GETTYSBURG HOSPITAL

MEDICAL STAFF RULES AND REGULATIONS

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RULES AND REGULATIONS

DEFINITIONS

The definitions set forth in the Bylaws of the Medical Staff of Gettysburg Hospital shall apply to these Rules and Regulations.

ARTICLE I. ADMISSIONS, TRANSFERS, AND DISCHARGES

1.1 Except in emergencies, no patient shall be admitted to the Hospital unless a provisional diagnosis has been stated and the consent of the proper authority for the patient's legal permissions obtained. If there is any question concerning the admission of a patient, the Chairman of the Department to which the patient is to be admitted shall determine the necessity for, or deferment of, the admission.

1.2 No appointee of the Medical Staff shall admit a patient to the service of another Medical Staff appointee without his consent.

1.3 Each appointee of the Medical Staff who does not admit or attend his/her own patients at the Hospital, shall specifically designate another appointee/hospitalist of the Medical Staff with appropriate clinical privileges who shall be responsible to attend any of the appointee's patients in an emergency or in the event the appointee's patients need to be admitted to the Hospital. By acceptance of such designation, the designated appointee/hospitalist shall be required to promptly respond to the Hospital's request to attend any of the appointee's patients in an emergency or in the event the appointee's patients need to be admitted to the Hospital, and may not refuse to attend any such patients on any basis, including but not limited to the patient's source of payment.

In the event the designated appointee can not be contacted by the Hospital, or fails to promptly attend to the appointee's patients upon request, the appropriate Department Chairperson or designee may authorize any other qualified member of the Medical Staff to provide such as care as is necessary. The Department Chairperson shall notify the appointee of the designated appointee's failure to attend the appointee's patients, and the designated appointee shall be subject to corrective action.

1.4 Appointees of the Medical Staff admitting patients shall provide, in advance, all available information as required by Hospital admission policies and as may be necessary to ensure the protection of the patient, other patients, and the Hospital staff.

1.5 A transfer of a patient from one clinical unit to another must be initiated by an order from that patient's attending Medical Staff appointee.

1.6 A patient may be transferred from one Medical Staff appointee's service to another appointee's service during the course of hospitalization only if the transferring appointee orders the transfer and the receiving appointee accepts the patient in transfer.

1.7 Discharge shall be made only on order of the attending Medical Staff appointee, or his designee.

1.8 If a patient is admitted and no orders are received or can be obtained by the nursing staff within appropriate time for the patient's care, the head nurse shall contact the Chairman of the Department to which the patient is admitted for appropriate action and orders.

1.9 The Admissions Department will admit, transfer, and discharge patients without regard to age, sex, race, creed, color, or national origin.

1.10 All patients in the Hospital who are at recognized suicidal risk shall be managed under policies and procedures established for that group of patients.

1.11 When a patient, with a Gettysburg Hospital Medical Staff Physician as his ongoing care physician, is seen in the Gettysburg Hospital Emergency Department by an Emergency Department attending, and agreement as to the patient's disposition cannot be made by telephone, the ongoing care physician, or his coverage, must evaluate the patient in person and make final disposition.

ARTICLE II. MEDICAL RECORDS

2.1 ATTENDING MEDICAL STAFF APPOINTEE

The attending Medical Staff appointee for each patient shall be responsible for the preparation and completion of the medical record of such patient.

2.2 INPATIENT RECORD

A complete inpatient medical record shall include: complete identification, complete history and physical examination, signed informed consent forms, reports of diagnostic studies, consultations, progress notes, discharge summary, diagnosis(es), follow-up notes, and autopsy report when indicated.

2.3 HISTORY AND PHYSICAL EXAMINATION

(a) A complete history shall include: chief complaint, history of present illness, past history, social history, family history, and system review.

(b) A complete physical examination shall include such examinations and tests as the attending physician deems appropriate taking into account the patient's medical condition, age and medical history. Neither the examination nor the chart will be considered complete unless these are recorded, except if the attending Medical Staff appointee has made a note as to the contraindications or reasons why the procedures were not done and/or a statement indicating when the procedures were last performed. The attending Medical Staff appointee's impressions on admission and course of treatment planned also shall be included.

(c) The history and physical examination must be performed within twenty-four (24) hours of admission. It must be legibly written or dictated. If a complete history and physical examination has been obtained within thirty (30) days before admission, a durable legible copy may be used, providing any changes which have occurred in the interim have been so recorded. A consultation with complete history and physical examination elements may suffice as the history and physical examination if performed within twenty-four (24) hours of admission. An outpatient consultation may also be used, providing it was

performed within thirty (30) days of admission and contains all of the essential elements of a history and physical examination. When a patient is readmitted within thirty (30) days for the same or a related problem, an interval history and physical examination reflecting any subsequent changes may be used, provided that the original information is readily available.

(d) A history and physical examination must be on the chart before surgery. This includes both inpatient and outpatient surgery records.

(e) An updated obstetrical progress note shall be completed on all obstetrical patients to supplement the Pre-Natal Forms.

(f) Any alteration(s) made within the medical record must be signed and dated when the alteration(s) is made. A single line should be drawn through the incorrect entry and the initials of the individual making the change should be documented at the revised entry.

2.4 SIGNATURES

(a) Every clinical entry must be personally signed and dated. (This includes all inpatient and outpatient records.) Use of a rubber stamp is no longer permitted; however, electronic signature is permitted per the Medical Staff Rules and Regulations.

(b) All transcribed reports in the Gettysburg Hospital Medical Record must be authenticated and electronically signed in order to be considered the final official record. Any changes to transcribed reports that a physician wishes to make must be done electronically, either by the physician electronically making the change(s) or by dictating the change(s) for transcription staff to correct the electronic record. Any changes to a transcribed, paper report that are made on a written version will not be transcribed and, therefore, will not be an official version of the report.

(c) A card file of Medical Staff appointees' signatures and initials shall be maintained in the Medical Records Department.

2.5 OPERATIVE REPORT

(a) Documentation of a procedure done in the operating room requires two components, a dictated operative report and a legibly completed perioperative progress note. The perioperative progress note should be completed immediately after surgery. A complete operative report must be dictated within 24 hours. These two documents are required for both inpatient and outpatient surgical procedures. The dictated operative report should contain a description of the findings, the technical procedures used, the specimens removed, the post-operative diagnosis, and the name of the primary surgeon and any assistants. The perioperative progress note must also have all of these elements completed in an abbreviated form and should contain a brief plan.

(b) Repeated instances of not completing the perioperative progress note immediately after surgery or not dictating the operative report within 24 hours following surgery will be addressed. The Department Chairman will be responsible for addressing the issue individually with physicians who have late operative reports. Physicians with repeated non-compliant behavior will be encouraged to obtain IT assistance and/or review his/her perioperative workflow. If the physician is responsible for continued instances of not

completing the perioperative progress note immediately after surgery or not dictating the operative report within 24 hours following surgery within any twelve month period, the Vice President of Medical Affairs will be asked to counsel the physician. At the discretion of the Department Chairman or the Vice President of Medical Affairs, prolonged behavior will be referred to the MEC for discussion and action, and may require instituting the Disruptive Physician Policy.

2.6 PROGRESS NOTES

The frequency with which progress notes are made is determined by the condition of the patient. This may vary from several times a day in rapidly changing clinical conditions to less frequently in static conditions. It is Gettysburg Hospital's policy that a progress note be completed daily for all admitted patients.

2.7 DISCHARGE SUMMARY

(a) All relevant diagnoses established by the time of discharge as well as all operative procedures performed should be recorded, using acceptable disease and operative terminology that includes topography and etiology as appropriate. Abbreviations can be used if approved by the Medical Staff.

(b) The discharge summary should recapitulate concisely the reason for hospitalization; the significant findings; any "present on admission" findings; the procedures performed and treatment rendered; the condition of the patient on discharge; and the specific instructions given to the patient and/or family, particularly in relation to physical activity, medication, diet, and follow-up care. The condition of the patient on discharge should be stated in terms that permit a specific measurable comparison with the condition on admission, avoiding the use of vague relative terminology such as "improved." When preprinted instructions are given to the patient or family, the record should so indicate and a sample of the instruction sheet in use at the time should be on file in the Medical Records Department. A copy of the clinical resume may be sent to any known medical practitioner and/or medical facility responsible for the subsequent medical care of the patient.

(c) A final progress note may be substituted for the resume in the case of patients with problems of a minor nature who require less than a forty-eight (48) hour period of hospitalization, and in the case of normal newborn infants and uncomplicated obstetrical deliveries. The final progress note should include any instructions given to the patient and/or family.

(d) In the event of death, a summation statement should be added to the record either as a final progress note or a separate resume. This final note should indicate the reason for admission, the findings and course in the Hospital, and events leading to death.

(e) When a necropsy is performed, provisional anatomic diagnoses should be recorded in the medical record within three (3) days, and the complete protocol should be made part of the record within sixty (60) days.

2.8 EMERGENCY DEPARTMENT RECORDS

Medical records of patients treated in the Emergency Department shall be completed by the responsible emergency physician and shall be subject to all of the rules in Sections 3.9 and 3.10 of these Rules and Regulations.

2.9 CHART COMPLETION

All records shall be completed within thirty (30) days after the discharge or treatment of the patient or within fourteen (14) days of a completion assignment date.

(a) After direct communication between the Office of the Vice President of Medical Affairs and the offending practitioner or his office staff, failure to comply with this Section 2.9 will subject the offending practitioner to automatic and immediate suspension of all clinical privileges or rights to perform patient care services in the Hospital until his charts are completed. Patients already hospitalized may be cared for, but no new patients may be cared for during the time of suspension, including admissions, consultations, surgical procedures, etc. Medical Records Department personnel shall have the authority to review current charts of partners or other practitioners to determine that the suspended practitioner is not caring for new patients. Any variances shall be reported directly to the Vice President of Medical Affairs.

(b) Repeated suspensions which impact patient care will be dealt with by utilization of the disruptive physician policy. The Department Chairman will be responsible for addressing the issue with physicians who receive three suspensions due to medical records delinquencies within any twelve month period. Physicians who receive five suspensions due to medical records delinquencies within any twelve month period may be asked to address the issue at a Medical Executive Committee Meeting, at the discretion of the Department Chairman. Continued suspensions due to medical record delinquencies may require utilization of the Disruptive Physician Policy, at the discretion of the Department chairman and VPMA.

(c) Section 2.10 below contains the specifics of the Hospital's Chart Count Procedure.

2.10 INCOMPLETE CHART COUNT PROCEDURE

(a) Physicians will also have continuous access to their Millennium inboxes to monitor the type and amount of work to be done.

(b) Delinquent medical records will be handled according to the Suspension Policy and Procedure. Notification will be made to the following departments/areas:

- Admissions
- Director, Surgical Services
- Emergency Department
- Department Chairpersons and their designees
- Vice President for Medical Affairs
- Director, Medical Record Services
- Attending physician (and designees)

In addition, physicians known to be ill or on vacation will be notified of any incomplete records upon their return. A grace period of at least one week will be granted for reasons of vacation, illness or chart unavailability.

(c) As physicians complete their assigned records, Medical Records will clear them from suspension. When clearing a physician, calls will be placed to Admissions, Emergency Department Administrative Office, and the Operating Room. A priority email will also be distributed to appropriate individuals.

(d) Chart completion is a recognized part of patient care and shall remain the final responsibility of each physician.

2.11 SECURITY AND CONFIDENTIALITY

All records are the property of the Hospital and shall not be removed from the Medical Records Department at any time without notification and specific permission of the Medical Records Administrator. Infractions of this regulation shall be treated as are incomplete charts in Sections 2.9 and 2.10 above. Information concerning records or their contents will only be released upon written request and permission of the patient, except to Medical Staff appointees or Allied Health Professionals in good standing who are currently involved in the care of the patient; Medical Staff appointees using charts for academic purposes (i.e., conferences, studies, etc.); or those individuals involved in required quality assurance activities.

2.12 DICTATED DOCUMENTS

(a) All dictated documents must include the date and time of dictation and date and time of transcription.

(b) Practitioners must review and sign all documents which they have dictated.

(c) A note indicating that the report was dictated must be written in the chart, preferably on the Progress Note sheet.

(d) Dictation completed outside the central Hospital system is subject to the same requirements as that dictated via the Hospital system.

ARTICLE III. PHYSICIAN'S ORDERS

3.1 GENERAL

Medical orders generally should be written. Some emergency situations, however, create the necessity of oral and telephone orders, together referred to herein as oral orders.

3.2 ORAL MEDICATION AND TREATMENT ORDERS

(a) Definition & Authorization of Personnel: Oral medication and treatment orders may be dictated by a licensed physician, dentist, podiatrist, certified registered nurse practitioner, physician assistant, pharmacist, or certified nurse midwife and are defined as any medication and/or treatment order that is (a) given physically in the presence of, or (b) received via telephone by personnel authorized to receive such order as outlined in Section 3.2(b). All authorized personnel are expected to dictate only those oral orders pursuant to their role/scope of practice within the institution. Personnel explicitly forbidden to give oral medication and treatment orders include medical students and all Physician's/Dentist's Office Staff Nurses.

(b) Receipt of Oral Orders: Personnel approved to receive oral medication and treatment orders are; registered nurses, licensed practical nurses, pharmacists, physical therapists, and respiratory therapists. All authorized personnel are expected to receive and transcribe only those oral orders pursuant to
their role/scope of practice within the institution. All other personnel not specifically mentioned in this section are to be considered unauthorized to receive oral orders.

(c) Procedure For Receiving Oral Orders: All personnel authorized to receive oral medication and treatment orders as outlined in Section 3.2 (b) shall document provider's first and last name, credential, and numerical second identifier; and transcribe the oral order as received to the Orders section of the medical record. Authorized receiving personnel must then read the order back, in its entirety, to the ordering individual and wait for a confirmation of accuracy from the authorized ordering personnel prior to executing the order. The order, as transcribed on the Orders section of the medical record, must include the date and time the order was received in addition to the ordering provider's first and last name, credential, and numerical second identifier and name of the receiving personnel along with an indication as to the method the order was received.

(d) All oral medication and treatment orders must be electronically authenticated (counter/signed, dated and timed) by the ordering individual or an associate of the ordering individual within twenty-four (24) hours of issue.

3.3 **WRITTEN ORDERS** (Both outpatient surgery and inpatient medical records).

(a) Written orders are recorded on the Physician's Treatment Record directly by the prescribing physician, dentist, podiatrist**,** certified registered nurse practitioner, certified nurse midwife, pharmacist, or physician assistant and may be honored immediately if clear to the transcriber.

(b) Any orders written by a medical student must be validated by the supervising physician/dentist/podiatrist prior to the execution of the order.

(c) All orders written by a physician assistant must be co-signed by the supervising physician within 72 hours.

(**d**) All orders for Respiratory Therapy Services written by a physician assistant or nurse practitioner must be co-signed by the supervising physician or attending physician within 24 hours.

3.4 **TRANSFER OF SERVICES**

A patient may be transferred from one physician's service to another during the course of hospitalization. The current procedure for effecting a transfer of service is as follows:

(a) The transferring physician orders the transfer of the patient to another physician's service.

(b) The physician to whom the patient has been transferred acknowledges acceptance of the patient in transfer.

(c) All transfers of service must be clearly documented on the Physicians Treatment Record.

(Steps (a) and (b) may be in the form of a written or oral order.)

3.5 PATIENT RESTRAINTS

(a) Physicians are required to follow the Gettysburg Hospital Restraint Policy.

(b) PRN restraint orders are never acceptable.

ARTICLE IV. CONSULTATIONS

4.1 Consultations are encouraged among appointees of the Medical Staff in cases of difficult diagnosis and critically ill patients.

4.2 All requests for consultations shall be in writing and shall be signed by the requesting Medical Staff appointee. Findings of the consultant shall be dictated into the medical record, signed and dated by the consultant, and placed on the patient's chart.

4.3 Emergency Department Consultation Response Time: Gettysburg Hospital attending staff members are expected to respond within thirty (30) minutes, by telephone, to calls from the Emergency Department and are expected to physically be present in the Emergency Department, when requested, within one (1) hour after telephone confirmation of the request is received.

4.4 A consultation must be performed within twenty-four (24) hours of the request being written in the chart. If the patient's condition warrants the patient being seen sooner, the requesting physician should convey this to the consultant, preferably by speaking directly to the consultant. All consult orders must contain the reason for the consult and the time frame within which the consult is expected to be completed. If the consulted physician is not able to complete the consult within the requested time frame, it is incumbent upon the consulted provider to make that known to the consulting provider as soon as possible, and hopefully by direct telephone contact, so that alternate arrangements can be made in a timely fashion. Involving third parties (e.g nursing staff) in this discussion is both inefficient and inappropriate.

ARTICLE V. PATIENT RIGHTS

5.1 A Patient's Bill of Rights consistent with the Pennsylvania Department of Health regulations and approved by the Medical Executive Committee and by the Board shall be followed in the Hospital.

ARTICLE VI. OPERATIVE PROCEDURE

6.1 Operative Procedures shall be performed in accordance with the Operating Room Regulations.

6.2 Patients for inpatient surgery shall be admitted long enough in advance to have the necessary preparation. The medical history, physical examination, and appropriate work will be recorded on the patient's medical record by an appointee of the Medical Staff except under emergency patient care conditions.

ARTICLE VII. INFECTION CONTROL

7.1 All appointees of the Medical Staff are bound by the Isolation Policies and Procedures Manual of the Hospital. Each practitioner is responsible for ensuring that every patient with known or suspected infection is placed on appropriate isolation precautions. Copies of the Isolation Policies and Procedures Manual shall be available at every patient unit, and in the Office of the Vice President of Medical Affairs.

7.2 The Hospital Infection Control Nurse may suggest that appropriate cultures be obtained on patients with known or suspected infections in cases of disagreement concerning diagnosis and/or need for isolation; the matter will then be referred to the Department Chairman of the attending Medical Staff appointee for discussion and appropriate action.

7.3 Each Department of the Medical Staff should offer at least one educational program for its members each year on infection control.

ARTICLE VIII. REPORTABLE CASES

8.1 Certain cases are reportable to government agencies and the State Medical Examiner as required by law. A list of reportable cases is available for review in the Office of the Vice President of Medical Affairs.

ARTICLE IX. REPORTABLE CONDUCT BY PHYSICIANS

9.1 Certain conduct by physicians is reportable to government agencies and the State Medical Board as required by law. A list of reportable conduct by physicians is available for review in the Office of the Vice President of Medical Affairs.

ARTICLE X. ORGAN DONATIONS

10.1 Organ procurement and transplantation at the Hospital shall be handled as required by, and in a manner consistent with, the Organ Tissue Donation Policy as approved by the Ethics Committee and Medical Executive Committee, a copy of which is available for review in the Office of the Vice President of Medical Affairs.

ARTICLE XI. AUTOPSIES

11.1 It shall be the responsibility of each appointee of the Medical Staff actively to seek autopsy permission from the next of kin of all patients who have died during their stay at the Hospital. If the attending Medical Staff appointee is not available, his designee may obtain the permission. The final authority as to the adequacy of the consent shall be the pathologist acting as prosector for the autopsy.

11.2 It shall be the responsibility of the attending Medical Staff appointee or his designee to notify the Coroner of any case that is considered a Coroner's case or of any case in which there is a question as to the cause of death. The following are classified as Coroner's cases:

(a) all patients brought to the Hospital to be pronounced "dead," except those who have died from natural causes if the attending Medical Staff appointee will sign the death certificate;

(b) all patients dying from any cause whatsoever within twenty-four (24) hours after admission, or where the medical attendant has changed in the past twenty-four (24) hours;

(c) all cases of death from homicide, suicide, poisoning, or criminal abortion (in cases where toxic agents may have caused the illness, any gastric contents, urine, or other available excreta should be preserved, properly labeled, and in the event of the patient's death, should be forwarded to the morgue with the body or to the Pathology Department for analysis, and the Coroner's office notified of their existence);

(d) all deaths from accidents of any type (automobile, industrial, mines, home, burns, drownings, cave-ins, shooting, etc.) where the death occurs within a period of one (1) year and one (1) day following the accident;

(e) all cases of criminal assault, or any cases in which external violence acted as a contributory cause and where death occurred within a period of one (1) year and one (1) day after such violence;

(f) all cases of death in the Operating Room;

(g) all cases in which the cause of death is under reasonable suspicion, in which a definitive diagnosis cannot be made with reasonable certainty, in which the cause of death is not properly certified, or in which the attending Medical Staff appointee is physically unable to supply the necessary data;

(h) stillborn or fetal deaths (over sixteen (16) weeks gestation) where the patient has had no prenatal care and the attending Medical Staff appointee is physically unable to supply the necessary data, or any baby dying less than twenty-four (24) hours after birth;

(i) all cases of death of children where there is reasonable cause to suspect that the child died as a result of child abuse;

(j) all deaths of prematurely born infants where the cause of death is not properly certified; and

(k) all cases which suggest the death was sudden, violent, suspicious in nature, or is the result of other than natural causes.

ARTICLE XII. LEGAL PERMISSIONS

12.1 Legal permissions shall be obtained as required by, and in a manner consistent with, the Hospital's Informed Consent Policy, a copy of which is available for review in the Office of the Vice President of Medical Affairs.

ARTICLE XIII. MISCELLANEOUS

13.1 COVERAGE

Each appointee of the Medical Staff shall be expected to have on record with the switchboard, other accessible area within the hospital (e.g. Department of Medical Affairs, electronic sources, Credentials office), and in his office, an alternate Medical Staff appointee who could be contacted for emergency or other problems of patient care in his absence. If such a name is not on file, or the alternate Medical Staff appointee is unavailable, the Department Chairman or senior departmental member available shall have the right to arrange for substitute care to be rendered to the patient, pending the return of the attending or admitting Medical Staff appointee.

13.2 BIRTH AND DEATH CERTIFICATES

Birth and death certificates are the responsibility of the attending Medical Staff appointee, and are to be completed within twenty-four (24) hours.

13.3 ADMINISTRATION OF DRUGS

A drug shall be administered directly by an appointee of the Medical Staff or by a professional nurse or a licensed practical nurse with pharmacy training. A medical student may also administer drugs, but only under the supervision of a Medical Staff member. Properly trained technicians may administer drugs within established Hospital guidelines. Graduate practical nurses, graduate nurses, and students from approved schools of nursing may be authorized to administer drugs, but only under the supervision of a registered professional nurse or a Medical Staff appointee.

13.4 QUALIFIED MEDICAL PROVIDER (QMP) AUTHORIZATION

The following categories of Qualified Medical Providers are determined to be qualified and authorized by the Gettysburg Hospital Board of Directors to perform initial medical screening examinations as required by EMTALA:

a. In the Emergency Department:

   i. Physicians, including medical residents under direct attending supervision
   ii. Midlevel Practitioners (Nurse Practitioners and Physician Assistants)
   iii. SAFE RNs (for the victims of sexual assault when only an evidentiary exam is required)
   iv. Crisis Counselors for psychiatric complaints not involving ingestions or trauma

b. In the Labor & Delivery unit:

   i. Physicians, including medical residents under direct attending supervision
   ii. Midlevel Practitioners (Certified Nurse Midwives, Nurse Practitioners and Physician Assistants)
   iii. Labor & Delivery Nurses

13.5 TREATMENT OF FAMILY MEMBERS

As a general policy, Medical Staff appointees should not treat themselves, members of their immediate families, or other individuals whose relationship with the Medical Staff appointee may compromise the Medical Staff appointee's objectivity. Medical Staff appointees should also refrain from treating individuals outside of a bona fide provider – patient relationship; this restriction would apply to writing prescriptions for friends and co-workers.

In an emergency, where there is no other qualified provider available, Medical Staff appointees may treat themselves, immediate family members, or other individuals for whom treatment would be generally inappropriate under this policy until another qualified provider becomes available. While Medical Staff appointees should not normally serve as a primary or regular care provider for an immediate family member, there are some situations where routine care is acceptable for short-term, minor problems. This does not include performing surgery or administering anesthesia to an immediate family member. Medical Staff appointees should not prescribe controlled substances for themselves or immediate family members.

When a Medical Staff appointee provides treatment for any patient, including an individual for whom treatment would be generally inappropriate under this policy, the Medical Staff appointee must obtain a patient history, perform a physical examination and appropriately document the treatment.

Medical Staff appointees providing treatment to themselves or their immediate family members should be mindful of State and Federal laws and regulations regarding proper prescribing, record keeping, and the requirement for a bona fide provider – patient relationship, as well as the American Medical Association's Code of Ethics and ethical statements and policies of other professional societies. Medical Staff appointees should also be mindful of Medicare regulations which prohibit payment for services to immediate relatives.

13.6 COMMUNICATION

The Medical Staff of Gettysburg Hospital recognizes that electronic communication via email is the primary source of communication to meet the needs of our Hospital and Medical Staff. Electronic communication is a necessary tool to practice medicine and to be a responsible partner in the Gettysburg Hospital community.

(a) All medical staff members shall maintain a WellSpan email address at all times in order to receive timely and important information.
(b) Individual Wellspan Health addresses will be made available in the Wellspan Health Email Directory. Non-Medical Staff members will be discouraged from communicating to Medical Staff members via email.
(c) Distribution lists of Medical Staff members will be secure and maintained by the Medical Affairs Office, in an effort to prevent unauthorized use.
(d) Transmittal of patient data is permitted within the WellSpan network, assuming that the recipients of the email are entitled to receive the confidential information. Transmittal of patient data for any reason, outside of the WellSpan network, will be considered an unauthorized disclosure of confidential information.
(e) It shall be the responsibility of all Medical Staff members to review the information sent to their email addresses minimally once a week.

ARTICLE XIV. ADOPTION AND AMENDMENT

14.1 AMENDMENT

These Medical Staff Rules and Regulations may be amended or repealed, in whole or in part, as provided by Sections 12.2.2 of the Medical Staff Bylaws.

14.2 ADOPTION

14.2.1 MEDICAL STAFF

The foregoing Medical Staff Rules and Regulations were adopted and recommended to the Board by the Medical Staff in accordance with and subject to the Medical Staff Bylaws.

____
PRESIDENT OF THE MEDICAL STAFF

____
DATE

14.2.2 BOARD

The foregoing Medical Staff Rules and Regulations were approved and adopted by resolution of the Board after considering the Medical Staff's recommendation.

____
CHAIRMAN OF THE BOARD OF DIRECTORS

____
DATE