

**SANTA MONICA-UCLA MEDICAL CENTER & ORTHOPAEDIC HOSPITAL
SURGERY/ANESTHESIA SERVICE
RULES AND REGULATIONS – 2020**

I. NAME

The name of this Service shall be the Surgery/Anesthesia Service of the Medical Staff of Santa Monica-UCLA Medical Center & Orthopaedic Hospital as provided for in the Bylaws of the Medical Staff of Santa Monica-UCLA Medical Center & Orthopaedic Hospital, Article VIII, Section 1.

The members of the Surgery/Anesthesia Service and those Medical Staff members of other services who utilize the surgical suite, the post anesthesia recovery unit (PACU) or the ambulatory care unit (PTU) are required to abide by these Rules & Regulations.

II. ORGANIZATION

A. The Service Chief shall be appointed by the Chief of Staff from representatives of the Surgery/Anesthesia Service on the Medical Staff Executive Committee.

B. The Division of Surgery Committee Vice-Chair shall be the alternate representative of the Surgery & Anesthesia Service. In the absence of the Chair, the Vice-Chair shall assume all duties of the Chair.

C. The Division of Surgery Committee Chair shall recommend to the Chief of Staff Chiefs of each of the following surgical sections: Dentistry, General Surgery, Neurosurgery, Ophthalmology, Oral and Maxillofacial Surgery, Orthopedic Surgery, Otolaryngology-Head & Neck Surgery, Plastic Surgery, Podiatry, Thoracic Surgery, Cardiovascular Surgery, Urology and Vascular Surgery.

D. Composition. The Division of Surgery Committee shall consist of those specialties related to Surgery/Anesthesia. Other members of the Division of Surgery may be appointed by the Chief of Staff upon recommendation of the Chief of the Surgery/Anesthesia Service

E. Subcommittees

Surgery Case Review Committee

a. Composition. The Surgery Case Review Committee shall consist of at least five (5) members of the Medical Staff, including surgeons and anesthesiologists and at least one pathologist. It shall be chaired by a physician member of the Medical Staff.

b. Duties. For surgical cases, the Committee shall review surgical deaths and complications, and procedure-specific reviews for surgical appropriateness and quality of care according to criteria established by the Committee. For tissue cases, the committee shall review charts with significant discrepancy between the preoperative and pathological diagnoses and where no tissue was removed during surgery when expected, or when a specimen was removed and not submitted to pathology if specimen is not on the exempt list (Refer to HS Policy 1427 "Specimens Exempt from Surgical Pathology Examination and/or Microscopic Examination". Recommendations regarding surgical care shall be forwarded to the appropriate service for additional review when indicated and subsequently to the

Surgery/Anesthesia Service.

c. Meetings. The Committee shall meet monthly at least ten (10) times annually and shall maintain a permanent record of its proceedings and actions.

III. PRIVILEGES

A surgeon may perform only those surgical procedures for which privileges have been granted based upon evidence of training and/or experience as indicated on the surgery privilege form.

A. New or Additional Privileges

Requests for new or additional privileges must be made on the approved privilege form. New or additional privileges will be recommended for approval only if written documentation of training and/or experience substantiating competency is provided. The burden of proof of competency rests with the requesting surgeon.

B. Assist Only Privileges

Privileges may be granted for surgical assisting only. Surgeons with Assist Only privileges are not proctored. Surgeons with Assist Only privileges shall still be required to maintain a sufficient volume of assisting cases so that competency can be evaluated at the time of reappointment.

1. The Assistant Surgeon

The primary surgeon has the discretion to determine whether an assistant surgeon is required for the case. If an assistant is requested who is not a member of the Medical Staff, temporary privileges must be obtained according to Medical Staff Bylaws, except as required by State or Federal Law.

2. Family Medicine, Surgery, Anesthesia & Ob/Gyn Residents and ACGME Fellows

Family Medicine, Surgery, Anesthesia and Ob/Gyn residents may assist in surgery and participate in the pre-operative and post-operative care of the patient subject to the supervision of the appropriate Medical Staff member.

3. Fellows

a. Assist Only Privileges

A Fellow in an approved surgical training program may be allowed to assist in surgery provided he has been appointed to the Medical Staff. These Assist Only privileges and the Fellow's surgical experience shall be limited to working with and under the direction of the supervising physician.

b. Primary Surgeon or Co-Surgeon

The surgical privileges of a Fellow is commensurate with the level of completed training. The Fellow will be proctored when performing surgery independently.

C. Back-Up Coverage

Each member with admitting privileges must provide, in writing, the names of member staff member(s) who have agreed to provide coverage in the event of the member's unavailability.

D. Operating Room Privileges

Privileges for surgical procedures performed in the operating room shall be defined and delineated by the Surgery/Anesthesia Service. Non-surgeons who obtain such privileges shall be subject to the same credentialing, proctoring and quality review as surgeons.

Nurse Practitioners and Physician Assistants are granted privileges in accordance with protocols established in the Interdisciplinary Practice Committee. The Surgery Committee will review and provide input on protocols and the scope of practice that determine privileges for nurse practitioners and physician assistants. Performance of nurse practitioners and physician assistants will be monitored by the supervising physician. Any problems identified will be referred to the Surgery Case Review Committee for review.

E. Proctoring

The Surgery/Anesthesia Service has established a concurrent proctoring program as outlined below.

1. Who Shall Be Proctored

Provisional members shall be concurrently proctored on five (5) cases during the 12-month Provisional term. Reciprocal proctoring from St. John's Health Center or Ronald Reagan UCLA Medical Center will be accepted as outlined in the Reciprocal Proctoring Policy.

2. Methodology

The surgeon being proctored shall contact his/her assigned proctor prior to the procedure being scheduled, to assure the proctor's presence during the surgery. Proctoring Forms are obtained from Medical Staff Administration. The completed proctoring forms must be returned to Medical Staff Administration for review by the Service Chief for recommendation. The proctors' evaluations will determine whether the surgeon's performance was satisfactory. If unsatisfactory, the reasons will be so stated.

3. Selection of Proctors

Provisional members are responsible to make arrangements with his/her proctor prior to scheduling cases. The proctor may not be an office partner or office associate, unless approved by the Service Chief or designee, prior to the performance of the case. The proctor must have the training and experience necessary to evaluate the performance of the proctored surgeon.

4. Proctoring Reports

Reports must be submitted by the proctor to Medical Staff Administration following completion of each case.

5. Proctoring Completion
Reappointment/advancement will not be recommended for members who have failed to satisfy the proctoring requirements.

- F. Board Certification
Board Certification by a board recognized by the American Board of Medical Specialists, in their specialty, is a requirement for initial staff membership. Applicants who are not Board certified at the time of appointment must become Board certified within five (5) years from the date of graduation from their training program (reference Medical Staff Bylaws: ARTICLE III, Section 2 – Qualifications for Membership)

IV. REAPPOINTMENT

Criteria for reappointment shall include current clinical competence, ethics and conduct, relations with other staff members and employees, trended and aggregated data, Medical Center activity, quality assessment and improvement data, malpractice and litigation history, National Practitioner Data Bank response, mental and physical health status as it pertains to ability to perform requested privileges and clinical competence, compliance with Bylaws and rules and regulations and peer recommendation.

- A. Activity Requirements
 1. Active Staff
To achieve or maintain Active Staff membership, the surgeon must have completed eighteen (18) cases within a two-year period.
 2. Courtesy Staff
To achieve or maintain Courtesy Staff membership, the surgeon must have completed at least six (6) cases within the two-year period. Advancement from Courtesy Staff to Active Staff requires meeting the minimum activity.
 3. Provisional Staff
Provisional Staff members must have successfully completed proctoring on five major cases before advancing to Active or Courtesy staff.
- B. Failure to Meet Requirements
Active Staff members who fail to meet the minimum activity will be reclassified to the Courtesy Staff. Courtesy Staff members who fail to meet the minimum activity will be separated from the Medical Staff. Provisional Staff members who fail to successfully complete the proctoring requirement will be separated from the Medical Staff, and must wait for 12 months before reapplying for Medical Staff membership.

V. THE SURGERY SUITE

- A. Physical Limits
The surgery suite includes all of the operating rooms and the attached service areas.
- B. Authority
1. Authority for the administrative management of the surgical suite is delegated to the nurse manager. Disagreement will be arbitrated by the Medical Director, Surgical Services.
2. Authority for quality of care or other Medical Staff policy issues is delegated to the Chief of the Surgery/Anesthesia Service or designee.
- C. Traffic
1. The surgery suite is not to be used as a pass through by medical or other personnel. Traffic into or out of any room for any reason during performance of surgical procedure or frozen section in the Pathology Lab is to be strongly discouraged.
2. The doors into the individual operating rooms must be closed at all times during surgery.
- D. Radio and Television
1. Listening or watching commercial television is not permitted in any operating room.
2. Music will be permitted in the operating rooms only if agreed to by the surgeon and the anesthesiologist. The music will play at a volume that does not interfere with patient monitoring or communication.
3. Radio earphones are not permitted in the surgery suite and environs.
- E. Telephone
The telephone in the OR shall be used only for urgent medical business.
- F. Scrub Guidelines
The first scrub of the day is to last for at least five minutes. Subsequent scrubs should last for three minutes if the surgeon/technician has not left the department between cases. The alcohol based waterless scrub can be used as the re-entry surgical hand scrub-not to be used as the initial scrub of the day.
- G. Family members may accompany patients to the PTU holding area but may not come into the operating room. Special requests may be made by the anesthesiologist for a family member to be present during pediatric induction.

VI. POST ANESTHESIA CARE UNIT (PACU)

A. Purpose and Functions

To provide an area during the critical period immediately after surgery where the patient can receive immediate medical attention and continuous services by nurses who are trained to intervene appropriately according to the patients' needs.

The PACU shall be equipped to: monitor the patient's functions and to assess post-operative recovery; protect and care for the patient during critical periods; quickly utilize special equipment, gases and medications when needed.

B. Medical Staff Responsibilities

1. Primary Responsibility

Both the surgeon and the anesthesiologist have responsibility for the overall management of the patient's care in the PACU. If care is delegated by either of these individuals, the nursing staff must be made aware of which physician is accepting responsibility and the name of the physician to call.

2. Patient Transport

The patient's surgeon or anesthesiologist shall accompany the patient to the PACU and give a report of the patient's condition to the responsible nurse.

3. Orders

All patients who have been transferred from one level of care to another (i.e. critical care, telemetry, medical/surgical, obstetrical, skilled nursing), and patients immediately post surgery shall have orders rewritten. For patients with complex medical problems, the primary care physician or appropriate medical consultant may participate in the provision of post-operative orders.

4. Relatives in the PACU

The surgeon, with employee support, should advise the relatives and friends of the use and function of the PACU and inform them that:

a. Immediate family members, two people at maximum, may be in the PACU at the discretion of the surgeon, anesthesiologist and charge nurse, after the patient has been assessed and stabilized.

b. The family should wait in the surgical waiting area for notification of the patient's arrival to, and discharge, from the unit.

C. Administrative Policy

1. The overall management and coordination of the PACU is the responsibility of the Medical Director of Surgical Services and nurse

manager.

2. The Chief of the Division of Anesthesia is responsible for the development and implementation of all Medical Staff policies relating to the PACU. Said policies must be approved by the Surgery/Anesthesia Service Committee and the Medical Staff Executive Committee.

D. Criteria

1. Admission

All patients who have received general or conduction anesthesia will be admitted to the PACU, at the discretion of the anesthesiologist. Any patient, who meets Phase I Discharge criteria in the operating room, may bypass PACU and be admitted to the floor at the discretion of the anesthesiologist. Patient may be admitted directly to a critical care unit at the discretion of the anesthesiologist, provided there is appropriate nurse staffing in the critical care unit. Any patient having received a local anesthetic may be admitted to the PACU at the request of the surgeon or anesthesiologist. PACU policies and procedures will be followed in these cases.

Patients who have had special radiology or cardiology procedures may be admitted to the PACU at the request of the Medical physician or anesthesiologist. Such patients shall be subject to all general rules and regulations of the PACU.

2. Protocols

- a. The patient shall be accompanied to the PACU by the anesthesiologist or surgeon who will review the patient's orders with the responsible nurse and give notice of any special precautions, procedures or instructions for care.
- b. Any adult patient undergoing general, regional, local or spinal anesthetic must have IV access started before entering the PACU.
- c. In the case of infants and children under age 13, the anesthesiologist shall decide whether IV access is necessary.

3. Discharge

- a. The decision to discharge a patient shall be made by an anesthesiologist, except for local anesthesia cases when the surgeon will discharge the patient. The presence of the anesthesiologist is not necessary at the time of discharge.
- b. Before discharge from the PACU, all patients will be recovered in accordance with the guidelines established by the Chief of the Anesthesia Division.

E. Isolation

Patients who must be placed in Airborne Precautions following a surgical procedure shall be recovered in the OR with the room door closed at all times or taken immediately back to a negative pressure isolation room. PACU room #3524 may be used for Airborne Precautions cases. Patients in Droplet or contact Precautions may be recovered in the PACU, keep 3-6 feet between patients and the curtains pulled for a barrier separation.

F. Transfer to the nursing unit:

1. The patient's medical record will be completed and the time of transfer noted.
2. One of the PACU nursing staff will accompany the patient to the nursing unit.
3. The PACU nurse will give a full report to the patient's nurse on the nursing unit, including: general condition, review of physician's orders for continuing care, medications ordered and administered, narcotics administered and time when full dosage may be given, any unusual reactions noted, placement and condition of any wounds, drains, catheters.

VII. PATIENT TREATMENT UNITS (PTU)

A. Purpose

The PTUs are designed to provide patient care services to those patients scheduled for surgery or medical treatments on an outpatient basis, and to serve as a pre-operative holding area for AM Admit patients. All general rules regarding patient care apply to patients in the PTUs.

B. Physician Responsibility

The attending physician plans and directs the medical care of the patient. The attending physician is responsible for informing the patient that admission to the Medical Center may be necessary in the event it is medically indicated. If the patient does require admission to the Medical Center, it will be the responsibility of the physician to provide a written order for admission and orders for the patient in the appropriate Medical Center unit.

C. Medical Record Requirements

A written history and physical or consultation with all required elements shall be on the chart prior to any invasive radiologic, surgical or medical procedure. If the patient is admitted, the medical record must be in compliance with Medical Center policy as it relates to inpatients.

D. Criteria

1. Surgical

Candidates for the PTUs must be patients who need surgical procedures that do not require anticipated overnight hospitalization except for AM surgery admissions.

2. Medical

Candidates for the PTUs are patients who need procedures that require acute nursing care and Medical Center facilities for a limited time, typically less than 24 hours.

All patients having special radiologic or other procedures requiring general or local standby anesthesia must be scheduled and admitted to the PTUs. After the procedure, the patient may be discharged by order of either the radiologist or attending physician.

Patients scheduled for procedures without anesthesia may be admitted to the PTUs at the discretion of the attending physician.

E. Supervision

1. The Medical Staff has primary responsibility for the overall management and coordination of the patient's care in the PTU.

2. The PTU Medical Director shall report periodically to the Surgery Committee and shall recommend policies and procedures, act as utilization coordinator of the unit, monitor standards of care for the unit. Supervise proper functioning and utilization of equipment, be involved in the training of personnel in the unit on a continuing basis and shall be a member of the Surgery Committee.

F. Consents

1. The policy for PTU consents shall be the same as for inpatients.

2. The operating surgeon is responsible for obtaining and explaining the California State Sterilization form.

G. Surgery on Children

Children under four years of age who are undergoing surgery shall have a documented complete History & Physical exam performed by a pediatrician, family physician who has pediatric privileges, surgeon with pediatric training or emergency physician who has been in consultation with one of the above-referenced physicians. A family practice resident is not eligible to perform the pediatric History & Physical.

H. A.M. Admits

Patients who have been scheduled for elective surgery are admitted to the

Ambulatory Care Unit the day of surgery. After meeting Phase, I Discharge Criteria, the patient will be admitted to the assigned nursing unit.

I. In-House Admits

Occasionally, the attending physician will schedule procedure to be done in the PTUs on in-house patients. Routine PTU procedures will be followed and the patient will be transferred back to the room after an appropriate recovery time.

J. Scheduling

1. Surgical

- a. All surgical procedures for patients in the PTU will be scheduled through the surgery booking office.
- b. Pediatric and Type I diabetic patients are to have priority scheduling.
- c. The booking slip must be complete at the time of scheduling for purposes of preadmission.
- d. All local anesthetic patients should arrive in PTU on hour prior to scheduled surgery time.
- e. All general anesthetic patients must arrive two (2) hours prior to their scheduled surgery time.

2. Medical

All medical procedures performed in the PTUs will be scheduled through the surgery booking office.

K. Preoperative Studies

Pre-Op testing would be up to the discretion of the Surgeon and Anesthesiologist. There are no pre-operative diagnostic test requirements for outpatient surgery performed under local anesthesia or conscious sedation.

L. Recovery

- a. Outpatients who are scheduled for local anesthesia will be returned directly to the PTU unless the physician requests that the patient be admitted to the PACU.
- b. Patients who are scheduled for local anesthesia may be recovered in the PTU or the PACU at the discretion of the anesthesiologist.
- c. Patients who are scheduled for general or regional anesthesia will be recovered in the PACU.

M. Discharge

1. The Medical Staff shall develop protocols for the discharge of patients from the PACU. Patients whose conditions do not meet the requirements of the protocols shall be seen by a physician prior to discharge. The

attending physician is responsible for writing the discharge order for patients undergoing local anesthesia.

N. Medical Records

1. For patients operated upon in the surgical suite, record requirements include a complete history and physical examination, the completion of the admission and discharge record, short form physician orders and patient instruction sheets.
2. Providing an H&P for patients undergoing minor surgery requiring no more than local anesthesia, is at the discretion of the Attending physician with consideration of the acuity of the patient and the risk of the procedure.
3. For patients undergoing pain procedures, the pain multidisciplinary progress notes which includes pre and post op physicians notes, relevant history and appropriate physical examination, written documentation that the risks and benefit attestation of the procedure was discussed with the patient and patient instructions sheet must be complete. If the pain procedure requires conscious sedation, the sedation form must be filled out.
4. An operative report is required for all surgical cases and must be dictated immediately after the case prior to the patient's discharge from the PACU.
5. The anesthesiologist shall document the pre-operative assessment.
6. The progress notes shall be dated.

VIII. EMERGENCY DEPARTMENT ON CALL PANELS

A. Participation

Participation in the Emergency Department on call panel shall be by members of the Medical Staff. Each division and section shall define its criteria for inclusion in the Emergency Department on call panel. Participation in the Emergency Department on call panel within each division or section shall either be voluntary or mandatory, dependent upon the need for coverage.

B. Call Obligation

Surgeons who are listed on the Emergency Department call panel are expected to honor their obligation to take emergency call. In the event the surgeon cannot take call, it is the surgeon's own responsibility to find a substitute and inform Emergency Department personnel of the name of the substitute. In no instance will Santa Monica-UCLA Medical Center & Orthopaedic Hospital personnel be responsible for finding a substitute for a surgeon who does not take call. Any changes to Contact information, i.e. cell phone, office phone, etc. must be relayed to Medical Staff Administration.

C. Call Panel for Plastic Surgery

The Plastic Surgery ED On-Call Panel is voluntary. Surgeons who do not present at the Emergency Department while on call will be subject to removal from future on-call rosters. First time offenders will receive a warning letter. Second time offenders (in a two-year period) will lose their ability to take ED call.

D. Call Panel for Foot and Ankle Trauma

The Foot and Ankle Emergency Room (voluntary) Call Panel shall be composed of interested podiatrists who have completed a 3-year surgical residency program and have privileges at Santa Monica-UCLA Medical Center & Orthopaedic Hospital. Call may be shared by members of the same group. For example, any member of the orthopedic group may cover for another member in the same group and any member of a podiatry group may cover for another member in that group. All foot and ankle trauma is to be referred to the on-call doctor. This will include:

All foot and ankle fractures
All tendon tears
All lacerations
All infection and ulcer cases

The podiatrists on the call panel are qualified to cover the above noted trauma cases only if such privileges are approved by Santa Monica-UCLA Medical Center & Orthopaedic Hospital.

IX. MEDICAL RECORDS

A. History & Physical Exams

1. Elective and urgent cases must have a complete history and physical examination (within 30 days) recorded on the chart before anesthesia begins. Further interval documentation, with a note recorded within 24 hours of the surgery, shall also be made.
2. In dire emergencies, when a patient's life or recovery is in jeopardy, a brief admission note will suffice. The formal history and physical shall be completed within 24 hours.

B. Consultation

When the operating surgeon is not the admitting physician, elective and urgent cases must have a written consultation by the operating surgeon completed preoperatively.

C. Postoperative Orders

Postoperative Orders must be written immediately following any surgical procedure.

D. Dictations and Documentation

1. A postoperative progress note must be written immediately following any surgical procedure.
2. An operative report shall be dictated immediately following surgery prior to patient's discharge from PACU.
3. The surgeon must write and date daily progress notes during the patient's recovery period.
4. The surgeon is responsible for dictating the discharge summary only if the primary reason for admission is the surgery.

E. PreOperative Patient Discussion to Obtain Consent

The operating surgeon is responsible for having a preoperative discussion with the patient (or legal representative if the patient is incompetent) regarding the proposed surgical procedure that addresses the indications for, nature of, alternatives to, expected natural course without, and the risks, benefits and complications associated with the procedure. A witnessed, signed, informed consent form must be on the chart prior to surgery. Except in emergencies, neither surgical, special diagnostic nor therapeutic procedures shall be performed unless consent is obtained. The chart must contain written documentation that informed consent was obtained by the physician.

If the patient is a competent adult, the patient shall give consent. Incompetent patients include patients who have been declared incompetent to give consent by a court and those patients who, in the opinion of their attending physician, are mentally retarded, senile, temporarily unconscious, under the influence of alcohol or drugs, or otherwise incapable of giving consent.

For an incompetent adult patient, consent can be obtained in the following order or priority:

- An attorney-in-fact, if the patient has executed a Durable Power of Attorney for Healthcare that remains valid;
- A conservator if one has been appointed;
- The patient's closest available relative who is related by blood, marriage or adoption and who appears to be close to the patient;
- Significant others
- A court if there is a dispute regarding who is authorized to consent;
- In the absence of the parties listed above, and if competent consent cannot be obtained, documentation of the emergency situation must be provided in writing by the attending surgeon. Appropriate documentation consists of the nature of the emergency, reasons consent could not be secured, recommended treatment and probable result if treatment is delayed or not provided.

A minor is a patient who is under 18 years of age. Consents must generally be obtained from the minor's parent or guardian. Special considerations are when the parents are divorced, when a child is being placed for adoption or has been declared a ward of the court, or if the parents or guardians are unavailable. The

Medical Staff Rules and Regulations itemize the circumstances under which a minor may give consent.

F. Medical Record Suspension

Medical record suspension for incomplete medical records shall include suspension of all surgical privileges, including that of primary or assistant surgeon. The Surgery Scheduling Staff may not accept a booking from a surgeon who is on suspension. Elective cases that are already booked by surgeons who are on suspension shall not be performed until all outstanding charts are completed.

X. PATHOLOGY AND BLOOD USAGE

A. Surgical Specimens

1. Pre-operative diagnosis

The pre-operative diagnosis, post-operative diagnosis and/or relevant history and the procedure performed shall be reported on the pathology slip by either the operating surgeon or surgery personnel prior to the beginning of the operation.

3. Surgical specimens removed in the operating room or PTU shall be forwarded to the Pathology Department. Where indicated, a pathologist's report of the findings will be filed in the patient's medical record.

3. Exceptions to 2 above are:

a. Skin and tissue removed during cosmetic surgical procedures from body areas that have not had prior non-cosmetic surgery and can be reasonably examined visually in the operating room for pathological changes. This would include such tissues obtained from procedures such as from blepharoplasties, rhinoplasties, otoplasties and rhytidectomies, non-tumorous adipose tissue from liposuction, dermabrasion or chemosurgery. Specimens containing breast tissue other than skin may not be excluded from examination by pathology.

b. Myringotomy tubes.

c. Teeth removed during routine dental care.

d. Placentas from uncomplicated deliveries.

e. Foreskins from newborns.

- f. Cataracts, paracentesis of anterior chamber, removal of vitreous.
- g. Therapeutic radioactive implants.
- h. Arthroscopy shavings, bone removed exclusively for exposure.

B. Blood

- 1. Surgeons should have knowledge of current guidelines regarding indications for blood transfusion and be aware of possible adverse risks.
- 2. The Paul Gann Act requires patients to be informed by their physicians about the options of using autologous and/or donor directed blood prior to an elective procedure, allowing sufficient time to obtain such units.

XI. SCHEDULING

Only surgeons or their designees may schedule or cancel cases. Contaminated cases should be scheduled at the end of the day. No operative procedure will be scheduled if the surgeon or assistant surgeon is on the Medical Record suspension list.

A. Surgical Categories

- 1. Emergency: The operation must be done immediately or within a few hours, as delay could threaten the patient's life or recovery.
- 2. Urgent: The operation should be done within 12 or 48 hours because of the patient's discomfort, anxiety or medical need, but this delay does not threaten patient's life or recovery.
- 4. Elective: Time not relevant.

B. Block Booking

Block booking shall require prior approval by the Surgery Committee and the Medical Director of Surgical Services.

C. Emergency Scheduling

Emergency cases may be scheduled at any time and shall be given priority over any scheduled elective or urgent case not yet in progress. If there is any doubt as to the emergent nature of the case, it may be discussed further with the scheduling surgeon or others in the line of authority for a final decision. All cases scheduled as emergencies are subject to review.

D. Urgent/Emergent Scheduling

Scheduling of emergent or urgent cases when the scheduling office is closed shall be through the OR desk or Medical Center administrator on call.

E. Routine Scheduling

The surgery scheduler will obtain specific information from the surgeon's office at the time the case is scheduled. Information required includes, but is not limited

to: the patient's name, sex, phone number, diagnosis, surgical procedure, x-rays, preference for anesthesia, estimated time required for the procedure, instrumentation required, surgical assistant and whether a proctor is required for the case. Induction of anesthesia will not begin until the surgeon is present in the hospital.

- E. The practice of overlapping elective surgeries when a surgeon is running more than one operating room concurrently is a significant concern as it relates to patient safety, operative outcome, informed consent, and appropriate billing. Reference Overlapping Elective Surgical Procedures Policy (medical staff policy #132).

XII. DENTAL AND PODIATRIC CASES

All patients admitted by dentist and podiatrist Medical Staff members shall receive the same basic medical appraisal as patients admitted by physicians.

- A. Responsibilities of the Dentist or Podiatrist shall be the same for physicians with these exceptions:
1. The dentist or podiatrist must arrange with a physician member of the Medical Staff for medical coverage to include preoperative History & Physical exam, surgery clearance and medical care through the period of hospitalization.
 2. Oral surgeons may dictate the history and physical examinations for their own patients.
 3. To provide a detailed dental or podiatric history examination and diagnosis.

XIII. PEDIATRIC SURGERY

Admitting history and physicals must be performed by a pediatrician a family physician with pediatric privileges, a surgeon with pediatric training or an emergency physician who has been in consultation with one of the above-referenced physicians for all surgery under general anesthesia on patients under two years of age, except in emergencies. The decision to operate must be made jointly between the surgeon, anesthesiologist and pediatric consultant.

XIV. SURGEONS AND RELATIVES

Surgeons, their assistants and anesthesiologists are prohibited from operating upon, providing anesthesia services or observing surgery for members of their immediate families. Immediate families are defined to include: grandparents, parents, spouse, children and grandchildren.

XV. SURGICAL OBSERVERS

The following persons are allowed to observe in the surgery suite: physicians who are unrelated to the patient, nurses, allied health personnel and medical students. For non-medical visitors (i.e., film crews, reporters, medical photographers, etc.), a signed

authorization is required. In all cases, the surgeon and patient must consent to having a surgical observer.

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| Surgery/Anesthesia Committee: | July 14, 2020 |
| Medical Staff Executive Committee: | July 25, 2020 |
| Governing Body: | July 31, 2020 |