

**LUTHERAN HOSPITAL OF INDIANA
FORT WAYNE, INDIANA**

**MEDICAL STAFF
RULES AND REGULATIONS**

**ADOPTED BY EXECUTIVE COMMITTEE
JUNE 28, 1993**

ADVISORY BOARD APPROVAL

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PART I. GENERAL CONSIDERATIONS

- 1.1 All members of the Medical Staff and all those granted privileges by the Advisory Board shall abide by these Rules and Regulations and all other policies and manuals applicable to Medical Staff members.
- 1.2 For the purpose of these Rules and Regulations, an emergency is defined as a condition in which the life of the patient is in immediate danger and in which any delay in administering treatment would increase the danger.

PART II. ADMISSIONS AND CARE OF PATIENTS

- 2.1 All admissions to the Hospital shall be arranged through the Patient Registration Department with the exception of pediatric patients.
- 2.2 The type of admission shall be determined by the admitting physician. Patient Registration will be notified of the type, emergency, urgent, or elective.
 - 2.2.A Emergent. The patient must be admitted to receive emergency services...after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:
 - a) placing the patient's health in serious jeopardy;
 - b) serious impairment of bodily functions; or
 - c) serious dysfunction of any bodily organ or part.

Urgent. The patient must be admitted for a prompt diagnostic workup or treatment of a medical disorder that could become an emergency if not diagnosed or treated in a timely manner; that delay is likely to result in prolonged temporary impairment; and that unwarranted prolongation of treatment increases the risk of treatment by the need for more complex or hazardous treatment or the risk of development of chronic illness or inordinate physical or psychosocial suffering by the patient.

Elective. The health of the patient is not endangered by delayed admission. Such patients are usually scheduled for admission several days to several weeks in advance.

- 2.3 Anyone with admitting privileges shall provide at the time of admission information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatsoever, or to assure protection of the patient from self harm.
- 2.4 When there is no bed available for admission of a patient to an Intensive Care Unit (ICU), and the attending physicians disagree on which patient will be transferred, the following procedure will be followed:
 - 2.4.A The responsibility for the decision lies with the Chairman of the Critical Care Committee or his designee.
 - 2.4.B If the attending physician disputes the decision of the committee, the matter shall be referred to the President of the Medical Staff or the Chief Medical Officer
- 2.5 Inpatients shall receive daily physician visits (some exceptions for day of discharge).
- 2.6 Patients shall be discharged only on written order of a member of the Medical Staff or a Specified Professional Personnel.
- 2.7 Required Consultation
 - 2.7.A Consultation with two members of the Active Staff shall be required in all therapeutic abortions, with the exception of therapeutic abortion of an anencephalic fetus, which will be permitted when the following conditions have been met:
 - (1) Twenty-four (24) hours has elapsed from the time of notification of the patient and informed consent is obtained and the elected method is done.
 - (2) Diagnosis has been made by an ultrasound exam or other radiographic study.
 - (3) Consultation with other members of the Medical Staff will not be required in this instance, with the exception of a radiologist to confirm the findings of the ultrasound exam or other radiographic study.

- (4) The patient has been informed of the risks of the intended method of pregnancy termination such as dilation and curettage or prostaglandin induction of labor.

2.7.B All consultations shall be recorded in the medical record.

2.8 Medical Staff members are discouraged from providing care to their own family members.

PART III. DRUGS, ORDERS AND TESTS

3.1 Automatic stop orders are to be applied to the following categories of drugs:

- A. Schedule II controlled substance -- 5 days
- B. Antineoplastics -- 5 days
- C. Anticoagulants -- 5 days (excluding Coumadin)
- D. Amphetamines -- 10 days
- E. Antibiotics -- 10 days unless otherwise specified by the doctor's written order

The attending physician will reorder the drug, change the order, or cancel the order upon notification of the stoppage of the drug.

3.2 Pharmacy Operating Policies

3.2.A Formulary

- (1) A listing of all Drug Formulary items stocked in the Pharmacy will be maintained in binders to be located at each nursing station.

- (2) Medication orders written for trade-name drugs will be filled with the formulary drug, but not necessarily with the brand name called for under the registered trade name unless the physician specifically writes "Do Not Substitute" on the patient order sheet.
- 3.2.B Requests for new drugs to be used in the Hospital prior to their need--it is recommended that Staff physicians contact the Director of the Pharmacy, either in person or by using the special request forms which are included in the Pharmacy Catalogue in the nursing stations when a new item is desired.
- 3.2.C Additions and Deletions to the Hospital Formulary
 - (1) The decision to add or delete a drug from the Hospital Formulary is the responsibility of the Pharmacy-Therapeutics Committee and shall be based on criteria consistent with scientific information that support basic objectives of the Committee.
 - (2) Requests for new drugs to be used in the hospital prior to Pharmacy-Therapeutics approval should be made to the director of the Pharmacy, either in person or by using the special request forms which are included in the Hospital's formulary binder located in the nursing stations.
 - (3) Staff members shall be notified whenever a drug is under consideration for deletion so that they may submit evidence for its retention.
 - (4) Investigational drugs may be administered following IRB approval and in accordance with IRB guidelines. All investigational drugs are to be dispensed from the Pharmacy Department.
- 3.2.D Information services--the Pharmacy shall maintain an adequate library and an extensive product information file to make information concerning drugs available to the Staff members.
- 3.3 An automatic stop order becomes effective for all medications when the patient goes to surgery. Medications are resumed postoperatively upon the written order of the physician.
- 3.4 Intravenous therapy may be given by a member of the Intravenous Therapy Team in this Hospital. Intravenous admixtures are to be prepared within the Pharmacy Department under laminar air flow except for emergency situations.
- 3.5 Verbal orders regarding medications and nursing functions shall be dictated to the following Lutheran Hospital associates: 1) registered nurses; 2) registered pharmacists; 3) credentialed respiratory care practitioners (inhalation medications only); and 4) radiology and nuclear medicine technologists who are administering medications as part of procedural protocol. Verbal and/or telephone orders regarding medications or specific patient care functions may also be taken by a registered nurse or a licensed practical nurse who is providing services as an allied health professional to patients of his/her employer.

Verbal and/or telephone orders may be taken by other Lutheran Hospital associates that relate directly to the care and procedures they provide.

- A. The radiology secretary may take orders for procedures. This is followed by a written order from the physician. Radiographic IV contrast materials and radioisotopes are considered ordered when the specific procedure is ordered.
- B. Cardiac Rehab associates may take verbal and/or telephone orders for departmental procedures.
- C. Verbal and/or telephone orders may be taken by a licensed/ registered occupational therapist, physical therapist or speech pathologist that relates to these therapies only.
- D. A registered dietician may take a verbal and/or telephone order for nutritional aspects of care.
- E. Verbal orders to admit a patient as either inpatient or observation status may be taken by the Patient Registrars. Patient Registrars may not take orders for treatment.
- F. Case Managers/RN's may take verbal and/or telephone orders for: admitting a patient to either inpatient or observation status; discharge/care related to home health services; discharge/level of care to any extended, long term or continuum of care facility; and need for ambulance/stretchers transport.
- G. Case Managers/SW's may take verbal and/or telephone orders for: discharge/ services to any extended, long term, or continuum of care facility (rehab, hospice, LTAC); discharge related to home health services; and need for ambulance/stretchers transport.

All verbal and telephone orders must be repeated and verified with the ordering physician. Verbal and telephone orders will be documented as V.O.R. & V/or T.O.R. & V/Dr/nurse. This means verbal (V) or telephone (T) order repeated (R) and verified (V) with the physician giving the order.

Verbal orders must include date and time order is written.

The physician giving the order shall sign the verbal orders before closure of the chart. A partner cannot sign these orders.

When there is a need for clarification of the order of an attending physician, the pharmacist receiving the order shall contact the attending practitioner. When the order is clarified, it may be conveyed directly to the nurse by the attending physician or by the pharmacist at the discretion of the attending physician.

- 3.6 Daily laboratory tests ordered for an unspecified duration, shall be called to the attention of the attending physician upon the expiration of three (3) days. The attending physician will reorder, change, or cancel the test. The exception to this order would be if the physician specifically specifies an expiration of more than three (3) days.
- 3.7 Medications brought from home by the patient are to be identified by the Pharmacy Department. The physician's order to continue medications from home shall list the

specific medication, dosage, and instructions. Medications brought from home may be self-administered by the patient if the following criteria are met:

- A. The physician writes an order;
- B. The patient is competent to administer.

PART IV. MEDICAL RECORDS

4.1 The purposes of the medical record are:

- A. To serve as a basis for planning patient care and for continuity in the evaluation of the patient's condition and treatment;
- B. To furnish documentary evidence of the course of the patient's medical evaluation, treatment, and change in condition during the hospital stay, or while being followed in the hospital-administered home care program;
- C. To document communication between the responsible practitioner and any other health professional who contributes to the patient's care;
- D. To assist in protecting the legal interests of the patient, the Hospital, and the responsible practitioners; and
- E. To provide data for use in billing, continuing education, and in research.

4.2 Attending Physician's Responsibilities

4.2.A The attending physician shall be held responsible for the preparation of a complete medical record for each of his patients. A complete medical record shall contain the following:

- (1) Identification data; when not obtainable, the reason shall be entered in the record;
- (2) The medical history of the patient;
- (3) The report of a relevant physical examination;
- (4) Diagnostic and therapeutic orders;
- (5) Evidence of appropriate informed consent; when consent is not obtainable, the reason shall be entered in the record;
- (6) Clinical observations, including results of therapy;

- (7) Results and/or reports of procedures and tests; and
- (8) Summary of treatment with final diagnoses and disposition.

4.2.B

Inpatient medical records shall include at least the following:

- (1) Identification data including patient's full name, address, and date of birth. A permanent identification number shall be assigned which identifies the patient and all medical records.
- (2) An admission note should be present on the chart within 24 hours of admission, which validates the reason for admission and outlines the plan of treatment.
- (3) The medical history of the patient shall include the chief complaint; details of present illness including, when appropriate, assessment of the patient's emotional, behavioral, and social status; relevant past, social, and family histories; and inventory of body systems. For children and adolescents, an evaluation of developmental age factors, immunization status, educational needs, and the family's expectations and involvement should be included, as appropriate. Each patient shall have a history and physical examination completed no more than thirty (30) days before or 24 hours after an admission by a doctor of medicine or osteopathy (or oral maxillofacial surgeon who has been granted such privilege), and shall include a statement of conclusions, impressions, and course of action plan. History and physicals may be done by nurse practitioners or physician assistants who have been granted appropriate privileges. History and physicals done 30 days prior to admission are acceptable but must be updated at the time of admission. The history and physical is the responsibility of the admitting physician but may be done by other physicians within that same practice group; or by other physicians that have privileges at the hospital but are not in that practice group. History and physicals are required on inpatient admissions. The history and physical is required for invasive procedures including catheterizations, endoscopies, percutaneous aspirations, angioplasties, implantations, but not for venipuncture and IV therapy. On the day of the procedure, the history and physical must be updated by the surgeon, proceduralist, nurse practitioner, or physician assistant. Based on this reassessment, the findings (including "no changes") will be documented on the chart prior to the procedure.
- (4) A comprehensive physical examination shall be completed within the first 24 hours of admission to inpatient services.
 - (a) When a patient is readmitted within 30 days for the same or a related problem, an interval history and physical examination reflecting any subsequent changes may be used in the medical record.
 - (b) A prenatal office physical assessment must be updated at the time of admission.

- (c) In all procedural cases including surgery, cardiac catheterizations, endoscopies, and radiology procedures, the medical record must contain a current, thorough history and physical examination completed and signed prior to performance of the procedure. A history and physical completed more than 24 hours, but less than 30 days prior to admission, must be updated and signed prior to performance of the procedure. No operations shall proceed until the history and physical and pertinent laboratory work have been completed.

Authentication will be done by the operating physician or by a Physician Assistant or Nurse Practitioner who is credentialed to perform history and physical examinations. Specified Professional Personnel may have their examinations updated by the physician who did the examination or by the Anesthesiologist doing the case.

- (5) Diagnostic and therapeutic orders (verbal, standing, or written) shall be authenticated by the responsible practitioner.
- (6) A discharge order given by a Medical Staff member, resident, or Specified Professional Personnel is required to release a patient.
- (7) The informed consent is the responsibility of the attending physician to obtain. The medical record shall contain evidence that an informed consent form shall be signed by the patient or legal guardian and by a witness and shall be made a part of the record before any major procedure is performed.
- (8) Progress notes shall reflect the condition of the patient and shall be recorded daily on all patients, with the exception of psychiatry which requires a progress note at least every forty-eight (48) hours and at least five of every seven days. The progress note shall present a chronological picture and an analysis of the clinical course of the patient. In cases where multiple physicians are involved, a single progress note will meet this requirement.
- (9) Consultation reports shall contain the written opinion by the consultant that reflects, when appropriate, an actual examination of the patient and the patient's medical record.
- (10) Opinions requiring medical judgment are to be written or authenticated by Medical Staff members, residents, and other practitioners who have been granted clinical privileges. This includes, but is not limited to, the medical history and physical examination. The parts of the medical record that are the responsibility of the physician or dentist in charge of the patient shall be authenticated by his signature. Staff physicians, residents, qualified oral surgeons, and clinical medical students are the only individuals competent to write or dictate the medical history and physical examination. (Qualified oral surgeons are those individuals who have successfully completed a postgraduate

program in oral surgery accredited by a nationally recognized accrediting body approved by the U.S. Office of Education, and have been granted privileges to record history and physical examination on patients who are Class I anesthesia risks.) In any case in which it is anticipated that controlled hypotension is to be used, a medical consultation is required prior to admission of the patient.

- (11) All treatments, examinations, and procedures should be documented in the medical record within 24 hours of completion.
- (12) Clinical laboratory, radiology, and nuclear medicine examinations shall be entered in the patient's record within 24 hours of completion.
- (13) All surgical specimens removed shall be sent to the laboratory, and an acknowledgement that the tissue has been received and a gross description of the findings shall also be made a part of the patient's record. The microscopic examination is to be carried out by the pathologist when in his opinion such examination is necessary for the proper diagnosis of a disease state in the tissue submitted.
- (14) A postoperative handwritten note for the chart shall be completed immediately after any surgical/invasive procedure. A full operative note shall be dictated within 24 hours when conscious sedation, general anesthesia, regional anesthesia including blocks, MAC, and local anesthesia is administered. A postoperative handwritten note and a full dictated report are also required for any case done in the operative suites. The operative reports shall include: date of surgery, pre- and postoperative diagnosis, procedure performed, surgeon, specimen removed, findings, type of anesthesia, estimated blood loss, drains and complications if any, and narrative description of the procedure.
- (15) A preanesthesia evaluation shall be completed within 48 hours prior to surgery by a physician credentialed to administer anesthesia. The physician administering the anesthesia shall be responsible for completing the intraoperative anesthesia record during the procedure. The physician administering the anesthesia shall be responsible for the completion of a postanesthesia report within 48 hours.
- (16) When an organ is obtained for transplantation from a live donor, the medical record shall meet the same requirements as any surgical inpatient medical record. When the donor organ is obtained from a brain-dead patient, the medical record of the donor shall include the date and time of brain death, documented by and identification of the physician who determined the death, the method of transfer and machine maintenance of the patient for organ donation, as well as an operative report. Reference to pertinent Indiana anatomical gift legislation shall appear on the appropriate forms used for organ donor transplantations and shall be reviewed annually or as required by law or applicable

regulation.

- (17) A discharge summary written or dictated at the time of discharge should concisely document the reasons for admission, the principal and additional or associated diagnoses, the procedures performed, the treatment rendered, the condition of the patient at discharge, and any specific instructions given to the patient and/or family.

For hospitalizations under 48 hours, the final progress note may serve as a discharge summary. However, it must contain: (1) the outcome of the hospitalization; (2) disposition of the case; (3) instructions given and provisions made for follow-up care, and; (4) must include the discharge diagnosis.

- (18) In the event of death, a final progress note or summary is required which shall indicate the reason for admission, the findings, the course in the Hospital, and events leading to death.
- (19) Final diagnoses, operations, and procedures shall be coded in ICD-9-CM codes. No abbreviations are acceptable in final diagnoses, operations, and procedures.
- (20) The attending Medical Staff member or Specified Professional shall legibly sign or initial all entries which he makes in the medical record. In addition, he shall countersign any face sheet, surgery report, and/or delivery record completed by the resident and all entries made by other health professionals acting on his behalf. All entries made by nonphysician agents of the attending physician shall be countersigned. Use of rubber signature stamp is prohibited. Electronic signatures may only be used by the individual to whom the electronic code has been uniquely assigned.

4.2.C

Outpatient medical records shall include the following:

- (1) Identification data including patient's full name, address, and date of birth. A permanent identification number shall be assigned which identifies the patient and all medical records.
- (2) The medical history and physical examination shall be completed prior to administration of general anesthesia or emergency treatment. If a complete physical examination has been performed within thirty (30) days prior to admission by a Medical Staff member, a durable, legible copy of the report may be used in the patient's Hospital record provided any changes have been recorded at the time of treatment. The history and physical is the responsibility of the admitting physician but may be done by other physicians within that same practice group; or by other physicians that have privileges at the hospital but are not in that practice group. History and physicals may be done by nurse practitioners and physician assistants who have been given appropriate privileges. History and physicals are required on observations and for outpatient procedures. The history and

physical is required for invasive procedures including catheterizations, endoscopies, percutaneous aspirations, angioplasties, implantations, etc., but not for venipuncture and IV therapy. On the day of the procedure, the history and physical must be updated by the surgeon, proceduralist, nurse practitioner, or physician assistant. Based on this reassessment, the findings (including "no changes") will be documented on the chart prior to the procedure.

- (3) Diagnostic and therapeutic orders (verbal, standing, or written) shall be authenticated by the responsible practitioner. A discharge order given by a Medical Staff member, resident, or Specified Professional Personnel is required to release a surgical patient.
- (4) The informed consent is the responsibility of the attending physician to obtain. The medical record shall contain evidence that an informed consent has been obtained by the attending physician or other treating physician before any major procedure. The informed consent form shall be signed by the patient or legal guardian and by a witness and shall be made part of the record before any major procedure is performed.
- (5) Opinions requiring medical judgment are to be written or authenticated by Medical Staff members, residents, and other practitioners who have been granted clinical privileges. This includes, but is not limited to, the medical history and physical examination. The parts of the medical record that are the responsibility of the physician or dentist in charge of the patient shall be authenticated by his signature. Staff physicians, residents, medical students, qualified oral surgeons, and clinical medical students are the only individuals competent to write or dictate the medical history and physical examination.
- (6) All treatments, tests, examinations, and procedures should be documented in the medical record within 24 hours of their completion.
- (7) Clinical laboratory, radiology, and nuclear medicine examinations shall be entered in the patient's record within 24 hours of completion if possible. reports from approved laboratories outside the Hospital are acceptable in lieu of tests performed inside the Hospital. Laboratory procedures must be done within five days prior to treatment.
- (8) All surgical specimens removed shall be sent to the Laboratory, and an acknowledgement that the tissue has been received and a gross description of the findings shall also be made a part of the patient's record. The microscopic examination is to be carried out by the pathologist when in his opinion such examination is necessary for the proper diagnosis of a disease state in the tissue submitted.
- (9) A postoperative handwritten note for the chart shall be completed immediately after any surgical/invasive procedure. A full

operative note shall be dictated within 24 hours when conscious sedation, general anesthesia, regional anesthesia including blocks, MAC, and local anesthesia is administered. A postoperative handwritten note and a full dictated report are also required for any case done in the operative suites. The operative reports shall include: date of surgery, pre- and postoperative diagnosis, procedure performed, surgeon, specimen removed, findings, type of anesthesia, estimated blood loss, drains and complications if any, and narrative description of the procedure.

- (10) A preanesthesia evaluation shall be completed within 48 hours prior to surgery by a physician credentialed to administer anesthesia. The physician administering the anesthesia shall be responsible for completing the intraoperative anesthesia record during the procedure. The physician administering the anesthesia shall be responsible for the patient meeting established postoperative criteria for discharge.
- (11) Discharge instructions shall be given to the patient and/or family as necessary, especially for emergency and surgical patients.
- (12) The original autopsy report shall be made a part of the patient's record. The provisional anatomic diagnosis should be recorded in the medical record within three days, and the complete protocol should be made part of the record within 60 days.
- (13) Final diagnoses, operations, and procedures shall be coded in ICD-9-CM codes. No abbreviations are acceptable in final diagnoses, operations, or procedures.
- (14) The attending physician shall legibly sign or initial all entries which he makes in the medical record. In addition, he shall countersign any surgery report completed by the resident. All entries made by non-physician agents of the attending physician shall be countersigned.

4.3 Completion of Inpatient Medical Records

All medical records shall be completed within 30 days of discharge. Medical Staff members will be required to make two visits to complete charts each month, once between the 16th and the first of the previous month, and again between the first and 15th of the present month, thereby providing a system of chart completion within 30 days following discharge. Shortly after the 15th of the month, letters will be mailed to those physicians who have made no visits during this period and have incomplete charts reminding them to have their charts completed prior to the Medical Executive Committee meeting which occurs the first Monday of the month. The only exception shall be those physicians awaiting transcription of their dictated reports whereby they will be given two (2) weeks to sign the same. One week prior to the Executive Committee meeting, the delinquent physician will receive a certified letter notifying him/her that privileges to admit non-emergency patients and schedule elective procedures shall be suspended by the Executive Committee. One additional letter will be mailed to delinquent physicians after the Executive Committee meeting notifying him/her of the effective date of suspension. Physicians under suspension will be expected to continue care for hospitalized patients as well as Emergency Department patients. Such physicians shall

remain suspended until the delinquent records have been completed. The Registration Admitting Office and Emergency Department shall be notified of this action. Upon completion of said records and reports, the Record Management Department will notify the above-named departments.

Three (3) such suspensions of admitting privileges within any 12-month period shall be sufficient cause for termination of the practitioner's privileges.

The records of discharged patients should be completed within a period of time that in no event exceeds thirty (30) days following discharge.

4.3.A The practitioner will not be responsible for:

- (1) Charts not available when he visited the Record Management Department;
- (2) Completing charts prior to the next completion period if on vacation or ill for seven working days within his completion period, and this was reported to the Record Management Department prior to the end of his completion period.

4.3.B The practitioner will be responsible for:

- (1) Visiting the Record Management Department during his completion period;
- (2) Completion of all charts available at the time of his visits to the Record Management Department;
- (3) Any dictation missed on charts provided;
- (4) Notifying the Record Management Department of vacations or illnesses.

4.3.C A medical record shall be considered complete when required reports have been dictated and/or written and signed, all progress notes and doctors' orders have been signed, and the face sheet has been completed and signed.

4.3.D Legal Status of the Medical Record

The medical record is the property of the Hospital and shall not be removed except by enforceable subpoena duces tecum, court order, or statute.

4.3.E Accessibility of the Medical Record

- (1) Free access to the medical records of all patients shall be afforded to Staff Members and Specified Professional Personnel for bonafide study and research, consistent with preserving the confidentiality of personal information concerning individual patients.
- (2) Subject to the discretion of the Chief Executive Officer of the

Hospital and as permitted by applicable federal and state laws, rules and regulations, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients, covering all periods during which they were attending such patients in the Hospital.

- (3) On readmission of a patient, all previous records shall be available for the use of the attending physician. This shall apply whether the patient is to be attended by the same physician or another.

PART V. PODIATRISTS

5.1 Podiatrists

- A. History and physical for general anesthesia cases, inpatient and outpatient, must be done and signed by a physician.
- B. Short stay history and physical is required for outpatient local cases.
- C. There must be a physician with admitting privileges for outpatient cases as well as inpatient cases. The podiatrist must consult with the attending physician before admitting an outpatient.
- D. Podiatrists must schedule admissions or procedures in coordination with the attending physician; all inpatients and outpatients must be seen by the admitting physician prior to commencement of surgery.
- E. Face sheet completion is the responsibility of the podiatrist.
- F. Discharge summary completion is the responsibility of the podiatrist.
- G. Orders within the scope of their licenses and progress notes may be written by podiatrists.
- H. Podiatric surgery report is to be dictated and signed by the podiatrist.
- I. Podiatric history and physical is the responsibility of the podiatrist.
- J. Podiatrists shall be under the overall supervision of the Surgery Service.
- K. Procedures in classes I and II may be done without supervision.

**PART VI. RULES AND REGULATIONS FOR MEDICAL RESIDENTS AND
MEDICAL STUDENTS**

- 6.1 Residents shall be subject to the applicable policies, Rules and Regulations of the Fort Wayne Medical Education Program.
- 6.2 Medical students shall be subject to the following rules:
 - A. Medical students shall provide services under the direct supervision of their medical education directors and/or the Medical Staff members to whom they are assigned.
 - B. First and second-year medical students' activities shall be limited to the observation of patients and training in the taking of patient histories and the performance of physical examinations.
 - C. Third and fourth-year medical students may take histories and perform physicals, provided that records of such activities are countersigned by an attending member of the Medical Staff. Such students may also assist in surgical, obstetrical, and other invasive procedures, provided that such assistance occurs under the direct and continuing supervision of an appropriately-credentialed Staff member.

PART VII. DISTRIBUTION

- 7.1 A copy of these Rules and Regulations shall be provided to each Staff member, practitioner, and person granted privileges in any manner or form by the Medical Staff.

PART VIII. DISASTER PLAN

- 8.1 All physicians on the Medical Staff accept the duties and responsibilities as outlined in the Hospital's master disaster plan.

PART IX. AUTOPSIES

- 9.1 Every member of the Medical Staff is expected to be actively interested in securing autopsies. No autopsy shall be performed without written consent of a relative or legally authorized agent. All Hospital autopsies shall be performed or supervised by the Hospital pathologists or by a physician delegated this responsibility.

PART X. AMENDMENT

10.1 Amendment

This Rules and Regulations Manual may be amended or repealed, in whole or in part, by one of the following mechanisms:

10.1.A A resolution of the Medical Executive Committee recommended to and adopted by the Board; or,

10.1.B A resolution of the Medical Staff and confirmed by the Executive Committee, and approved by the Board.

10.2 Responsibilities and Authority

The procedures outlined in the Bylaws and Hospital Corporate Bylaws regarding Medical Staff responsibility and authority to formulate, adopt, and recommend the Bylaws and amendments thereto, and the circumstances under which the Board may resort to its own initiative in accomplishing those functions apply as well to the formulation, adoption, and amendment to this Rules and Regulations Manual.

PART XI. APPROVAL

Approved by Executive Committee on _____,

Chairman, Medical Executive Committee

Approved by Advisory Board on _____,

Secretary

