UNIVERSITY OF IOWA HEALTH CARE
Iowa City, Iowa

IOWA
HEALTH CARE

GRADUATE MEDICAL AND DENTAL EDUCATION APPOINTMENT CONTRACT

I, Jane Smith Doe, M.D., accept the offer of a graduate educational appointment as a Resident (Stipend Level x) in Medicine in the Department of Medicine by the University of Iowa Health Care (UI Health Care) for the period 7/1/2027 through 6/30/2028.

EDUCATIONAL EXPERIENCE AND RESPONSIBILITIES. I agree to meet the responsibilities inherent in the appointed position to the best of my ability for the duration of the appointment. I have read and acknowledge the following policies shall apply during this appointment: the General Statement of Educational Experience Locus and General Responsibilities of House Staff; the Policy on Patient Safety, Quality Improvement, Supervision and Accountability; and the Policy for GME Trainees on the Learning and Working Environment: Professionalism, Well-Being, Fatigue Mitigation, Transitions of Care, Clinical Experience and Education.

I have read the Amended and Restated Bylaws, Rules and Regulations of the University of Iowa Hospitals and Clinics and its Clinical Staff and I agree to be bound by its terms. I further agree to abide by all other policies, procedures and rules of UI Health Care, its clinical departments, the University of Iowa, and affiliated organizations, and applicable policies of any clinical site to which I am assigned as part of this training program, which may be in force during the appointment period. Further, in carrying out my work pursuant to this appointment, I agree to comply with all applicable laws and regulations.

I represent and warrant that all of the information provided in my application for this appointed position is correct and complete to the best of my knowledge and beliefs. I understand that willful falsification or willful omission of information could result in the immediate termination of my appointment. I understand that this appointment is contingent upon my successful licensure by the Iowa Board of Medicine or the Iowa Dental Board, as appropriate; completion of a successful background check; completion of health history, health screening, and other specified employment compliances; and upon having (or obtaining) appropriate work authorization and maintaining that authorization for the entire duration of this appointment. Further, I understand that failure to satisfy these employment contingencies by the start date of my training program or to maintain such status through the duration of this appointment renders this contract null and void.

MOONLIGHTING. During the appointment period, I agree to engage in no clinical practice activity outside of my training program without the prior written approval of my program director. If I engage in any clinical practice outside of my training program, I do so as a private practitioner. I understand that neither UI Health Care nor my program director accepts any responsibility for outside practice and that I am exclusively responsible for all liability or other legal matters associated with such outside practice. I agree to comply with the attached Moonlighting Policy and Procedures for House Staff.

STIPEND AND BENEFITS. Stipend and other benefits for the appointment period will be as described in the attached Statement on Stipends and Benefits for Graduate Medical Education (GME). This includes, but is not limited to health, dental and medical coverage, professional liability, disability and life insurance, paid time off, leaves and eligibility for specialty board examinations.

DUE PROCESS. In the event of suspension without pay or discharge, Article IV, Section 4.7 of the Bylaws shall be applicable. Any other concerns of House Staff members, including non-promotion or non-renewal, will be addressed in the manner described in the attached Statement on House Staff Member Concerns

CONDITIONS FOR REAPPOINTMENT AND PROMOTION. I understand that a renewal educational appointment contract may be issued for no more than one year at a time contingent upon my demonstration of satisfactory performance of progressive scholarship, clinical competence and professional growth as described in the attached Policy and Procedures for the Evaluation and Advancement of House Staff, and depending on the availability of funding and the approved program complement. This contract may be extended at the discretion of the Program Director and the Associate Dean for GME.



Amy Stier, M.D., M.M.E.,
Associate Dean and Designated Institutional Official, Graduate Medical Education

_____
Resident/Fellow

_____
Program Director

GRADUATE MEDICAL EDUCATION CONTRACT ATTACHMENTS

2027 - 2028

Graduate Medical Education Documents

- Statement of Stipends and Benefits for Graduate Medical Education
- Disability Accommodation Policy
- General Statement of Educational Experience Locus and General Responsibilities of House Staff
- Interruption, Reduction or Closure of Graduate Training Programs
- Moonlighting Policy and Procedures for House Staff Physicians and Dentists
- Policy for GME Trainees on Eligibility, Selection, Transfer
- Policy for GME Trainees on the Learning and Working Environment:
    - Professionalism; Well-Being; Fatigue Mitigation; Transitions of Care; Clinical Experience and Education
- Policy and Procedures for the Evaluation and Advancement of House Staff
- Policy on Supervision and Accountability for GME Trainees
- Policy on Patient Safety and Quality Improvement for GME Trainees
- Statement on House Staff Member Concerns
- Substance Abuse Identification and Intervention — House Staff

University of Iowa and UI Health Care Documents

- UI Sexual Harassment Policy
- Staff Medical Conscience Protection
- UI Health Care Bylaws, Rules & Regulations

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University of Iowa Health Care

STATEMENT OF STIPENDS AND BENEFITS FOR GRADUATE MEDICAL EDUCATION

2027 - 2028

Table of Contents

Stipends..... 1

Benefits 1

Professional Liability Coverage 1

Board Certifications 1

Paid Time Off and Leaves 2-5

STIPENDS: UI Health Care highly values its core mission of educating the next generation of outstanding physicians and dentists. This is reflected in the ongoing development of new educational initiatives and programming, the development of faculty and staff, and the provision of stipends that recruit and sustain GME trainees.

Annually, the stipends levels are reviewed. The ability of house staff to maintain a comfortable standard of living with the Iowa City area is a major focus. UI Health Care also aims to recognize the crucial importance of our house staff members' contributions by providing competitive annual stipends as they progress through their programs.

To ensure fairness, all residents and fellows appointed to GME programs at UI Health Care receive compensation based on a published stipend schedule. (In some situations for Fellow Associates in non-ACGME GME programs, their departments may choose to further supplement total compensation).

Stipends for the 2027-2028 year are currently under review. Stipends for the 2026-2027 fiscal year were:

House Staff Level	2026-2027 Annual Stipend
PGY-1	$71,100
PGY-2	$73,700
PGY-3	$76,700
PGY-4	$80,800
PGY-5	$84,100
PGY-6	$87,300
PGY-7	$92,100

House Staff level is equal to the number of years of graduate medical or dental training that counts toward meeting board eligibility requirements of the specialty in which the house staff member is currently training or as otherwise approved by the GME Associate Dean/Designated Institutional Official (DIO).

Payment of stipends begins the first day of the month following the contracted start date and continues on the first day of each following month. Federal Insurance Contributions Act (FICA) and payroll taxes are withdrawn as required by the Internal Revenue Service (IRS).

BENEFITS: An extensive program provides medical, hospital care, pharmacy, dental, and counseling services for house staff physicians, dentists, and their dependents. In addition, house staff members are provided disability, and life coverage. Details about these benefits are available online: http://hr.uiowa.edu/benefits/house.

The University of Iowa reserves the right to change the benefit programs at any time. As with all benefit programs, the University of Iowa is unable to guarantee that the details listed will be in effect throughout your employment.

PROFESSIONAL LIABILITY COVERAGE: House staff members who have signed GME contracts are provided professional liability coverage at no cost via the Iowa State Tort Claims Act, Chapter 669 of the Iowa Code. The Act is the equivalent of an occurrence malpractice policy in that no tail is required. The Act is not a policy and thus has no policy number. The Act does not contain dollar limits in coverage for clinical services rendered by house staff in Iowa which are within the scope of their training program.

BOARD CERTIFICATIONS: Medical specialty certification in the United States is a voluntary process which serves multiple purposes for the trainee and the public. It is the responsibility of the resident or fellow to become familiar with the specific Board eligibility requirements. Certification:

- is one mission of the training program to produce trainees who meet board eligibility criteria;
- distinguishes a physician as someone with a distinct level of expertise;
- provides more opportunities when applying for employment;
- presents resources and tools by the American Board of Medical Specialties (ABMS);
- is a commitment to life-long improvement for providing the best patient care; and
- elevates physicians into the ranks of doctors committed to the highest standards of healthcare.

For more information visit the American Board of Medical Specialties site.

UNIVERSITY OF IOWA HEALTH CARE

GRADUATE MEDICAL EDUCATION

POLICY ON PAID TIME OFF (PTO) AND LEAVES OF ABSENCE (LOA)

Core Values Informing Policy

- Navigating time away from training requires collaboration between each resident/fellow and their Program Director (PD)
- Maintaining benefits & PD flexibility to manage all PTO and potential LOAs is a priority
- This GMEC Policy should be considered a minimum leave; program directors should use discretion in allowing more time off as their board requirements and program expectations allows.
- The PD holds responsibility for managing request review, discussions, and decision-making with residents/fellows, including current information on impact of an extended LOA on successful completion of program to earn board eligibility and program-specific requirements
- The PD must seek input/approval from GME Office for atypical or extended LOA requests, including all possible extensions of training
- GMEC adheres to all ACGME and certifying board requirements and federal and state laws regarding leave

Policy Statement

Pursuing Graduate Medical Education is a complex endeavor that necessitates planning and open communication between the resident/fellow and their PD. Board certification is available for most GME programs, and we work collaboratively with GME trainees to provide support necessary to achieve board eligibility. This policy is applicable for all trainees on GME contracts regardless of whether their program is accredited by ACGME.

Each accrediting body has program-specific expectations for successful completion. All specialty certifying boards have unique expectations for board-eligibility, some of which restrict the amount of time away from clinical work that can be taken without having to extend training. **It is the responsibility of the PD to remain current on all requirements to ensure accurate advice for each resident/fellow regarding a potential LOA from their program**. Any planned extension of training beyond the standard period, for any reason, should be reviewed and approved by the central GME office in advance.

Key Points

1. **Annual Paid Time Off**: Each resident/fellow is eligible for 4 weeks of paid time off (PTO) each year (3 weeks of vacation + 1 week of sick time). Vacation weeks can be scheduled ahead of time; sick time is flexible and exists to ensure trainees are able to accommodate their personal health

needs. Weeks are defined as calendar weeks unless otherwise specified by program. PTO and sick time do not carry over year to year. Residents/fellows must arrange for PTO with their PD. Additionally, each PD manages an equitable approach to provide time away for short-term illnesses, holidays, educational conferences, and to interview for future positions.

2. **Personal Health Care Needs**: All GME programs encourage their residents and fellows to seek health care when needed. Each program must have processes which permit time off to attend their health-related appointments.
3. **Other Leave**: Residents/fellows may face circumstances that require time away from training, including the resident/fellow's own health needs, parental responsibilities, caregiving responsibilities, bereavement, or other qualifying circumstances. The PD is responsible for advising residents/fellows about potential training extension, in the context of their personal and board eligibility requirements. PDs considering whether a training extension may be necessary must work closely with the GME Office to ensure consistent decision-making.
4. **Federal and State Statutory Requirements**: Federal and state law set some minimum entitlements for all employees regarding leave. When more than one leave entitlement applies to the same absence, the applicable leaves will run concurrently to the extent permitted by law and University policy. GME leave is granted in addition to the minimum entitlements under the law. PDs should contact the Leave and Disability Administration and the GME Office to ensure consistent application and communication.

Leave of Absence:

1. **General Principles**
   A. Types of leave: All residents/fellows are eligible for Parental, Medical, or Caregiver Leave if needed. Parental Leave is intended for use by non-birth parents. A birth parent's need for parental leave is provided under Birthing Leave.
   B. Leave parameters: Consistent with ACGME Institutional Requirements, residents and fellows are eligible for a minimum of six weeks of paid medical, parental, and/or caregiver leave for qualifying reasons during their GME program, beginning on the first day of employment. The first six weeks of qualifying leave taken during their program will be paid at 100% of the resident/fellow's stipend with continuation of applicable health and disability benefits. Further leave beyond six weeks requires explicit approval by GME and may be unpaid. The leave may be continuous or intermittent, but it must adhere to program specific policies. Any required extension of training resulting from an approved LOA will be supported with stipend and benefits.
   C. Communication: The need for leave of absence can be unexpected and unpredictable. Residents/fellows should communicate with their PD in advance for planned LOA and as soon as possible for urgent/unexpected LOA. All requests for an extended (more than 3 weeks) LOA must be submitted in writing to the PD for review and approval, following discussion of potential ramifications (e.g. whether necessary to extend training). A copy of the approved request must be filed with the GME Office. The PD must inform the GME office prior to approval of any leave request beyond 6 weeks.

D. Federal and State Statutory Requirements: Federal law (FMLA) requires public employers to offer up to 12 work weeks of *unpaid* leave per year for qualifying conditions, while maintaining health benefits and job position. FMLA eligibility begins after 1 year of employment. Iowa Paid Parental Leave (IPPL) requires public employers to offer up to 4 weeks of paid leave for birthing or adoptive parents, and one week of paid leave for non-birthing parents. When more than one leave entitlement applies to the same absence, the applicable leaves will run concurrently to the extent permitted by law and University policy. UIHC is required to provide this entitlement via a notice from the Leave and Disability Administration (LDA), but *paid* GME leave is granted beyond what is required by FMLA and IPPL.

2. Birthing Leave:

A. Amount of Leave: A resident/fellow birthing parent is entitled to take paid leave for each pregnancy. The GME office supports 6 weeks of birthing leave for each pregnancy independent of other PTO. If medically necessary either before or after delivery, additional paid LOA up to 6 weeks is available upon receipt of written documentation from the resident/fellow's treating provider (i.e. at least 12 weeks of paid leave). Weeks are defined as calendar weeks unless otherwise specified by program. Birthing leave is available within 12 months of the birth of a child. The leave may be intermittent, but intervals must be approved by the PD. If a birthing parent desires further time away from the program for personal reasons, consultation with and approval by the PD is required to schedule additional LOA, which is unpaid. The PD must inform trainees of the impact on their board eligibility and potential need for extension of training. The PD must inform the GME office of any birthing leave beyond 6 weeks.

B. Resident/Fellow Choice: Residents/fellows may elect to use available PTO in connection with additional time away when permitted by applicable requirements. At least one week of PTO must be reserved for use outside of the 6 weeks of approved birthing leave.

C. Benefit Coverage Retention: The resident/fellow on birthing leave will retain benefit coverage for up to 12 weeks. Should leave exceed 12 weeks as outlined above necessitating a birth-related unpaid LOA, the resident/fellow can retain coverage through payment of premium costs.

3. Parental (non-birth Parent):

A. Amount of Leave: We recognize the importance of the early development of a relationship between a parent and their new child, including if the child joins the family by birth, adoption, foster placement, legal guardianship, or the arrival of a child through gestational surrogacy. Thus, non-birth parents on a GME contract are eligible for up to 6 weeks of paid LOA once per GME program. UI Health Care additionally renews this paid leave benefit for every three years of continuous GME training (for programs longer than 3 years). Weeks are defined as calendar weeks unless otherwise specified by program. This parental leave is available within 12 months of the birth or adoption of a child. The leave may be intermittent, but intervals must be approved by the PD. The PD must inform trainees of the impact on their board

eligibility and potential need for extension of training. The PD must inform the GME office of any leave beyond 6 weeks.

B. Resident/Fellow Choice: Residents/fellows may elect to use available PTO in connection with additional time away when permitted by applicable requirements. At least one week of PTO must be reserved for use outside of the 6 weeks of approved medical, parental or caregiver leave.

C. Benefit Coverage Retention: Resident/fellow benefits will continue uninterrupted during this paid LOA for up to 6 weeks. Any LOA beyond 6 weeks must be approved by the PD and the GME office on a case-by-case basis. For any extended LOA, the resident/fellow will retain benefit coverage up to 12 weeks, after which they can retain coverage through payment of premium costs.

4. Medical or Caregiver Leave:

A. Amount of Leave: All residents/fellows are eligible for Medical or Caregiver Leave. Any resident/fellow on a GME contract is eligible for up to 6 weeks of paid LOA once per GME program.

B. Resident/Fellow Choice: Residents/fellows may elect to use available PTO in connection with additional time away when permitted by applicable requirements. At least one week of PTO must be reserved for use outside of the 6 weeks of approved medical, parental or caregiver leave.

C. Benefit Coverage Retention: Resident/fellow benefits will continue uninterrupted during this paid LOA for up to 6 weeks. Any LOA beyond 6 weeks must be approved by the PD and the GME office on a case-by-case basis. For any extended LOA, the resident/fellow will retain benefit coverage up to 12 weeks, after which they can retain coverage through payment of premium costs.

Graduated Medical Education Committee Approved	*12/15/2023*
Graduated Medical Education Committee Approved	*10/1/2024*
Graduated Medical Education Committee Approved	*11/3/2026*

IOWA HEALTH CARE

Graduate Medical Education

DISABILITY ACCOMMODATION POLICY & TECHNICAL STANDARDS FOR GME

GENERAL STATEMENT: Graduate Medical Education (GME) at University of Iowa Health Care is governed by the overarching University of Iowa policy on *Human Rights (Operations Manual, II Community Policies, Division I Human Rights, Affirmative Action, and Equal Opportunity, Chapter 3, Section 3.1),* which states, *"The university is committed to the principle of equal opportunity including access to facilities. Differences in treatment are prohibited when based on race, creed, color, religion, national origin, age, sex, pregnancy (including childbirth and related conditions), disability, genetic information, status as a U.S. veteran, service in the U.S. military, sexual orientation, gender identity, or associational preferences. This principle must be observed in the internal policies and practices of the university; specifically in the admission, housing, and education of students; in policies governing programs of extracurricular life and activities; and in the university's treatment of its applicants and its employees. Consistent with state and federal law, reasonable accommodations will be provided to persons with disabilities and to employees with known limitations related to pregnancy, childbirth, or related medical conditions, and to accommodate religious practices. The university shall work cooperatively with the community in furthering these principles."* GME strives to make reasonable accommodations for the functional limitations of applicant and existing residents, whether medical or dental, and fellows, (collectively, "Trainees"), with disabilities. Like all staff, faculty, and students, Trainees are protected from coercion, retaliation, interference, or discrimination for filing a complaint or assisting in the investigation of a complaint. Inquiries about anti-discrimination and retaliation policies and complaints should be directed to the Division of Access Opportunity and Diversity (EOD).

UI Health Care's commitment to diversity acknowledges that physicians and dentists with disabilities offer unique perspectives. In that regard, UI Health Care seeks to foster an environment for Trainees based on equality of opportunity, full participation, independent living and economic self-sufficiency while also meeting the training requirements mandated by its GME programs via the Accreditation Council for Graduate Medical Education (ACGME), certifying boards, and UI Health Care Bylaws. All applicants and Trainees at UI Health Care must possess the intellectual, ethical, physical and emotional capabilities to meet the Technical Standards described in this policy, with or without accommodation.

I. **TECHNICAL STANDARDS FOR ADMISSION & RETENTION:** Technical standards are criteria that go beyond academic requirements or training prerequisites for acceptance as a GME Trainee and are essential to meeting the academic and clinical requirements of the particular GME training program, though additional performance expectations may occur in certain GME programs. Trainees with or without disabilities, applying to and continuing in a GME program will be expected to meet the same requirements and will be held to the same fundamental standards. Beginning and continuing in a GME training program assumes a certain level of cognitive and technical skill. Although not all Trainees are expected to gain the same level of proficiency with all technical skills, some skills are so essential that mastery must be achieved, with the assistance of reasonable accommodations where necessary. Reasonable accommodations will be provided to assist in learning, performing and satisfying the technical standards, in compliance with the law and University policy. Applicants and active Trainees must possess the capability to complete the entire curriculum of the GME program, with or without accommodation. Abilities and skills required are noted in six areas below. Technological accommodation can be made for some disabilities in certain of these areas, but each Trainee must meet the essential technical standards in a way such that the Trainee will be able to perform in a reasonably independent manner and progress to the point of autonomous practice in the Trainee's GME specialty or sub-specialty training program. The use of a trained intermediary is not acceptable in many clinical situations as it implies that the Trainee's judgment must be mediated by someone else's power of selection and observation.

The technical standards are:

- Observation – Trainees must have the functional ability to observe and must have sufficient use of the senses necessary to perform all necessary physical examinations and patient care pursuant to their specialized area of training.
- Communication – Trainees must be able to relate reasonably to patients and establish sensitive, professional relationships with patients, peers, colleagues and staff. They must be able to communicate to the patient and to their colleagues with accuracy, clarity and efficiency.
- Motor – Trainees must be able to participate in diagnostic maneuvers, procedures and treatments required for their specialty.
- Intellectual, Conceptual, Integrative and Quantitative Abilities – Trainees must be able to analyze, synthesize, solve problems, and reach reasonable diagnostic and therapeutic judgments. Trainees must be able to display good judgment in the assessment and treatment of patients. They must be able to respond with prompt and appropriate action in emergent situations.
- Behavioral and Social Attributes – Trainees must be able to accept criticism and respond with appropriate modification of their behavior. They must possess the perseverance, diligence, and consistency necessary to complete the training program's curriculum, gain progressive independence according to the timeline outlined by the Program Director's established curriculum and enter the autonomous practice of medicine at the completion of the program. They must demonstrate professional and ethical demeanor and behavior in all dealings with peers, faculty, staff and patients.
- Cultural Competency – Trainees must be able to communicate with and care for persons whose culture, sexual orientation or religious beliefs are different from their own. They must be able to provide patient care for any patient regardless of the Trainee's and patient's race, creed, color, religion, national origin, age, sex, pregnancy, disability, genetic information, status as a U.S. veteran, service in the U.S. military, sexual orientation, gender identity, associational preferences, or any other classification that deprives the person of consideration as an individual. Similarly, Trainees must be able to interact professionally with colleagues and other healthcare professionals without regard to race, creed, color, religion, national origin, age, sex, pregnancy, disability, genetic information, status as a U.S. veteran, service in the U.S. military, sexual orientation, gender identity, associational preferences, or any other classification that deprives the person of consideration as an individual.

II. REASONABLE ACCOMMODATIONS: Whether it is an applicant or a current Trainee, GME does not discriminate in access to its programs on the basis of disability. Reasonable accommodations for disabilities are determined on a case-by-case basis through an assessment of individual needs and an interactive process. Any documents containing disability related information are confidential and maintained securely in the Program and/or in the GME Office or in University of Iowa Health Care HR offices, as appropriate.

III. PROCESS: As noted above, to remain in good standing, medical residents and fellows and dental residents with and without disabilities are required to meet the technical standards set forth in this policy and any other achievement standards determined by the faculty, the particular standards of the training program and of the respective specialty or sub-specialty. The process for considering reasonable accommodation(s) for any disability (pre-dating entry to the program or newly acquired) is as follows:

- Accommodation Request – Leave and Disability –
    - A *new* (incoming) Trainee seeking reasonable accommodation(s) for a disability pre-dating entry to the program must contact the Leave and Disability (LDA) office within UI Health Care Human Resources to initiate the interactive process, preferably no later than the end of the first week of training. The LDA office will collect necessary information, including but not limited to satisfactory written documentation of the need for accommodation.
    - A *current* Trainee who is experiencing new difficulties related to an existing disability or a new disability and would like to engage in the interactive process regarding reasonable accommodation(s) must also contact the LDA office as soon as reasonably possible to initiate the process.

- Interactive Accommodation Process – The Program Director will work with the Trainee, the LDA office and in some cases, the Trainee's health care provider, in an interactive process to develop a plan for reasonable accommodation(s) consistent with the needs and the interests of the Trainee and training program.

Reviewed/Approved by the Graduate Medical Education Committee	1/3/2012
Reviewed/Approved by the Graduate Medical Education Committee	1/9/2020
Reviewed/Approved by the Graduate Medical Education Committee	10/1/2024

IOWA HEALTH CARE

Graduate Medical Education

GENERAL STATEMENT OF EDUCATIONAL EXPERIENCE LOCUS AND GENERAL RESPONSIBILITIES OF HOUSE STAFF

University of Iowa Health Care provides an opportunity to fulfill the training requirements for specialty certification through inpatient and outpatient rotations at UI Health Care in Iowa City and at affiliated hospitals, private practices, and programs, all which facilitate patient safety and health care quality. Many residents and fellows are assigned to rotations at the Veterans Affairs Medical Center in Iowa City, as well as other affiliated hospitals and clinics in several other Iowa cities. Some residents and fellows participate in UI Health Care's outreach programs, which provide screening or clinical services both at UI Health Care, and in other Iowa communities. The specific affiliations, programs and locations vary from year to year. Each is governed by an appropriate agreement (e.g., affiliation agreement, memorandum of understanding or program letter of agreement). As required by the Institutional Requirements of the Accreditation Council for Graduate Medical Education (ACGME) and in concert with the UI Health Care's *Institutional Commitment Statement on Graduate Medical and Dental Education*, the training programs are designed to ensure that house staff members are able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. This means that house staff members must:

- Have the requisite medical knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social behavioral) sciences and can apply this knowledge to patient care;
- Establish and improve learning skills that involve investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvement of patient care;
- Develop interpersonal and communication skills that result in effective information exchange and teaming with patients, their families, and other health professionals;
- Incorporate professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population; and
- Demonstrate an awareness of and responsiveness to the larger context and system for health and the ability to effectively call on system resources to provide care that is of optimal value.

House staff members are expected to develop a personal program of learning to foster continued professional growth. Guidance comes from the teaching staff as house staff members participate fully in the educational and scholarly activities of their programs and as required, assume responsibility for teaching and supervising other residents and students. It is expected that house staff members will participate in appropriate institutional committees and councils to which they are appointed, elected or invited, especially those that relate to patient safety and quality of care education activities. House staff members are also expected to be responsible to evaluate their programs by submitting to the program director or to a designated institutional official, at least annually, confidential written evaluations of the faculty and of the educational experiences in their training program.

House staff members are responsible for participating in required programming and instruction, including but not limited to programs on substance abuse and physician impairment, mandatory reporting of child and elder abuse, Health Insurance Portability and Accountability Act (HIPAA), blood borne pathogens and safety in the workplace, and other activities necessary for the successful orientation to UI Health Care and training in the house staff member's specialty. Furthermore, it is the responsibility of the house staff member to communicate with his/her program director, coordinator and other graduate medical education (GME) personnel in a timely manner and as necessary for administration of the program, including participation in program reviews, accreditation site visits, the completion of documentation (including but not limited to EPIC and MedHub) as required for duty hours (including all approved time away from the program, time at other sites and/or moonlighting), procedures, schedules, conferences, and evaluations, and other aspects of the house staff member's work environment.

House staff members are obligated to perform their duties and at all times conduct themselves in compliance with the Bylaws, Rules, and Regulations of the University of Iowa Health Care and Its Clinical Staff, all Graduate Medical Education Committee policies and procedures, the established practices, procedures and policies of the trainee's program, clinical department and other institutions to which the house staff member is assigned, as well as with all state and federal rules, regulations, and laws. All house staff members must maintain through the duration of their contracts a valid license (medical or dental, as appropriate) in the State of Iowa. Appropriate visa status, in compliance with *the Policy on Visas for GME Trainees*, is the responsibility of the individual house staff member.

With respect to participation in patient care activities, overall professional training and academic affairs, the house staff members are responsible to the program director of his/her respective training program, the members of the clinical staff at UI Health Care under whose supervision they may serve to the Clinical Service Head of the Department and to the GME Associate Dean/Associate Hospital Director.

For purposes of this policy the terms house staff, resident, and fellow mean any trainee in a medical or dental training program at UI Health Care who is currently party to a *GME Medical and Dental Appointment Contract*.

Approved by the Graduate Medical Education Committee	11/1/2011
Approved by the Graduate Medical Education Committee	3/17/2016
Approved by the Graduate Medical Education Committee	9/20/2020
Approved by the Graduate Medical Education Committee	10/1/2024

IOWA HEALTH CARE

Graduate Medical Education

POLICY ON THE INTERRUPTION, REDUCTION OR CLOSURE OF GRADUATE TRAINING PROGRAMS

A recommendation to modify the resident complement of or to close a graduate training program must be made by the individual Program Director via a petition to the Graduate Medical Education Committee (GMEC) at UI Health Care according to the procedures outlined in the "Policy and Procedures for Adding New Programs and Program Modification," which governs both increases and decreases to the size or scope of a training program.

A recommendation to close a graduate training program, to reduce the size of the program, or to close the sponsoring institution by UI Health Care must be communicated to the GMEC, the DIO and the residents as soon as possible. Such recommendations will then be presented to the Clinical Systems Committee (CSC) for review and approval. The appropriate ACGME Residency Review Committee will be notified in accordance with ACGME requirements.

If UI Health Care is to be closed or if an individual program is closed, reduced or interrupted for any reason, including a disaster or interruption in patient care, the following procedures will govern:

1) The Program Director will give the affected residents written notice of the program reduction or closing as soon as possible following the decisions and approval by the GMEC and CSC, as applicable. This notice will include specific dates and the terms by which the program is closing or downsizing.
2) Any resident not completing the affected program will be assisted in the continuation of his/her education in one of the following ways:
    a) The resident will be allowed to complete the program, if possible, depending on the dates of the program closure/reduction and on the resident's demonstration of satisfactory progress; or
    b) The resident will be assisted by the Program Director in identifying and enrolling in another program at UI Health Care; or
    c) The resident will be assisted by the Program Director in identifying and enrolling in another accredited program outside of UI Health Care, by making the necessary communications.

    A meeting with the resident, the Program Director, the DIO, and the Director of GME will occur to decide the best strategy for the affected resident.
3) The Graduate Medical Education Office will assist the resident with issues concerning stipend, benefits, contract and other administrative issues caused by the change or closure of the program.
4) Financial obligations of UI Health Care will follow the terms of the resident's contract but will not include any reimbursement for expenditures due to relocation.

The term "resident" in this policy shall refer to residents and fellows at all house staff levels.

House staff residents and fellows are also governed by the UI Health Care "Emergency Operations Plan," which describes planning and training for on-site emergency situations and/or disasters as well as the implementation of an organized response, including but not limited to staff deployment, communications, safety and security, patient evacuation, immunization, decontamination and recovery.

Approved by the Graduate Medical Education Committee	8/7/2007
Approved by the Graduate Medical Education Committee	10/4/2011
Approved by the Graduate Medical Education Committee	12/9/2020
Approved by the Graduate Medical Education Committee	10/1/2024

IOWA HEALTH CARE

Graduate Medical Education

MOONLIGHTING POLICY AND PROCEDURES FOR HOUSE STAFF

Moonlighting in this document refers to voluntary, compensated, medically related work beyond a resident's or fellow's clinical experience and education hours, and additional to the work required for successful completion of the program.

Whether to allow moonlighting of any kind is determined by the program director.
External moonlighting: Voluntary, compensated, medically related work performed outside the site of the resident's or fellow's program, including the primary clinical site and any participating sites.
Internal moonlighting: Voluntary, compensated, medically related work performed within the site of the resident's or fellow's program, including the primary clinical site and any participating sites.

ACGME Definitions
6.25. Moonlighting
Moonlighting must not interfere with the ability of the resident or fellow to achieve the goals and objectives of the educational program and must not interfere with the trainee's fitness for work nor compromise patient safety. (Core)

6.25.a. Time spent by trainees in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. (Core) *No other clinical and educational work hour requirements apply*
6.25.b. PGY-1 residents are not permitted to moonlight. (Core)

Moonlighting must not be required of any trainee during their training.
ACGME Glossary of Terms, last update 9/2025:ab_ACGMEglossary.pdf

Forms required:

Program – Yearly approval required by DIO, reviewed by GMEC
Confirm supervisor, shifts available, pay per hour, and eligibility for trainees
Work Hours audit and list of trainees participating must accompany application

Individual – Yearly approval by PD
Must confirm good standing, appropriate progress, individual work hours, and appropriate licensure
Must confirm current visa allows moonlighting, and if so, must notify ECFMG

"Good Standing" Requirements to be eligible for Moonlighting or Extra Shifts:
-Trainee remains up to date in all compliances, as well as work hours and clinical documentation.
-Trainee is progressing as expected through the specialty-specific milestones and is not under any remediation review.
-Trainee is on track to complete program on time with no extensions related to performance.
-Shifts during vacation, FMLA or approved Leave of Absence are not allowed.
-Work hour reporting for the program is at least 75% over 3mo rolling.

Procedure:

- PD must submit proposal for each internal or external moonlighting opportunity, and include audit of previous year's moonlighting activity, annually by May 1st / June 1st.

- Individual trainee must submit annual application.
- GME office will review and bring forward to GMEC for approval on an annual basis.
- Programs or trainees who fail to report timely and/or accurate work hours will lose moonlighting privileges.

External Moonlighting

Moonlighting that occurs outside of UI Health Care's physical and organizational structures. An outside entity is employing the trainee for work outside of their training and outside of UI Health Care.

Requirements for Program and Site:

- Program Director must review and approve site, supervision, compensation, and proposed shifts, and must approve individual trainees, annually. PD reserves the right to rescind approval at any time.
- Program Director must ensure work hour reporting for the program is at least 75% over 3mo rolling.
- Program Director is responsible for monitoring performance and work hours for each trainee, and providing annual audit of participating trainees and hours worked. PD must confirm individuals' fitness for work and ensure patient safety will not be compromised by participating.
- Program Director is responsible for outlining services performed and how these are different from, or will enhance, those required as a part of their training program.
    - Work cannot be a part of the required curriculum or counted towards required minimums
    - Work hours must be counted towards total hours per week
    - Work must not interfere with ability of trainee to achieve goals and objectives of training program
- Site must provide malpractice or require trainee to secure independently.
- Approval must be secured by DIO/GMEC annually. GME reserves the right to rescind approval at any time.

Requirements for Trainee:

- Must apply for eligibility annually.
- Must be PGY2 or greater and have a permanent license
- Active military trainees are prohibited from moonlighting.
- Must be in good standing in the program and track all work hours weekly. Moonlighting hours should be designated as such in Med Hub. Trainee is not eligible for moonlighting shifts if on performance improvement plan or remediation, or while on vacation / FMLA / leave from training program.
- Trainees holding visas must confirm with PD and GME prior to applying.

Internal Moonlighting / Extra Shifts

Moonlighting that occurs internal to UI Health Care, the sponsoring institution. Includes shifts that are not part of core training requirements.

Tier 1 Internal Moonlighting/Extra Shifts

- Trainee receives compensation outside normal working hours to provide patient care with attending supervision
- Outside normal working hours or normal assigned shifts but can be similar to the level or type of care provided in training program. Trainee must have confirmed competency in type of care required to be eligible for moonlighting.
    - **Tier 1a** – Trainees performing ***'extra shifts for extra compensation'*** in their program, similar to the level of care they would otherwise do, to provide increased coverage on busy services or where increased experience is desired. *This type of moonlighting is discouraged at UIHC, and will be*

approved only in very limited circumstances, unless it is an established part of the training program. In those cases, it will be classified as "Extra Shifts" but is tracked and monitored in the same way.
    - Example – Resident doing extra shifts within their own training program
    - Example – Extra Meritorious Service for senior residents in Anesthesia
  - **Tier 1b** – Trainees performing frontline care in another service or program within their department, but ***at a lower level of care*** than they would normally perform in their current training program, and at a level of competency that has already been achieved
    - Example – Fellow providing frontline, resident-level care in their department
    - Example – SHE Hospitalist coverage in Internal Medicine
- Iowa limited temporary training license is sufficient
- Supervising attending is responsible for billing for services. Trainee cannot bill for services.
- Malpractice – Per hospital legal team, malpractice is covered as a part of the training program and additional assessment from UIP is not needed.

Tier 2 Internal Moonlighting

- Trainee receives compensation outside normal working hours to provide patient care as an independent medical practitioner
- Outside normal working hours or normal assigned shifts, separate from level or type of care provided in training program. Trainee must have confirmed competency in type of care required to be eligible for moonlighting.
- In accredited programs, moonlighting monitoring is required. In un-accredited or NST programs, PD may incorporate billable activities as part of the training program.
- Valid full Iowa medical license required. *CSO can credential trainee prior to start of moonlighting shifts and consider them a "Fellow Associate" with a separate identity from trainee.*
- GME and training programs do not cover cost of licensure for moonlighting.
- Trainee is eligible to bill independently.
- Trainee must obtain malpractice coverage from UIP, and must establish a second identity for billing in Epic.

Requirements for Program and Site:

- Program Director must review and approve site, supervision, compensation, and proposed shifts, and must approve individual trainees, annually. PD reserves the right to rescind approval at any time.
- Program Director is responsible for outlining services performed and how these are different from those required as a part of their training program.
  - Work cannot be a part of the required curriculum or counted towards required minimums
  - Work hours must be counted towards total hours per week
  - Work must not interfere with ability of trainee to achieve goals and objectives of training program
  - Moonlighting cannot be used for Jeopardy or scheduled back-up shifts already in effect during training program.
- Program Director must ensure work hour reporting for the program is at least 75% over 3mo rolling.
- Program Director is responsible for monitoring performance and work hours for each trainee, and providing annual audit of participating trainees and hours worked. PD must confirm individuals' fitness for work and ensure patient safety will not be compromised.
- Approval must be secured by DIO/GMEC annually. GME reserves the right to rescind approval at any time.

Requirements for Trainee:

- Must apply for eligibility annually.
- Must be PGY2 or greater and have appropriate licensure.
- Active military are prohibited from moonlighting.
- Must be in good standing in the program and track all work hours weekly. Moonlighting hours should be designated as such in Med Hub. Trainee is not eligible for moonlighting shifts if on performance improvement plan or remediation, or while on vacation / FMLA / leave from training program.
- Trainees holding visas must confirm with PD and GME prior to applying. J1 visa holders are now eligible to moonlight internally only, and are not eligible to bill independently. An additional form is required by ECFMG.

Comparison of GME Moonlighting Options

	External Moonlighting	Internal Tier 1a - Extra Shifts	Internal Tier1b	Internal Tier 2	Other Types of Moonlighting
Requirements	Full Iowa Medical License Billing Eligible	Must be considered part of training program Cannot include required, unexpected, or unplanned work or shifts within training program	Limited temporary training license No Billing	Full Iowa medical license Billing Eligible	No billing All proposals must be reviewed by GME
Description	Outside of UIHC	At UIHC A – level of care in current training program	At UIHC B – different level of care than in current training program	At UIHC	Consulting No clinical work required
Supervision	Per Site Director Attending supervision not required	Direct or indirect supervision by attending required	Direct or indirect supervision by attending required	Per Site Director Attending supervision not required	
Eligible Trainees	PGY2 or greater Residents or Fellows No J1 visa holders	PGY2 or greater Residents or Fellows *J1 visa holders eligible	PGY2 or greater Residents or Fellows *J1 visa holders eligible	Fellows or Chief Residents only No J1 visa holders	
Malpractice	Must be provided by site or individual trainee	Covered under training program	Covered under training program	UIP	Depending on task – must be reviewed by legal
Tracking by GME	Med Hub Hours	Paycheck approval Med Hub Hours	Paycheck approval Med Hub Hours	Paycheck approval Med Hub Hours	Med Hub Hours

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IOWA HEALTH CARE

Graduate Medical Education

POLICY FOR GME TRAINEES ON

- **ELIGIBILITY**
- **SELECTION**
- **TRANSFER**

University of Iowa Health Care policies and procedures for eligibility, selection, and transfer that affect the recruitment and appointment of graduate medical education (GME) trainees are described in this policy. UI Health Care through its Graduate Medical Education Committee (GMEC) and GME Office monitors each Accreditation Council for Graduate Medical Education (ACGME) program for compliance with this policy.

The terms learner, trainee, house staff member, resident and fellow may be used interchangeably in this policy.

I. **Eligibility.** Applicants with one of the following qualifications are eligible for appointment to an ACGME-accredited GME program at UI Health Care:

   A. Graduate of a medical school in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).
   B. Graduate of a college of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA).
   C. Graduate of a medical school outside the United States and Canada who meets one of the following qualifications:
      1. Holds a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG); or
      2. Holds a full and unrestricted license to practice medicine in a US licensing jurisdiction in which they are training.
   D. Graduate of a medical school outside the US who has completed a Fifth Pathway* program provided by an LCME-accredited medical school.
   E. Fellowship eligibility for ACGME-accredited programs requires:

      1. Completed ACMGE-accredited residency program or Royal College of Physicians and Surgeons (RCPS)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency program located in Canada or verification of the entering fellow's level of competency in the required field using ACGME or CanMEDS (i.e., the Canadian competency framework) milestones from the core residency.

      2. If prior residency as described in I.E.1 above cannot be verified, then to be considered an applicant must first be granted an exception by the GMEC as an exceptionally qualified applicant prior to being extended an offer. The process of granting 'exceptional' status requires the following, at a minimum:

         a. That the specific program's Residency Review Committee (RRC) standards are met, as well as any applicable overarching ACGME standards;
         b. That the program director and fellowship selection committee assess the fellow's suitability to enter the program based on prior training and review of the applicant's summative evaluations of training and core specialty; and
         c. Final review and approval by the GMEC or a workgroup designated by the GMEC.

II. Selection.

   A. The UI Health Care ensures that all GME programs (ACGME-accredited and non-accredited) select eligible applicants on the basis of their preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity. Programs must not

discriminate with regard to sex, race, age, religion, color, national origin, disability, veteran status or any other applicable legally protected status.

B. In selecting qualified applicants, all programs sponsored by UI Health Care are strongly urged to participate in an organized matching program (e.g., National Resident Matching Program), as available.

III. Transfer.

A. For a house staff member transferring to a UI Health Care GME program (or for an applicant who is already at UI Health Care but who may have prior GME training), before making a decision to accept a resident or fellow, the UI Health Care Program Director must:

B. Obtain written or electronic verification of previous educational experiences ensuring the applicant is eligible. Such eligibility requires the completion of an ACGME-accredited training program or completion of a RCPS-accredited or CFPC-accredited program located in Canada or, if not complete, the UI Health Care residency program must obtain verification of the applicant's level of competency in the required clinical field using ACGME or CanMEDS milestone assessments from the prior training program (advanced postgraduate year (PGY) level upon entry to a UI Health Care GME program must be determined by the UI Health Care program director in conjunction with the GME Office in cases where a prior residency or training in a different specialty exists or where milestone assessments indicate the possibility of advanced status);

1. Obtain a summative competency-based performance evaluation of the transferring resident or fellow; and
2. Participate in an in-person phone call with the external Program Director.

C. For a house staff member transferring out of a UI Health Care GME program, the UI Health Care Program Director is responsible to:

1. Provide a timely verification of the transferring resident or fellow's education, in written or electronic form as described above in III.A.1 of this policy;
2. Provide a summative competency-based performance evaluation of the transferring resident or fellow; and
3. Participate in an in-person phone call with the external Program Director.

Any change in program complement must follow the process outlined in the *UI Health Care Policy and Procedures for Adding New Programs and Program Modification*; in the case of an ACGME-accredited program, the Program Director must petition for GMEC approval through this program modification process PRIOR to submitting any such request to the ACGME and the respective RRC.

A. In the event a UI Health Care GME program should be closed, interrupted or reduced in size in any way (including disaster) that affects a current UI Health Care GME resident or fellow, the *UI Health Care Policy on Interruption, Reduction or Closure of Graduate Training Programs* is followed.

**A Fifth Pathway program is an academic year of supervised clinical education provided by an LCME-accredited medical school to students who meet the following conditions: (1) have completed, in an accredited college or university in the United States, undergraduate premedical education of the quality acceptable for matriculation in an accredited United States medical school; (2) have studied at a medical school outside the United States and Canada but listed in the World Health Organization Directory of Medical Schools; (3) have completed all of the formal requirements of the foreign medical school except internship and/or social service; (4) have attained a score satisfactory to the sponsoring medical school on a screening examination; and (5) have passed either the Foreign Medical Graduate Examination in the Medical Sciences, Parts I and II of the examination of the National Board of Medical Examiners, or Steps 1 and 2 of the United States Medical Licensing Examination (USMLE).*

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IOWA HEALTH CARE

Graduate Medical Education

POLICY FOR GME TRAINEES ON THE LEARNING AND WORKING ENVIRONMENT

- **PROFESSIONALISM**
- **WELL-BEING**
- **FATIGUE MITIGATION**
- **TRANSITIONS OF CARE**
- **CLINICAL EXPERIENCEE AND EDUCATION**

I. Professionalism. University of Iowa Health Care recognizes that the GME program, in concert with UI Health Care, is responsible to educate GME learners and faculty about their professionalism duties, including their obligation to be appropriately rested and fit to provide patient care.

In this policy, the terms learner, trainee, house staff member, resident and fellow may be used interchangeably.

A. *Objectives*. Professionalism education must occur:

- Via an appropriate mix of supervised patient care duties, clinical teaching and didactic educational events;
- Without excessive reliance on GME learners to fulfill non-physicians duties; and
- While ensuring manageable patient care responsibilities.

B. *Program Director Duties.* In partnership with UI Health Care, it is incumbent on the Program Director to provide a culture of professionalism that supports both patient safety and personal responsibility.

C. *Learner and Faculty Member Duties.* The GME learner and program faculty members

1. Must recognize their personal roles in the:
   a. Provision of patient- and family-centered care;
   b. Safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events;
   c. Assurance of their fitness for work, including:
      1) Management of their time before, during and after clinical assignments;
      2) Recognition of impairment, including from illness, fatigue and substance abuse in themselves, their peers and other members of the health care team (as resources, see the *GME Transportation Policy and the GME Policy on Substance Abuse Identification and Intervention)*;
      3) Commitment to lifelong learning;
      4) Monitoring of patient care improvement indicators; and
      5) Accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data.
2. Must understand when it is appropriate to transition patient care to another qualified and rested provider. It is recognized that this requires a responsiveness to patient needs that supersedes self-interest.

D. *Programs and UI Health Care.* The GME work and learning environment must be professional, respectful and civil, free from mistreatment, abuse or coercion of all members of the healthcare team, including students, residents/fellows, faculty and staff.

1. Supporting Policies: The policies of the University of Iowa and UI Health Care strictly forbid a hostile work environment, harassment and/or retaliation. Policies and reporting venues include, but are not limited to the lists below.

a. Due Process - GME maintains guidelines for a system of due process through its *Statement of House Staff Member Concerns*, supported by the UI Health Care Bylaws.
b. UI Health Care and University of Iowa policies providing due process, supporting non-retaliation, non-discrimination, and a non-hostile work environment and preventing harassment.
c. Confidential reporting of concerns about unprofessional behavior can occur in various ways and may result in investigation and produce remedies specific to the situation, as appropriate. Reporting bodies include, but are not limited to the following:
    1) UI Health Care HELPline;
    2) Program Director;
    3) GME Office (GME Director and/or DIO/Associate Dean);
    4) GMEC;
    5) UI Health Care Compliance Office;
    6) UI Equal Opportunity and Diversity Office;
    7) UI Health Care HR; and/or the
    8) University of Iowa Omsbuds Office

II. Well-Being. It is recognized that learners and faculty in GME programs are at risk for burnout and depression in the complex health care environment. Care of their psychological, emotional and physical well-being is essential to their ability be resilient and, in turn, to provide care competently and compassionately.

A. *Responsibility*. Programs, supported by UI Health Care, must address the importance of well-being for physicians. To do this, the following must occur:
1. Efforts made to emphasize that the following are important to being a physician:
    a. Protecting time with patients;
    b. Minimizing non-physician obligations;
    c. Providing administrative support;
    d. Promoting progressive autonomy and flexibility; and
    e. Enhancing professional relationships.
2. Attention given to:
    a. Scheduling;
    b. Work intensity; and
    c. Work compression that impacts resident well-being.
3. Evaluation of and addressing:
    a. Workplace safety data; and
    b. The safety of learners and faculty.
4. Implementation of policies and training programs that:
    a. Encourage optimal learner and faculty well-being;
    b. Give the learner the opportunity to attend medical, mental and dental health appointments, including those scheduled during work hours (see the *Policy for GME Trainees on Paid Time Off (PTO) and Leaves of Absence* – part of the *Statement on House Staff Stipends and Benefits*); and
    c. Allow the learner to be absent (and have coverage) for concerns including but not limited to fatigue, illness, and family emergencies (see the *Policy for GME Trainees on Paid Time Off (PTO) and Leaves of Absence* – part of the *Statement on House Staff Stipends and Benefits*). Time off required for these or other reasons specified in the UI Health Care GME Time-Off policy shall be used by the learner without fear of negative consequences for the trainee who is unable to provide clinical work.
5. Education of GME trainees and faculty to:
    a. Identify the symptoms of burnout, depression, suicidal ideation, violence potential, and substance abuse in themselves and others; and
    b. Be aware of resources, tools and/or self-screening available, who to contact and how to seek appropriate care for such concerns, including access to confidential and affordable mental health assessment, counseling, and treatment for urgent and emergent needs, 24x7.

III. Fatigue Mitigation.

A. *Programs must*:
   1. Educate all faculty and GME learners:
      a. to recognize the signs of fatigue and sleep deprivation; and
      b. in alertness management and fatigue mitigation processes.
   2. Encourage all GME learners to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning; and
   3. Ensure continuity of patient care, consistent with when concerns (as referenced in 2.4.c. above) occur due to fatigue (as well as illness or family emergency).

B. *The programs, in concert with UI Health Care, must provide:*
   1. Adequate sleep facilities (such as call rooms dedicated to house staff and rest areas including the House Staff Lounge), and/or
   2. Safe transportation to safely return home when trainees are too fatigued (see the *GME Transportation Policy*).

IV. Transitions of Care (Transitions of Care, Clinical Responsibilities, and Teamwork).

A. *Transitions of care must:*
   1. Occur in a program-designed clinical assignment that optimizes transitions in patient care, including their safety, minimal and/or appropriate frequency, and structure;
   2. Monitor effective, structured handover processes as ensured by the program and UI Health Care to facilitate continuity of care and patient safety;
   3. Be performed by trainees whose programs ensure that they are competent in communicating with team members in the handover process;
   4. Occur within schedules developed and communicated by programs at all clinical sites such that attendings and trainees are appropriately informed about their responsibility to care for patients; and
   5. Assure continuity of patient care, as defined by program policies and procedures, to back up a trainee who is unable to perform patient care duties due to fatigue, illness or family emergency.

B. *Clinical responsibilities must be based on the following* (and as further defined by the applicable RRC):
   1. PGY level;
   2. Patient safety;
   3. Trainee ability;
   4. Severity and complexity of the patient's illness/condition; and
   5. Available support services.

C. *Teamwork means that trainees must:*
   1. Care for patients in an environment that maximizes effective communication; and
   2. Be trained as a member of effective interprofessional teams that are appropriate to the specialty's delivery of care and within the larger health system.

V. Clinical Experience and Education. Programs, in concert with support from UI Health Care, are responsible to create an effective program structure that provides learners with educational and clinical experiences while affording them reasonable opportunities for rest and personal activities. Note: Program Directors must also adhere to any additional or varied duty hour limitations or requirements specified by their RRC standards.

A. *Hours per week:* Clinical and educational work hours must:
   1. Not exceed 80 hours per week when averaged over a 4-week period; and
   2. Count all hours of the following:
      a. In-house clinical and educational activities (time spent on both elective and required in-house educational activities must be counted)
      b. Clinical work done from home
      c. Night-float hours
      d. Moonlighting
      e. Additional hours that occur due to rare circumstances as occur pursuant to this policy

B. *Time Free of Clinical Work and Education*: Reasonable opportunities for rest and personal well-being must be afforded. This means:
   1. Eight (8) hours off between scheduled clinical work and education periods should be afforded to trainees;
      a. Exception: There may be circumstances when trainees choose to stay to care for patients or return to the hospital with fewer than 8 hours free of clinical experience and education, but this must occur within the 80-hour limitation and one-day-off-in-seven requirement.
   2. Fourteen (14) hours free of clinical work and education must be afforded to trainees after 24 hours of in-house call; and
   3. One day in seven (1 in 7) free of clinical work and education must be scheduled for trainees, as follows:
      a. The one-day-in-seven off is averaged over a 4-week period
      b. At-home call cannot be assigned during this day off
      c. Night-float cannot occur during this day off

C. *Periods of Clinical Work and Education*
   1. Twenty-four (24) continuous hours of scheduled clinical assignments must not be exceeded
      a. Exception: Up to 4 hours of additional time may be used for activities related to patient safety (such as providing effective transitions of care and/or resident education); during these 4 additional hours, additional patient care must not be assigned to the learner)
   2. In-house call by learners must not be scheduled more frequently than every third night (when averaged over 4 weeks)
   3. Home call
      a. must not be so taxing or frequent as to preclude rest or reasonable personal time
      b. must be counted toward the 80-hour work week if the work done at home is clinical
      c. must not occur on the 1 day off in 7 (when averaged over 4 weeks)
      d. is not subject to the every third night limitation
      e. allows a trainee to return to the hospital to provide direct care for new or established patients, and any return time is counted toward the 80-hour weekly maximum (travel time is not counted toward the 80-hour weekly maximum)

D. *Exceptions*: In rare circumstances, and after handing off all other duties, a learner, may elect on his/her own initiative to remain at the site or return to home call (see V.C.3.f. above) in order to:
   1. Provide care to a single severely ill or unstable patient;
   2. Provide humanistic attention to the needs of a patient or family; or
   3. Attend unique educational events

   Additional hours that occur due to these rare circumstances must be counted toward the 80-hour weekly limit.

E. *10% Approved Duty Hour Expansion*: Not to exceed a maximum of 88 hours, a program may submit a rotation-specific petition for an up-to-10% expansion of their duty hours. Prior to expanding hours, expansion requests must be:
   1. Rotation-specific
   2. Based on sound educational rationale
   3. Submitted by the Program Director to the GMEC and DIO for review and approval, and then
   4. Submitted to the appropriate RRC for review and approval

F. *Moonlighting:*
   1. Any moonlighting must not interfere with the ability of the trainee to achieve the program's goals and objectives
   2. Must be counted toward the 80-hour weekly limit
   3. Those not permitted to moonlight are PGY-1 house staff members and any trainee on a J-1 or J-2 visa.
   4. See also the UI Health Care Moonlighting Policy and Procedures for House Staff Physicians and Dentists

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IOWA HEALTH CARE

Graduate Medical Education

POLICY AND PROCEDURES FOR THE EVALUATION AND ADVANCEMENT OF HOUSE STAFF

All house staff members at the University of Iowa Health Care will be promoted upon the satisfactory completion of the program year and evidence of satisfactory progressive scholarship and demonstration of clinical competence and professional growth. Each house staff member receives regular and timely assessment of his/her overall performance and competencies (in patient care, medical knowledge, practice-based learning, interpersonal and communication skills, professionalism, and systems-based practice). The procedures referenced in this policy are designed to ensure that all house staff members are promoted to a higher level of responsibility at the appropriate time.

Those house staff members who have not satisfactorily completed the program year and who fail to show evidence of satisfactory progressive scholarship or to demonstrate clinical competence and professional growth, may be offered a remediation plan of action prior to promotion, as deemed appropriate by the Program Director and as described in this policy. House staff members denied promotion or reappointment are provided due process as described in the *UI Health Care Statement on House Staff Member Concerns* and in Article IV, Section VII of the *Amended and Restated Bylaws, Rules and Regulations of the UI Health Care and its Clinical Staff*; in the case of a denial of promotion or denial of a reappointment, the Program Director should consult with the Graduate Medical Education (GME) Director who may confer with UI Health Care Legal Services.

Programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) must follow procedures as described below in this policy and as described by their specialty-specific Residency Review Committee (RRC).

For purposes of this policy the terms house staff and resident mean any resident or fellow in a medical or dental training program at UI Health Care who is currently party to a *GME Medical and Dental Education Appointment Contract*.

1. EVALUATIONS:

A. Feedback and Evaluation: Each Program Director must develop objective assessments for evaluating each house staff member and ensure the following:

1. Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment.
2. The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones and must provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice.
3. Each evaluation must be documented at completion of the assignment.
4. The evaluations must utilize multiple sources (e.g., faculty, peers, patients, self, and other professional staff).
5. Evaluations of a resident's performance must be accessible for review by the resident.
6. The evaluation process must follow any applicable ACGME or RRC requirements for the program.
7. At least annually, there must be a summative evaluation of each resident that includes the resident's readiness to progress to the next year of the program, if applicable.

B. Clinical Competency Committee: A Clinical Competency Committee, as described below, must be appointed by the program director and must ensure that the following are met:

1. Clinical Competency Committee (CCC) Composition:

a. The CCC must have a minimum of three members of the program faculty, at least one of whom is a core faculty member.
b. The CCC may have additional members who must be physician faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents.

2. The CCC must:
   a. Review all resident evaluations at least semi-annually.
   b. Determine each resident's progress on achievement of the specialty-specific milestones.
   c. Meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress.
   d. Meet and review with each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific milestones.
   e. Assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth.
   f. Develop plans for residents failing to progress, following institutional policies and procedures.

C. Final Evaluation: Each Program Director must complete and provide a written final evaluation for each house staff member who completes the program. The final evaluation must:

1. Verify that the house staff member has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice; for house staff members in ACGME programs, the Program Director must use the Specialty-Specific Milestones as a tool to ensure house staff are able to engage in autonomous practice upon completion of the program.
2. Be shared with the resident upon completion of the program.
3. Be made part of the house staff member's permanent record maintained by the institution and accessible for review by the resident in accordance with institutional policy.
4. Be submitted to the GME Office by the Program Director within 30 days of the house staff member's completion of the program.

2. REMEDIATION PLAN OF ACTION OR EXTENSION: Program Director action plans for remediation and/or extension must comply with applicable accreditation and/or UI Health Care and GMEC requirements.

A. Remediation Plan: If the Program Director determines that the house staff member has not completed some portion of his/her training satisfactorily, the Program Director must determine whether or not remediation would benefit the house staff member. If remediation is deemed appropriate, the Program Director must:

1. Establish a written remediation plan of action for the house staff member, including:
   a. A mentoring plan;
   b. A plan for monitoring progress;
   c. An identified date for re-evaluation; and
   d. The production of a report which summarizes results.

2. Ensure that the remediation plan is signed and dated by both the house staff member and the Program Director, reviewed by the Director of GME and filed in the house staff member's file in the GME Office.

B. Extension: If the Program Director determines that the house staff member would benefit from an extension before promotion to the next level, the Program Director must:

1. Produce a written plan, monitor progress, and track results;
2. Ensure that the written plan is signed and dated by both the house staff member and the Program Director, reviewed by the Director of GME, and filed in the house staff member's file in the GME Office; and
3. Must contact the GME Office regarding the request for a contract extension by completing an online MedHub form and providing supporting documentation explaining why the extension is necessary.

3. **ADVANCEMENT PROCEDURES AND DEADLINES:** After assessing each house staff member according to this policy and any applicable accreditation requirements, the Program Director must communicate his/her decision to the GME Office to advance/promote, remediate, extend, not renew or terminate the house staff member. The GME Office reminds the Program Directors through Program Coordinators of the need to submit such plans to the GME Office at least 4 months prior to the termination date of the house staff member's current appointment contract. Program Coordinators utilize MedHub to advance house staff, to make an extension for remediation, or to make non-renewal or termination requests.
4. **RECOMMENDATION FOR CERTIFICATION:** Recommendation of certification of a house staff member by a specialty board will be made by the Program Director when the last evaluation of the resident establishes that the house staff member's knowledge, clinical skills and professional attitudes are consistent with the standards for that specialty.

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Approved by the Graduate Medical Education Committee	3/24/2016
Approved by the Graduate Medical Education Committee	1/9/2020
Approved by the Graduate Medical Education Committee	10/1/2024

IOWA HEALTH CARE

Graduate Medical Education
POLICY ON SUPERVISION AND ACCOUNTABILITY FOR GME TRAINEES

Purpose: To ensure safe, effective patient care and support the professional development of residents and fellows through structured supervision, progressive responsibility, and compliance with the standards of ACGME, the Joint Commission, and other accrediting bodies.

Scope: Supervision is required to provide safe and effective care to patients. It also ensures the trainee's development of the skills, knowledge and attitudes required to enter the unsupervised practice of medicine and establishes a foundation for continued professional growth. This policy applies to all trainees participating in Graduate Medical Education (GME) programs at UI Health Care, as well as supervising providers across all affiliated clinical sites, and applies to all institutions to which a trainee rotates.

Definitions: Resident/Fellow/Trainee: A physician in an accredited or non-accredited GME training program.
Supervising Physician: A credentialed faculty or licensed independent practitioner (LIP) responsible for supervising the performance of, and care rendered by, resident or fellow, in accordance with Medical Staff and Departmental Policies, as well as ACGME requirements. Every physician shares a responsibility and is accountable for their contribution to patient care. Senior trainees can provide direct and indirect supervision for junior trainees, but all activities are under the oversight of the Faculty / Attending Supervisor.

Levels of Supervision: Programs will use the following classifications of supervision to promote oversight of trainee supervision while providing for graded authority and responsibility:

- **Direct Supervision** – the supervising physician is either (a) physically present with the resident / fellow during key portions of the patient interaction, or (b) if permitted by a Program's applicable ACGME Review Committee and the supervision policy of the specific Program, the supervising physician is not physically present with the trainee but is concurrently monitoring the patient care through appropriate telecommunication technology.
- **Indirect Supervision** – the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the trainee for guidance and is available to provide appropriate Direct Supervision.
- **Oversight** – the supervising physician is available to provide review of procedures/encounters and documentation, with feedback (including performance evaluations) provided after care is delivered.

Types of supervision included in these categories can include, but are not limited to, in person, electronic or telephonic, review of documentation, and submission and review of performance evaluations.

Policy: When providing care as part of their training program, all trainees must be supervised at all times, in accordance with their level of training, competence, and the complexity of patient care. Supervising physicians are ethically and legally responsible for patient outcomes and must ensure trainees are informed of their roles and limitations. Programs are responsible for structuring on-call schedules for supervisors and senior trainees to ensure that direct supervision is readily available to those who require it, and that supervision assignments are of sufficient duration to assess, evaluate, and delegate effectively.

REQUIREMENTS FOR PROGRAMS:
Each program will have a written, program-specific supervision policy consistent with this policy and with the ACGME Common and Specialty-/Subspeciality-specific Program Requirements. (Continued on next page.)

Program-specific policies will include the following:

- **Definition** of who is qualified to supervise trainees (in addition to faculty attendings) including more advanced trainees or licensed independent practitioners as specified by the applicable ACGME Review Committee.
- **Criteria and competencies** in compliance with applicable ACGME Review Committee requirements that define when a trainee is approved to safely and effectively perform procedures or clinical activities without direct supervision, and when the physical presence of a supervising physician is required. In general, Program Directors and supervisors determine the level of progressive authority, responsibility, and conditional independence accorded to each trainee based on these guidelines and determine readiness for supervisory roles. The supervising physician determines the nature of supervision and delegates appropriate responsibility based on the complexity of the patient care situation, the level of training and experience, and direct interaction with the trainee.
- **In all programs, PGY-1 residents** must initially be under Direct Supervision, with the physical presence of the supervising physician during key portions of the patient interaction. In this case, the supervising physician can be a senior trainee if deemed appropriate by the Faculty / Attending Supervisor.
- **Mechanism by which trainees can be deemed competent** to perform a procedure(s) under Indirect Supervision or Oversight. Programs may have lists of approved clinical activities by program year.
- **Process for consistent formative feedback and summative evaluation**, guided by specialty-specific competencies, to determine level of supervision required and readiness for graduated responsibility and autonomy. Each trainee must know the limits of their scope of authority and under what circumstances conditional independence is permitted.

Each program will have a process to identify the following:

- **Attending / Faculty Supervisor**: Each patient must have an identifiable and appropriately credentialed and privileged physician or licensed independent practitioner (as specified by the applicable RRC), who is responsible and accountable for the patient's care. This provider must be available to each trainee, faculty member, or other health care team members and patients.
- **Roles:** Each patient must be informed by the learner and faculty member as to their roles in providing the patient with care.

Each program will also include guidelines for circumstances in which trainees must communicate with the Attending/ Faculty Supervisor. These should be specific to patient situations, trainee level, who is to be contacted (by position), and what to do if the contact does not respond. **Per Institutional Guidelines, all trainees must communicate directly with Supervising Physician in the following cases:**

- Unexpected death
- Code or Rapid Response Activation
- Acute Decompensation (significant change in the care plan or code status, transfer to Intensive Care, emergent or unexpected need for procedure or surgery)

Procedure

1. Documentation. Supervision must be documented in the medical record, including:
a. Attending and/or supervisor involvement in care
b. Consultations and procedures
2. Each program's policy will be available from Program Director or Coordinator upon request.

Approved by the Graduate Medical Education Committee	12/19/2025

IOWA HEALTH CARE

Graduate Medical Education

POLICY ON PATIENT SAFETY AND QUALITY IMPROVEMENT FOR GME TRAINEES

Purpose: This policy is aimed at creating and supporting a learning and working environment for medical and dental residents and fellows that promotes excellence in the safety and quality of care rendered to patients by trainees and faculty during their participation in a University of Iowa Health Care Graduate Medical Education (GME) program. Incorporating the importance of quality and safety into our GME programs goes beyond the present as we recognize that carrying forward that excellence into our learners' future practices is critically important to the patient care they will provide when they are unsupervised and themselves responsible to effect quality improvement measures.

In this policy, the terms learner, trainee, house staff member, resident and fellow may be used interchangeably.

I. **Patient Safety**. GME at UI Health Care actively promotes patient safety, with both the learner and the faculty supervisor sharing responsibility for patient safety and the quality of patient care. The continuous overriding focus is on the safety, individual needs and humanity of the patients being cared for. Supervision, knowledge, skills and abilities factor into that focus. In that regard, practitioners must understand the limits of their knowledge and experience and seek assistance as required to provide optimal patient care. It is critical that residents and fellows, along with faculty members, work consistently in a well-coordinated manner with other health care professionals to achieve patient safety goals. Our GME learners must be able to demonstrate the ability to analyze the care they provide, understand their roles within the health care team, and play an active role in system improvement processes, carrying it forward into their unsupervised future practices. Programs must document that the following occur:

   A. ***Safety Culture***. UI Health Care's mission includes an ongoing willingness to deal with safety vulnerabilities. Through each program, UI Health Care has formal mechanisms in place which the programs document, such as assessments of the knowledge, skills and attitudes of our learners. Learners and faculty must communicate any needed areas of improvement.
   B. ***Education on Patient Safety***. Each residency and fellowship program at UI Health Care must provide formal educational activities that promote patient safety related goals, tools, and techniques. The program must tailor these activities appropriately for their learners and document and retain learner participation at the program level.
   C. ***Patient Safety Events***. Trainees, along with faculty and other health care team members, must know their responsibilities in reporting and how to report adverse events, near misses, and unsafe conditions at the clinical site; UI Health Care makes available to these individuals a summary of patient safety reports that occur. Additionally, learners must be involved in real or simulated interprofessional patient safety activities, including but not limited to root cause analyses that formulate and implement actions.
   D. ***Resident Education and Experience in Disclosure of Adverse Events***. Through its Compliance Office, UI Health Care discloses to patients (and, as necessary, families) when an adverse event has occurred. Residents must be included as participants in real or simulated disclosure events.

(Continued on next page.)

II. **Quality Improvement**. Within each program, the following must be documented:

A. ***Education in Quality Improvement***. Residents and fellows must receive training and gain experience in the quality improvement process, including an understanding of health care disparities. This means that the program must provide quality-related goals, tools, and techniques for learners to achieve
quality improvement goals, especially those related to health care disparities that affect their patients.

B. ***Quality Metrics***. In order to prioritize care activities and evaluate the success of improvement efforts, trainees and faculty member must have access to and therefore receive data on quality metrics and benchmarks related to their patient population.

C. ***Engagement in Quality Improvement Activities***. For learners to develop the ability to identify and institute sustainable systems-based changes to improve patient care, they must have the opportunity in their training program to participate in interprofessional quality improvement activities, which should include activities aimed at reducing health care disparities.

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Approved by the Graduate Medical Education Committee	6/9/2020
Approved by the Graduate Medical Education Committee	10/1/2024
Amended (Supervision removed for standalone policy)	12/19/2025

IOWA HEALTH CARE

Graduate Medical Education

STATEMENT ON HOUSE STAFF MEMBER CONCERNS

The University of Iowa Health Care strives to make the residency and fellowship experience as rewarding as possible for the physician and dentist in training. However, questions and concerns can arise during the training period. This Statement on House Staff Member Concerns provides a mechanism for house staff members to obtain answers to or resolve disputes or disagreements that arise with respect to the work environment, academic performance, issues related to the program or faculty or administrative matters. The mechanisms established in this Statement are aimed at minimizing conflicts of interest.

I. WORK ENVIRONMENT, ACADEMIC PERFORMANCE (INCLUDING NON-PROMOTION NOT DUE TO AN APPROVED LEAVE OF ABSENCE), PROGRAM/FACULTY ISSUES, AND ADMINISTRATIVE MATTERS. The following avenues are available for the house staff member to address/resolve concerns:

A. PROGRAM DIRECTOR:
All questions and concerns should first be directed to the Program Director or his/her designee. The Program Director or his/her designee will be best able to address most questions or concerns that arise.

B. GRADUATE MEDICAL EDUCATION OFFICE (GMEO) REVIEW:
Questions regarding benefits or other administrative matters, which cannot be answered by the Program Director or his/her designee, should be directed to the Graduate Medical Education Office (GMEO). Personnel in the GMEO can provide answers to many questions and can also direct house staff members to the appropriate source for assistance.

C. GME ADMINISTRATIVE REVIEW:
When the GMEO staff members cannot answer the question or resolve the issue, they will refer the house staff member to the Director of Graduate Medical Education (GME) and/or the Associate Dean/Associate Hospital Director for GME to review the matter. The house staff member will be required to meet with one or both of these individuals and present a written description of the concern or issue at hand.

D. CEO/DIRECTOR'S REVIEW:
If the house staff member is not satisfied with the response from the GME Administrative Review (and the concern is not a matter of departmental discretion), the house staff member may make a written request to the CEO/Director of UIHC to review the matter. The CEO/Director, or his/her designee, will review the matter and provide to the house staff member a written response, which is final. The CEO/Director may in his/her discretion refer the matter to the Graduate Medical Education Working Group (also known as the GME Committee or GMEC) or an ad hoc committee for its recommendation prior to review by the CEO/Director. The processing of matters of departmental discretion is further addressed in this policy under "Due Process and Grievance Procedure" (Section III).

II. GENERAL HOUSE STAFF CONCERNS.

A. GRADUATE MEDICAL EDUCATION COMMITTEE (GMEC):
General house staff member concerns may be communicated to members of the GMEC, pursuant to a charge of the GMEC to "provide a forum for house staff issues as expressed by the house staff representatives on the Working Group or by other house staff." GMEC members include elected house staff members, active clinical staff, Program Directors, GME administrative staff from UIHC, and administrators from the Carver College of Medicine. To obtain information about contacting

GMEC members, house staff members should contact the GMEO or any of their GMEC House Staff Representatives.

III. DUE PROCESS AND GRIEVANCE PROCEDURES. (SUSPENSION, DISCHARGE, DISCIPLINARY ACTIONS, NON-RENEWAL)

A. SUSPENSION OR DISCHARGE:

If a house staff member is suspended or discharged from a training program, the procedures specified in Article IV, Section 7 of the Amended and Restated Bylaws, Rules and Regulations of the University of Iowa Health Care and Its Clinical Staff will be followed. If notice of non-renewal of a contract is given less than three months before the expiration of the contract, the non-renewal shall be considered a discharge.

B. OTHER DEPARTMENTAL ACTIONS (OTHER THAN SUSPENSION OR DISCHARGE):

Other departmental actions include individual disciplinary actions by the Program or Department and non-renewal or non-promotion of a house staff member's contract. It should be noted that non-renewal and non-promotion require a written notice of intent no later than three months prior to the end of the resident's current agreement. The following review process shall be followed:

1. Departmental Committee Review:
   The action will be reviewed by a Departmental Committee selected by the Program Director, if the house staff member requests such a review within 10 days of his or her becoming aware of the action, unless the house staff member has already been afforded an opportunity to present the information to such a Departmental Committee which prepared recommendations to the Program Director before the action and the house staff member has been informed of the Program Director's action in writing.
   a. Composition of Departmental Committee: The Departmental Committee described above will be composed of at least two active clinical staff members and one house staff member.
   b. Departmental Committee Recommendations: After its review, the Departmental Committee will submit its recommendations to the Program Director. If the Departmental Committee recommends a change in the action, the Program Director will then reconsider the action, giving due consideration to the Departmental Committee's recommendation.
2. Program Director's Decision:

Following receipt of the Departmental Committee's recommendations, the resulting decision of the Program Director shall be provided by the Program Director to the house staff member and to the CEO/Director of UI Health Care Medical Center Main Campus in writing and shall be final, unless the house staff member believes that the action could significantly threaten his or her intended career development (see Director's Review of Program Director's Decision, below). Actions will not be postponed while they are being reviewed, unless the Program Director in his/her discretion decides to do so.

3. CEO/Director's Review of Program Director's Decision:

If the house staff member submits a written request to the CEO/Director of UI Health Care Medical Center Main Campus within 10 days of receipt of the Program Director's written decision (described in III.B.2 of this policy) and the request includes the reasons for the belief that the action could significantly threaten the house staff member's intended career development, the CEO/Director will first determine if the alleged threat is significant and, if so, shall review the decision.

   a. Advice to CEO/Director: The CEO/Director may seek the advice of the Graduate Medical Education Committee, the Clinical Staff Affairs Subcommittee, and/or an ad hoc committee as part of the review.
   b. Notice and Final Decision:

1) Non-Renewals: If the action is non-renewal of a contract prior to completion of the training program, the decision of the CEO/Director shall be given to the house staff member and Program Director in writing and is final.
2) All Other Actions: For all other actions, if the CEO/Director approves the Program Director's decision, the decision of the CEO/Director shall be given to the house staff member and the Program Director in writing and is final. If the CEO/Director recommends that the Program Director modify the decision, the Program Director will then reconsider the action, in consultation with the CEO/Director; the resulting decision of the Program Director, with CEO/Director approval, shall be provided to the house staff member and the CEO/Director in writing and is final.

Approved by the Graduate Medical Education Committee	10/9/2008
Approved by the Graduate Medical Education Committee	10/4/2011
Approved by the Graduate Medical Education Committee	3/10/2016
Approved by the Graduate Medical Education Committee	2/5/2020
Approved by the Graduate Medical Education Committee	10/1/2024

Graduate Medical Education
GME Policy on Substance Abuse Identification and Intervention
- House Staff -

University of Iowa Health Care and its Clinical Staff operate under their Amended and Restated Bylaws, Rules and Regulations which provide a mechanism to intervene on behalf of patient care and to assist the impaired clinical staff member (dentist or physician). Substance abuse carries significant personal risk to the individual clinical staff member as well as to the staff member's patients. Chemical dependency (substance abuse) is a medical disease, and some clinical departments may have greater risks because of the availability of potent drugs. A significant prevalence of alcoholism among professional groups, including physicians, also implies a clear need for careful crisis intervention. (See Appendix A, "Risks of Abuse in Physicians").

The following policy is designed to provide guidance and consistency to the assessment and handling of house staff member work-related performance problems associated with substance abuse.

Step 1: PROGRAM DIRECTOR RECEIVES WORK-RELATED PERFORMANCE PROBLEMINFORMATION FROM STAFF, STUDENTS OR PATIENTS: The Program Director may receive reports of alleged or actual house staff member substance abuse regarding work-related performance problems (See Appendix B, "Signs, Symptoms and Considerations in Identifying Potential Chemical Dependency").

Prior to approaching the house staff member with the substance abuse work-related performance problem information, the Program Director should consult with his or her Clinical Service Head, the Director of GME, the Associate Dean/Associate Hospital Director of GME, and UI Health Care legal counsel (or, in their absence, the designee of each). These individuals will identify resources available to conduct an investigation, if necessary. The investigation may include pharmacy audits, consultations with the Department of Psychiatry and other relevant investigational tools.

In the event that a house staff member **voluntarily** identifies substance abuse work-related performance problems, the Program Director should follow the procedures outlined in this policy beginning with **Step 3**.

Step 2: PROGRAM DIRECTOR DISCUSSES WORK-RELATED PERFORMANCE PROBLEMS WITHHOUSE STAFF MEMBER: The Program Director will notify the house staff member with the allegations of potential substance abuse, framing the discussion in the context of information received related to work performance problems. The Program Director has the discretion to determine that a substance abuse problem does not exist and what, if any, further action is warranted.

If the house staff member indicates a desire to terminate discussions of this nature with the Program Director, s/he may do so at any time during the conversation.

Step 3: PROGRAM DIRECTOR ASSESSES THE ACCEPTANCE OR DENIAL OF THE ALLEGEDSUBSTANCE ABUSE PROBLEM. Step 4 or Step 5 is then followed as appropriate.

Step 4: <u>ACCEPTANCE</u> – HOUSE STAFF MEMBERAGREES THAT HE/SHE HAS A SUBSTANCE ABUSE PROBLEM.

1. The Program Director notifies the Clinical Service Head, the GME Director, the GME Associate Dean, UI Health Care legal counsel and other entities as required (or they designee), including but not limited to the UI Administration and, as appropriate, the Iowa Board of Medicine (IBOM).
2. The house staff member seeks intervention and is entered into a treatment program with the expenses borne by the UI Health Care. The Program Director, the Clinical Service Head, the Director of GME and the Associate Dean of GME must approve the treatment program. The house staff member is encouraged to self-report the substance abuse problem to the IBOM if he/she has not already done so.
3. The Program Director will decide whether the house staff member may re-enter the program, contingent upon considerations including but not limited to the nature of the work-related performance problem, year in training, the effect on the training program, licensing board limits, etc. To re-enter, the Program Director must document that the treatment has been effective, that he/she has received reports on the house staff member's progress while in the treatment program, that the house staff member is in compliance with the treatment program, and that the house staff member is willing to adhere to an aftercare program.
4. If the house staff member is allowed to re-enter the program, the Program Director will monitor the house staff member's compliance with the aftercare program, as set forth by the prescribed treatment program.
5. If a relapse occurs, the aftercare program is not followed or if there is a recurrence of the work-related substance abuse problem, the Program Director may:

a. terminate the house staff member immediately and rehabilitation is not provided at the expense of UI Health Care; or

b. show evidence to and obtain a finding from the Graduate Medical Education Committee (or a body designated by the Graduate Medical Education Committee) that this is an isolated incident following a substantial period of compliance. In this instance, a second rehabilitation maybe provided by UIHC. If a relapse occurs, the aftercare program is not followed or if there is a recurrence of the work-related substance abuse problem after this second rehabilitative attempt, the house staff member must be terminated from the program by the Program Director, and no third rehabilitation shall be provided by UI Health Care.

Step 5: <u>DENIAL</u> – HOUSE STAFF MEMBER DENIESTHAT HE/SHE HAS A SUBSTANCE ABUSE PROBLEM.

1. The Program Director documents his/her discussion with the house staff member, including the house staff member's denial that a problem exists.
2. The Program Director provides copies of all relevant documentation to the Clinical Service Head, the GME Director, the GME Associate Dean and UI Health Care legal counsel. The Program Director must also notify the Iowa Board of Medicine (IBOM), as required.
3. The Program Director shall not require the house staff member to submit to a drug test without first consulting with UI Health Care legal counsel to determine if sufficient evidence exists to satisfy a reasonable suspicion standard for drug testing. In considering whether a house staff member should be required to submit to a drug test, the Program Director must be aware that there are many other strong indicia, other than drug testing, that can point to the existence of a substance abuse problem and that a negative test result does not conclusively indicate the absence of a substance abuse problem. If a drug test result is positive, and it is the house staff member's first offense, he/she cannot be terminated but must be offered entry into an evaluation and treatment program. If the Program Director does not have sufficient grounds to request entry into a treatment program or termination, no further action will be taken. However, the Program Director will continue to monitor the house staff member's performance. If suspected substance abuse problems persist or if further allegations emerge, the Program Director will return to Step 2.
4. Termination from the program must result if:

a. the house staff member is required and refuses to submit to a drug test;

b. the house staff member agrees to a drug test, the test result is positive and the house staff member refuses to enter treatment;

c. the house staff member does not successfully complete a substance abuse treatment program;

d. sufficient information exists regarding substance abuse related work performance problems to terminate the house staff member;

e. after an initial rehabilitative attempt, a relapse occurs, the aftercare program is not followed or a recurrence of the work-related substance abuse problem occurs and there is an isolated incident following a substantial period of compliance; or

f. there is a recurrence of the work-related substance abuse problem after a second rehabilitative attempt

Note: If the house staff member is terminated, then all provisions of the Statement on House Staff Member Concerns will apply. The Program Director must notify the Director of GME, the Associate Dean of GME and the UIHC legal counsel of the termination. The Program Director must also notify the IBOM and University Administration of the termination. The house staff member will be afforded due process as outlined in Article IV, Section 7 of the University of Iowa Hospitals and Clinics Amended and Restated Bylaws, Rules & Regulations. If termination does not result, the Program Director will continue to monitor the work performance of the house staff member and may re-visit the steps of this policy if problems persist or recur.

Approved by the Graduate Medical Education Committee	12/6/2005
Approved by the Graduate Medical Education Committee	10/4/2011
Approved by the Graduate Medical Education Committee	10/1/2024

RISK OF SUBSTANCE ABUSE IN PHYSICIANS

All physicians and dentists who have access to addictive drugs are at risk for substance abuse. Substances external to their work environment also present risks. Several factors contribute to the development of chemical dependency:

- Drugs are available in hospitals and operating rooms and other patient care circumstances;
- Current culture accepts alcohol consumption which can lead to potential misuse of moderate to heavy drinking where alcoholic beverages are easily available;
- Experimentation with mood-altering drugs exists in all employment venues, and they are available to all members of our society;
- Highly skilled and achievement-oriented specialties increase job stress;
- Intense work effort associated with the provision of medical care to patients can be draining in many ways; and
- Substance abuse can be a way of dealing with psychological pain, stress, fatigue, worry and physical discomfort.

SIGNS, SYMPTOMS AND CONSIDERATIONS IN IDENTIFYING POTENTIAL SUBSTANCE ABUSE

The early clinical and behavioral characteristics of alcohol and/or substance abuse impairment may be subtle and difficult to recognize, especially when substance use is intermittent and/or the house staff member is not yet dependent or acting overtly impaired. Clues that could raise suspicion include behavioral changes, deterioration in work performance, an increased incidence of volunteering for shifts, tardiness, irresponsibility, or anti-social conduct as well as overt manifestations such as drunkenness, hallucination, euphoria, depression, anxiety and even traffic violations related to driving while intoxicated (DWI).

Social behavior, health and work performance may be variably affected by chemical dependence. Social dysfunction is not limited to but may manifest in any of the following ways:

- withdrawal from leisure activities, friends and family;
- uncharacteristic or inappropriate behavior at social gatherings and/or impulsive behavior. These may include:
    - gambling or overspending;
    - mood swings;
    - frequent illness;
    - prominent desire to work alone and undisturbed;
    - hostility; and/or
    - refusal to eat lunch or to take breaks
- domestic turmoil (e.g., separation from spouse, child abuse, sexually inappropriate behavior);
- change in behavior of children or spouse; and/or
- legal problems (e.g., DWI)

Changes in health status may manifest as follows:

- deterioration in personal hygiene;
- striking sensitivity to temperature (may mask the desire to wear long sleeves to cover puncture sites);
- increased number of accidents; and/or
- increased number of personal health complaints and/or increased need for medical attention.

Changes in professional relationships, particularly deterioration of work performance, include:

- unreliability:
    - missed appointments;
    - inappropriate responses to emergencies;
    - inappropriate volunteering for additional patient care duties;
    - absences;
    - poor record keeping;
    - poor patient care; and/or
    - anesthesia mishaps
- complaints by patients and/or other staff;
- inappropriate drug requests:
    - over-prescription of medications;
    - excessive ordering of drugs from mail-order houses; and/or
    - heavy use of adjuvant drugs
- unstable employment history (e.g., relocation to several institutions or hospitals); and
- working at a level of professional responsibility below that consistent with the physician's qualifications

University of Iowa
Chapter 4 – Sexual Harassment and Sexual Misconduct

Office of Civil Rights Compliance

(President 7/28/86; 12/91; 7/1/02; 3/21/05; 12/05; 12/08; 4/09; 11/09; 8/10; 1/18/11; 8/13; 10/1/14; 7/15; 7/1/17; 6/18; 9/21/18; 1/20; 8/14/20; 1/29/21; 7/8/21; 8/13/21; 12/17/21; 1/28/22; 3/30/22 9/2/22; 9/23/22; 7/1/25)

https://policy.uiowa.edu/community-policies/sexual-harassment-and-sexual-misconduct

Human Resources– Policy HR.P.20

SUBJECT/TITLE: **Staff Medical Conscience Protection**

PURPOSE: To outline University of Iowa Health Care (UI Health Care) staff members' freedom from discrimination and abuse, and their freedom to adhere to religious or ethical beliefs.

SCOPE: System

DEFINITION: None

POLICY:

A. UI Health Care staff members have a right to freedom from discrimination in the workplace. Additional information is available in the University Policy Manual, Chapter 6 – Nondiscrimination Statement.

B. At no time should a staff member be subject to discrimination on the basis of their race, creed, color, religion, national origin, age, sex, pregnancy (including childbirth and related conditions), disability, genetic information, status as a U.S. veteran, service in the U.S. military, sexual orientation, or associational preference.

C. Staff members have the right to expect consideration and respect for their personal values and beliefs.

D. UI Health Care staff have the right to refrain from participating in care or treatment (modalities or interventions) that conflicts with the staff member's religious, cultural, or ethical beliefs.

PROCEDURE:

A. If a staff member is subject to discrimination, they can report to their supervisor, human resources, Volunteer Services (if a volunteer is involved), the applicable education program (if a student is involved), or the Office of General Counsel; or they can file an incident report, or contact the UI Office of Civil Rights Compliance.

B. UI Health Care staff who refrain from participating in care or treatment (modalities or interventions) that conflicts with the staff member's religious, cultural, or ethical beliefs will follow the process below:

    1. It is the responsibility of the staff member to advise UI Health Care at time of employment, or as soon as the potential conflict is identified, of religious or ethical constraints that may impact performance or the staff member's ability to meet job

expectations, e.g., inability to work certain days or perform certain functions.

2. The staff member must submit a written request for accommodation that:
    a) Identifies the specific aspect(s) of care from which they wish to be exempt;
    b) States specific reasons or justification for the exemption; and
    c) Is made in time to allow the supervisor to investigate alternate work assignments.
3. The immediate supervisor will discuss restrictions with the staff member and determine if there are accommodations that can be made.
4. If a staff member is faced with an immediate conflict, the supervisor should be notified immediately; care to the patient must be provided until other arrangements can be made. At no time should the care of any patient be compromised because a caregiver refuses to provide or participate in needed care.

C. UI Health Care staff have the right to be treated with consideration and respect by colleagues, patients, families, and visitors.
    1. In a situation where a patient might treat staff disrespectfully, consideration must be given to those patients who have medical conditions that interfere with their ability to control or understand their actions.

D. If subjected to verbal abuse or threatened with or subjected to physical abuse, staff should contact their immediate supervisor and/or Safety & Security as appropriate.

RELATED POLICIES:

Workplace Violence and Threatening or Disruptive Behavior

Source: Professional Practice Subcommittee
Effective Date: November 1, 1995
System Effective Date: February 7, 2024
Version Number: 3
Date Revised: June 4, 2025
Date Reviewed: November 17, 2004; 3/08, December 29, 2021

AMENDED AND RESTATED BYLAWS RULES & REGULATIONS

of
the University of Iowa Hospitals and Clinics
and Its Clinical Staff

2023

Revised and Adopted by The
Clinical Systems Committee
(formerly the University Hospital Advisory Committee)
8/73, 9/75, 11/76, 4/77, 5/77, 12/77, 7/78, 8/78, 3/79, 10/79, 6/80, 8/80, 11/80, 12/80, 3/81, 4/81, 7/81, 10,81, 6/82, 9/82, 12/82, 5/86, 10/87, 8/88, 10/89, 1/90, 3/90, 4/90, 7/91, 10/92, 4/93, 3/94, 8/96, 9/97, 9/98, 12/98, 8/99, 11/00, 4/01, 8/01, 1/02; 12/02; 2/03; 4/03; 5/03; 6/04; 4/05; 10/07; 12/08; 3/10; 10/10; 4/11; 10/13, 12/15; 11/16; 7/19; 12/22

Approved by the Board of Regents, State of Iowa
as Trustees of the UIHC
12/76, 1/78, 11/78, 3/79, 2/80, 9/80, 1/81, 10/81, 3/82, 3/83, 10/87, 10/88, 11/89, 5/90, 7/91, 10/92, 4/93, 3/94, 9/96, 10/97, 10/98, 3/99, 10/99, 12/00, 5/01, 9/01, 3/02; 1/03; 5/0310/03; 8/04; 6/05; 3/09; 10/10; 6/11; 2/14; 2/16; 12/16; 9/19;4/23

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AMENDED AND RESTATED BYLAWS, RULES AND REGULATIONS OF THE UNIVERSITY OF IOWA HOSPITALS AND CLINICS AND ITS CLINICAL STAFF

BYLAWS, RULES AND REGULATIONS OF
THE UNIVERSITY OF IOWA HOSPITALS AND CLINICS
AND ITS CLINICAL STAFF

PREAMBLE....4
ARTICLE I: INSTITUTIONAL IDENTIFICATION....4
ARTICLE II: ORGANIZATIONAL STRUCTURE....4
Section 1: Board of Regents, State of Iowa....4
Section 2: Administration....5
Section 3: Clinical Services and Administration....6
Section 4: UIHC Departments....8
ARTICLE III: UNIVERSITY OF IOWA CLINICAL SYSTEMS COMMITTEE AND SUBCOMMTITEES....8
Section 1: Name and Delegation of Authority....8
Section 2: Purpose....9
Section 3: Membership....9
Section 4: Selection of At-Large Members....10
Section 5: Meetings....10
Section 6: Removal of Members....10
Section 7: Quorum/Action at Mtgs/Tele and Electronic Participation/Written Consents....11
Section 8: Officers....11
Section 9: Subcommittees and Working Groups....12
ARTICLE IV: CLINICAL STAFF....24
Section 1: Responsibility....24
Section 2: Purposes....24
Section 3: Clinical Staff Membership....24
Section 4: Clinical Privileges....27
Section 5: Procedures for Delineating Clinical Privileges....31
Section 6: Corrective Action....33
Section 7: House Staff Member Rights....38
Section 8: Patient Care Responsibility....39
Section 9: Clinical Service Meetings....40
ARTICLE V: EVALUATION OF CLINICAL CARE....40
Section 1: Performance Improvement Program....40
Section 2: Medical and Dental Audit....40
Section 3: Surgical Pathology Review....40
Section 4: Clinical Service Ongoing Review....40
ARTICLE VI: CLINICAL SERVICE RULES AND REGULATIONS....41
ARTICLE VII: AMENDMENTS....41
ARTICLE VIII: PATIENT CARE RULES AND REGULATIONS....41
Section 1: Patient Service Assignment....41
Section 2: Assignment Without Regard to Financial Status....41
Section 3: Admission Information....41
Section 4: Order Documentation....41
Section 5: Preparation of Medical Record....42
Section 6: Standard Orders....42
Section 7: Documentation of History and Physical....42
Section 8: Informed Consent....42
Section 9: Discharge....43
Section 10: Autopsies....43
Section 11: Death Certificates....43
Section 12: Formulary....43
Section 13: Joint Patient Responsibility....44

Section 14: Dental Care Coordination 44
Section 15: Emergency Services 44
Section 16: Continuing Education 44
Section 17: Professional Charges 44
Section 18: Faculty Practice Plan and Dental Service Plan 45
Section 19: Disaster Plan 45

PREAMBLE

The Amended and Restated Bylaws, Rules, & Regulations of the University of Iowa Hospitals and Clinics and its Clinical Staff ("Bylaws") herein contained shall serve as (1) a set of guidelines whereby the University of Iowa Hospitals and Clinics ("UIHC") and its Clinical Staff can function effectively and cooperatively to carry out the tripartite mission of University of Iowa Health Care of patient care, teaching, and research, and (2) a guide for responsible decision-making and goal-attainment for all departments of this teaching institution. The Bylaws shall: (1) establish effective cooperation through defined objectives; (2) serve as a resource document for employees, staff, and the public; (3) cause appropriate interaction and effective coordination with the public; and (4) serve to comply with accreditation and certification requirements of various accrediting and advisory bodies.

ARTICLE I. INSTITUTIONAL IDENTIFICATION

The UIHC is a major teaching hospital whose existence is predicated upon the provisions contained in Chapters 225, 262, and 263 of the Code of Iowa. The UIHC, in compliance with the Code of Iowa, serves as the teaching hospital and comprehensive health care center for the state of Iowa, thereby promoting the health of the citizens of Iowa, regardless of their ability to pay. The UIHC, in concert with the University of Iowa health science colleges, functions in support of health care professionals and organizations in Iowa and other states by: (1) offering a broad spectrum of clinical services to all patients cared for within the UIHC and through its outreach programs; (2) serving as the primary teaching hospital for the University; and, (3) providing a base for innovative research to improve health care.

The patient population of the UIHC shall include patients referred by community physicians and dentists because of the broad scope of clinical competency available within the UIHC; medically indigent patients of the state of Iowa admitted for observation, diagnosis, care, and treatment; and other patients admittedor seen for diagnosis and treatment in outpatient clinics or through outreach programs.

No prospective patient shall ever be denied admission or treatment on the basis of sex, race, creed, color, national origin, religion, age, disability, veteran status, sexual orientation, gender identity, associational preference, or any other attribute protected by law. No patient who requires care on an emergency basis shall be denied such care on the basis of source of payment or any other criteria not related to medical indications.

ARTICLE II. ORGANIZATIONAL STRUCTURE

Section 2.1. Board of Regents, State of Iowa. The UIHC is a state institution, part of the University of Iowa, and an integral part of the health sciences complex at the University of Iowa. Chapter 262 of the Code of Iowa, which authorizes and identifies the responsibilities of the Board of Regents, State of Iowa (hereinafter referred to as the "Board of Regents"), delineates the authority given to the Board of Regents to act as the ultimate governing body of the UIHC as an organizational unit of the University of Iowa.

The Board of Regents is composed of nine (9) citizens of Iowa who are appointed by the governor and confirmed by the state senate. Board members serve six (6) year, staggered terms with the terms of three members expiring every second year. The Board of Regents acts to assure that the governance and development of the UIHC is in the best interests of the people of Iowa.

Section 2.2. Administration.

2.2.1. Organization. The UIHC is a component of University of Iowa Health Care, which is comprised of the UIHC, Carver College of Medicine ("CCOM"), and the faculty practice plan referred to as University of Iowa Physicians. Consistent with the authority delegated by the Board of Regents as described in Article III, Section 3.1, Name and Delegation of Authority, the President of the University delegates to the Vice President for Medical Affairs responsibility for the operations of University of Iowa Health Care. The Vice President for Medical Affairs delegates to the Chief Executive Officer of the UIHC the responsibility for the operation of the hospitals and clinics. This is achieved through an organizational structure defined by the President of the University.

2.2.2. Chief Executive Officer. The Chief Executive Officer of the UIHC shall report to the Vice President for Medical Affairs. The Chief Executive Officer of the UIHC shall be qualified by education, experience, competence, and judgment appropriate to the proper discharge of the responsibilities of the position. Such qualifications shall be judged appropriate by the Vice President for Medical Affairs. The appointment of the Chief Executive Officer of the UIHC shall be in accord with the rules and regulations of the University of Iowa as set forth in the University Operations Manual. The duties of the Chief Executive Officer of the UIHC shall include the following:

A. To be continuously responsible for the operation, programming, maintenance and administrative affairs of the UIHC commensurate with the authority conferred by the Vice President for Medical Affairs and consonant with expressed goals and policies of the UIHC.

B. To be responsible for the application and implementation of appropriate federal and state, Board of Regents, and University policies and directives in the operation of the UIHC.

C. To provide liaison with the Clinical Staff, the Clinical Services of the UIHC, the health college deans, the University Administration, the Board of Regents, and between the UIHC and the statewide community, and to work collaboratively with the health college deans to support their academic missions.

D. To provide periodically through the Vice President for Medical Affairs a report to the Board of Regents summarizing actions taken by the Clinical Systems Committee pursuant to Article III, Section 3.1, Name and Delegation of Authority.

E. To maintain the financial integrity and optimal utilization of the physical resources of the UIHC; this shall include the responsibility for submission, through University of Iowa operating channels, of an annual operating budget after consultation with the Clinical Systems Committee.

F. To establish and maintain employee relations policies and procedures that adequately support sound patient care.

G. To designate an individual to act for the Chief Executive Officer in the Chief Executive Officer's absence, in order to assure the UIHC continuous, coordinate administrative direction.

H. To organize the administrative functions of the UIHC, delegate duties and establish formal means of accountability for subordinates.

I. To establish such hospital departments as are indicated, provide for departmental and interdepartmental meetings and attend, or be represented at, such meetings.

J. To co-chair or send a delegate to all meetings of the Clinical Systems Committee and other meetings of pertinence.

K. To develop and transmit reports to the Clinical Staff, Vice President for Medical Affairs, President of the University, and the Board of Regents on the overall activities of the UIHC and on appropriate federal, state and local developments that affect the UIHC.

L. Through the Vice President for Medical Affairs and President of the University, to provide the Board of Regents with short-range and long-range hospital objectives and programs, both of an operational and capital nature, after consultation with the Clinical Systems Committee.

Section 2.3. Clinical Services and Administration.

2.3.1. Organization. The Clinical Staff of the UIHC shall be organized into Clinical Services coordinate with the departmental structure plus the Hospital Dentistry Clinical Service. Each Clinical Service shall have a Head who shall be responsible for the overall supervision of the clinical, teaching, and research functions within the service. The Clinical Services of the UIHC shall be as follows:

Anesthesia
Cardiothoracic Surgery
Dermatology
Emergency Medicine
Family Medicine
Hospital Dentistry
Internal Medicine
Neurology
Neurosurgery
Obstetrics & Gynecology
Ophthalmology and Visual Sciences
Orthopedics and Rehabilitation
Otolaryngology-Head and Neck Surgery
Pathology
Pediatrics
Psychiatry
Radiation Oncology
Radiology
Surgery
Urology

2.3.2. Clinical Service Head. The appointment of each medical and surgical Clinical Service Head shall be accomplished by the CCOM in accordance with rules and regulations of the University of Iowa set forth in the University Operations Manual and the Manual of Procedure of the College of Medicine. Serving both as a department head within the CCOM and as a Clinical Service Head within the UIHC, the Head shall be a member in good standing of the Active Clinical Staff.

The Head of the Hospital Dentistry Clinical Service shall be jointly appointed by the Chief Executive Officer of the UIHC and the Dean of the College of Dentistry. The appointment shall be accomplished in accordance with rules and regulations of the University of Iowa as set forth in the University Operations Manual.

A. Qualifications and Responsibilities. Each Clinical Service Head shall be qualified by education, knowledge, competence, experience, and judgment appropriate to the proper discharge of the responsibilities of the position. Such qualifications shall be judged appropriate by the respective Dean of the CCOM or Dentistry, the Vice President for Medical Affairs, the President of the University, and the Board of Regents.

B. Duties. Each Clinical Service Head shall:

1. Monitor all professional and administrative activities within the Clinical Service.

2. Serve as a member of the Clinical Systems Committee providing guidance on the policies of University of Iowa Health Care.

3. Maintain continuing review of the professional performance of all members and other practitioners with privileges within the Clinical Service, including conduct of the triennial review provided in Article IV, Section 4.5.3, Triennial Review of Clinical Privileges.

4. Be responsible for enforcement within the Clinical Service of these Bylaws.

5. Be responsible for the clinical care, teaching, and research programs of the Clinical Service.

6. Participate in planning and decision-making relating to the Clinical Service through collaborative activities with the UIHC administration in all matters affecting patient care.

2.3.3. Chief of Staff.

A. Appointment.

1. Nominating Committee. The co-chairs of the Clinical Systems Committee and the Dean of the CCOM shall select two (2) members in good standing of the Clinical Systems Committee to serve with them as a nominating committee of five (5). The nominating committee shall select not more than two (2) candidates from the Active Clinical Staff for the position of Chief of Staff after seeking advice from the Clinical Staff.

2. Selection by Active Clinical Staff. The nominees shall be submitted to the Active Clinical Staff, who shall select the Chief of Staff in an election conducted in the same manner as the elections of at-large members of the Clinical Systems Committee in Article III, Section 3.4, Selection of At-Large Members; provided, however, that members of the Clinical Systems Committee shall be permitted to vote in a Chief of Staff election.

B. Term of Appointment. The appointment of the Chief of Staff shall be for a three (3) year term. An individual may be elected to no more than two (2) consecutive terms.

C. Qualifications. The Chief of Staff shall be a member of the Active Clinical Staff and shall possess the background, knowledge, education, experience, judgment, and demonstrated competence to fulfill the duties of the position.

D. Removal. The Clinical Systems Committee, by a two-thirds vote at a meeting, may remove the Chief of Staff for conduct detrimental to the interest of the UIHC or its Clinical Staff, or if the Chief of Staff is suffering from a physical or mental infirmity that renders the individual

incapable of fulfilling the duties of that office, provided that notice of the meeting at which such action shall be decided is given in writing to the Chief of Staff at least ten (10) days in advance of the meeting. The Chief of Staff shall be afforded the opportunity to speak prior to the taking of any vote on such removal.

E. Responsibilities. The Chief of Staff shall:

1. Serve as the Vice Chair of the Clinical Systems Committee.

2. Chair the Clinical Staff Affairs Subcommittee, and in that capacityassure that such subcommittee fulfills its responsibilities as defined in the Bylaws and monitor the activities of other subcommittees of the Clinical Systems Committee with a focus on clinically relevant initiatives.

3. Serve as Ombudsman for the Clinical Staff and provide liaison between the Clinical Staff and the Chief Executive Officer of the UIHC and Deans of the CCOM and College of Dentistry.

4. In cooperation with the co-chairs of the Clinical Systems Committee, provide periodically through the Vice President for Medical Affairs, a report to the Board of Regents summarizing actions taken by Clinical Systems Committee pursuant to Article III, Section 3.1, Name and Delegation of Authority.

5. Advise the co-chairs of the Clinical Systems Committee on the selection of co-chairs and members to select standing subcommittees of the Clinical Systems Committee.

Section 2.4. UIHC Departments. The UIHC departments established pursuant to Article II, Section 2.2.2(I) shall be listed in an appendix to these Bylaws. When a department is established for a discipline, that discipline shall be practiced in the UIHC only by persons who meet applicable licensure requirements and are in one of the following categories:

2.4.1. persons with appointments in that department; or

2.4.2. persons with other formal means of accountability to that department approved by the head of the department and the Chief Executive Officer of the UIHC.

ARTICLE III. CLINICAL SYSTEMS COMMITTEE AND ITS SUBCOMMITTEES

Section 3.1. Name and Delegation of Authority. The UIHC administration and the Clinical Staff shall express their joint policy-making efforts regarding the clinical operations of University of Iowa Health Care via the primary internal policymaking body of the UIHC and its Clinical Staff—the Clinical Systems Committee. The Board of Regents delegates through the President of the University and the Vice President for Medical Affairs to the Clinical Systems Committee the responsibility to act as an internal governing body of the clinical operations of University of Iowa Health Care, including the UIHC, in performing the following functions:

3.1.1. establishing and approving internal policies and procedures for the UIHC.

3.1.2. receiving, reviewing, and, as necessary, following up on reports of: (A) studies evaluating the quality of professional services, and (B) studies reviewing the utilization of the UIHC facilities and services.

3.1.3. granting and decreasing clinical privileges.

Section 3.2. Purpose. The purpose of the Clinical Systems Committee shall be:

3.2.1. To cause all patients to be properly evaluated, diagnosed, treated, or admitted to the UIHC as appropriate, and to make recommendations to the Board of Regents on matters of clinical management and planning.

3.2.2. To further the objectives of this health science center in education, and research.

3.2.3. To represent and act on behalf of the Clinical Staff between annual meetings of the Clinical Staff. This authority is delegated to the Clinical Systems Committee by approval of these Bylaws.

3.2.4. To provide a means whereby problems of a clinical-administrative nature may be discussed between the Clinical Staff and the UIHC administration.

3.2.5. To initiate and maintain policies, rules, and regulations relating to the coordinate operation of the Clinical Services at the UIHC.

3.2.6. To provide a forum for the review of operational problems, recommended action on clinical-administrative matters, and the formulation of policies and procedures.

3.2.7. To provide a forum whereby the UIHC administration may discuss programs and proposals of an institution-wide nature with the Clinical Staff.

3.2.8. To pass judgment on major proposals affecting the clinical-administrative operations of the institution.

3.2.9. To designate subcommittees to conduct the business of the UIHC and its Clinical Staff consistent with these Bylaws, and to receive and act upon subcommittee reports.

3.2.10. To provide a medium for dissemination of information to the Clinical Staff.

Section 3.3. Membership. Membership of the Clinical Systems Committee shall consist of the following:

3.3.1. The Heads of the respective Clinical Services.

3.3.2. The Chief Executive Officer of the UIHC.

3.3.3. The Chief of Staff.

3.3.4. The Vice President for Medical Affairs.

3.3.5. The Dean of the CCOM (if not the same individual as the Vice President for Medical Affairs).

3.3.6. The Executive Director of University of Iowa Physicians.

3.3.7. Executive Dean of the CCOM.

3.3.8. The Director of the Clinical Cancer Center.

3.3.9. Five at-large members of the Clinical Staff selected pursuant to Section 3.4.

3.3.10. Such individuals appointed by the Vice President for Medical Affairs.

Section 3.4. Selection of At-Large Members. The at-large members of the Clinical Systems Committee shall be elected by ballot with each Active Clinical Staff member, excluding those Clinical Staff members who are already members of the Clinical Systems Committee, allotted a single vote. No more than two (2) of the at-large members shall have privileges in the same Clinical Service. Elections shall be held every three (3) years on April 1. In the event that an at-large position becomes vacant more than six (6) months prior to a scheduled election, a special election shall be held. The term of the member(s) elected in the special election will run until the next regular election. A member-at-large shall remain a member of the Clinical Systems Committee until resignation or until replaced by a subsequent at-large election. An at-large member may be elected to no more than two (2) consecutive terms. Notwithstanding the foregoing, an at-large member of the Clinical Staff elected to the Clinical Systems Committee may resign at any time.

Section 3.5. Meetings. The Clinical Systems Committee shall meet at least quarterly. The co-chairs may schedule additional meetings as deemed necessary. Special meetings may be called at the request of any three (3) members of the Clinical Systems Committee. An agenda shall be prepared by the co-chairs and sent to Clinical Systems Committee members prior to each meeting. Any member of the Clinical Staff may request that specific topics be included on the agenda. Any member of the Clinical Systems Committee who is unable to attend a meeting may designate a person to represent the member at the meeting. The representative may not cast the vote of the member and does not count for purposes of meeting quorum as further described in Article III, Section 3.7.1, Quorum.

Section 3.6. Removal of Members.

3.6.1. Failure to Attend Meetings. If any member or the member's representative(s) is not present or represented at three (3) regularly scheduled meetings in an academic calendar year (July 1 through June 30) without cause, the member or the member's representative shall be notified by the co-chairs that a fourth unexcused absence during the same academic year from a regularly scheduled meeting will lead to the designation of an alternate. Upon the fourth unexcused failure to be present or represented during an academic year, the co-chairs, after consultation with the member and the Clinical Systems Committee, shall designate an alternate. In the case of an at-large member, the member shall cease to be a member, a special election shall be held to replace the member if such vacancy occurs more than six (6) months prior to a scheduled election for at-large members, and the designated alternate shall serve as the member until the special election is completed.

3.6.2. Removal of At-Large Members by Clinical Systems Committee. An at-large member of the Clinical Staff elected to the Clinical Systems Committee may be removed by the Clinical Systems Committee, by a two-thirds vote, for conduct detrimental to the interest of the UIHC or its Clinical Staff,

or if the at-large member is suffering from a physical or mental infirmity that renders the individual incapable of fulfilling the duties as a member of the Clinical Systems Committee. A removal notice of the meeting at which such action shall be decided shall be given in writing to the at-large member of the Clinical Staff being considered for removal at least ten (10) days in advance of the meeting. The at-large member of the Clinical Staff shall be afforded the opportunity to speak prior to the taking of any vote on such removal by the Clinical Systems Committee.

Section 3.7. Quorum/Action at Meetings/Telephonic and Electronic Participation/Written Consents.

3.7.1. Quorum. Fifty (50) percent of the total voting membership of the Clinical Systems Committee shall constitute a quorum for the transaction of business at any meetings of the Clinical Systems Committee. Member-designated representatives shall not count toward a quorum. In the absence of a quorum at any meeting of the Clinical Systems Committee, a co-chair or a majority of the Clinical Systems Committee present may adjourn the meeting to another date, time, and place with notice to the members of the Clinical Systems Committee.

3.7.2. Action at Meetings. Unless otherwise specifically provided by law or in the Bylaws, the vote of a majority of a quorum at a meeting of the Clinical Systems Committee shall constitute an action of the Clinical Systems Committee.

3.7.3. Telephone and Electronic Conference Meetings and Participation. The members of the Clinical Systems Committee may participate in a meeting by means of telephone or other communications equipment that enables all of the Clinical Systems Committee participating in the meeting tocommunicate with each other (including computer, video, or other electronic equipment). Such participation shall constitute presence in person at the meeting.

3.7.4. Written Consents. Any action required or permitted at any Clinical Systems Committee meeting may be taken without a meeting, if all members of the Clinical Systems Committee consent to such action in writing, and the writing or writings are filed with the minutes of proceedings of the Clinical Systems Committee. Consents under this subsection may be given via electronic communication. Such written consent will have the same effect as a vote for all purposes.

Section 3.8. Officers.

3.8.1. Co-Chairs. The Clinical Systems Committee shall have two (2) co-chairs: the Chief Executive Officer of the UIHC and a Clinical Systems Committee member with Active Clinical Staff privileges appointed by the Vice President for Medical Affairs.

3.8.2. Vice Chair. The Chief of Staff shall be the Vice Chair of the Clinical Systems Committee. The Vice Chair, or in the absence of the Vice Chair one of the co-chairs, shall preside at all meetings.

3.8.3. Recorder. A member of the hospital administrative staff selected by the Chief Executive Officer of the UIHC shall be the Recorder. This function may be rotated at the Chief Executive Officer's discretion. The Recorder shall not be a member of the Clinical Systems Committee and, thus, shall have no vote.

3.8.4. Appointment. Appointment of the Chief Executive Officer of the UIHC co-chair and Vice Chair shall be *ex officio*. Selection of the Recorder will be as set forth in Article III, Section 3.8.3, Recorder.

Appointment of the other co-chair shall be a member of the Clinical Systems Committee with Active Clinical Staff privileges as determined by the Vice President for Medical Affairs.

3.8.5. Term of Appointment. The appointment of the co-chair appointed by the Vice President for Medical Affairs from amongst the members with Active Clinical Staff privileges shall be for a three (3) year term. An individual may be reappointed to no more than two (2) consecutive terms. The co-chair's term will begin on July 1 and end on June 30.

A. Qualifications. The co-chair selected from amongst the members with Active Clinical Staff privileges shall possess the background, experience, judgment, knowledge and demonstrated competence to fulfill the duties of the position.

B. Removal. The co-chair selected from amongst the members with Active Clinical Staff privileges may be removed by the Vice President for Medical Affairs or by the Clinical Systems Committee, by a two-thirds vote, for conduct detrimental to the interest of the UIHC or its Clinical Staff, or if the co-chair is suffering from a physical or mental infirmity that renders the individual incapable of fulfilling the duties of that office. Notwithstanding the foregoing, in the event removal is by the Clinical Systems Committee, a removal notice of the meeting at which such action shall be decided shall be given in writing to the co-chair who was selected from amongst the members with Active Clinical Staff privileges at least ten (10) days in advance of the meeting. The co-chair shall be afforded the opportunity to speak prior to the taking of any vote on such removal by the Clinical Systems Committee.

C. Vacancy. Whenever a vacancy occurs in the co-chair position selected from amongst the members with Active Clinical Staff privileges, the Vice President of Medical Affairs may select another member meeting the qualifications of the co-chair position to fill theunexpired term.

Section 3.9. Subcommittees and Working Groups.

3.9.1. Structure.

A. Membership.

1. Subcommittees. Subcommittees shall be either standing or *ad hoc*. Membership of a subcommittee may consist of Clinical Staff members, University of Iowa Health Care administrative staff members, and other professional staff of University of Iowa Health Care. Subcommittee membership shall be constituted in relationship to the particular problem to be addressed. Potential members of each subcommittee shall be nominated by the co-chairs of such subcommittee and submitted to the co-chairs of the Clinical Systems Committee for approval and appointment; provided, however, the Credentials Subcommittee shall have the composition specified below in this subsection and the Chair of Clinical Staff Affairs Subcommittee shall be as set forth in Article III, Section 3.9.1(C), Subcommittee Co-chairs.

2. Working Groups. Working groups shall be either standing or *ad hoc*. Membership of a working group may consist of Clinical Staff members, University of Iowa Health Care administrative staff members, and other professional staff of University of Iowa Health Care. *Ad hoc* working group membership shall be constituted in relationship

to the particular problem to be addressed. Potential members of each working group of a subcommittee shall be nominated by the co-chairs of such working group and submitted to the co-chairs of the Clinical Systems Committee for approval and appointment.

If a subcommittee or working group is empowered to adopt policies that apply to the CCOM's non-clinical operations as well as the University of Iowa Health Care clinical operations, CCOM faculty and staff who are not members of the Clinical Staff may serve as members of the subcommittee or working group.

3. Credentials Subcommittee. The Credentials Subcommittee shall be composed of one (1) Active Clinical Staff member for each Clinical Service, designated by the Head of the Clinical Service. Clinical Service Heads and members of the Clinical Systems Committee shall not be members. The members of the Credentials Subcommittee shall be divided into Medical and Surgical Credentials Panels as follows:

a. Medical: Dermatology, Emergency Medicine, Family Medicine, Internal Medicine, Neurology, Pathology, Pediatrics, Psychiatry, Radiation Oncology, and Radiology; and

b. Surgical: Anesthesia, Cardiothoracic Surgery, Hospital Dentistry, Neurosurgery, Obstetrics & Gynecology, Ophthalmology and Visual Sciences, Orthopedics and Rehabilitation, Otolaryngology-Head and Neck Surgery, Surgery, and Urology.

The Chairs of each Panel shall be selected from among the voting membership of the Panel by the co-chairs of the Clinical Systems Committee, in conjunction with the Vice Chair. Each Panel shall also include a member of the UIHC administrative staff *ex officio*, without vote, appointed by the Chief Executive Officer of the UIHC.

4. Credentials Subcommittees. Two subpanels—the Physician Assistant/Advanced Registered Nurse Practitioner ("PA/ARNP") Subpanel and the Health Care Professional Subpanel—shall report jointly to the Medical and Surgical Credentials Panels.

a. PA/ARNP Subpanel. The PA/ARNP Subpanel shall be composed of four (4) PAs, four (4) ARNPs, one (1) physician member of the Active Clinical Staff supervising the practice of a PA, one (1) physician member of the Active Clinical Staff with a collaborative agreement with an ARNP, and one (1) member of the Active Clinical Staff to serve as chair selected by the chair of the Clinical Staff Affairs Subcommittee. Members of the PA/ARNP Subpanel shall be appointed by the chair of the Clinical Staff Affairs Subcommittee, upon recommendations from the Clinical Services Heads in which PAs and ARNPs regularly practice. The PA/ARNP Subpanel will be representative of the Clinical Services in which PAs and ARNPs practice. The PA/ARNP Subpanel shall also include a member of the UIHC administrative staff *ex officio*, without vote, appointed by the Chief Executive Officer of the UIHC.

b. Health Care Professional Subpanel. The Health Care Professional Subpanel shall be composed of four (4) health care professionals (e.g., psychologists, medical physicists, optometrists, etc.) representative of theClinical Services in which health care professionals practice, two (2) physicians, and one (1) member of the Active Clinical Staff to serve as chair selected by the chair of the Clinical Staff Affairs Subcommittee. Members of the Health Care Professional Subpanel will be selected by the chair of the Clinical Staff Affairs Subcommittee, upon recommendations from the Clinical Service Heads in which health care professionals practice. Subpanel membership will be representative of these Clinical Services. The Health Care Professional Subpanel shall also include a member of the UIHC administrative staff *ex officio*, without vote, appointed by the Chief Executive Officer of the UIHC. An illustrative list of the health care professionals credentialed by the Health Care Professional Subpanel is listed in Appendix II.

B. Terms. Subcommittee and working group members shall be appointed to three (3) year renewable terms if the positions they occupy are not assigned by the Head of the Clinical Service, associated with a specific administrative, management or supervisory position or other UIHC-sponsored positions.

C. Subcommittee Co-Chairs. Except as set forth in Article III, Sections 3.9.1(A), Membership and 3.9.1(C) Subcommittee Co-Chairs, each subcommittee shall have two co-chairs. One (1) co-chair will be appointed by the Chief Executive Officer of the UIHC and one (1) co-chair will be selected by a majority vote of the members of the Clinical Systems Committee with Active Clinical Staff privileges. Subcommittee co-chairs shall be appointed to a three (3) year term that may be renewed for one (1) additional three (3) year term; provided, however, if a subcommittee co-chair's appointment is associated with a specific office or leadership position they hold within the UIHC, a subcommittee co-chair shall remain co-chair as long as the associated administrative office or leadership position is held ("*Ex Officio* Term"). If an existing subcommittee member is appointed a subcommittee co-chair, the term of their original membership on the subcommittee will immediately cease, and a three (3) year term or *Ex Officio* Term, if applicable, as subcommittee co-chair will begin immediately. At the conclusion of a subcommittee co-chair's term, that individual may be reappointed as a member of that subcommittee. If a former subcommittee co-chair is reappointed as a member of that subcommittee, the term of such subcommittee membership shall begin as a new three (3) year term, subject to Article III, Section 3.9.1(B), Terms. Except as expressly set forth to the contrary herein, a subcommittee co-chair may not simultaneously hold another chair or co-chair position on the Clinical Systems Committee or on a subcommittee or working group thereof. Whenever a vacancy occurs in a subcommittee co-chair position prior to the end of a term, the Chief Executive Officer of the UIHC or the members of the Clinical Systems Committee with Active Clinical Staff privileges, as applicable, shall follow the process in this Section for selecting an individual to fill the unexpired term of the subcommittee co-chair; after filling the unexpired term of the subcommittee co-chair, such co-chair shall remain eligible to be appointed to a three (3) year term that may be renewed for one (1) additional three (3) year term.

The Vice Chair of the Clinical Systems Committee shall be the chair of the Clinical Staff Affairs Subcommittee.

D. Working Group Co-Chairs. Each working group shall have two co-chairs. One (1) co-chair will be appointed by the Chief Executive Officer of the UIHC and one (1) co-chair will be appointed by the co-chair of the Clinical Systems Committee whom is appointed by the Vice President of Medical Affairs. Working group chairs shall be appointed to a three (3) year term that may be renewed for one (1) additional three (3) year term. If an existing working group member is appointed a working group co-chair, the term of their original membership on the working group will immediately cease, and a three (3) year term as working group co-chair will begin immediately. At the conclusion of a working group co-chair's term, that individual may be reappointed as a member of that working group. If a former working group co-chair is reappointed as a member of that working group, the term of such working group membership shall begin as a new three (3) year term, subject to Article III, Section 3.9.1(B), Terms. Except as expressly set forth to the contrary herein, a working group co-chair may not simultaneously hold another chair or co-chair position on the Clinical Systems Committee or on a subcommittee or working group thereof. Whenever a vacancy occurs in a working group co-chair position prior to the end of a term, the Chief Executive Officer of the UIHC or the co-chair of the Clinical Systems Committee whom is appointed by the Vice President of Medical Affairs, as applicable, shall follow the process in this Section for selecting an individual to fill the unexpired term of the working group co-chair; after filling the unexpired term of the working group co-chair, such co-chair shall remain eligible to be appointed to a three (3) year term that may be renewed for one (1) additional three (3) year term.

3.9.2. Subcommittee and Working Group Meetings. Standing subcommittees shall meet at least annually. Working groups may meet on an as-needed basis. Minutes of subcommittees and working groups, and a listing of the members in attendance shall be kept. Any member who misses three (3) subcommittee or working group meetings in an academic year (July 1–June 30) without an excuse approved by a co-chair of the subcommittee or working group, as applicable, shall be notified that a fourth unexcused absence during the academic year may be deemed a resignation from the subcommittee or working group. Upon a fourth unexcused absence, the subcommittee or working group co-chairs or chair, as applicable, may notify the member and that the member's position is vacant and a new member shall be approved and appointed in accordance with the procedures in Article III, Section 3.9.1(A)(1) and (2) for subcommittee and working group membership, respectively. Notwithstanding the foregoing, any subcommittee or working group member may resign at any time, at which time a new member shall be approved and appointed in accordance with the procedures in Article III, Section 3.9.1(A)(1) and (2).

3.9.3. Annual Reports. In accordance with the Clinical Systems Committee's obligations under Article III, Section 3.2.9, the co-chairs of each standing and *ad hoc* subcommittee and working group shall create an annual report summarizing the actions taken during the preceding academic year and submit such annual report to the co-chairs of the Clinical Systems Committee. The annual reports under this Section 3.9.3 shall be submitted to the Clinical Systems Committee by September 30 of each academic calendar year.

3.9.4. Quorum/Action at Meetings/Telephonic and Electronic Participation/Written Consents.

A. Quorum. Fifty (50) percent of the total voting membership of the subcommittee or working group shall constitute a quorum. In the absence of a quorum at any subcommittee or working group, a co-chair or chair, as applicable, or a majority of the members present may adjourn the meeting to another date, time, and place with notice to the members of the subcommittee or working group.

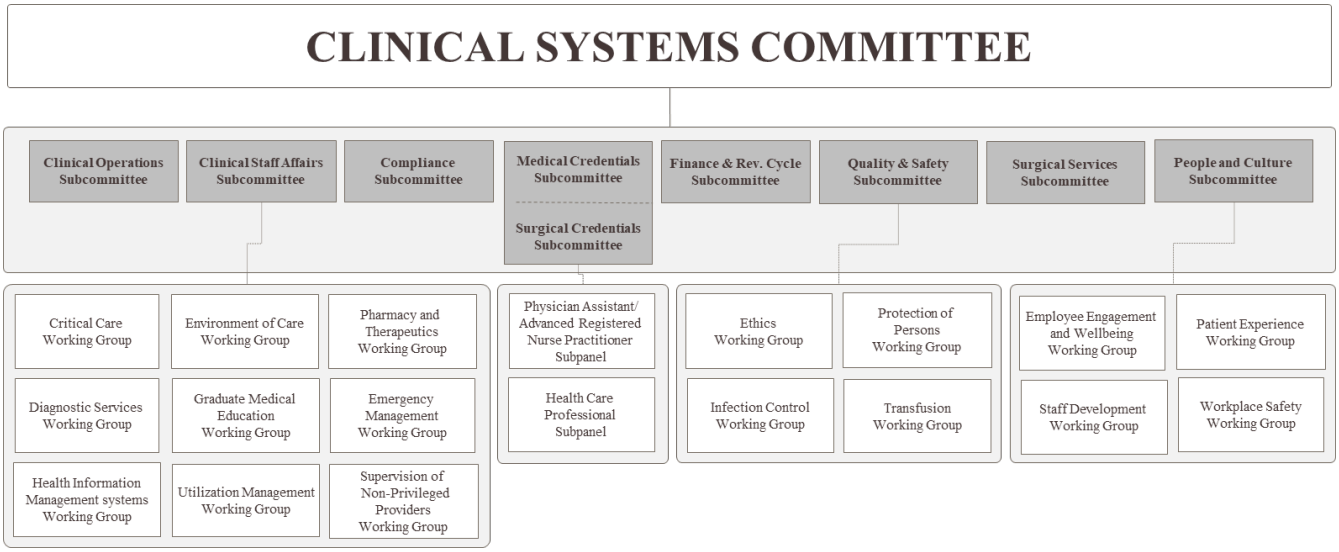
B. Action at Meetings. Unless otherwise specifically provided by law or in the Bylaws, the vote of a majority of a quorum at a meeting of a subcommittee or working group of the Clinical Systems Committee shall constitute an action of such subcommittee or working group.

C. Telephone and Electronic Participation. The members of any subcommittee or working group may participate in a meeting by means of telephone or other communications equipment that enables all of the members of such subcommittee or working group participating in the meeting to communicate with each other (including computer, video, or other electronic equipment). Such participation shall constitute presence in person at the meeting.

D. Written Consents: Any action required or permitted at any subcommittee or working group meeting may be taken without a meeting, if all members of such subcommittee or working group consent to such action in writing, and the writing or writings are filed with the minutes of proceedings of such subcommittee or working group. Consents under this subsection may be given via electronic communication. Such consent will have the same effect as a vote for all purposes.

3.9.5. Standing Subcommittee Charges

As of adoption of these Bylaws, the standing subcommittees and working groups of the Clinical Systems Committee are as follows:



The standing subcommittee's respective charges are as follows:

A. Clinical Operations Subcommittee. To collaboratively review the operations of specific Clinical Services at the UIHC and provide a forum for collaboration amongst Clinical Staff leaders, patient care service leaders, support service leaders, and the UIHC administration. A service line specific working group assisting this Subcommittee may be established or modified at any time by the Clinical Systems Committee. In fulfilling this charge, the Clinical Operations Subcommittee will:

1. Review operational performance, including:

a. Patient access and patient throughput performance.

b. Operational efficiency and cost management performance.

c. Provider satisfaction and efficiency.

d. Staff engagement and efficiency.

e. Facilities and support services.

f. Service-specific revenue cycle issues.

g. Other operational issues as brought up by Clinical Staff and the UIHC personnel.

Clinical Systems Committee may supplement or amend these duties with subcommittee specific duties at any time.

B. Clinical Staff Affairs Subcommittee. To cause patient care delivered at the UIHC to be consistent with professionally recognized standards of care and adjudicate conflicts regarding professional practice, care for the well-being of health care providers so that they are in the best position to care for patients. In fulfilling this charge, the Clinical Staff Affairs Subcommittee will:

1. Adjudication.

a. Hear and adjudicate problems of a professional and ethical nature involving the clinical practice of either House Staff or Clinical Staff members.

b. Review interdisciplinary or inter-clinical department conflicts with the corollary responsibility for recommending to the Clinical Systems Committee policy statements or protocols to remedy such occurrences and otherwise foster harmonious interdepartmental relationships aimed at ensuring quality patient care.

2. Critical Care Working Group. Through oversight of a standing Critical Care Working Group, formulate cross-departmental policies, procedures and programs, identify and seek solutions to current challenges, develop plans for future operations and to enhance the overall utilization and operating efficiency of all the UIHC intensive care units, intermediate care units, and emergency treatment centers so that standards of patient care may be maintained at the highest level. The working group will also oversee the hospital-wide system for management of acute cardiopulmonary resuscitation emergencies and advise the Director of the Respiratory Care Department on policy formulation, establishment of patient care and didactic instruction programs, and on the provision of effective and efficient respiratory care services.

3. Diagnostic Services Working Group. Through oversight of the standing Diagnostic Services Working Group, provide the Clinical Staff and the UIHC's administration with information and advice concerning the quality, availability, and proper

use of clinical laboratory and imaging services. In fulfilling this charge, the Diagnostic Services Working Group will:

a. Assist in formulating operational policies designed to assure the most expeditious performance of diagnostic services for patients in all clinical departments in accord with available resources.

b. Advise and make recommendations regarding optimal provision and utilization of clinical laboratory and imaging services for patients coordinate with cost considerations and market forces extant within the health care industry and in accord with the patient care, educational, and research missions of the UIHC.

c. In accord with these recommendations and other pertinent factors including regulatory provisions and accreditation standards, review and provide recommendations on additions to and deletions from the UIHC publications and documents on diagnostic services.

4. Emergency Management Working Group. Through oversight of the standing Emergency Management Working Group, organize, conduct and update an all hazards emergency management program to assure that the UIHC is prepared to deal effectively with all disaster situations and the treatment of mass casualties which may result therefrom. In fulfilling this charge, the Emergency Management Working Group will:

a. Conduct a Hazard Vulnerability Analysis (HVA) on an annual basis.

b. Maintain a written Emergency Operations Plan which features a Hospital Incident Command System (HICS) for organizing the UIHC's response to all hazards and standard operating procedures to address the hazards identified.

c. Arrange at least twice yearly exercises of the Emergency Operations Plan.

d. Provide continuity of operations plans to guide the UIHC's maintenance and restoration of essential services.

e. Provide that all staff with HICS assignments and other staff designated for responding to disasters and major emergencies receive training in accord with the UIHC requirements and regulatory guidelines and understand their role(s) and responsibilities for responding to various disasters and emergencies.

f. Maintain relationships and participates in County, State, and Federal programs related to emergency management.

g. Assure that the UIHC meets the Emergency Management Standards of The Joint Commission and CMS Conditions of Participation in Medicare and Medicaid programs and follows the National Incident Management

System (NIMS) and HICS as standardized organizational and operational structures for meeting the demands of major emergencies and disasters.

5. Environment of Care Working Group. Through oversight of the standing Environment of Care Working Group, establish, implement, and maintain the UIHC Environment of Care Program, in accordance with the requirements of The Joint Commission and applicable state and federal laws. The working group develops and/or approves recommendations and interventions to protect the well-being of patients, visitors, and staff in the areas of fire protection, safety, hazardous materials and waste, medical equipment, utilities, and security.

6. Graduate Medical Education Working Group. Through the oversight of the standing Graduate Medical Education Working Group, advise on all matters pertaining to the House Staff training programs at the UIHC, including, but not limited to the following: assist in the recruitment, orientation, and scheduling of House Staff physicians and dentists; conduct periodic reviews of all the UIHC residency programs in accordance with Accreditation Council for Graduate Medical Education guidelines; and provide a forum for House Staff issues as expressed by the House Staff representatives on the working group or by other House Staff.

7. Health Information Management Systems Working Group. Through the oversight of the standing Health Information Management Systems Working Group, maintain broad responsibility for the ongoing management and development of the medical records and other health information systems management at the UIHC to facilitate their efficiency and effectiveness. In fulfilling this charge, the Health Information Management Systems Working Group will:

a. Review, analyze and evaluate the quality of systems and processes to enable complete, accurate medical record documentation in the UIHC in compliance with applicable regulations of governmental agencies, accrediting bodies, and payers, and make recommendations for improvement where appropriate.

b. Oversee all medical record forms including documents created during clinical information systems downtime and make appropriate recommendations for their improvement.

c. Review procedures for safeguarding medical records against loss, defacement, tampering, or use by unauthorized persons, and make appropriate recommendations for their improvement. Review strategic planning for application system development.

d. Evaluate the appropriateness of security and backup procedures for health care data in all settings, including the exchange of data with other computers. Review for consistency the strategic plans of the UIHC projects which have incremental computing equipment implications and/or an impact on patient and management data maintained on the health care information system.

e. Review the use of computers in the UIHC administrative and patient care settings with particular regard to appropriateness of application, security of patient information, and system maintenance.

f. Monitor system processes to ensure compliance with regulatory guidelines for safeguarding patient data security.

g. Following review of project and equipment requests, the working group will forward recommendations to the UIHC administration.

8. Pharmacy and Therapeutics Working Group. Through the oversight of the standing Pharmacy and Therapeutics Working Group, promote evidence-based, best practice standards in the formulary decision-making process to assure clinical efficacy, patient safety and cost-effective prescribing within the UIHC. In fulfilling this charge, the Pharmacy and Therapeutics Working Group will:

a. Review policies and procedures related to proper medication administration to assure medications are administered safely and appropriately.

b. Facilitate education of health care providers and students regarding medication-related issues.

c. Assure that medications are prescribed appropriately, safely and effectively through medication use evaluation processes.

d. Assure compliance with The Joint Commission, FDA and other regulatory and accreditation guidelines related to medication use.

e. Review and support investigational medication studies to ensure patient safety and adherence to the UIHC's policies.

f. Evaluate and assess point-of-care and other technology systems and processes to effectuate safe, prompt and efficient prescribing in both the inpatient and ambulatory care settings.

9. Supervision of Non-Privileged Providers Working Group. Through oversight of the standing Supervision of Non-Privileged Providers Working Group, manage supervision of other providers whose services may be independently billable but require appropriate Clinical Staff member medical direction and oversight to supervise clinically appropriate and compliant practice of non-privileged providers.

10. Utilization Management Working Group. Through oversight of the standing Utilization Management Working Group: (1) promote the efficient use of facilities (including coordination of admission and continued stay reviews); and (2) formulate, maintain and review a utilization review plan appropriate for the UIHC and consistent with applicable federal requirements. In fulfilling this charge, the Utilization Management Working Group will:

a. Describe the UIHC activities to cause services to be provided to patients that are medically necessary and at the appropriate level of care.

b. Monitor utilization activities and outcomes.

c. Minimize reimbursement penalties and physician sanctions through screening and appropriate documentation.

d. Centralize communication with external review agencies, including the quality improvement organization.

C. Compliance Subcommittee. To (a) provide oversight and guidance for the regulatory, audit, and compliance activities of the UIHC; and (b) to enable the organization to adopt and implement policies and procedures that will meet the intent of and comply with all applicable laws, rules, regulations, and policies. In fulfilling this charge, the Compliance Subcommittee will:

1. Review and address the activities of the Joint Office for Compliance as it relates to the elements of the United States Sentencing Commission Guidelines and the Federal Compliance Program Guidance including: (1) designation of a compliance officer and other compliance-related governing bodies; (2) development and distribution of compliance policies and procedures; (3) developing open lines of communication; (4) provision of appropriate training and education; (5) internal regulatory monitoring and auditing; (6) response to detected deficiencies; and (7) enforcement of disciplinary standards.

2. Annually review the "Code of Ethical Behavior, a Guide for Staff" to assure it addresses all applicable federal, state and local laws, regulations and other compliance requirements.

3. Oversee the enterprise risk assessment with the goal to align risk and strategy; enhance risk response decisions; increase operational predictability; identify and manage multiple and cross-enterprise risks; proactively manage and minimize risks while achieving strategic objectives; and align deployment of resources with risk mitigation strategy.

D. Credentials Subcommittee. To review the credentials of all members or other practitioners applying for initial or increased privileges; to review proposals for decreased privileges either as part of the biennial review and reaffirmation or as part of a corrective action as described in these Bylaws; to make a recommendation to the Clinical Systems Committee on each application, reaffirmation, or corrective action described in this paragraph; and to report problems related to clinical practice or professional policy through the Clinical Staff Affairs Subcommittee to the Clinical Systems Committee.

E. Finance and Revenue Cycle Subcommittee. To cause proper oversight of financial systems and process of payment to be handled accurately and completely in accordance with applicable laws, regulations, and payer contractual obligations. In fulfilling this charge, the Finance and Revenue Cycle Subcommittee will:

1. Oversee proper financial systems management and reporting.

2. Facilitate timely, accurate, and complete documentation of medically necessary services rendered.

3. Enable timely, accurate, and complete submission of invoices for payment for medically necessary services rendered.

4. Provide coding and documentation accuracy oversight.

5. Oversee third-party payor contracting efforts.

6. Collaborate with other University of Iowa Health Care groups to further payment for quality initiatives.

7. Oversee payment processes including but not limited to prior authorization, eligibility and benefits verification, payment posting, denials management and appeals processing, and payment process reporting.

8. Collaborate with other University of Iowa Health Care groups to develop revenue cycle- and finance-related provider and staff education.

F. Quality and Safety Oversight Subcommittee. To cause patient care delivered by the Clinical Staff of the UIHC to be provided in a safe manner that is consistent with professionally recognized standards of care. In fulfilling this charge, the Quality and Safety Oversight Subcommittee will:

1. Coordinate the quality and performance improvement activities of the UIHC.

2. Review, analyze and evaluate on a continuing basis the performance of the Clinical Service Quality and Performance Improvement Program in formulating standards of care; measuring outcomes of care; annual review of organ transplant outcomes; and taking constructive intradepartmental action on the evaluation results, as specified in the UIHC Performance Improvement Program.

3. Ethics Working Group. Through oversight of the standing Ethics Working Group:

a. Develop and carry out educational programs that will enhance awareness and understanding of biomedical ethical issues for clinical and the UIHC staff, undergraduate and graduate trainees, patients and their families, and propose policies and guidelines regarding the ethical aspects of medical, surgical, and dental practice.

b. Provide consultation on ethical issues to members of the UIHC Clinical Staff, House Staff, and Professional Staff.

4. Infection Control Working Group. Through oversight of the standing Infection Control Working Group, review infection data, policies, procedures and processes, and revise policies and procedures, and recommend changes in procedures and

practices as necessary so that appropriate interventions to prevent infections in the UIHC and its associated clinics are made.

5. Protection of Persons Working Group. Through oversight of the standing Protection of Persons Working Group, facilitate the protection of persons, including minors and dependent adults, to identify, treat, and as permitted or required by law, report cases of suspected child or dependent adult abuse or domestic violence.

6. Transfusion Working Group. Through oversight of the standing Transfusion Working Group, review the records of transfusions of blood and blood components so as to assess transfusion reactions, to evaluate blood utilization, and to make recommendations regarding specific improvements in the transfusion service program.

G. Surgical Services Subcommittee. To review, deliberate, resolve, and, where indicated, formulate recommendations relative to all appropriate operational elements of the several surgical services with special emphasis upon the operating room suite.

H. People and Culture Subcommittee. To address and respond to organizational culture, team development, recruitment, retention, diversity, equity and inclusion, and safety of all people within University of Iowa Health Care. In fulfilling this charge, the People and Culture Subcommittee will:

1. Employee Engagement and Well-Being Working Group. Through oversight of the standing Employee Engagement and Well-Being Working Group, foster employee engagement and care for the well-being of all personnel regardless of role, background, education, and experience so that they are in the best position to care for and provide support to patients, including review of employee engagement satisfaction survey data and develop recommendations for improvement.

2. Patient Experience Working Group. Through oversight of the standing Patient Experience Working Group, evaluate and explore organizational opportunities to improve the patient experience and advise on strategies, recommendations, and plans to address such findings.

3. Staff Development Working Group. Through oversight of the standing Staff Development Working Group, evaluate and explore organizational opportunities to improve staff development and advise on strategies, recommendations, and plans to address such findings.

4. Workplace Safety Working Group. Through oversight of the standing Workplace Safety Working Group, evaluate and examine workplace safety and advise on strategies, recommendations, plans, or any course of action to address such findings.

I. *Ad Hoc* Subcommittees and Working Groups.

1. Subcommittees. *Ad hoc* subcommittees may be created by action of the Clinical Systems Committee under Article III, Section 3.7.2, Action at Meetings as necessary to study particular problems in response to the recommendations of any member of the Clinical Systems Committee. The meeting minutes of the Clinical Systems

Committee creating an *ad hoc* subcommittee shall list the name of the *ad hoc* subcommittee and describe the charge of the subcommittee. The processes and procedures applicable to subcommittees of the Clinical Systems Committee in Article III shall apply to any *ad hoc* subcommittee created under this section. Any *ad hoc* subcommittee created under this Section shall terminate pursuant to an act of the Clinical Systems Committee under Article III.

2. Working Groups. *Ad hoc* working groups of a subcommittee may be created by action of such subcommittee under Article III, Section 3.9.4(B), Action at Meetings as necessary to study particular problems in response to the recommendations of any member of such subcommittee; provided, however, after creation by a subcommittee, any *ad hoc* working groups shall be approved by the Clinical Systems Committee. The meeting minutes of the subcommittee creating an *ad hoc* working group shall list the name of the *ad hoc* working group and describe the charge of the working group. The processes and procedures applicable to working groups of any subcommittee of the Clinical Systems Committee in Article III shall apply to any *ad hoc* working group created under this Section. Any *ad hoc* working group created under this Section shall terminate pursuant to an act of the Clinical Systems Committee under Article III.

ARTICLE IV. CLINICAL STAFF

Section 4.1. Responsibility. The Clinical Staff of the UIHC ("Clinical Staff") shall be responsible for the quality of health care within the hospitals and ambulatory care facilities of the UIHC, and shall accept this responsibility subject to the ultimate responsibility of the Board of Regents.

Section 4.2. Purposes. The purpose of the Clinical Staff is:

4.2.1. To cause all patients admitted to or treated in any of the facilities, departments, or services of the UIHC to receive medical and dental diagnosis, treatment, and personalized care consistent with applicable standards of care.

4.2.2. To cause, through ongoing review and evaluation procedures, a high-level of professional and ethical performance of all those persons authorized to practice within the UIHC.

4.2.3. To provide an appropriate educational setting that will lead to continuous advancement of professional knowledge and skill.

4.2.4. To provide an optimal forum in which the Clinical Staff may conduct medical education, training, and research.

Section 4.3. Clinical Staff Membership.

4.3.1. Nature of Clinical Staff Membership. Membership on the Clinical Staff of the UIHC shall be extended only to professionally competent persons who are physicians, dentists, or members of other health care professions and who continuously meet the qualifications, standards and requirements setforth in these Bylaws.

4.3.2. Basic Qualifications for Clinical Staff Membership. All members of the Clinical Staff shall meet the following basic qualifications and shall, in addition, satisfy the qualifications of one of the specific categories of Clinical Staff membership set forth in subsection 4.3.3 below.

A. Physicians and dentists licensed to practice in the state of Iowa and who are graduates of an approved or recognized medical, osteopathic, or dental school shall be qualified for membership on the Clinical Staff. Other health care professionals with a Ph.D. or equivalent terminal degree, who are graduates of professional schools and/or approved clinical training programs, and who hold any necessary licensure to practice in the state of Iowa, shall be qualified for membership on the Clinical Staff. Such physicians, dentists, and other health care professionals must document their appropriate experience and training, ability to form positive, productive working relationships, satisfactory health status, and demonstrated competence and adherence to the ethics of their profession with sufficient adequacy to assure that any patient treated by them on behalf of a Clinical Service within the UIHC will be provided high quality health care.

B. As a condition of membership, the Clinical Staff shall strictly abide by the code of ethics of the American Medical Association, the American Osteopathic Association, the American Dental Association, or, in the case of membership in other disciplines, the ethical guidelines of their profession as promulgated by their comparable association.

C. No applicant for Clinical Staff membership shall be denied membership on the basis of sex, race, creed, color, national origin, religion, age, disability, veteran status, sexual orientation, gender identity, associational preference, or any other attribute protected by law.

4.3.3. Categories of Clinical Staff. There shall be five (5) categories of Clinical Staff at the UIHC: Active Clinical Staff, Emeritus Staff, Courtesy Staff, Temporary Staff, and House Staff. Each category of Clinical Staff membership shall be associated with one of the following classifications:

Medical Staff Category	Medical or Dental School Faculty Track	Medical or Dental School Title/Status
Active	Tenure	Professor, Associate Professor, Assistant Professor, Instructor
	Clinical	Clinical Professor, Clinical Associate Professor, Clinical Assistant Professor, Clinical Instructor
	Visiting	Visiting Professor, Visiting Associate Professor, Visiting Assistant Professor, Visiting Instructor
Emeritus	N/A	Emeritus Professor, Emeritus Clinical Professor
Courtesy	N/A	Adjunct Professor, Adjunct Associate Professor, Adjunct Assistant Professor, Adjunct Instructor
Temporary	N/A	N/A
House	N/A	N/A

A. Active Clinical Staff.

1. Upon receiving one of the following appointments to a clinical department according to the procedure set forth in the Manual of Procedure of the CCOM and the University Operations Manual, a physician who meets the qualifications for membership shall be a member of the Active Clinical Staff of the UIHC:

a. tenure track appointment;
b. salaried clinical track appointment;
c. instructor or clinical instructor in a clinical department; or
d. visiting faculty appointment.

2. Upon receiving a faculty appointment with UIHC patient treatment responsibilities from the University of Iowa College of Dentistry, according to the procedures of the College of Dentistry and the UIHC (including approval by the Head of the Hospital Dentistry Clinical Service) and the procedures of the University Operations Manual, a dentist who meets the qualifications for membership shall be a member of the Active Clinical Staff of the UIHC.

3. Upon receiving an academic appointment to a clinical department that constitutes a Clinical Service listed in Article II, Section 2.2.1, Organization, according to the procedures set forth in the Manual of Procedure of the CCOM and the University Operations Manual, a health care professional faculty member, who meets the qualifications for membership (see Article IV, Section 4.3.2, Basic Qualifications for Clinical Staff Membership), and is continuously involved in the patient care program of a Clinical Service, shall be a member of the Active Clinical Staff of the UIHC. The Active Clinical Staff member's practice shall be limited to the clinical duties and responsibilities intrinsic to the professional discipline and privileges granted.

4. All Active Clinical Staff members are eligible to vote on matters brought before the Active Clinical Staff. Active Clinical Staff are expected to contribute to the organizational and administrative affairs of the Clinical Staff, which may include service on committees and duties of office to which elected or appointed, and must participate in quality management, utilization review, and peer review activities.

B. Emeritus Staff. Only persons who are members of the Active Clinical Staff at the time of their retirement, and who continue to meet the qualifications for Clinical Staff membership, are qualified for membership on the Emeritus Staff of the UIHC. Emeritus status is granted or revoked according to the procedure set forth in the University Operations Manual. All Emeritus Staff members with privileges are expected to contribute to the organizational and administrative affairs of the Clinical Staff, which may include service on committees and duties of office to which elected or appointed, and must participate in quality management, utilization review, and peer review activities. Emeritus Staff may attend meetings of the Clinical Systems Committee, but may not vote, on matters brought before the Clinical Systems Committee. Emeritus Staff may not chair or co-chair the Clinical Systems Committee, a subcommittee of the Clinical Systems Committee, or a working group.

C. Courtesy Teaching Staff. Upon receiving an academic appointment to the non-salaried clinical track of the CCOM or College of Dentistry, according to the procedures of the applicable College and the University Operations Manual, a physician or dentist who meets the qualifications for membership to the Clinical Staff under Article IV, Section 4.3.2, Basic

Qualifications for Clinical Staff Membership shall be a member of the Courtesy Teaching Staff of the UIHC.

D. Temporary Staff. Upon receiving a written invitation from the Clinical Service Head to visit at the UIHC for a period of time not to exceed thirty (30) days, a physician or dentist who meets the following qualifications for membership shall be a member of the Temporary Staff of the UIHC during that visit: (1) is a graduate of an approved or recognized medical, osteopathic, or dental school; (2) holds a current and unrestricted license to practice his or her respective profession in the state of Iowa; (3) demonstrated current clinical competence; and (4) adequate professional liability insurance that will provide coverage for such individual's acts or omissions while providing professional services at the UIHC.

E. House Staff. Upon receiving an appointment to the House Staff from the Chief Executive Officer of the UIHC, pursuant to nomination by the appropriate Clinical Service Head, a physician or dentist who: (1) has a fully executed House Staff Graduate Medical or Dental Education Appointment Contract with the UIHC; (2) is a graduate of an approved or recognized medical, osteopathic, or dental school; and (3) holds a current and unrestricted license to practice his or her profession in the state of Iowa shall be a member of the House Staff of the UIHC.

1. Temporary Member; House Staff. Physicians and dentists who have received an appointment to a residency program that has a written affiliation agreement with the University of Iowa in effect and have been assigned to a rotation at the UIHC by that program shall be a temporary member of the House Staff of the UIHC during the approved rotation, provided that such individual: (i) has received the written approval of the Head of the Clinical Service in which the rotation will be served; (ii) is a graduate of an approved or recognized medical, osteopathic, or dental school; (iii) holds a current and unrestricted license to practice his or her profession in the state of Iowa; and (iv) has signed an agreement to abide by these Bylaws, directives of the Clinical Systems Committee, and rules and regulations of the applicable Clinical Service.

Section 4.4. Clinical Privileges. Members of the Clinical Staff and other practitioners, as described in Article IV, Section 4.4.6, Clinical Privileges for Other Practitioners, are eligible to apply forprivileges.

4.4.1. Practice Limited to Clinical Privileges. Each Clinical Staff member or practitioner who is granted privileges shall be entitled to exercise only those privileges specifically granted to him or her by the Clinical Systems Committee or by these Bylaws.

4.4.2. Qualifications for Privileges.

A. Each applicant must sign an agreement to abide by these Bylaws, directives ofthe Clinical Systems Committee, and rules and regulations of the applicable Clinical Service.

B. All Clinical Staff members or other practitioners with privileges must report to the Head of the Clinical Service in which privileges are held or sought any of the following items:

1. Previously successful or currently pending challenges to any licensure or registration, the voluntary relinquishment of such licensure or registration, or any lapse in licensure or registration.

2. Any currently pending or previously filed lawsuits, administrative claims, or other legal action(s) that allege a breach of the professional standard of care on the part of the physician, dentist, health care professional, or practitioner whether or not he or she is a named defendant.

3. Any settlements, judgments or verdicts entered in an action in which the physician, dentist, health care professional, or practitioner was alleged to have breached the standard of care, whether or not he or she was a named defendant.

4. Any voluntary or involuntary termination of Clinical Staff membershipor voluntary or involuntary limitation, reduction, or loss of privileges at another hospital.

C. All members and other practitioners with privileges must be free of, or have under adequate control, any significant physical or behavioral impairment that interferes with, or presents a substantial probability of interfering with, or that will or may adversely affect the member's or practitioner's ability to provide quality patient care services.

D. Each applicant must provide references, before initial privileges are granted, verifying the applicant's professional and clinical competency.

4.4.3. Clinical Privileges of Physicians and Dentists. All privileges granted by the Clinical Systems Committee are contingent on the person receiving and continuing to possess an appointment to the faculty of either the CCOM or the College of Dentistry. Clinical privileges shall be suspended automatically during any period when the faculty member is on administrative leave from his or her respective College. Privileges shall be re-instated automatically at the end of the administrative leave unless the faculty appointment terminates or corrective action is taken pursuant to Article IV, Section 4.6, Corrective Action.

A. Clinical Privileges of Active Clinical Staff (Physicians/Dentists). Physicians and dentists who are members of the Active Clinical Staff (or applicants for appointments which would qualify them for Active Clinical Staff membership whose appointments have been recommended to the Dean by the Head of the Clinical Service in which privileges are sought) may apply for privileges according to the procedure in Article IV, Section 4.5, Procedures for Delineating Clinical Privileges.

Physicians with Visiting Instructor appointments shall serve as House Staff members in performing services other than those for which they are granted privileges on the Active Clinical Staff.

Members of the Active Clinical Staff who are licensed physicians and licensed dentists and have clinical privileges may admit patients.

B. Clinical Privileges of Courtesy Teaching Staff. Members of the Courtesy Teaching Staff (and applicants for appointments which would qualify them for Courtesy Teaching Staff membership whose appointments have been recommended to the Dean by the Head of the Clinical Service in which privileges are sought) whose teaching responsibilities require them to be involved in patient treatment may apply for privileges according to the procedure in Article IV, Section 4.5, Procedures for Delineating Clinical Privileges. Clinical privileges granted to members of the Courtesy Teaching Staff shall not exceed those necessary to effectively fulfill the member's teaching responsibilities, and can only be exercised under the supervision of a member of the Active Clinical Staff who has privileges to perform the procedures and who finds the Courtesy Teaching

Staff member qualified to participate. Members of the Courtesy Teaching Staff shall not admit patients.

The Clinical Systems Committee may adopt findings that the needs of the UIHC, in fulfilling its tripartite mission, require that opportunities be given to members of the Courtesy Teaching Staff to practice without supervision. Following the adoption of such findings, the Clinical Systems Committee may, upon request of the Clinical Service Head, authorize a Courtesy Teaching Staff member, who has been granted privileges according to the procedure in Article IV, Section 4.5, Procedures for Delineating Clinical Privileges, to practice without supervision, and to admit patients.

C. Clinical Privileges of Temporary Staff. The co-chairs of the Clinical Systems Committee may grant temporary privileges to a Temporary Staff member, upon recommendation of the Clinical Service Head, who is responsible for verifying the required qualifications of the Temporary Staff member (Article IV, Section 4.3.3(D), Temporary Staff and Article IV, Section 4.4.2, Qualifications for Privileges). The Clinical Service Head shall then assign the Temporary Staff member to a member of the Active Clinical Staff for supervision. Temporary privileges, unless otherwise limited, shall permit the Temporary Staff member to perform any procedures which the assigned Active Clinical Staff member has privileges to perform and authorizes the Temporary Staff member to perform. The Clinical Systems Committee may, in its discretion, authorize a Temporary Staff member to practice without supervision by approving temporary privileges upon the recommendation of the applicable Credentials Panel. Temporary privileges shall cease in accord with the written invitation to the Temporary Staff or when the Clinical Service Head or co-chairs of the Clinical Systems Committee in their sole discretion, ends the temporary privileges.

Members of the Temporary Staff shall not admit patients and shall not, without the prior approval of the Clinical Systems Committee, practice without supervision. Temporary privileges may not exceed one hundred and twenty (120) days.

The Temporary Staff member shall wear an identification badge identifying him or her as a Temporary Staff member of the Clinical Staff.

The credentials of a Temporary Staff member appointed pursuant to this subsection shall be verified in the same manner as the credentials of any other Temporary Staff member, except that the process may occur retrospectively. The process for verifying credentials shall begin as soon as the immediate situation that resulted in the declaration of a "full-scale disaster" is under control.

D. Clinical Privileges of House Staff. It is the responsibility of a supervising member of the Active Clinical Staff, or the Emeritus Staff to authorize each House Staff member, including temporary House Staff members, to perform only those services which the House Staff member is competent to perform under supervision.

4.4.4. Clinical Privileges of Emeritus Staff. Members of the Emeritus Staff, who have assigned Clinical Service responsibilities by the Colleges of Medicine or Dentistry, may apply for privileges according to the procedure in Article IV, Section 4.5, Procedures for Delineating Clinical Privileges.

Members of the Emeritus Staff who have privileges may admit patients.

4.4.5. Clinical Privileges of Other Members of the Active Clinical Staff. All privileges granted by the Clinical Systems Committee are contingent on the health care professional (as defined in Article IV, Section 4.3.2(A)) receiving and continuing to possess a faculty appointment to a clinical department inthe CCOM. Health care professionals who are members of the Active Clinical Staff (or applicants for appointments which would qualify them for Active Clinical Staff membership whose appointments have been recommended to the Dean by the Head of the Clinical Service in which privileges are sought) may apply for privileges limited to the clinical duties and responsibilities intrinsic to the applicable professional discipline (Article IV, Section 4.3.3(A)(3)) according to the procedure in Article IV, Section 4.5, Procedures for Delineating Clinical Privileges. Health care professionals with privileges may not admit patients.

4.4.6. Clinical Privileges of Other Practitioners. Employees of the UIHC or the CCOM, who are employed as Advanced Registered Nurse Practitioners ("ARNP") or Physician Assistants ("PA"), shall not be members of the Clinical Staff, but may apply for privileges as described in this Section according to the procedure set forth in Article IV, Section 4.5, Procedures for Delineating Clinical Privileges.

ARNPs or PAs shall not have the authority granted to physicians and dentists to limit substitution or standardization pursuant to protocols approved by the Pharmacy and Therapeutics Working Group and shall not, unless specified in the protocol approved by the Pharmacy and Therapeutics Working Group, be authorized to override protocol or restricted drug indications.

A. Advanced Registered Nurse Practitioners. ARNPs may provide clinical services pursuant to collaborative practice agreements approved by the Head of the Clinical Service in which they practice. The collaborative practice agreements shall define privileges granted. ARNPs providing clinical services pursuant to a collaborative practice agreement must be licensed by the Iowa Board of Nursing.

Delegated medical functions performed by ARNPs shall be limited to those granted in the collaborative practice agreement approved by the appropriate Clinical Service Heads and shall be based upon the applicant's training, experience, and demonstrated competence. The Clinical Service Head shall submit the collaborative practice agreements to the chair of the applicable Credentials Panel according to the procedure in Article IV, Section 4.5, Procedures for Delineating Clinical Privileges. These collaborative practice agreements shall delineate specifically the methods by which the responsible attending physician shall direct the delegated medical functions performed by the ARNP.

B. Physician Assistants. PAs may provide medical services with the supervision of physician members of the Clinical Staff. PAs providing medical services at the UIHC shall be licensed by the Iowa State Board of Physician Assistants in accordance with the laws of the state of Iowa. Patient care responsibilities of PAs shall be limited to those privileges defined in the written policy, and shall be based upon the applicant's training, experience and demonstrated competence. The Clinical Service Head shall submit a written policy, including a listing of the privileges requested, to the chair of the applicable Credentials Panel according to Article IV, Section 4.5, Procedures for Delineating Clinical Privileges. This policy shall delineate specifically the methods by which the responsible attending physician shall direct and supervise the activities of the PA. PAs shall not be authorized to order or prescribe Schedule II controlled substances which are listed as stimulants or depressants. A prescription written by a Physician Assistant shall include the name of the supervising physician.

4.4.7. Emergency Privileges. In the case of emergency, any Clinical Staff member or practitioner, with privileges at the UIHC, shall be permitted to do everything possible to save the life of a patient. For the purpose of this paragraph, an "emergency" is defined as a condition which might result in permanent harm to the patient or in which the life of the patient is in immediate danger and any delay in administering treatment would add to that danger.

4.4.8. Disaster Privileges.

A. Persons granted disaster privileges are not members of the Clinical Staff and have no rights under Article IV, Sections 4.5–4.7, Procedures for Delineating Clinical Privileges; Corrective Action; House Staff Member Rights.

B. Disaster privileges may be granted to physicians, dentists, PAs, or ARNPs who are not otherwise eligible for privileges only when the UIHC's Emergency Operations Plan has been activated in response to a disaster and the UIHC is unable to meet immediate patient needs. Disaster privileges may be granted only by the co-chairs of the Clinical Systems Committee.

C. The Emergency Operations Plan shall specify how the identity of persons will be verified before disaster privileges are granted, how primary source verification will occur, and how the performance of persons granted disaster privileges will be overseen.

D. Disaster privileges terminate automatically. The mechanism for termination, including notification of any persons granted disaster privileges, shall be specified in the Emergency Operations Plan.

Section 4.5. Procedures for Delineating Clinical Privileges.

4.5.1. Initial or Increased Clinical Privileges. Each application for initial or increased privileges shall be made with the assistance of the Head of the Clinical Service in which privileges are sought.

If the applicant is a physician or dentist, the Clinical Service Head shall forward the application along with a recommendation to the chair of the applicable Credentials Panel—Medical or Surgical. That Credentials Panel shall examine the supporting documentation provided by the applicant and other available information concerning the applicant's training, experience, health status, and demonstrated competence.

If the applicant is a health care professional, as described in Article IV, Section 4.3.2(A), or an ARNP or PA, as described in Article IV, Section 4.4.6, Clinical Privileges of Other Practitioners, the chair of the applicable Credentials Panel will forward the application to the Health Care Professional Subpanel or the PA/ARNP Subpanel, respectively. This subpanel will be responsible for examining the supporting documentation provided by the applicant and other available information concerning the applicant's training, experience, health status, and demonstrated competence. Within thirty (30) days of receiving the completed application for review, the chair of the applicable subpanel will forward a recommendation to the chair of the applicable Credentials Panel. The Credentials Panel may return the application to the subpanel with a request to respond to delineated concerns.

All applicants shall be responsible for providing sufficient information to demonstrate their qualifications and competency in the privileges sought and shall provide any requested or missing information in a timely manner. All applications that are missing information shall be deemed incomplete and such applicant shall not be eligible for any fair hearing or appeal rights under the Bylaws.

Within forty-five (45) days of receiving the completed application for review or the subpanel recommendation, the chair of the Credentials Panel shall forward a recommendation, together with the supporting documentation, to the Clinical Systems Committee for review and final action (Article IV, Section 4.6.4, Clinical Systems Committee Action). Within thirty (30) days of receipt of the recommendation, the Clinical Systems Committee shall make its decision and send the applicant written notification. If the decision of the Credentials Panel is not to grant privileges as requested (*see* Article IV, Section 4.6.2, Credentials Panel Recommendations), the applicant will be notified of the specific reasons for the denial of privileges, the rights to a hearing as provided in Article IV, Section 4.6.3, Hearing, and a summary of the applicant's rights in the hearing. Failure to make a written request for a hearing to the chair of the Clinical Staff Affairs Subcommittee within thirty (30) days of receiving notice shall constitute waiver of the right to a hearing.

4.5.2. Provisional Status. All initial privileges shall be provisional for the first six (6) months. The Head of the Clinical Service in which privileges are granted shall designate one (1) or more members of the Active Clinical Staff to proctor the individual's clinical competence and professional ethical conduct for that time period. Subject to other requirements elsewhere in these Bylaws, the privileges shall cease to be provisional at the end of the six (6) months, following a written report from the proctor to the Clinical Service Head verifying the individual's clinical competence and professional/ethical behavior. The Clinical Service Head shall forward the report to the chair of the appropriate Credentials Panel recommending termination of the provisional status. If necessary, the proctor shall submit a written report to the Clinical Service Head recommending additional reviews. If such a report is submitted, the Head, after consultation with the individual and the chair of the appropriate Credentials Panel, shall take appropriate action. This includes (1) extending the provisional status or (2) recommending modification in the individual's privileges. The total period of provisional status may not exceed one (1) year. If modification, including termination, of privileges is recommended, the recommendation shall be handled as provided in Article IV, Section 4.6, Corrective Action.

4.5.3. Biennial Review of Clinical Privileges. Biennially, the Head of each Clinical Service shall review the privileges and the physical and mental condition of all members and practitioners who hold privileges in that Clinical Service and forward a recommendation to the applicable Credentials Panel, along with the supporting documentation which should include the results of ongoing professional practice evaluations and, if applicable, focused professional practice evaluations. The review of privileges and the physical and mental condition of the Clinical Service Heads shall be conducted by an *ad hoc* review committee composed of three (3) members of the Active Clinical Staff who have the rank of professor and who are selected by the chair of the applicable Credentials Panel. The review shall be documented and the recommendation forwarded to the applicable Credentials Panel, along with the supporting documentation.

If the review is for a health care professional, ARNP, or PA, the applicable Credentials Panel shall forward the recommendation to the applicable subpanel for review. The subpanel will review the application, supporting documentation, and the recommendation of the Clinical Service Head. The subpanel will document their review and send their recommendation to the applicable Credentials Panel.

The Credentials Panel shall submit a list of all members and practitioners, which the Clinical Service Heads recommend for no change in privileges and the applicable Credentials Panel affirms, to the Clinical Systems Committee. The Clinical Systems Committee shall either reaffirm the privileges of each listed member or practitioner or refer the matter of the member's or practitioner's privileges to the applicable Credentials Panel. The Credentials Panel, or applicable subpanel, shall conduct a review of all referred matters which shall include an opportunity for the affected member or practitioner to submit supplemental information and, within thirty (30) days of the referral, shall submit a recommendation.

If the applicable Credentials Panel recommends that the member's or practitioner's privileges be reduced, not reaffirmed, or makes any other adverse recommendation, that adverse recommendation will be handled as provided in Article IV, Section 4.6.2, Credentials Panel Recommendations. Each member's or practitioner's privileges shall continue until final action by the Clinical Systems Committee, unless such individual is suspended under Article IV, Section 4.5.5, Professional Liability Reporting or Article IV, Section 4.6.6, Summary Suspension.

4.5.4. Voluntary Reduction. A voluntary reduction in privileges may occur at any time separate from reaffirmation as described in Article IV, Section 4.5.3, Biennial Review of Clinical Privileges. A voluntary reduction apart from reaffirmation may be initiated by a member or practitioner by requesting to the Clinical Service Head a reduction in privileges. The reduction request must be signed and dated by the requesting member or practitioner and shall be effective upon a signed and dated acknowledgement from the Clinical Service Head, with the reduction effective upon the later of the date of signature of acknowledgement by the Clinical Service Head or the effective date set forth in the request.

Any reinstatement to prior privileges or increase in privileges requires an application for those privileges, consistent with the requirements for a Clinical Staff member or practitioner's application for new privileges.

4.5.5. Professional Liability Reporting. If the items listed in Article IV, Section 4.4.2, Qualifications for Privileges occur subsequent to the initial granting of privileges, they must be reported to the Head of the Clinical Service in which privileges are held at the time they become known to the affected Clinical Staff member or practitioner. The Clinical Service Head shall immediately forward the information to the chair of the applicable Credentials Panel (Medical or Surgical). That Credentials Panel, or subpanel if the person is a health care professional or practitioner, shall review the information provided by the member or practitioner and may request that additional information be submitted. The Panel may recommend action pursuant to Article IV, Section 4.6, Corrective Action.

4.5.6. Physical and Mental Examinations. To the extent permitted by applicable law, whenever the Clinical Service Head or chair of the applicable Credentials Panel reasonably believes, based on specific conduct or activities, that the member or practitioner may be suffering from a physical or mental impairment that will, or may, adversely affect the member or practitioner's ability to provide quality patient care services, the Clinical Service Head or chair of the applicable Credentials Panel may request that the member or practitioner undergo a physical and/or mental examination by one or more physicians of the member's or practitioner's choice who are also acceptable to the Head and the chair who makes the request. If the member or practitioner and the Head or chair are unable to select a mutually acceptable examining physician within ten (10) days of the initial request, the applicable Credentials Panel shall designate the examining physician. If the member or practitioner refuses to undergo a physical and/or mental examination, the Clinical Service Head or chair of the applicable Credentials Panel may summarily suspend the member or practitioner's privileges in accordance with Article IV, Section 4.6.6, Summary Suspension. Any time limit for action by the Credentials Panel shall be extended for the number of days from the request for the examination to the receipt of the report of the examination by the chair.

Section 4.6. Corrective Action.

4.6.1. Decreased Clinical Privileges. Clinical privileges may be reduced, suspended, or terminated for activities or professional conduct considered to be lower than the standards of the UIHC and its Clinical Staff, or to be disruptive to operations of the UIHC, or for violation of these Bylaws, directives of the Clinical Systems Committee, or rules and regulations of the applicable Clinical Service. Action to

reduce a member's or practitioner's privileges may be initiated by written request to the chair of the applicable Credentials Panel by any of the following parties: (1) the co-chairs of the Clinical Systems Committee, (2) the chair of the Clinical Staff Affairs Subcommittee, (3) the applicable Clinical Service Head, or (4) a majority of a review committee created pursuant to Article IV, Section 4.5.3, Biennial Review of Clinical Privileges. The request shall be supported by reference to specific activity or conduct which constitutes the grounds for the request. A copy of the request shall be sent to the affected member or practitioner. If the affected member or practitioner signs a written acceptance of the requested reduction, the reduction shall take effect when the member or practitioner signs the acceptance. If the member or practitioner does not sign such an acceptance within ten (10) days of receipt of the request, the Credentials Panel, or applicable subpanel, shall conduct an investigative review which shall include an opportunity for the affected member or practitioner to submit information. Within forty-five (45) days of receipt of the request by the chair, the Credentials Panel shall prepare a recommendation which shall be handled as provided in Article IV, Section 4.6.2, Credentials Panel Recommendations.

4.6.2. Credentials Panel Recommendations. The Credentials Panel, in consultation with the Clinical Service Head, may: (1) recommend a formal letter of reprimand; (2) recommend reduction, suspension, or termination of privileges, which may include a requirement of consultation or supervision; (3) impose conditions on the exercise of privileges; (4) recommend terms of a probationary period; (5) recommend the member or practitioner obtain appropriate therapy or counseling; or (6) recommend such other actions which are deemed appropriate by the Credentials Panel, in consultation with the Clinical Service Head, under the circumstances.

When the recommendation is to deny the request for decreased privileges, the chair of the Credentials Panel shall forward it, together with the supporting documentation, to the Clinical Systems Committee for review and final action. The recommendation from the chair of the Credentials Panel shall specify whether or not the Panel was unanimous. If the Panel was not unanimous, dissenting members of such panel may attach a minority report.

When the recommendation is adverse to the member or practitioner, the chair of the Credentials Panel shall send written notification to the member or practitioner within five (5) days of preparation of the recommendation, including the specific reasons for the recommended action, the right to a hearing as provided in Article IV, Section 4.6.3, Hearing, and a summary of the affected member's or practitioner's rights in the hearing. Failure to make a written request for a hearing to the chair of the Clinical Staff Affairs Subcommittee within thirty (30) days of receiving notice shall constitute a waiver of the right to a hearing. The chair of the Credentials Panel shall forward the recommendation, together with supporting documentation, to the Clinical Systems Committee. If the hearing is conducted, the Credentials Panel, or in the case of a health care professional or practitioner, the applicable subpanel, shall, within fifteen (15) days of receipt of the report and recommendation of the Hearing Committee, consider them and prepare a reconsidered recommendation. The chair of the Credentials Panel shall forward the reconsidered recommendation to the Clinical Systems Committee. If the reconsidered recommendation continues to be adverse, the chair of the Credentials Panel shall also send written notification to the affected member or practitioner within five (5) days of the preparation of the reconsidered recommendation. The affected member or practitioner shall have ten (10) days from receipt of the notice to submit a written statement to the co-chairs of the Clinical Systems Committee.

4.6.3. Hearing.

A. Hearing Committee, Notice and Personal Presence. Whenever a member or practitioner or an applicant that has been rejected for membership makes a timely request for

hearing pursuant to Article IV, Section 4.6.2, Credentials Panel Recommendations, 4.6.4, Clinical Systems Committee Action, or 4.6.6, Summary Suspension, the hearing date shall not be less than thirty (30) days nor more than sixty (60) days from the date of the hearing notice. The hearing committee shall be composed of five (5) members of the Clinical Staff Affairs Subcommittee, the Active Clinical Staff, or the practitioners' discipline, selected by the chair of the Clinical Staff Affairs Subcommittee, to cause that the committee to be impartial (the "Hearing Committee"); provided, however, no member or practitioner who has actively participated in consideration of the adverse recommendation shall be appointed a member of the Hearing Committee. Written notice of the place, time, and date of the hearing, including specific charges or reasons for the adverse recommendation and a list of witnesses, if any, expected to testify, shall be sent to the person requesting the hearing no less than thirty (30) days before the hearing. This notice shall be prepared by the chair of the Credentials Panel for persons receiving an adverse recommendation from this Panel, by the co-chairs of the Clinical Systems Committee for persons receiving an adverse recommendation by this Committee or suspension of privileges, and by the Training Program Director for House Staff members. The person requesting the hearing shall be given an opportunity to inspect documentary evidence against such individual. The person may be represented by legal counsel at the hearing if prior written notice is given to the chair of the Clinical Staff Affairs Subcommittee at least fifteen (15) days prior to the hearing. The person may call witnesses and introduce other evidence, including patient charts, if the person gives seven (7) days' prior written notice to the chair of the Clinical Staff Affairs Subcommittee. Rebuttal evidence and/or witnesses may be added in response, with notice to the affected person prior to the hearing. Personal presence of the affected person or the affected person's representative shall be required, and failure without good cause to appear shall constitute a waiver of the right to a hearing.

At the written request of the affected person and the approval of the chair of the Clinical Staff Affairs Subcommittee, the affected person may waive adherence to the hearing time requirements.

B. Presiding Officer. The Hearing Committee shall select from its membership a chair who shall be the presiding officer at the hearing. The presiding officer shall act to ensure that all participants in the hearing have a reasonable opportunity to be heard and present oral and documentary evidence, and to ensure that decorum is maintained. The presiding officer shall be entitled to determine the order of procedure during the hearing and shall have the authority and discretion to make rulings on all questions.

C. Conduct of the Hearing. At a hearing both sides shall have the following rights: to call and examine witnesses, to introduce exhibits, to cross-examine any witness on any matter relevant to the issues and to rebut any evidence. The hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence shall be admitted by the presiding officer if it is the sort of evidence on which reasonable persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a memorandum of points and authorities, and the Hearing Committee may request such a memorandum to be filed following the close of the hearing. The Hearing Committee may interrogate witnesses or call additional witnesses if it deems it appropriate. The presiding officer shall have the discretion to take official notice of any matters relating to the issues under consideration. Participants in the hearing shall be informed of the matters to be officially noticed, they shall be noted in the record of the hearing, and the person requesting the hearing shall have the opportunity to refute the noticed matter. The Hearing Committee shall maintain a record of the hearing by one of the following methods: a

shorthand reporter present to make a record of the hearing; a recording; or minutes of the proceedings. The cost of such shorthand reporter shall be borne by the party requesting the reporter, unless the party who did not request the shorthand reporter requests a copy of the transcript, in which case the parties shall share in the costs equally. The presiding officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice.

D. Decision of the Hearing Committee. The decision of the Hearing Committee shall be based on the preponderance of the evidence produced at the hearing. Within thirty (30) days of the completion of the hearing, the Hearing Committee shall submit its written recommendation, including a statement of the basis for the recommendation(s), to the Credential Panel in the case of Article IV, Section 4.6.2, Credentials Panel Recommendations hearings, to the Clinical Systems Committee in the case of 4.6.4, Clinical Systems Committee Action or 4.6.6, Summary Suspension hearings, or to the Clinical Service Head if the affected member is House Staff. The affected person has the right to receive the written recommendation of the Hearing Committee, including a statement of the basis of the recommendation(s).

4.6.4. Clinical Systems Committee Action. When the Clinical Systems Committee receives the recommendation or reconsidered recommendation from the chair of the Credentials Panel, it shall consider records created in the proceedings (including any recommendations, and the documentation on which the recommendations are based, of the Credentials Panel or Hearing Committee), any written statement timely submitted by the affected person, and, in the Clinical System Committee's discretion, other evidence. Within thirty (30) days of receipt of the recommendation or reconsidered recommendation, the Clinical Systems Committee shall make its decision and send the affected person written notification, including a statement of the basis of the decision. A member or practitioner shall also be notified of the right to request appellate review to the co-chairs of the Clinical Systems Committee within thirty (30) days of the notice.

If the decision is to grant fewer privileges than requested or to reduce, suspend, or terminate privileges and the affected member or practitioner did not have an opportunity to request a hearing under Article IV, Section 4.6.2, Credentials Panel Recommendations or 4.6.6, Summary Suspension, the Clinical Staff member or practitioner shall be entitled to a hearing as provided in Article IV, Section 4.6.3, Hearing. Failure to make a written request for a hearing to the chair of the Clinical Staff Affairs Subcommittee within thirty (30) days of receiving notice shall constitute a waiver of the right to a hearing. If a hearing is conducted pursuant to Article IV, Section 4.6.3, Hearing, the Clinical Systems Committee shall, within thirty (30) days of receipt of the report and recommendation of the Hearing Committee, make a reconsidered decision, and send the affected member or practitioner written notification of the decision, including a statement of the basis of the decision and the right to request appellate review to the co-chairs of the Clinical Systems Committee within thirty (30) days of the notice.

4.6.5. Appellate Review. If the decision is adverse to the member or practitioner, the affected member or practitioner may request appellate review by the Clinical Systems Committee on the grounds that:

A. there was substantial failure of the Hearing Committee or the Clinical Systems Committee to comply with these Bylaws or the procedures adopted by the Clinical Systems Committee for the conduct of the hearing and decisions upon hearing so as to deny due process or a fair hearing;

B. the action was taken arbitrarily, capriciously or with prejudice; or

C. the action of the Hearing Committee or Clinical Systems Committee was not supported by substantial evidence in the record as a whole.

Failure to make a written request for appellate review to the co-chairs of the Clinical Systems Committee within thirty (30) days of receiving notice shall be deemed an acceptance of the decision of the Clinical Systems Committee. The Clinical Systems Committee shall notify the affected member or practitioner, no less than fourteen (14) days before the appellate review, of the date, time, and place of the review. The appellate review committee shall be composed of five (5) members of the Clinical Systems Committee, selected by the co-chairs of the Clinical Systems Committee, to ensure that the committee is impartial. Any individual who has participated in initiating or investigating the underlying matters at issue is disqualified from serving on the appellate review committee.

At the written request of the affected member or practitioner and the approval of the co-chairs of the Clinical Systems Committee, the affected person may waive adherence to the hearing time requirements. When the member or practitioner requesting review is under suspension, such review shall be scheduled as soon as arrangements for it may be reasonably made, upon mutual consent of the co-chairs of the Clinical Systems Committee and the affected member or practitioner.

The affected member or practitioner shall have access to the report and record of the Hearing Committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation. The affected member or practitioner shall have ten (10) days from the time of the request to submit to the co-chairs of the Clinical Systems Committee a written statement in support of the position on appeal, specifying the factual or procedural matters that are the basis for the appeal, which are limited to the grounds for appellate review listed in Article IV, Section 4.6.5, Appellate Review and the reasons for such disagreement.

The appellate review committee shall review the records created in the proceedings, the written recommendation of the Hearing Committee, and shall consider any written statement timely submitted by the affected member or practitioner for the purpose of determining whether the adverse recommendation against the affected member or practitioner was supported by substantial evidence in the record, was not arbitrary or capricious, and whether due process and a fair hearing was provided to the affected member or practitioner. The affected member or practitioner shall be present at the appellate review and may be represented by an attorney. The person shall be permitted to speak against the adverse recommendation, limited to the scope of the appellate review, and shall answer questions of any member of the appellate review committee. The Clinical Staff may be represented by the chair of the Clinical Staff Affairs Subcommittee, or other individual to speak in favor of the adverse recommendation, and shall answer questions of any member of the appellate review committee. The appellate review committee may not accept additional oral and written evidence. Within twenty-one (21) days of completion of the appellate review, the appellate review committee shall submit its report to the Clinical Systems Committee. The Clinical Systems Committee may affirm, modify, or reverse its prior decision, within thirty (30) days of receiving the report from the appellate review committee. The affected member or practitioner shall be sent written notification of the final decision, including a statement of the basis of the decision, within five (5) days.

The decision of the Clinical Systems Committee is final, subject only to the discretionary appeal to the Board of Regents provided in Section III-31 of the University Operations Manual.

The procedures provided in Section III-29.6 of the University Operations Manual shall not be available in any action concerning privileges.

4.6.6. Summary Suspension. The co-chairs of the Clinical Systems Committee, chair of the Clinical Staff Affairs Subcommittee, or the Clinical Service Head for the member or practitioner shall have the authority, whenever action must be taken immediately in the best interests of patient care at the UIHC, to summarily suspend all or any portion of the privileges of any member or practitioner, and the suspension shall be immediately effective. The affected member or practitioner will be notified in writing of the reasons for the suspension within twenty-four (24) hours. The affected member or practitioner shall be entitled to a hearing, within a reasonable time, as provided in Article IV, Section 4.6.3, Hearing. Upon mutual consent of the affected member or practitioner and the chair of the Clinical Staff Affairs Subcommittee, the hearing will be held as soon as arrangements can be made. Failure to make a written request for a hearing to the chair of the Clinical Staff Affairs Subcommittee within thirty (30) days of the suspension shall constitute a waiver of the right to a hearing. If the right to a hearing is waived, the suspended privileges can be restored only by an application for increased privileges as provided in Article IV, Section 4.5, Procedures for Delineating Clinical Privileges. If the hearing is not waived, the Hearing Committee may temporarily restore all or part of the suspended privileges, pending final determination by the Clinical Systems Committee. The Hearing Committee, in accord with Article IV, Section 4.6.3, Hearing, shall make its report and recommendation to the Clinical Systems Committee and they shall be handled as a recommendation of the Credentials Panel as provided in Article IV, Section 4.6.4, Clinical Systems Committee Action. The Hearing Committee shall also send written notification to the affected member or practitioner, including a statement of the basis of the recommendation.

The chair of the Clinical Staff Affairs Subcommittee or the applicable Clinical Service Head will be responsible for arranging for alternative medical coverage for the patients of the suspended member or practitioner still in the UIHC at the time of suspension.

4.6.7. Automatic Suspension. The co-chairs of the Clinical Systems Committee, the chair of the Clinical Staff Affairs Subcommittee, or the applicable Clinical Service Head shall have the authority to automatically suspend the privileges of any member or practitioner who fails to complete medical records in accordance with the Clinical Staff rules and regulations or whenever a member's or practitioner's license to practice in Iowa is revoked, restricted, or suspended. Privileges will be reinstated by the co-chairs of the Clinical Systems Committee or the chair of the Clinical Staff Affairs Subcommittee upon demonstrated compliance.

The chair of the Clinical Staff Affairs Subcommittee or the applicable Clinical Service Head will be responsible for arranging alternative medical coverage for the patients of the suspended member or practitioner still in the UIHC at the time of suspension.

Section 4.7. House Staff Member Rights. The House Staff Graduate Medical or Dental Education Appointment Contract is for no more than a twelve (12) month duration and may be renewed annually upon satisfactory performance in the training program. In the event that the Training Program Director does not recommend renewal of a House Staff member's contract due to unsatisfactory progress in the training program and the training program has not been completed, the affected House Staff member shall be so notified in writing at least three (3) months prior to the expiration of the contract, which shall include a statement of the grounds for the decision. A decision not to renew made within three (3) months of the expiration or a decision to cancel a renewed contract before the beginning of the contract period shall be considered a discharge and must be based on grounds that would justify discharge during a contract period.

A Training Program Director may suspend without pay or discharge a House Staff physician or dentist during a contract period for unprofessional or unethical conduct, illegal actions, gross unsatisfactory performance, or failure to observe these Bylaws, directives of the Clinical Systems Committee, or rules and

regulations of the applicable Clinical Service. After explaining the grounds for suspension or discharge to the House Staff member, the Training Program Director shall give written notice of the suspension or discharge to the House Staff member, including a statement of the grounds for the action, the right to a hearing as provided in Article IV, Section 4.6.3, Hearing, and a summary of the House Staff member's rights.

A suspended or discharged House Staff physician or dentist shall be entitled to a hearing before a body appointed by the chair of the Clinical Staff Affairs Subcommittee. Failure to make a written request for a hearing to the chair of the Clinical Staff Affairs Subcommittee within thirty (30) days of receiving written notice of suspension or discharge shall constitute a waiver of the right to a hearing. The Hearing Committee shall be composed of no less than four (4) members of the Clinical Staff Affairs Subcommittee and three (3) House Staff physicians or dentists, selected so as to provide an impartial tribunal. The hearing shall be conducted in accordance with Article IV, Section 4.6.3, Hearing, except for the composition of the Hearing Committee and the recipient of the Hearing Committee's decision. The chair of the Hearing Committee shall give written notice of the committee's decision to the affected House Staff physician or dentist, the Training Program Director, and the Chief Executive Officer of the UIHC, including a statement of the basis for the decision. At the written request of the affected House Staff physician or dentist and the approval of the chair of the Clinical Staff Affairs Subcommittee, the House Staff physician or dentist may waive adherence to the hearing time requirements.

The decision of the Hearing Committee is final, subject only to discretionary appeal to the Board of Regents provided in Sections III-31 of the University Operations Manual. This procedure and those in this Section shall be exclusive.

The procedures provided in Section III-29.6 of the University Operations Manual shall not be available in any action concerning privileges.

Other concerns of House Staff members shall be addressed through procedures approved by the Clinical Systems Committee.

Section 4.8. Patient Care Responsibility.

4.8.1. Clinical Service Head. Each Clinical Service Head shall have supervision over the clinical activities of the Clinical Service.

4.8.2. Services. Each Clinical Service shall provide for one or more Services. A Service shall consist of one or more Attending Physicians or Dentists, and may include one or more House Staff members. On admission to the UIHC, each patient is assigned to the Service of an Attending Physician or Dentist.

4.8.3. Attending Physicians and Dentists. An Attending Physician or Dentist shall be a member of the Active Clinical Staff or the Emeritus Staff. The Attending Physician or Dentist shall be responsible for ordering (and when appropriate, performing) all diagnostic and therapeutic procedures performed for the patients assigned to the Attending Physician or Dentist's Service. The Attending Physician or Dentist may delegate to other members of the Service or the patient care team those procedures which, based on professional judgment, they are capable of performing legally, safely, and effectively, providing that the Attending Physician or Dentist or another Attending Physician or Dentist, is readily available for consultation during the performance of these activities. Under these circumstances, the Attending Physician or Dentist retains responsibility for these clinical activities.

In the event that the Attending Physician or Dentist expects to be unavailable, the Attending Physician or Dentist shall be responsible to designate another member of the Active Clinical Staff or the Emeritus Staff as Attending Physician or Dentist for the patient(s) and to report this action to the Clinical Service Head. If, for any reason, the Attending Physician or Dentist fails to make this designation and is not available, another member of the Active Clinical Staff or Emeritus Staff shall be designated by the Clinical Service Head as the Attending Physician or Dentist for the patient(s) concerned.

In the discharge of this responsibility for the care of patients, on the Service, the Attending Physician or Dentist shall comply with the regulations and policies issued by the Clinical Services.

Section 4.9. Clinical Service Meetings. Each Clinical Service shall meet on a regular basis, not less than once per month, and attendance by the members and practitioners with privileges in the Clinical Service shall be required. Such meetings shall serve as an instrument to accomplish a critical review of all medical or dental practices within each Clinical Service. Minutes shall be maintained and shall contain at least a listing of the Clinical Service members present, the subject matter and clinical problems discussed and actions taken. Attendance will be reported to the appropriate credentials panel through the Clinical Service Head for consideration during the credentialing process.

ARTICLE V. EVALUATION OF CLINICAL CARE

Section 5.1. Performance Improvement Program. The Clinical Systems Committee shall adopt, annually review, and, as necessary, revise a Performance Improvement Program to evaluate the quality of professional services and to take appropriate actions based on those evaluations. The Performance Improvement Program shall include the Clinical Service Quality and Performance Improvement Program, the Quality and Safety Oversight Subcommittee, the Clinical Systems Committee, and other subcommittees designated by the Clinical Systems Committee.

Section 5.2. Medical and Dental Audit. Each Clinical Service shall have a Medical or Dental Quality and Performance Improvement Committee which shall be appointed by the Clinical Service Head and be a working group of the Quality and Safety Oversight Subcommittee. The Committee shall measure the extent to which patient care delivered in the Clinical Service satisfies standards of care formulated pursuant to the Performance Improvement Program and take constructive intradepartmental action on the evaluation results.

Section 5.3. Surgical Pathology Review. Any tissues removed surgically must be sent to Pathology unless prior written approval has been obtained by the responsible physician from the Director of Surgical Pathology, or designee. Each instance of normal tissue and/or variation between preoperative diagnosis and pathological findings shall be reported to the appropriate Clinical Service Head. These cases shall be prepared for presentation at a subsequent Clinical Service conference.

Section 5.4. Clinical Service Ongoing Review. Each Clinical Service shall maintain a continuous review of the clinical practice of those persons having privileges in the Clinical Service. Particular attention shall be devoted to cases involving selected deaths, unimproved patients, nosocomial infections, questionable diagnosis or treatment, and patients with complications of their illnesses. It shall be the responsibility of the Clinical Service Heads to assure the accomplishment of this review objective and that the specific procedures as contained in Article V, Sections 5.2, Medical and Dental Audit and 5.3, Surgical Pathology Review are followed.

ARTICLE VI. CLINICAL SERVICE RULES AND REGULATIONS

Each Clinical Service Head shall adopt such clinical rules and regulations as may be necessary for proper conduct and administration of the Clinical Service. These shall relate to the proper conduct of Clinical Service organizational activities as well as the level of practice that is to be required of each person with privileges in the respective Clinical Service. No rules, regulations or procedures in conflict with these Bylaws may be adopted.

ARTICLE VII. AMENDMENTS

Proposals for amendments or changes in amendments to these Bylaws must be presented in writing by a member of the Clinical Systems Committee. Such proposals shall require the approval of the Clinical Systems Committee by a majority vote of a quorum of the Committee.

Amendments to Article VIII shall take effect upon such approval by the Clinical Systems Committee. Amendments to Articles I through VII, inclusive, shall also require approval by a majority of the Board of Regents upon recommendation by the President of the University, and shall take effect upon approval by the Clinical Systems Committee, the President of the University, and the Board of Regents. The Bylaws will be reviewed as necessary by the Clinical Systems Committee.

ARTICLE VIII. PATIENT CARE RULES AND REGULATIONS

Section 8.1. Patient Service Assignment. All patients admitted to the UIHC as inpatients or housed outpatients shall be assigned to the Clinical Service of their Attending Physician or Dentist who pledges to provide or arrange for continuous care for patients. Except in an emergency, no patient shall be admitted to the UIHC until after a provisional diagnosis has been made. In cases of emergency, the provisional diagnosis shall be stated as soon after admission as possible.

Section 8.2. Assignment Without Regard to Financial Status. Patient care activities shall be related to the UIHC's teaching programs without regard to the financial status of the patient. Each patient shall be assigned to a patient care team headed by an Attending Physician or Dentist. House Staff physicians, dentists, and students of various health disciplines may be assigned to the patient care team of any patient.

Section 8.3. Admission Information. Physicians and dentists requesting admission of patients shall be responsible for providing such information as may be necessary to assure the protection of other patients and the UIHC personnel from those patients who constitute a source of danger from any cause whatsoever.

Section 8.4. Order Documentation. Orders for medication or treatment shall be in writing, shall be timed and dated, and shall be signed by the member or practitioner giving the order, with the following exceptions:

8.4.1. In cases of emergency, verbal orders may be accepted from members or practitioners.

8.4.2. In cases when the member or practitioner is unable to be present to write the necessary order and delaying administering the medication or performing the treatment would be adverse to the patient's welfare.

8.4.3. All verbal orders, including those regarding bed occupancy, will be accepted and documented per hospital policy.

Medical students who have completed eighteen (18) months of medical school may write orders for review and approval by a licensed independent provider. Written orders by medical students shall be co-signed by the patient's Attending Physician or a House Staff member under his/her supervision before they will be carried out by the nursing staff or any other professional staff. It is the responsibility of the medical student to obtain the co-signature. For patients who have been declared brain dead per hospital policy and family has given consent to organ donation, the patient may have orders written by the Organ Donor Coordinator(s) from the Organ Procurement Organization.

For the purpose of this Article VIII, Section 8.4 Order Documentation, the words "sign" and "signature" include an electronic signature entered pursuant to a verification protocol approved by the Health Information Management Systems Working Group.

Section 8.5. Preparation of Medical Record. The Attending Physician or Dentist shall be responsible for the preparation of a complete, accurate, and legible medical record for each patient. This record shall be prepared in accordance with the format issued by the Health Information Management Systems Working Group and conform to the standards of The Joint Commission, and governmental regulating bodies. Medical records shall be safeguarded against loss, defacement, tampering, or use by unauthorized persons. Records shall be removed from the UIHC's jurisdiction only in accordance with a court order, subpoena, or statute.

Section 8.6. Standard Orders. Standard orders may be adopted, as needed by the various Clinical Services and Clinical Divisions, but they must be individually signed. Standard orders must be reviewed, revised as necessary, and readopted at least annually. Drug orders and prescriptions shall be written by the generic name unless the preparation has a simple proprietary name and a complex generic name. Drug dosages shall be written in the metric system.

Section 8.7. Documentation of History and Physical. A medical history and physical examination shall be completed and documented for each patient no more than thirty (30) days before, or twenty-four (24) hours after, admission or registration for a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a member of the Clinical Staff or other practitioners privileged pursuant to Article IV, Section 4.4.6, Clinical Privileges for Other Practitioners. An updated examination must be completed prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within thirty (30) days before admission or registration (in a non-inpatient setting). The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a member of the Clinical Staff or other practitioners privileged pursuant to Article IV, Section 4.4.6, Clinical Privileges for Other Practitioners. If the circumstances are such that a delay is necessary, a brief admission note may be recorded pending completion of the history and physical examination.

Section 8.8. Informed Consent. A procedure shall be performed only upon the informed consent of the patient or the patient's legal representative, except in emergencies or pursuant to a court order. Operative reports dictated or written immediately after surgery record the name of the primary surgeon and assistants, findings, technical procedures used, specimens removed, and postoperative diagnosis. The completed operative report is authenticated by the surgeon and filed in the medical record as soon as possible after surgery. When the operative report is not placed in the medical record immediately after surgery, a progress note is entered immediately. The medical record should reflect a post-anesthetic evaluation made by an individual qualified to administer anesthesia within forty-eight (48) hours after surgery. This report should document the cardiopulmonary status, level of consciousness, observations and/or patient instructions given, and any complications occurring during post-anesthetic recovery. All tissues removed will be sent

to the Pathology Laboratory, where such examinations will be made as may be considered necessary to arrive at a diagnosis. Reports of such examinations shall be signed by the responsible physician and filed in the medical record and in the pathology files.

In addition, when tissues that have been removed at other institutions are to be used as a basis for developing, recommending or continuing a treatment plan by an Attending Physician or Dentist, the tissues shall be sent to the Pathology Laboratory for a formal examination prior to implementing the treatment plan, unless, in the best medical judgment of the Attending Physician or Dentist, a delay in starting treatment would constitute a significant hazard for the patient. Specific exceptions to this policy may be granted by the Diagnostic Services Working Group following a written petition from a clinical division or department.

Section 8.9. Discharge. Patients shall be discharged only upon written order of a member or practitioner. Patients who sign out against medical advice shall be requested to sign a suitable release form. Records of discharged patients shall be completed within fourteen (14) days following discharge. The clinical resume should be concise and include information relative to the reason for hospitalization, pertinent findings, procedures performed, care, treatment and services provided, the condition of the patient on discharge, and instructions given to the patient and/or the family as appropriate. All final diagnoses shall be recorded in full.

Section 8.10. Autopsies. All members of the Clinical Staff are expected to be actively interested in acquiring permission to perform autopsies. No autopsy shall be performed without the written consent of a person legally authorized to consent. All autopsies shall be supervised by a member of the Active Clinical Staff of the Pathology Department. Physicians seeking permission for autopsies shall explain adequately to the decedent's representative what constitutes a routine autopsy and that the extent of the permission granted by such individual will not be violated. The Pathology Department shall be notified regarding exceptions in autopsy procedures so that the intent of the person giving the consent shall not be violated. The completed autopsy report shall be made part of the patient's medical record within ninety (90) daysof the patient's death.

Section 8.11. Death Certificates. The Attending Physician or resident physician is responsible for signing the death certificate in a timely manner when requested to do so by a funeral director and/or by a Decedent Care Center staff member.

Section 8.12. Formulary. The Formulary and Handbook of the UIHC shall be published each year for the benefit of the Clinical Staff and other health care professionals at the UIHC. This document shall include specific policies and procedures to be followed with regard to administrative and clinical matters andshall be reviewed and approved annually by the Pharmacy and Therapeutics Working Group.

Drugs used shall be those listed in the U.S. Pharmacopeia – National Formulary, the Formulary and Handbook of the UIHC, or approved by the Pharmacy and Therapeutics Working Group. When trade or proprietary nomenclature for a drug is employed, the Clinical Staff of the UIHC authorizes generically equivalent drugs approved by the Pharmacy and Therapeutics Working Group to be dispensed by the Pharmacy Department and administered by the Department of Nursing and other persons authorized to administer medications. Additionally, the Clinical Staff authorizes the substitution of drugs that are chemically dissimilar but have been judged by the Pharmacy and Therapeutics Working Group to be therapeutically equivalent. If substitution is not acceptable, the physician, or dentist must write on the prescription that only the brand specified is acceptable. The Pharmacy will act to obtain and dispense such brand on such indication that only a specific brand is acceptable.

The Clinical Staff authorizes the conversion of ordered doses of selected drugs, as specified by the Pharmacy and Therapeutics Working Group, to standardized dosages in accord with dose conversion protocols approved by the Pharmacy and Therapeutics Working Group. The Clinical Staff authorizes the Pharmacy Department to dispense, and the Nursing Department and other persons authorized to administer medications to administer, those converted doses. If conversion is not acceptable, the physician or dentist must write on the medication order that only the exact dose specified is acceptable. Pharmacy will prepare and dispense the specified dose on such indication that only that dose is acceptable.

Section 8.13. Joint Patient Responsibility. Where there is joint patient responsibility among Clinical Staff members of two or more Clinical Services, it shall be necessary to delineate responsibility. All members of the Clinical Services involved in the care of the patient shall accordingly know in whom basic responsibility for making the primary decisions lies and who, in turn, is performing a consultative function. Any conflicts with regard to basic responsibility for a patient shall be adjudicated by the Heads of the Clinical Services involved or, if they are unable to resolve the conflict, the Chief of Staff.

Section 8.14. Dental Care Coordination. In accord with The Joint Commission's standards, all inpatients of the Hospital Dentistry Clinical Service shall receive the same basic clinical appraisal as patients assigned to other Clinical Services. A physician member of the Active Clinical Staff or the Emeritus Staff shall be responsible for the care of any medical problem that may be present, or that may arise concerning a dental patient or other inpatient receiving dental care. A physician's monitoring of hospitalized dental patients is unnecessary unless a medical problem is present upon admission. It is the dentist's obligation to request consultation with an appropriate physician when a medical problem arises during hospitalization of the dental patient. The Head of the Department of Surgery, or his designee, shall provide overall supervision of surgical procedures performed by dentists who are not oral surgeons, which means that the Head of Department of Surgery shall be available for consultation or involvement as necessary, but does not mean that the Head of Department of Surgery must be present.

Section 8.15. Emergency Services. The Director of the Emergency Treatment Center shall be a member of the Active Clinical Staff. The Director shall be designated by the Chief Executive Officer of the UIHC, in concert with the Head of the Clinical Service in which the member is appointed, to be responsible for monitoring the daily operations of the Emergency Room. Each Clinical Service Head is responsible for arranging for the availability of members of the Clinical Service Head's Clinical Service to provide consultative and treatment services for emergency patients and to assure that patients presenting for specialty care are provided appropriate and timely service. All members of the Clinical Staff of the UIHC shall participate in the overall plan for the reception and treatment of emergency patients as set forth in the approved Emergency Service Operations Manual.

Section 8.16. Continuing Education. Members of the Clinical Staff are encouraged to participate in continuing education programs sponsored by the Clinical Services of the UIHC, the CCOM and the College of Dentistry, and organizations outside of the UIHC. Participation in the roles of both students and teachers is recognized as the means of continuously improving the service rendered by the Clinical Staff.

Section 8.17. Professional Charges. To avoid confusing multiple billings to patients and to assure appropriate controls of costs to patients, no professional charges for services rendered by a Clinical Staff member may be submitted to patients for services within the UIHC, except through the faculty practice plan currently known as University of Iowa Physicians and Dental Service Plan fee billings, unless prior written permission has been given by the Chief Executive Officer of the UIHC or designee.

Section 8.18. Faculty Practice Plan and Dental Service Plan. The Faculty Practice Plan is organized for the purpose of administering certain funds received in the course of medical practice at the UIHC and other locations. The Faculty Practice Plan shall purchase collection services from the UIHC. The Dental Service Plan is organized for the purpose of administering certain funds received in the course of dental practice at the UIHC and other locations. For services performed within the UIHC, the Dental Service Plan shall purchase collection services from the UIHC.

Section 8.19. Disaster Plan. In case of a civil or natural disaster, the UIHC shall follow the Disaster Plan approved by the Clinical Systems Committee.

APPENDICES

Appendix I	.....	The University of Iowa Hospitals and Clinics Departments
Appendix II	.....	Practitioners Credentialed by the Health Care Professionals Subpanel

APPENDIX I

THE UNIVERSITY OF IOWA HOSPITALS AND CLINICS DEPARTMENTS

The following hospital departments have been established pursuant to Article II, Section 2.2.2(I) of the Amended and Restated Bylaws, Rules and Regulations of the University of Iowa Hospitals and Clinics and its Clinical Staff:

Professional Departments

Food and Nutrition Services
Nursing Services and Patient Care
Rehabilitation Therapies
Respiratory Care
Pathology
Emergency Department
Pharmaceutical Care
Quality Improvement Program
Social Services & Care Coordination
Spiritual Services
Radiology

Other Departments

Capital Management
Emergency Management
Engineering Services
Environmental Services
Financial Operations
Guest Services
Health Care Information Systems
Health Information Management
Human Resources
Joint Office for Compliance
Marketing and Communications
Office of the Patient Experience
Operations Excellence
Patient Financial Services
Procurement
Revenue Management
Safety and Security
Supply Chain
Strategic Planning
Volunteer Services

APPENDIX II

PRACTITIONERS CREDENTIALED BY HEALTH CARE PROFESSIONALS SUBPANEL

The following categories of health care professionals is a representative list of those health care professions currently credentialed by the Health Care Professionals Subpanel under Article III, Section 3.9.1(A)(4)(b). The list in this Appendix II is for illustrative purposes only and is not intended to limit the categories of health care professionals that may be credentialed by the Health Care Professionals Subpanel.

Health Care Professionals

Audiologist (PhD)
Audiologist (AuD)
Cytogeneticist (PhD)
Licensed Marital and Family Therapist (PhD)
Licensed Marital and Family Therapist (LMFT)
Medical Physicist (PhD)
Medical Physicist (MS)
Optometrist (OD)
Podiatrist (DPM)
Psychologist (PhD)
Psychologist (PsyD)
Speech Pathologist (SLP)