# SAINT FRANCIS HOSPITAL AND MEDICAL CENTER

## MEDICAL STAFF RULES AND REGULATIONS

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ARTICLE I: INTRODUCTION

1.1 DEFINITIONS:

“ADVANCE DIRECTIVE” means a document or documentation allowing a person to give directions about future medical care, or to designate another person to make medical decisions if the individual loses decision-making capacity expressing the individual’s preferences as specified in the federal Patient Self-Determination Act and under state law.

“ADVANCED PRACTICE PROFESSIONAL” means physician assistants, advanced practice registered nurses, or nurse midwives who are authorized to care for patients under the supervision of a member of the Medical Staff.

“APPOINTEE” means any medical physician, osteopathic physician, dentist, or podiatrist holding a current license and practicing within the scope of that license as a member of the Medical Staff.

“ATTENDING PHYSICIAN” means the physician responsible for care of the patient. This responsibility may be shared by members of a group of practitioners.

“CLINICAL PRIVILEGES” means the authorization granted to a practitioner to render patient care and includes unrestricted access to those Hospital resources (including equipment, facilities, and Hospital personnel) that are necessary to effectively exercise those privileges.

“EMERGENCY” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

“FAMILY” means those persons who play a significant role in the individual’s life. This may include persons who are not legally related to the individual.

“LIFE-SUSTAINING PROCEDURE” means a medical procedure or intervention which serves only to prolong the dying process. Life-sustaining procedures do not include the administration of medication or other treatment for comfort care or alleviation of pain.

“HEALTH CARE REPRESENTATIVE” means an individual designated in a legal document as the person who has legal authority to make health care decisions on behalf of a person who is incapacitated.

“INVASIVE PROCEDURE” means a procedure involving puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including, but not limited to, percutaneous aspirations, biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties, and implantations, and excluding venipuncture and intravenous therapy.
“PATIENT” means any person undergoing diagnostic evaluation or receiving medical treatment under the auspices of the Hospital.

“PHYSICIAN” means an individual with a Doctor of Medicine or Doctor of Osteopathy degree as recognized by the Connecticut Board of Medical Examiners and who holds a current valid license to practice medicine and surgery in state of Connecticut.

“PRACTITIONER” means an appropriately licensed medical physician, osteopathic physician, dentist, podiatrist, or advance practice professional who has been granted clinical privileges.

“SURGEON” refers to any practitioner performing an operation or invasive procedure on a patient, and is not limited to members of the Department of Surgery.

“UNABLE TO CONSENT” or “INCOMPETENT” means unable to appreciate the nature and implications of the patient’s condition and proposed health care, to make a reasoned decision concerning the proposed health care, or to communicate that decision in an unambiguous manner.

Any definitions set forth in the Medical Staff Bylaws shall also apply to terms used in these Rules and Regulations.

1.2 APPLICABILITY: These Rules and Regulations are adopted by the Medical Executive Committee, and approved by the Board of Directors, to further define the general policies contained in the Medical Staff Bylaws, and to govern the discharge of professional services within the Hospital. These Rules and Regulations are binding on all Medical Staff appointees and other individuals exercising clinical privileges.

1.3 CONFLICT WITH HOSPITAL POLICY: Hospital policies concerning the delivery of health care may not conflict with the Medical Staff Rules and Regulations, and these Rules and Regulations shall prevail in any area of conflict.

1.4 DEPARTMENTAL RULES AND REGULATIONS: Members of the Medical Staff shall refer to the departmental Rules and Regulation for specific items pertaining to their respective departments. Where departmental Rules and Regulations appear to conflict with the Medical Staff Rules and Regulations, the Medical Staff Rules and Regulations shall take precedence.

1.5 AMENDMENT: These Rules and Regulations of the Medical Staff may be adopted, amended, or repealed only by the mechanism provided in the Medical Staff Bylaws.

ADOPTION: This article supersedes and replaces any and all other Medical Staff Rules and Regulations pertaining to the subject matter thereof.
ARTICLE II: ADMISSION AND DISCHARGE

2.1 ADMISSIONS: Members of the Medical Staff in the Active and Associate categories who are in good standing and who have admitting privileges may admit patients to the Hospital. The Admitting Office shall be contacted and a provisional diagnosis shall be given for all patients who are being admitted.

2.2 UNASSIGNED EMERGENCY PATIENTS: A patient who does not request a specific physician or member of the Medical Staff shall be assigned to an appropriate member of the Medical Staff for admission based upon the on-call schedule for the relevant department, clinical service, or clinical section. In general, patients with multi-system injuries due to trauma shall be admitted to the Trauma Service.

2.3 TRANSFERS: The member of the Medical Staff who admits the patient shall be responsible for the total care of the patient unless there is an agreement between two members of the Medical Staff to transfer the care of the patient to the other member. An order shall be entered into the medical record by the member who admitted the patient, or his representative, transferring the care of the patient to the member of the Medical Staff who has agreed to accept the transfer and assume care of the patient.

2.4 PROMPT ASSESSMENT OF EMERGENCY CONDITIONS: Patients experiencing an emergency condition shall undergo a prompt medical screening examination by a credentialed practitioner. All patients are entitled to a screening evaluation as outlined in the Hospital’s EMTALA policies, including with respect to certifying false labor.

2.5 DETERMINATION OF FALSE LABOR: If the patient is determined to be in false labor after the screening evaluation, then a physician shall certify the diagnosis within twenty-four (24) hours and document this certification in the medical record.

2.6 DISCHARGE ORDERS AND INSTRUCTIONS: Patients shall be discharged from the Hospital only upon the order of a credentialed practitioner. The attending physician, or his representative, is responsible for a clear set of discharge instructions that shall be communicated to the patient, or his health care agent, and to the next caregiver. A priority discharge summary shall be completed prior to the transfer of the patient to another institution.

2.7 DISCHARGE PLANNING: It is the responsibility of the attending physician, or his representative, to plan the discharge in a timely manner. Patients and their families shall be notified on the day prior to discharge of the scheduled discharge time so that transportation and appropriate services can be arranged. All home care and outpatient requirements shall be communicated to the Case Manager so that coordination of services can be accomplished.

2.8 DISCHARGE AND READMISSION THE SAME DAY: If a patient is discharged and readmitted within twenty-four (24) hours with the same problem and primary diagnosis, the attending physician, or his representative, may use the previous History and Physical but shall complete an update in the Progress Notes that addresses the changes in both the
patient’s condition and the physical examination, and shall also explain the reason for readmission.

2.9 **THERAPEUTIC LEAVE OF ABSENCE:** A patient may leave the Hospital when authorized by the attending physician, or his representative, for therapeutic reasons as long as an order has been placed in the CPOE system and the “Policy on Patient Passes to Leave the Hospital” has been followed.

2.10 **DISCHARGE AGAINST MEDICAL ADVICE:** A patient may leave the Hospital against medical advice as long as the “Policy to Discharge against Medical Advice” has been followed. If the attending physician, or his representative, feels that the patient is a danger to himself or to others, a psychiatric consultation shall be obtained as quickly as possible to determine if the patient needs to be committed or held against his wishes.

**ARTICLE III: MEDICAL RECORDS**

3.1 **GENERAL REQUIREMENTS:** The attending physician, or his representative, shall be responsible for the preparation of a complete medical record for each patient. The final obligation for completion of the medical record rests with the attending physician who discharges the patient unless it is clearly stated in the record that this responsibility rests with another member of the medical staff. The reason for the transfer of responsibility shall be clearly stated and the accepting member shall be identified. No medical record may be filed until it is complete or the Medical Records Committee has ordered the record to be filed.

3.2 **AUTHENTICATION OF ENTRIES:** The author of any entry in the medical record shall sign, date, and time all entries. The person making the entry shall ensure that this information is legible, and it is encouraged that they leave contact information, preferably a beeper number or a phone number.

3.3 **CLARITY, LEGIBILITY, COMPLETENESS:** All entries in the medical record shall be clear, legible and complete so that other Hospital personnel and medical professionals are able to understand the entry and the author’s intentions.

3.4 **ABBREVIATIONS:** Prohibited abbreviations have been determined by the Patient Safety Committee, and they shall not be used in the medical record. A list of the prohibited abbreviations appears in all medical records, and they also appear at the top of all progress notes. In general, the use of abbreviations is discouraged in order to avoid misinterpretation and confusion regarding the care of the patient.

3.5 **CORRECTIONS OF ERRORS:** Corrections to the medical record shall be made with a single line through the entry; the author shall time, date and sign this correction. When a dictated entry requires correction, the author shall dictate an addendum to the initial report.

3.6 **ADMISSION HISTORY AND PHYSICAL EXAMINATION:** A complete History and Physical Examination (H&P) shall be performed and documented by the attending
physician, or his representative, on all patients admitted to the Hospital. The requirements
for both the initial and updated History and Physical Examination (H&P) may be found in
the Medical Staff Bylaws in Part III: The Credentials Manual, paragraph 6.4. An H&P shall
be completed on all patients no more than thirty (30) days prior to admission or within
twenty-four (24) hours after the patient has been admitted. Any H&P completed thirty (30)
days prior to admission shall be updated within twenty-four (24) hours of admission or prior
to any surgical or invasive procedure. An H&P that is performed thirty (30) days prior to
admission may be completed by physicians who are not members of the Medical Staff; however, the updated H&P shall be completed by a member of the Medical Staff.

3.7 PREOPERATIVE DOCUMENTATION: Except in an emergency, a current History and
Physical Examination (H&P) shall be completed for all patients prior to undergoing any
surgical or invasive procedure. Per the Medical Staff Bylaws (Part III, paragraph 6.4) and
paragraph 3.6 (see above), any H&P completed thirty (30) days prior to admission shall be
updated prior to the surgery or the procedure. All required documentation, to include
applicable laboratory, radiological and cardiac testing and a properly executed consent form,
shall be available before the patient can undergo any surgical or invasive procedure.

3.8 PROGRESS NOTES: A daily progress note shall be completed by the attending physician,
or his representative, on each patient. Progress notes may be written or typed and placed in
the medical record. If the progress note is dictated, there shall be a notation in the medical
record that the dictated note is saved in the CPOE system.

3.9 OPERATIVE REPORTS: A brief Operative Note with all required data shall be entered in
the medical record upon completion of any surgical or invasive procedure. A complete
Operative Report shall be dictated within twenty-four (24) hours of the completion of any
surgical or invasive procedure or the physician may risk suspension in accordance with
Hospital policy.

3.10 CONSULTATIVE REPORTS: In general, consultative reports shall be placed in the
medical record within twenty-four (24) hours of the request. These consultations may be
written, typed or dictated. If the consultative report is dictated, there shall be a notation in
the medical record that the report has been completed and is in the CPOE system.

3.11 OBSTETRICAL RECORDS: A dictated discharge summary is not required for a normal
newborn or for the normal delivery of a term pregnancy provided that there were no
complications and the infant was not in the Neonatal Intensive Care Unit.

3.12 DISCHARGE SUMMARIES: The member of the medical staff who discharges the
patient shall be responsible for the discharge summary. A dictated discharge summary shall
be completed prior to the transfer of a patient to another facility. For patients going home,
the discharge summary shall be completed within thirty (30) days after discharge or the
physician may risk suspension in accordance with Hospital policy. Physicians are
encouraged to complete the discharge summary prior to or at the time of discharge. If the
discharge summary is not clear regarding the final diagnoses, a query may be sent to the
physician from the HIM Department requesting clarification. The physician shall submit the
reply to the query to HIM as soon as possible. A medical record is not complete until the discharge summary has been completed and all queries have been answered.

3.13 **DIAGNOSTIC REPORTS:** All diagnostic reports shall be included in the completed medical record. These reports may be filed in the medical record or may appear in an electronic version in the CPOE system.

3.14 **ADVANCED PRACTICE PROFESSIONALS:** Certain responsibilities of members of the Medical Staff regarding the care of the patient and completion of the medical record may be delegated to a member of the Advanced Practice Professional Staff, in accordance with the Medical Staff Bylaws (Part III, paragraph 6.1) and the Advanced Practice Professional Policy.

3.15 **ACCESS AND CONFIDENTIALITY:** Pursuant to state and federal law and all Hospital and HIPAA policies, all medical records are the property of the Hospital and may not be used for purposes other than patient care, research and education, peer review and risk management, and other valid Hospital and Medical Staff functions. Proper authorization shall be obtained prior to the release of any confidential information from the medical record in accordance with Hospital policies and state and federal regulations. Access to confidential information by members of the Medical Staff is permissible only when the person is involved in the care of the patient or engaged in authorized activities, such as peer review, credentialing, research, education, and risk management. Sharing or misuse of passwords to the CPOE system is prohibited and may result in suspension.

3.16 **MEDICAL RECORD COMPLETION:** Medical records shall be completed upon discharge of the patient from the Hospital; records not completed within thirty (30) days of discharge shall be considered delinquent. The attending physician shall be responsible for the completion of the medical record. If the medical record is not completed within twenty-one (21) days of the discharge date, the attending physician will receive a written notice that the record(s) must be completed within seven (7) days or his privileges to admit patients and to schedule surgical procedures will be suspended on the twenty-eighth (28) day. If the record(s) is not completed in this time period, a certified letter and fax will be sent to the attending physician on the twenty-eighth (28) day after discharge notifying him of the suspension of his admitting and surgical scheduling privileges. The physician will still have access to the CPOE system until the thirtieth (30) day after discharge. If the physician fails to complete the record(s) by the thirtieth (30) day, then all Hospital privileges will be suspended, to include access to the CPOE system, and he will be notified of this suspension by certified letter, fax and phone. A copy of the certified letter of suspension will be sent to his departmental chair/clinical service or section chief. The physician must contact the Director of HIM, or his representative, in order to regain access to the CPOE system and complete his record(s). Any physician suspended four (4) or more times per year will be reported to the appropriate Medical Staff Quality Review Committee and to the Medical Executive Committee (MEC) for possible disciplinary action.
3.17 ELECTRONIC RECORDS AND SIGNATURES: Signatures in the medical record may be written or electronic; an electronic signature is equivalent to a written signature and signifies concurrence with the order or report.

3.18 FORMS: All forms in the medical records, both printed and electronic, shall be approved by the Medical Records Committee and be assigned a form number prior to use in the medical record. Modification of current forms, which often result from changes in state and federal regulations, shall be handled expeditiously by the Medical Records Committee.

ARTICLE IV: STANDARDS OF PRACTICE

4.1 ATTENDING PHYSICIAN: The attending physician is the member of the Medical Staff who accepts the responsibility for the admission and care of the patient. This responsibility may be shared by members of a group, and some responsibilities may be delegated to members of the Allied Health Professional Staff. The attending physician, or his representative, shall be responsible for the completion of the admission History and Physical Examination (H&P), which shall include appropriate diagnostic strategies and a plan of treatment. The attending physician, or his representative, shall be responsible for ensuring appropriate communication to the patient and the patient’s family regarding the treatment plan and realistic goals of care. The attending physician, or his representative, shall also be responsible for the completion of the discharge summary and the medical record. If the responsibility for the care of the patient is shared by members of a group, the attending of record is the physician who discharges the patient unless otherwise clearly designated in the discharge summary.

4.2 COVERAGE AND CALL SCHEDULES: All departmental chairs/clinical service or section chiefs will arrange coverage for their departments, clinical services or sections in the form of on-call schedules. These schedules shall be prepared and communicated in a timely manner to the appropriate departments and personnel, such as the Hospital telecommunication office and the physician’s answering service, so that the physicians on-call may be contacted when their services are required. Any changes to these on-call schedules shall be communicated in a timely manner to the appropriate departments and personnel so that there is no delay in contacting the covering physician.

4.3 RESPONDING TO CALLS AND PAGES: Members of the Medical Staff shall respond to pages and calls in a timely manner; in general, all pages and calls shall be returned within fifteen (15) minutes unless there are extenuating circumstances. All STAT pages shall be returned immediately. If a member of the Medical Staff is personally unable to respond to a call or page in a timely manner due to an activity, such as surgery or involvement in a code, it is his responsibility to ensure that a qualified colleague is available to respond to any calls.

4.4 ORDERS: All orders shall be entered into the computer system, or written in the medical record in the event of computer downtime, by a physician or his designated representative. All orders shall be dated and timed and contain all required elements of information, such as dose, frequency, route for medication orders, so that the person carrying out the order has
complete understanding of the order. Verbal orders shall be utilized only when it is impractical for the prescriber to enter the order into the computer system, or written medical record during computer downtime. These orders may be entered into the CPOE system by appropriate Hospital personnel, i.e. registered nurse, dietician, pharmacist, or therapist (Occupational, Physical, Speech, or Respiratory). Verbal orders shall be countersigned by a physician within twenty-four (24) hours. The utilization of verbal orders shall be kept to an absolute minimum.

4.5 CONSULTATIONS: Except in emergency situations, consultations with an appropriate and qualified member of the Medical Staff shall be obtained when there is doubt regarding the best diagnostic and therapeutic measures to be utilized or when the proposed procedure may interrupt a known pregnancy. The attending physician, or his representative, shall arrange the consultation and specify the level of involvement of the consultant. For all STAT consultations, direct communication between the requesting physician, or his representative, and the consultant shall be required. Direct verbal communication between the attending physician and the consultant is strongly encouraged for all consultations in order to accomplish proper coordination of care.

4.6 SURGICAL AND INVASIVE PROCEDURES: All members of the Medical Staff shall have the appropriate clinical privileges for the surgical and invasive procedure that they plan to perform and shall adhere to all Hospital and departmental policies regarding these procedures. After the procedure, the physician performing the procedure and the referring physician shall decide and clearly document on whose service the patient shall be placed.

4.7 TISSUE SPECIMENS: All tissue specimens and foreign bodies removed at the time of surgery or invasive procedure, except those specified on the tissue specimen exclusion list, shall be sent to the Department of Pathology for examination in order to arrive at a pathological diagnosis. All specimens shall be handled in accordance with Hospital policies. Unless there are extenuating circumstances, the report of this examination shall be available within seventy-two (72) hours. In the event that a therapeutic intervention is planned for a patient that is based on pathological report from another institution, the physician who is planning the therapeutic intervention shall be responsible for the review of the specimen or the report prior to commencement of the therapeutic intervention.

4.8 SITE IDENTIFICATION FOR SURGERY OR PROCEDURE: In accordance with Universal Protocol, the physician shall ensure that appropriate site markings and a valid Time Out have been accomplished prior to starting a surgical or invasive procedure. These preoperative tasks shall conform to current Hospital policies.

4.9 DEATH: Members of the Medical Staff, or their representative, shall complete all required documents in the event of the death of their patient in the Hospital in accordance with Hospital policies.

4.10 AUTOPSY: Members of the Medical Staff, or their representative, shall request permission for autopsy for all deaths that occur in the Hospital unless the family or patient has previously declined permission.
4.11 SUPERVISION OF DEPENDENT PRACTITIONERS: Individuals who are credentialed by the Medical Staff and appointed to the Advanced Practice Professional Staff may participate in the management of patients under the supervision of a designated member of the Medical Staff. Specific activities of the Advanced Practice Professional Staff shall be delineated by the departmental chair in accordance with Hospital policies and their specific collaborative agreements.

4.12 INFECTION CONTROL: Members of the Medical Staff, and their representatives, shall comply with Hospital policies pertaining to infection control. Standard precautions shall be utilized in all patients where contact with blood or body fluids is anticipated. The responsible physician, nurse, Hospital epidemiologist, or their representatives, shall determine the need for additional precautions. Orders for such precautions shall be entered into the CPOE system, and a note shall be placed in the medical record stating the reason for these precautions. The Hospital epidemiologist shall have the final determination regarding the initiation and/or discontinuation of these precautions.

ARTICLE V: PATIENT RIGHTS

5.1 PATIENT RIGHTS: All patients who receive care at the Hospital shall be provided with a copy of the “Patient’s Bill of Rights” and the “Notice of Privacy Practices” that outlines their patient rights. All health care providers have the responsibility to keep the patient and their families informed with respect to the ongoing course of treatment to include such issues as diagnoses, medications, treatment options, risks and benefits, and unanticipated outcomes. All members of the Medical Staff, and their representatives, shall be aware of these patient rights and shall comply with Hospital policies pertaining to patient rights.

5.2 INFORMED CONSENT: Except in emergency situations, the responsible member of the Medical Staff, or his representative, shall obtain proper informed consent prior to any surgery, procedure, or treatment for which it is appropriate. A list of “Procedures Requiring Consent” will be maintained as an appendix to these Rules and Regulations. A properly executed consent form which contains all required elements of information shall be maintained in the patient’s medical record. Members of the Medical Staff, and their representatives, shall comply with all Hospital policies regarding informed consent and the consent process.

5.3 ADVANCE DIRECTIVES: Patients are encouraged to have “Advanced Directives” so that their physicians and health care agents can make decisions regarding their care in accordance with their wishes if they are unable to participate in this decision-making. All members of the Medical Staff shall comply with the patient’s “Advanced Directives” and with the Hospital’s Advance Directives Policy. If the physician is unable to comply with the patient’s wishes or “Advanced Directives”, then they shall assist the patient or health agent in finding another physician to assume the care of the patient.
5.4 WITHHELDING OR WITHDRAWING LIFE-SUSTAINING MEASURES: There are situations where allowing natural death to occur is appropriate and would entail withdrawing or withholding certain treatments. All members of the Medical Staff, or their representatives, shall comply with the Hospital’s Policy for Withdrawing or Withholding Life-Sustaining Measures. Before life-sustaining treatment can be withheld or withdrawn, there shall be documentation in the medical record of any agreement between the attending physician and the patient, or his health care representative or other legal surrogate decision-maker, regarding the consensus on care and the next steps to be taken.

5.5 RESTRAINTS AND SECLUSION: Treatment and healing occur optimally in the absence of physical restraints. Only when absolutely necessary and when all other therapeutic modalities have been attempted shall the attending physician, or his representative, place an order for restraints in the CPOE system. Members of the Medical Staff shall comply with all Hospital policies pertaining to restraints and seclusion.

5.6 RESEARCH AND HUMAN SUBJECTS: The health, welfare, and safety of human subjects shall be paramount in the performance of all research studies. Members of the Medical Staff shall obtain approval from the Institutional Review Board (IRB) prior to the initiation of any research studies, the results of which may be published or presented. All patient rights shall be observed and proper informed consent shall be obtained. The IRB has the right to terminate any research study when there is deviation from these tenets or from the approved research protocol.

ARTICLE VI: RULES OF CONDUCT

6.1 GENERAL: Members of the Medical Staff and their representatives shall conduct themselves in a professional manner in all interactions with patients, families, and Hospital personnel and shall comply with all Hospital and Medical Staff policies.

6.2 STAFF DUES: Medical Staff dues shall be determined by the Medical Executive Committee and approved at the Annual Meeting of the Medical Staff. Members of the Medical Staff shall receive bills for their dues each year in January and shall pay these dues within ninety (90) days. Late fees shall apply if the dues are not paid on time, and the member may have his privileges suspended for non-payment of the dues.

6.3 INAPPROPRIATE BEHAVIOR: Members of the Medical Staff and their representatives shall conduct themselves in a professional manner in all interactions with patients, families, and Hospital personnel. Inappropriate or disruptive behavior is defined in the Medical Staff’s Professional Code of Conduct Policy. Inappropriate behavior will not be tolerated, and incidents of inappropriate or disruptive behavior will handled in accordance with the Medical Staff’s Professional Code of Conduct Policy and the Medical Staff Bylaws.

6.4 SEXUAL HARASSMENT: Sexual harassment is considered inappropriate behavior and is addressed in the Medical Staff’s Professional Code of Conduct Policy and in Hospital
policies. Any incidents of sexual harassment will be handled in accordance with these policies and the Medical Staff Bylaws.

6.5 IMPAIRED PRACTITIONERS: When there is a concern that a member of the Medical Staff is impaired in a manner that would endanger patient care, that member shall be referred to the Physician Health Committee or to the appropriate agency that deals with these issues, e.g. HAVEN.

6.6 SMOKING POLICY: The Hospital is a smoke-free environment. Members of the Medical Staff shall comply with this rule and all other Hospital policies regarding smoking.

Approved by the Medical Executive Committee on July 20, 2010