BOSTON MEDICAL CENTER CORPORATION
MEDICAL-DENTAL STAFF RULES AND REGULATIONS

These are intended to be general guidelines to cover the usual case. It is understood that when good medical practice so requires, there may be deviations from these guidelines.

DEFINITIONS:

An Attending Physician is a member of the Medical Dental Staff who has delineated clinical privileges.

Diagnostic and therapeutic procedures are procedures performed by a member of the Medical Dental Staff that require clinical privileges.

House Staff are physicians/dentists in training, who include interns, residents and fellows who do not have delineated clinical privileges.

Medical/dental students are individuals who attend medical school/dental school and have not yet completed the studies required for their medical degree/dental degree.

A licensed independent practitioner (LIP) is an individual permitted by Massachusetts law and by Boston Medical Center to provide care, treatment, and services, without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges.

Delineated clinical privileges are the specific clinical privileges that a licensed independent practitioner has been granted by the Board of Trustees to provide specific care, treatment, and services.

SECTION I. ADMISSION OF PATIENTS

1. The hospital will admit, insofar as its facilities will allow, patients with all types of diseases, regardless of the ability to pay. Patients may be admitted only by physicians, dentists and podiatrists who have been duly privileged by the Medical-Dental Staff and who are in good standing.

2. Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis has been stated by the patient's physician. In the case of an emergency, the provisional diagnosis shall be stated as soon after the admission as possible.

3. Physicians, dentists and podiatrists admitting patients shall give such information as is necessary to assure the protection of other patients from related risk or to assure protection of the patient from self-harm.

4. All patients shall be admitted to that division or department of the hospital appropriate for the treatment of his/her condition. Patients who have an identified physician may be attended by their physician provided that physician holds a staff appointment with privileges. Patients who are admitted without an identified physician shall be assigned to an attending physician by the division, department or section concerned in the treatment of the condition which necessitated admission.

5. Emergency patients may be admitted at any time, but all other incoming patients should be admitted in accordance with established admitting policies.

SECTION II. PATIENT CARE

1. Each member of the Medical-Dental Staff shall be responsible for the care of patients under his/her charge and shall conduct him/herself in accordance with G.L. 111, 70E an Act Providing Certain Rights to Patients and Residents in Hospitals and Clinics. Each patient shall be assigned to an identifiable member of the Medical-Dental Staff who will serve as and be called his/her attending physician during his/her stay. All clinical activity shall occur under the direction of an attending physician.

2. The attending physician shall supervise the House Staff regarding all diagnostic examinations and therapies during hospitalization and outpatient visits. House Staff shall be supervised in accordance with laws of Massachusetts and the regulations of the Board of Registration in Medicine. Divisions, departments and sections may adopt their own policies consistent with this rule.

3. The Administrative Head or Chief of the division, department, or section is responsible for the quality of patient care, in accordance with the Performance Improvement Plan and the Patient Care Assessment Plan of Boston Medical Center, and for assessing and recommending off-site sources for needed patient care services not provided by the division, department, section, or hospital. The Chief of the division, department or section is responsible for organization of his/her division, department or section and his/her staff. He/she shall call at least quarterly meetings of his/her staff to conduct a thorough review and analysis of the clinical work of the division, department or section, including consideration of deaths, unimproved cases, infections, complications, errors in diagnosis, results of treatment, and results of division/department/section performance improvement programs.

4. All orders for diagnostic procedures or treatment shall be in writing or entered into the electronic record and signed or authenticated by a physician. An order shall be considered to be in writing if dictated to a nurse and signed by a physician. When a physician is not available to write or enter an order, and the physician determines

that a patient's condition would be adversely affected if the order is delayed until the physician is available, a registered nurse, pharmacist or respiratory therapist may carry out a physician's verbal order. The registered nurse, pharmacist, or respiratory therapist must document the verbal order in the patient's medical record by recording his or her name, title, the name of the physician giving the verbal order, and the date and time the verbal order was received on the Doctor's Order Sheet or in the electronic record and by reading back the order after he/she has written the order or entered the order into the computer. The physician who gives the verbal order shall countersign or authenticate, date, and time the order within forty-eight (48) hours.

~~5.~~ Licensed independent practitioners may write or enter orders to the extent specified in the privileges, position description or practice guidelines and consistent with the scope of services individually defined for him/her.

6. No transfer from one service to another or from one physician to another shall be made without the knowledge of the transferring and receiving attending physicians.

7. In accordance with the criteria contained in the Hospital's Autopsy Policy, an effort will be made to obtain an autopsy on all patients who die in the Hospital, except on bodies legally claimed by the Medical Examiner and those deceased patients who have no known family members to provide consent. Autopsies shall be performed by the Hospital Pathologist or a physician designated by him/her.

8. Sterilization or abortion shall be performed within the limits of the law. Appropriate consent forms approved by the federal government (where reimbursement is anticipated) and/or Hospital must be executed in each case.

9. Any member of the Medical-Dental Staff performing a surgical procedure in the operating room must be qualified to perform cardiac resuscitation or have immediately available another member of the staff so qualified.

SECTION III. CONSULTATION

Consultations with another qualified physician or dentist should be obtained (1) when medically indicated and the best course of care is beyond the scope of privileges of the requestor, except when precluded by the need for emergency actions, and (2) when the patient or his family requests a consultation.

A satisfactory consultation includes examination of the patient and the record. A written or electronic note signed by the consultant must be included in the medical record. When operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the operation.

Requests for consultation shall be written or entered electronically in the appropriate portion of the medical record and include the date and time and specific questions in reasonable detail.

Any member of the Medical Staff may call in consultation any other member of the Medical Staff. A member of the Staff who desires a consultation with a physician or dentist who is not a member of the Staff and who specializes in a field other than his own, may obtain such consultation only after approval of temporary privileges under the credentialing policies for same, limited to assistance in the care of a specific patient.

1. Standards for Inpatient Consultation

   Trainees, including residents and fellows, may be the initial respondent(s) to the request for consultation. An attending physician from the service being consulted must see and evaluate the patient. In the case of a Dermatology consultation this evaluation may be done virtually through real-time audio/video technology, or with the use of securely uploaded images, in concert with the trainee who is physically present with the patient. The attending physician must signify his or her accountability for the content of the consultation by appropriately documenting in the electronic medical record within four (4) hours of the request for urgent consultations and eighteen (18) hours of the request for non-urgent consultation, unless otherwise agreed by the attending physician requesting the consultation and the attending physician responding to the consultation.

2. Standards for Consultations to the Emergency Department

   All services shall call back the Emergency Department within fifteen (15) minutes of a request for consultation and be physically present within forty-five (45) minutes of the request, unless otherwise agreed by the attending physician requesting the consultation and the attending physician responding to the consultation. Residents, Fellows and Licensed Independent Practitioners may be the initial respondent to the request for consultation. An attending physician from the service being consulted must be contacted and assume responsibility for the consultative plan. This acceptance of responsibility will be signified in writing on the consultation record by a member of the consulted service.

SECTION IV. MEDICAL RECORDS

1. The hospital is the legal custodian of all medical records and the same shall not be removed from the premises except when subpoenaed and in accordance with Chapter 111, Section 70, of the Massachusetts General Laws. The right to examine and obtain a copy thereof shall also be governed by said statute. In the case of readmission of the patient, all previous medical records shall be available at any time of any day for the use of all physicians attending the patient.

2. The order sheets and all medical record forms in the medical record will be as determined by the Interdisciplinary Documentation Team and the Forms Committee.

3. The attending physician and appropriate hospital personnel are responsible for the preparation of a complete medical record for each patient including those portions delegated to the House Staff or other professional staff. The medical record shall include: identification data, chief complaint, history, psychosocial history, family history, review of systems, physical examination, diagnostic and therapeutic orders, special reports (such as consultations), clinical laboratory reports, x-ray reports, provisional diagnoses, including preoperative diagnoses where appropriate, pre-sedation or pre-anesthesia assessment where appropriate, medical and surgical treatments, evidence of informed consent, operative report, pathological report, progress notes, final diagnosis, condition at discharge, summary and discharge note, clinical resume and/or discharge summary, patient and family education, follow-up, and autopsy report when appropriate and available. All pages of the medical record shall have the patient's name and hospital number. Drug allergies shall be reported on the patient's chart in a conspicuous manner. No medical record shall be filed until complete and properly signed. In the event that a medical record remains incomplete by reason of the death, resignation, or other inability or unavailability of the responsible physician to complete the record, the Medical Records Committee shall consider the circumstances and may enter such reasons in the record and order it filed.

4. a) The complete history and physical examination in all cases shall be performed no more than 30 days before or 24 hours after admission. The history and physical exam must be performed by the licensed independent practitioner with privileges or the House Staff; however, this must be done in accordance with the current CMS Regulations and Medicare's Guidelines for Teaching Physicians, Interns, and Residents, and the full responsibility, in any case, rests with the attending physician. The medical history and physical examination must be entered in the patient's medical record within 24 hours after admission. When the history and physical examination is done within thirty (30) days prior to the day of admission, the history and physical must be updated within 24 hours after the admission documenting an examination for any changes in the patient's condition to include a physical assessment of the patient addressing significant changes at the time of admission or at the time of an outpatient procedure that requires a history and physical and any areas where more current data is needed.

   b) Except in an emergency when such a delay would constitute a hazard to the patient, in the case of all procedures requiring Anesthesia services (General Anesthesia, Regional Anesthesia, MAC, Deep Sedation or any procedure requiring the services of an Anesthesiologist or CRNA), or a high probability that the patient may require Anesthesia services based on an assessment of the

risks associated with the procedure or patient, including but not limited to patient age, diagnoses, the type and number of surgeries and procedures scheduled to be performed, comorbidities, and the level of anesthesia required for the surgery or procedure, patients must have a history and physical examination performed prior to the procedure by a physician or qualified oral and maxillofacial surgeon of the Medical-Dental Staff or House Staff. The history and physical must be updated prior to the procedure to include an assessment of the patient addressing significant changes at the time of any procedure that requires a history and physical.

c) The attending physician is responsible for establishing the pre-operative diagnosis.

d) Podiatrists are responsible for the part of their patients' history and physical examination that relates to podiatry.

e) Dentists are responsible for the part of their patients' history and physical examination that relates to dentistry.

5. The attending physician shall see that progress notes are written in the medical record to document significant changes. All entries in the record must be legible, include the title of the individual making the entry, and be dated.

6. All operations will be described in the progress notes section of the medical record by or for the operating surgeon immediately after the operation if the transcribed operative note is not immediately available.

7. All tissues removed at an operation and sent to the pathology laboratory shall have an appropriate history. The pathology laboratory shall make such examination as may be considered necessary for arriving at a diagnosis and a hospital pathologist shall sign a report which shall become part of the patient's medical record. A copy of this report shall be filed in the pathology laboratory.

8. The attending physician or his/her designee shall edit, correct, or amend the medical record, according to hospital procedure, and sign all entries made by him/her.

9. At discharge from inpatient care, the attending physician or his/her designee will complete a discharge summary that concisely summarizes: the reason for hospitalization, the significant findings, hospital course, the procedures performed and treatment rendered, discharge final diagnoses noted according to Standard Nomenclature, the patient's condition on discharge, discharge medications, and any specific instructions given to the patient and/or family, as pertinent, and plans for follow-up.

10. All discharge summaries must be reviewed and signed by the patient's attending physician. All inpatient medical records must be completed no later than thirty (30) days after discharge, or the attending physician shall have his/her admitting privileges suspended until such time as that record is complete.

SECTION V. MEDICATIONS

1. All drugs and medications administered to patients shall meet the standards of the United States Pharmacopoeia, the National Formulary, New and Non-Official Drugs, or the American Hospital Formulary Service, with the exception of those duly authorized by the Pharmacy and Therapeutics Committee or used for bonafide investigations approved by the Institutional Review Board.

2. Drug orders for specified amounts and routes of administration shall be entered as prescribed and signed or authenticated by the physician on the order sheet or in the computer. Physicians Assistants and Advanced Practice Nurses may write or enter drug orders only to the extent, if any, specified in their privileges, position description or practice guidelines and consistent with the scope of services individually defined for him/her.

3. Orders for continuous intravenous drug infusions, including hyperalimentation therapy, must be written or entered daily. (Should an I.V. solution need to be restarted, the infusion will be restarted with the previously prescribed solution, unless otherwise ordered.)

4. All "p.r.n." orders must specify the intended use for which the drug is ordered.

5. When using investigational drugs, the physician must supply the Pharmacy with information concerning the name or research number, dose, action, side effects, and antidote.

6. Pharmacists may write or enter orders for a medication per protocol, as approved by the Pharmacy and Therapeutics Committee (e.g., Aminoglycosides).

7. All respiratory therapy orders must be reordered every forty-eight (48) hours.

SECTION VI. SUPERVISION AND TRAINING OF MEDICAL STUDENTS, HOUSE OFFICERS, AND OTHER PERSONNEL

1. The first obligation of the members of the Medical-Dental Staff is to provide quality care for their patients. The education of House Staff, medical and dental students, and other professional personnel or personnel-in-training is important to this end. Members of the Medical-Dental Staff shall cooperate in the education of these individuals by participating in the teaching programs of the hospital.

2. Supervision and Training of House Staff

With the consent of the patient, any patient may be considered for the training of House Staff. However, the attending physician or the Chief of the division, department or section must perform all such teaching activities in accordance with all applicable laws and regulations, and in conformity with BMC's policy on Patients Right and Responsibilities. Members of the Medical-Dental Staff must remember that medical care takes precedence over teaching and that the quality of medical care shall not be compromised in the process of teaching.

a) Examinations, diagnostic procedures and therapies performed by House Staff participating in the care of patients in inpatient units or in outpatient clinics must be supervised by the attending physician in accordance with their division, department or section's Residents Roles and Responsibilities.

b) The attending physician shall read the entries of the House Staff in the patient's hospital or clinic record and, in addition, document his/her own care of the patient and supervision of the House Staff in accordance with the CMS Regulations and Medicare's Guidelines for Teaching Physicians, Interns, and Residents.

c) Attending physicians, dentists and podiatrists are obligated to provide appropriate supervision to the House Staff. Such supervision shall be provided on a twenty-four (24) hour a day basis. Each clinical service shall define the policy in their Residents Roles and Responsibilities by which such supervision occurs. Said policy should address both on-site and on-call supervision by the attending physician.

3. Supervision and Training of Medical and Dental Students and Other Personnel

With the consent of the patient, any patient may be considered for the education of medical and dental students, subject to the constraints outlined in item 2 above. Additionally, members of the Medical-Dental Staff must ensure that:

a) No diagnostic or therapeutic procedure will be performed by a student without supervision unless (1) the student has been deemed competent to perform the procedure, or (2) is supervised by a member of the Medical-Dental Staff with privileges to perform the procedure.

b) All entries by medical and dental students into the hospital or clinic records must be countersigned or authenticated by a physician.

c) No diagnostic or therapeutic decisions may be made by a student without consultation with and approval by the attending physician or his/her designee.

SECTION VII. DOCUMENT REVISION

1. Revisions of this document shall be effected in accordance with procedures established in the Bylaws of the Medical-Dental Staff, Article XIII, Section 1.

2. These rules and regulations shall replace any previous rules and regulations and shall become effective when approved by the Trustees.

Approved by the Medical Executive Committee on November 2, 2021
Ravin Davidoff, MB, BCh
Chair _____

Approved by the Board of Trustees on November 9, 2021
David Beck
Clerk _____