sub-committee; medication safety and policy sub-committee; and the therapeutic drug monitoring sub-committee.

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- (I) Establish methods by which serum blood levels may be used to improve the therapeutic activity of drugs.
- (J) Establish programs to educate health care providers to the appropriate methods of monitoring the therapeutic effect in drugs via serum drug assays.
- (K) Provide guidance to the therapeutic drug monitoring service at the CHRI.
- (L) Recommend the development of policies and procedures to the pharmacy and therapeutic and drug utilization executive subcommittee.

Transfusion and Isoimmunization Committee

- (A) The transfusion and isoimmunization committee has representation from physicians of the clinical departments frequently using blood products, nursing, transfusion service, and hospital administration. The majority of members shall be members of the medical staff. The committee shall meet at least quarterly and carry out the following duties:
  - (1) Evaluate the appropriateness of all transfusions, including the use of whole blood and blood components.
  - (2) Evaluate all confirmed or suspected transfusion reactions.
  - (3) Develop and recommend to the medical staff administrative committee policies and procedures relating to the distribution, use, handling, and administration of blood and blood components.
  - (4) Review the adequacy of transfusion services to meet the needs of patients.
  - (5) Review ordering practices for blood and blood products.
  - (6) Provide a liaison between the clinical departments, nursing services, hospital administration, and the transfusion service.
  - (7) Use clinically valid criteria for screening and more intensive evaluation of known or suspected problems in blood usage.
  - (8) Keep written records of meetings, conclusions, recommendations, and actions taken, and the results of actions taken, and make these available to each committee member and to the medical staff administrative committee.
- (B) Each member of the medical staff shall conform to the policies established by the transfusion committee, including the following:
  - (1) All pregnant patients admitted for delivery or abortion shall be tested for Rh antigen.
  - (2) No medication may be added to blood or blood products.

Infection Control Committee

- (A) The committee members shall be appointed and shall also include representation from nursing, environmental services, and hospital administration. The chairperson will be a physician with experience and/or training in infectious diseases and carry out the following duties.

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- (1) Oversee surveillance and institute any recommendations necessary for investigation, prevention, and containment of nosocomial and clinical infectious diseases of both patients and staff at all facilities operated by CHRI and subject to TJC standards.
- (2) The chairperson of the committee and the hospital epidemiologist, in consultation with the director of medical affairs of the CHRI, will take necessary actions to prevent and control emerging spread or outbreaks of infections; isolate communicable and infectious patients as indicated; and obtain all necessary cultures in emergent situations when the responsible medical staff member is unavailable.

Quality Leadership Council

The quality leadership council shall consist of members appointed pursuant to the university hospital's medical staff bylaws, and shall include the senior vice president for health sciences, the dean of the college of medicine and the chairperson of the professional affairs committee of the Wexner medical center board as ex officio members without a vote, and the director of medical affairs and chief of staff as voting members. The chief quality officer shall be the chairperson of the quality leadership council. The quality leadership council shall authorize policy groups to be formed to accomplish necessary hospital and medical staff functions on behalf of the CHRI and university hospitals.

CHRI representatives on the quality leadership council shall be appointed as provided in the CHRI bylaws.

(A) Duties include:

- (1) To design and implement systems and initiatives to enhance clinical care and outcomes throughout the integrated health care delivery systems.
- (2) To serve as the oversight council for the clinical quality management and patient safety plan.
- (3) To establish goals and priorities for clinical quality, safety and service on an annual basis.

(B) Clinical quality and patient safety committee.

(1) Composition.

The members shall include physicians from various clinical areas and support services, the director of clinical quality management policy group, and representation from nursing and hospitals administration. The chairperson of the policy group will be a physician.

(2) Duties.

- (a) Coordinate the quality management related activities of the clinical sections or departments, the medical information management department, utilization review, infection control, pharmacy and therapeutics and drug utilization committee, transfusion and immunization, and other medical staff and hospital committees.
- (b) Implement clinical improvement programs to achieve the goals of the CHRI quality management plan, as well as assure optimal compliance with accreditation standards and governmental regulations concerning performance improvement.
- (c) Review, analyze, and evaluate on a continuing basis the performance of the medical staff and other health care providers; and advise the clinical section or department clinical quality sub-committees in defining, monitoring, and evaluating quality indicators of patient care and services.

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- (d) Serve as liaison between the CHRI and the Ohio peer review organizations through the chairperson of the policy group and the director of clinical quality.
- (e) Make recommendations to the medical staff administrative committee on the establishment of and the adherence to standards of care designed to improve the quality of patient care delivered in the CHRI.
- (f) Hear and determine issues concerning the quality of patient care rendered by members of the medical staff and hospitals staff, make appropriate recommendations and evaluate action plans when appropriate to the director of medical affairs, the chief of a clinical section or department, or hospitals administration.
- (g) Appoint ad-hoc interdisciplinary teams to address hospital-wide quality management plan.
- (h) Annually review and revise as necessary the hospital-wide clinical quality management plan.
- (i) Report and coordinate with the quality leadership council all quality improvement initiatives.

(C) Clinical resource utilization policy group.

(1) Composition.

The members shall include physicians from various areas and support services, the director of clinical resource utilization policy group, and representation from nursing and hospitals administration. The chairperson of the policy group will be a physician.

(2) Duties.

- (a) Promote the most efficient and effective use of hospital facilities and services by participating in the review process and continued stay reviews on all hospitalized patients.
- (b) Formulate and maintain a written resource management review plan for hospitals consistent with applicable governmental regulations and accreditation requirements.
- (c) Conduct resource management studies by clinical service or by disease entity as requested or in response to variation from benchmark data would indicate.
- (d) Report and recommend to the quality leadership council changes in clinical practice patterns in compliance with applicable governmental regulations and accreditation requirements when the opportunity exists to improve the resource management.

(D) Clinical Practice Guideline Committee.

(1) Composition.

The members shall include physicians from various areas and support services, the director of the practice guidelines policy group, and representation from nursing and hospitals administration. The chairperson of the policy group will be a physician.

(2) Duties.

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- (a) Oversee the planning, development, approval, implementation and periodic review of evidence-based medicine resources (i.e. clinical practice guidelines, quick reference guides, clinical pathways, and clinical algorithms) for use within the CHRI. Planning should be based on the prioritization criteria approved by the leadership council and review should focus on incorporating recent medical practice, literature or developments. Annual review should be done in cooperation with members of the medical staff with specialized knowledge in the field of medicine related to the guidelines.
- (b) To report regularly to the quality leadership council for approval of all new and periodically reviewed evidence-based medicine resources for use within the CHRI.
- (c) Oversee the development, approval and periodic review of the clinical elements of computerized ordersets and clinical rules to be used within the information system of the CHRI. Computerized ordersets and clinical rules related to specific practice guidelines should be forwarded to the quality leadership council for approval. All other computerized value enhancement for approval. All other computerized ordersets and clinical rules should be forwarded to the quality leadership council for information.
- (d) To initiate and support research projects when appropriate in support of the objectives of the quality leadership council.
- (e) Oversee ongoing education of the medical staff (including specifically limited staff) and other appropriate hospital staff on the fundamental concepts and value of evidence-based practice and outcomes measurement and its relation to quality improvement.
- (f) Regularly report a summary of all actions to the quality leadership council.

(Board approval dates: 11/4/2005, 7/7/2006, 2/6/2009, 9/18/2009, 5/14/2010, 2/11/2011, 4/8/2011, 4/6/2016, 5/18/2021)

**12 Standards of practice.**

- (A) Surgical schedules shall be reviewed by the attending surgeon prior to the day of surgery. Attending surgeons must notify the operating room prior to the first scheduled case that they are physically present in the hospital and immediately available to participate in the case. Attending surgeons may accomplish this by being physically present in the operating room or by calling the operating room to notify the staff of such immediate availability. The operating room must be informed of the attending surgeon's availability prior to anesthetizing the patient. The only exception is an emergency situation, where waiting might compromise the patient's safety.
- (B) All medical staff members must abide by the quality and safety protocols that may be defined by the medical staff administrative committee and the Wexner medical center board.
- (C) Inpatients must be seen daily by an attending physician, with no exceptions, to provide the opportunity of answering patient and family questions.

(Board approval dates: 4/8/2011, 4/6/2016)

**13 Mechanism for changing rules and regulations.**

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- (A) These rules and regulations may be amended pursuant to rule 3335-111-12 of the Administrative Code.
- (B) Amendments so accepted shall become effective when approved by the Ohio state university Wexner medical center board.
- (C) These rules and regulations shall not conflict with the rules and regulations of the board of trustees of the Ohio state university.
- (D) Each member of the medical staff and those having delineated clinical privileges shall have access to an electronic copy of the rules and regulations upon finalization of the approved amendment changes.

(Board approval dates: 11/4/2005, 9/18/2009, 2/11/2011, 4/8/2011, 4/6/2016)

**14 Adoption of the rules and regulations.**

These rules and regulations shall be adopted by the medical staff administrative committee and forwarded for approval in successive order to the following: the professional affairs committee of the Wexner medical center board if it meets prior to the next scheduled Wexner medical center board meeting, and the Wexner medical center board.

(Board approval dates: 7/7/2006, 9/18/2009, 2/11/2011, 4/8/2011, 4/6/2016)

**15 Sanctions.**

Each member of the medical staff shall abide by policies approved by the medical staff administrative committee of the CHRI. Failure to abide may result in suspension of some or all hospital privileges.

(Board approval dates: 9/18/2009, 2/11/2011, 4/8/2011, 4/6/2016)