

## LEE HEALTH POLICY & PROCEDURES

<b>DEPARTMENT OF SURGERY CCH, GCMC, HPMC &amp; LMH</b>		<b>LOCATOR NUMBER</b>																		
<b>T Y P E</b>	<input type="checkbox"/> <b>System-wide</b> - A formal statement of values, intents (policy), and expectations (procedure) that applies to every employee throughout the System.	<b>CHAPTER: M14</b>																		
	<input checked="" type="checkbox"/> <b>Multidisciplinary</b> - A formal statement of values, intents (policy), and expectations (procedure) that applies to more than one discipline and is usually of a clinical nature. <b>Check below all areas to which this applies.</b>	<b>TAB: 01</b>																		
	<input type="checkbox"/> <b>Departmental</b> - A formal statement of values, intents (policy), and expectations (procedure) exclusive to a particular department or group of people within a department at one or multiple locations that does not impact any other area.	<b>POLICY #: 078</b>																		
<b>Disciplines / locations to which this multidisciplinary policy applies:</b>																				
<table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Health Information Management</td> <td><input type="checkbox"/> Pharmacy</td> <td><input type="checkbox"/> Acute Care Hospital Nursing</td> </tr> <tr> <td><input type="checkbox"/> Housekeeping</td> <td><input type="checkbox"/> Plant Operations</td> <td><input type="checkbox"/> Outpatient Services</td> </tr> <tr> <td><input type="checkbox"/> Information Systems</td> <td><input type="checkbox"/> Radiology</td> <td><input type="checkbox"/> Home Health</td> </tr> <tr> <td><input type="checkbox"/> Laboratory</td> <td><input type="checkbox"/> Rehabilitation Services</td> <td><input type="checkbox"/> Skilled Nursing Services</td> </tr> <tr> <td><input type="checkbox"/> Legal Services</td> <td><input type="checkbox"/> Respiratory</td> <td><input type="checkbox"/> Nutrition</td> </tr> <tr> <td><input checked="" type="checkbox"/> Medical Staff</td> <td><input type="checkbox"/> Security</td> <td><input type="checkbox"/> Rehab Hospital</td> </tr> </table>			<input type="checkbox"/> Health Information Management	<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Acute Care Hospital Nursing	<input type="checkbox"/> Housekeeping	<input type="checkbox"/> Plant Operations	<input type="checkbox"/> Outpatient Services	<input type="checkbox"/> Information Systems	<input type="checkbox"/> Radiology	<input type="checkbox"/> Home Health	<input type="checkbox"/> Laboratory	<input type="checkbox"/> Rehabilitation Services	<input type="checkbox"/> Skilled Nursing Services	<input type="checkbox"/> Legal Services	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Nutrition	<input checked="" type="checkbox"/> Medical Staff	<input type="checkbox"/> Security	<input type="checkbox"/> Rehab Hospital
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<b>Clinical Practice Council:</b>		<b>Date:</b>																		
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<b>Education Required:</b>	<b>Yes No:</b> <input type="checkbox"/> <input type="checkbox"/>	<b>Date:</b>																		
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<b>Policy Administrator:</b>	<b>Mark A. Greenberg, MD</b>	<b>Date: 9/8/20</b>																		
<b>As Needed:</b>																				
<b>GCMC Executive Committee</b>		<b>Date: 4/12/21</b>																		
<b>HPMC Executive Committee</b>		<b>Date: 4/13/21</b>																		
<b>LMH Executive Committee</b>		<b>Date: 4/14/21</b>																		
<b>CCH Executive Committee</b>		<b>Date: 4/19/21</b>																		
<b>GCHSWF Executive Committee</b>		<b>Date: 4/20/21</b>																		
<b>As needed:</b>																				
<b>Board of Directors</b>		<b>Date:</b>																		

## **Section 1 - Purpose of the Department:**

The purpose of the Department of Surgery is to develop, advance and coordinate all aspects of care within the Department of Surgery with the goal of providing safe, quality, efficient and effective care.

## **Section 2 - Appointment:**

All members of a surgical specialty or sub-specialty shall be members of this Department.

## **Section 3 - Department Structure and Meetings:**

- A. A physician from Lee Memorial Hospital ("LMH"), Cape Coral Hospital ("CCH"), Gulf Coast Medical Center ("GCMC") and HealthPark Medical Center ("HPMC") will be elected to chair the Department of Surgery meeting and serve on their respective Facility Medical Executive Committees (FMEC) for a two-year term which may be renewed upon Department Chair agreement and Nominating Committee recommendation.
- B. Each Department of Surgery for Cape Coral Hospital, Gulf Coast Medical Center, Lee Memorial Hospital and HealthPark Medical Center elects to operate jointly in order to develop, advance and coordinate patient care. Nothing herein is intended to abrogate the authority and responsibility of each Department and FMEC to oversee care delivery and quality improvements within each Department/FMEC's individual hospital. Each facility Department of Surgery, facility Medical Staff Quality Committee and FMEC retains all authority and responsibility for the quality of medical care provided to patients by its individual hospital as set forth in each facility medical Staff Bylaws.
- C. The Department of Surgery shall meet as frequently as needed to fulfill assigned duties and when requested by the FMEC as required in the Medical Staff Bylaws, Part 1, Section 6. Meetings may be called by a majority of Department Chairs or in the case of four Department Chairs, at least two chairs.

Meetings may be called with three days' notice and require an agenda with identified system-wide issues for discussion and/or action. The Medical Staff Services Department provides support for departmental meetings.

- D. Only Active Medical Staff appointees are eligible to vote at Department meetings. All actions of the Department will be decided by majority vote of those active appointees present and voting, or those submitting votes electronically or by other means approved for use in the voting, except changes to these Department Rules and Regulations require affirmative vote by 51 percent of voting active staff in the Department.
- E. Voting may be done by mail, email, fax, online survey tools or other electronic means available and approved by the Department Chairs.
- F. The Department of Surgery adopts Departmental Rules and Regulations in order to fulfill the duties set forth in the Medical Staff Bylaws and applicable Medical Staff Rules and Regulations. Revisions to such Department Rules and Regulations may be proposed to the FMEC by the Department Chair, to the Department by the Department Chair, or to the Department Chair by Department members. All revisions proposed by members must be approved by the Department Chairs before advancing for a vote. If Department

members wish to over-ride a decision by Department Chairs on advancing proposed revisions for a vote, the proposed revisions may be advanced for a vote upon a written request of 20 percent of Department members or 51 percent of those voting. Revisions to the Departmental Rules and Regulations require 15 days' advance notice to all active Department members and approval of 51 percent of active Department members submitting votes. Voting may be by mail, email, fax, online survey tools or other electronic means available and approved by the Department Chairs.

- G. Departmental Rules and Regulations will become effective upon approval of the FMEC. Should a conflict exist between the provisions of the Medical Staff Bylaws and the Rules and Regulations or Medical Staff policies, the Bylaws will prevail. Should a conflict exist between the provisions of the Rules and Regulations and the Medical Staff Policies, the Rules and Regulations will prevail.

#### **Section 4 – Department Sections:**

Sections may be formed within the Department of Surgery and meet as outlined in Part 1, Section 6.1.1 in the Medical Staff Bylaws.

#### **Section 5 - Sections of the Department of Surgery**

- A. Clinical Sections:  
Clinical Sections may be established and meet as specified in the M.S. Bylaws, Part 1, Section 6.1.1. Sections may be called with three days' notice and require written notice of items to be discussed delivered electronically by fax or email.
- B. Sections:  
Each physician practicing in a surgical specialty will be a member of that specialty Section. The following Sections have been established:
1. Colorectal
  2. Dental
  3. General/Vascular Surgery
  4. Neurosurgery
  5. Ophthalmology
  6. Oral and Maxillofacial Surgery
  7. Orthopedic Surgery
  8. Otolaryngology
  9. Plastic Surgery
  10. Podiatry
  11. Thoracic Surgery
  12. Trauma Surgery
  13. Urology

C. Section Chief Functions:

1. Interview all new physicians applying for staff privileges within his/her specialty or subspecialty.
2. Serve as liaison to Chairman of the Department of Surgery on performance improvement related issues for the Section.
3. Participate in standardization of EHR through Subject Matter Expert sessions and final approval of order sets with input from Section Members.
4. With input from Section Members, makes recommendations to the Department of Surgery for approval by the FMEC on system-wide call responsibility requirements, including relief from call, when appropriate. Proposed changes to emergency call requirements must be approved by a majority of specialists impacted by recommendation before elevation to the Department and FMEC.
5. Perform other duties and responsibilities as may be set forth in the Medical Staff Bylaws.

D. Section Functions

Members of the Section will:

1. Meet as frequently as needed.
2. Elect a Section Chief to serve a two-year term of office.
3. Review and recommend criteria for granting privileges for performing specialty or subspecialty procedures.
4. Review the quality of care provided by members of the Section and make appropriate recommendations for improvement.
5. Will assist hospital administration, if requested, in matters related to specialty or subspecialty service planning.
6. Address problems within the Section and if necessary recommend action to the Department of Surgery.

**Section 6 - Facility Meetings:**

Each facility Chair may organize and hold a facility-specific meeting to deal with facility-specific issues or facility-specific policies, procedures, or protocols. System-wide policies, procedures, protocols or issues may be recommended for action at a joint Department meeting.

**Section 7 - Emergency Call:**

All surgical specialties will provide a back-up roster of physicians on call to the Emergency Department.

- A. It will be the responsibility of the physician on call to find a replacement if he/she is unable to respond when called by the Emergency Department.
1. All call schedule changes must be submitted in writing as soon as possible to the Medical Staff Services Department M-F 7:30-4 and after hours called to the Emergency Department and in writing to the Medical Staff Services Department.
  2. If the member of a group cannot take call due to an emergent injury or illness or other significant practice interruption as determined by the Department Chair, it is the responsibility of the member's group to cover his/her call for the remainder of currently published schedule(s).
  3. If solo practitioner who takes call cannot take call due to emergent injury, illness or other significant practice interruption as determined by the Department Chair, it is the responsibility of the other practitioner(s) sharing call with the solo practitioner in cooperation with the remaining physicians taking call to cover his/her call for the remainder of the currently published schedules(s).
  4. If the physician on call cannot be reached, the following procedure is used:
    - Call the physician or the group covering for the physician on call the previous twenty-four hours.
    - If she/he is unavailable, call the physician or group covering for that surgeon that was on call forty-eight hours' prior.
    - If all of the above fails, call the Chairman of the Department of Surgery.
  5. If self-scheduling is allowed for Emergency Department on call by physician office staff, violations of the rules and regulations relating to self-scheduling may result in termination of the ability to self-scheduling by the Department Chair.

B. Trauma vs. Regional Call Responsibilities

1. Patients transported to Lee Memorial Hospital with isolated general vascular injuries are not necessarily considered trauma patients. It is the judgment of the ED physician as to whether to activate the trauma service.
2. If the patient triggers a trauma alert and is admitted to the trauma service and vascular surgery is required, the trauma vascular surgeon will manage the patient.

**CCH ONLY:** Did not approve language in #3. See General Rules and Regulations.

3. If the patient has an isolated vascular injury that could have been taken care of at any of the LMHS facilities, (even if the patient is at LMH but a trauma alert has not been called) the patient is the responsibility of the general vascular surgeon on call.
4. If a patient admitted to trauma requires additional surgical intervention for injuries discovered while hospitalized, the surgeon on trauma call the day of discovery of the injury is responsible to provide surgical consultation and any required surgical care, unless the surgical specialty needed is already involved in the patient's care.

## **Section 9 - Specialists On Call:**

### **A. General Surgery**

- All general surgeons are required to take call, unless an exemption applies.
- Each surgeon shall be designated a primary hospital based on highest volume of elective general surgery cases.
- Elective general surgery case volume will be reviewed in October and April of each year for the previous six (6) months. Physicians requesting to change their primary hospital G.S. ED call coverage should submit their request in writing to Medical Staff Services by October 1<sup>st</sup> and/or April 1<sup>st</sup>. All changes must be approved by all Facility Dept. of Surgery Chairmen prior to implementation. Since ED call schedules are prepared approximately three (3) months in advance, changes will become effective January 1<sup>st</sup> and/or July 1<sup>st</sup> of each year. Exceptions need to be approved by Department of surgery Chairs and FMECs.
- Hospitals with general surgery gaps in coverage will transfer (distributed proportionately) to hospitals with coverage.
- Each surgeon's call obligation shall be established based on the number of general surgeons providing call coverage system-wide.
- Call obligation exemption – a general surgeon may be relieved from Emergency Department call responsibility, upon written request, after twenty (20) years of ED call service in this community, providing there is a minimum of seventeen (17) general surgeons system-wide providing general surgery emergency call.

### **B. Vascular Surgery**

- All Associate and Active vascular surgeons are required to take vascular call. A vascular surgeon may be relieved from Emergency Department call responsibility, upon written request, after twenty-five (25) years of service.
- All Associate and Active vascular surgeons are required to take vascular trauma call. A vascular surgeon may be relieved from vascular trauma call responsibility, upon written request, after twenty-five (25) years of service. Providing there is a minimum of twelve (12) vascular surgeons system-wide on vascular trauma call.

### **C. Otolaryngology**

An otolaryngologist may be relieved from serving on the Emergency Department backup call roster upon his/her request, if he/she has fifteen (15) years of Emergency Department backup service at Lee Memorial Health System and providing a minimum of seven (7) physicians remain to provide Emergency Department coverage.

Associate staff members will act as backup to the Emergency Department call roster in order to maintain seven (7) person coverage. In the event that a member of the active staff drops off, an associate member will fill that call slot. If there is more than one associate Staff member, all associate members will participate on a rotational basis. In the event that the addition of one or more active staff members brings the roster above the minimum of seven (7), the associate member(s) will be taken off the roster until the total drops below seven (7).

D. **Neurosurgery**

A neurosurgeon may never be relieved from the Emergency Department backup call roster.

E. **Ophthalmology**

All new ophthalmologists shall require review and recommendation from the Section Chief for assignment to the appropriate Medical Staff category in order to ensure appropriate Emergency call coverage.

Effective 6-1-15, all ophthalmologists currently with Refer and Follow Privileges are grandfathered to keep these privileges and be exempt from Emergency Call. Effective 6-1-15, each member applying to the Ophthalmology Section will be required to have privileges at a minimum of one acute care facility and take emergency call at all hospitals at which the member has Active or Associate privileges.

An ophthalmologist may be relieved from serving on the Emergency Department backup call, at his/her request, provided a minimum of twelve (12) physicians remain on the roster to provide Emergency Department coverage. Any ophthalmologist who resigns from the Medical Staffs or drops privileges voluntarily without reason will lose call tenure and be required to begin ED call service at day one if he/she rejoins the Medical Staffs.

The following six holidays will be assigned to the six newest ophthalmologists on staff: New Year's Day; Memorial Day; Fourth of July; Labor Day; Thanksgiving; and Christmas.

F. **Hand Surgery:**

Physicians taking hand call must be members of the associate or active staff who have hand surgery training through a plastic surgery residency, orthopedic residency or a hand fellowship. Any physician with hand surgery privileges will be required to take Emergency Room hand call unless he/she has been on the staff longer than ten (10) years and providing there are at least seven (7) surgeons covering the Emergency Department hand call schedule.

G. **Plastic Surgery:**

All Associate and Active Plastic Surgeons will have an ED call responsibility of no more than two (2) calls per month. A Plastic Surgeon may be relieved from serving on plastic surgery emergency call at his/her request (in writing) provided s/he has served twenty (20) years on staff.

H. **Orthopedic Surgery:**

- All Orthopedic Surgeons are required to take call, unless an exemption applies.
- Each Orthopedic Surgeon shall be designated a primary hospital based on highest volume of orthopedic surgery cases.
- Orthopedic case volume will be reviewed in October and April of each year for the previous six (6) months. Physicians requesting to change their primary hospital orthopedic ED call coverage should submit their request in writing to Medical Staff

Services by October 1<sup>st</sup> and/or April 1<sup>st</sup>. All requests for changes must be reviewed/approved by the Orthopedic Section Chief prior to implementation. Since ED call schedules are prepared approximately three (3) months in advance, changes will become effective January 1<sup>st</sup> and/or July 1<sup>st</sup> of each year.

- Call obligation exemption – an Orthopedic Surgeon may be relieved from Emergency Department call responsibility, upon written request, after fifteen (15) years of ED call service in this community, providing there is a minimum of fifteen (15) Orthopedic Surgeons remaining on the call roster to provide orthopedic emergency coverage.
- Changes can be made with majority vote of the Orthopedic Section at a Section meeting with thirty (30) days' notice.

I. **Foot Surgery**

Practitioners taking foot call must be members of the Medical Staff who have foot surgery training through a podiatric residency or orthopedic surgery residency. Foot call is mandatory for all Staff Podiatrists with surgical privileges. Foot call will remain optional for other qualified physicians. All physicians on foot call must provide at least seven (7) years of service. S/he may then be relieved from the schedule provided ten (10) practitioners remain on the foot call roster.

J. **Urologic Surgery**

All Urologists (Associate and Active) will be required to take ED call. If unable to take call, it will be his/her responsibility to arrange for adequate coverage.

When the attending physician requests a routine non-stat inpatient urology consult after 10 p.m., the consultant has until 9 a.m. the following morning to accept or refuse the consult. If the consultant does not respond by that time, he/she will be responsible for the consult. If the consultant calls and refuses the consult, the consult will revert back to the Urologist on ED call at the time of the initial consult.

K. **Facial Fracture**

The following specialties comprise the Facial Fracture call coverage: Oral & Maxillofacial Surgery, Plastic Surgery, Otolaryngology and Ocular Plastic Surgery.

All new physicians in these specialties who are trained and can demonstrate competence are required to take facial fracture call. A physician may be relieved if he/she has served a minimum of fifteen (15) years and there is a minimum of twelve (12) physicians remaining on the roster.

**Section 10 - Tissue Removal:**

All tissue removed at surgery shall be referred to the Hospital's Pathologist for interpretation and report excepting those tissues listed below which should be left to the discretion of the attending surgeon as to whether or not they are sent for pathological examination:

- A. Tissue removed during the course of repair of fresh trauma, e.g., normal bone fragments, muscle, torn pieces of tendon



- B. Removed internal fixation hardware or wires
- C. Neurosurgical prosthesis and shunts
- D. Skull bone flaps and bone fragments
- E. Intracerebral and extracerebral blood clots
- F. Hyperplastic gingival tissue and teeth
- G. Nasal cartilage and nasal bone
- H. Ear ossicles
- I. Salivary stones
- J. Normal skin, necrotic skin and excised scars
- K. Cataracts
- L. Skin and tarsal plate resulting from plastic surgery to the eye
- M. I.U.D.
- N. Foreskin
- O. Hernia sacs
- P. Ribs
- Q. Varicocele and vein stripping products
- R. Meniscus
- S. Nails and bunions
- T. Atheromatous plaque
- U. Vascular grafts
- V. Gall stones
- W. Urinary tract stones
- X. Foreign bodies
- Y. Placenta from cesarean sections
- Z. Disc material taken during routine spine surgery

It is at the discretion of the pathologist whether he/she performs a gross and microscopic examination in an effort to establish a definitive pathologist diagnosis. All tissue removed at operation and all specimens from patients shall be the property of the hospital.

Approved by Surgery Council: 05-25-00

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Approved by Board of Directors 02-25-10

Approved by Dept. of Surgery, LMH & HPMC FMECs 03-14-12

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Approved by the Dept. of Surgery, LMH & HPMC FMECs – November 2012

Revisions approved by:

GCMC FMEC 3-10-14

HPMC FMEC 3-11-14

LMH FMEC 3-12-14

CCH FMEC 3-17-14

CCH FMEC 5/18/15  
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HPMC FMEC 5/12/15  
LMH FMEC 5/13/15  
CCH FMEC 04/15/17  
GCMC FMEC 04/10/17  
HPMC FMEC 04/11/17  
LMH FMEC 04/12/17