

CONNECTICUT VALLEY HOSPITAL
RULES AND REGULATIONS OF THE MEDICAL STAFF

Preamble

Article XIII of the By-Laws of the Medical Staff states:

"The Medical Staff shall from time to time adopt such Rules and Regulations as may be necessary to implement more specifically any general principles found within these By-Laws."

Any Rule or Regulation that is inconsistent with appropriately approved revisions or amendments to the Medical Staff By-Laws shall be considered repealed once the change in Medical Staff By-Laws becomes effective.

Nothing in these Rules and Regulations shall prohibit the Hospital administration from establishing Policies and Procedures to facilitate the efficient management of patient care services, or from complying with government and departmental regulations, except that: (1) such policies shall occur only after consultation with the Medical Staff Executive Committee, (2) such policies shall be clearly communicated to the Medical Staff in writing, and revised texts of such shall be supplied, and (3) such policies shall be consistent with ensuring professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff.

As a condition and appointment to the Medical Staff, members agree to abide by the provisions set forth in the Medical Staff Bylaws, Rules and Regulations, and Hospital Policies and Procedures.

ARTICLE I: MEETINGS

1. As a condition of appointment to the Active Medical Staff, members agree to actively participate in Medical Staff meetings and committees. Participation in such committees helps fulfill the Medical Staff's obligation to assure the quality of care to the patients of Connecticut Valley Hospital.
2. Attendance requirements for Medical Staff and committee meetings are stipulated in Article XII of the Connecticut Valley Hospital Medical Staff By-Laws.
3. Each full time active member of the Medical Staff shall serve on at least two (2) Medical Staff or-Hospital committees. Each part-time active member of the Medical Staff (25 hours or less/week) shall serve on at least one (1) Medical Staff or Hospital committee.] Attendance requirements at committee meetings shall be the same as that for Medical Staff Meetings.

Medical Staff Rules and Regulations

Page 2

ARTICLE II: ADMISSIONS

1. All patients shall be assigned an attending psychiatrist on admission. This individual shall be responsible for all the clinical care rendered to his/her patient and shall be the clinical supervisor to all members of the treatment team.
2. All patients shall have a psychiatric history and mental status examination completed and entered into the record within 24 hours of admission. This shall be completed by the attending psychiatrist or, in his/her absence, a covering psychiatrist or on-call physician.
3. All patients shall have an admission medical history and physical examination completed and entered into the record within 24 hours of admission. This medical history and physical examination shall be completed by a physician/advanced practice registered nurse (APRN) from Ambulatory Care Services or an on-call physician. If the examination is completed by an on-call physician, the regularly assigned Ambulatory Care Services physician shall review the history and physical on the next business day and take further action as appropriate, providing documentation of the same in a progress note (see Article X, section 6 for further details). The history and physical examination shall include an assessment of pain (see Article X, section 10 for further details).
4. Patients shall be admitted to the hospital pursuant to state law by a physician member of the Medical Staff. All admissions shall be in accordance with the established admission criteria of the hospital.
5. A physician member of the Medical Staff shall be responsible for the diagnostic formulation and all attendant care and treatment of each patient at the hospital, for necessary special instructions, for transmitting reports of the condition of the patient to referring professionals and to relatives of the patient, for assuring continuity of care upon transfer or discharge of each patient and for providing 24 hour on-call coverage for all patients.
6. No patient shall be admitted to the hospital until a provisional diagnosis or valid reason for admission has been stated.
7. On admission, all patients must sign a voluntary admission application or be accompanied by a properly completed Physician's Emergency Certificate (PEC), police hold or court order for commitment.
8. The admitting physician or attending psychiatrist shall order any necessary special diagnostic procedures and/or laboratory studies which may include, but not be limited to, serum chemistries, hematological or endocrinological panels, electrocardiogram, x-rays, electroencephalogram and urinalysis. He/she shall also order any clinically warranted consultations from dietitians, physical or occupational therapists, neurologists, other allied health professionals, or other medical specialists.
9. A routine electrocardiogram (EKG) shall be performed within 10 days of admission for all patients over age 40. This requirement may be waived if the patient has no symptoms of heart disease and there is documentation of an EKG obtained within the past six months. Before initiating any potentially cardiotoxic medications, physicians shall

Medical Staff Rules and Regulations

Page 3

consult the Pharmacy & Therapeutic Committee's Drug Utilization Guidelines for EKG recommendations.

10. All women of childbearing potential who are admitted to CVH shall have a pregnancy test performed as part of their initial laboratory assessment.

ARTICLE III: DISCHARGES

1. Patients shall be discharged only on a physician's order.
2. Discharge plans including arrangements for follow-up care, as appropriate, must be completed for each patient discharged. The attending psychiatrist is responsible for assuring that continuity of care will occur and that referrals have been properly completed.

ARTICLE IV: MEDICAL RECORDS

1. All medical records shall be the property of Connecticut Valley Hospital and shall not be removed from the Hospital.
2. Each member shall be responsible for maintaining complete and legible records for each of his/her patients.
3. The admission psychiatric evaluation shall include a preliminary treatment plan.
4. A master treatment plan (MTP) shall be completed under the direction of the attending psychiatrist within 10 days of admission or transfer of a patient. This master treatment plan shall be based on the assessments completed by all members of the treatment team including, nurses, social workers, psychologists, ambulatory care service physician, dietitians and/or other allied health professionals as stipulated by hospital policy.
5. The attending psychiatrist shall be responsible for the completion of an integrated clinical formulation or summary based on the assessments completed by members of the treatment team. This formulation shall outline the patient's presenting problems and shall form the basis for the patient's MTP. This document shall be completed within 10 days of admission and shall become a part of the master treatment plan.
6. Progress notes shall be entered into the medical record of each patient on a weekly basis for the first 8 weeks after admission and monthly thereafter. The attending psychiatrist shall summarize all the treatment rendered to his/her patients and shall indicate progress made towards treatment goals. The progress notes shall address each problem identified in the MTP.
7. All progress notes shall be signed, dated and timed in accordance with Health Information Management requirements.
8. At the time of discharge, the attending psychiatrist or On-Call physician shall be responsible for completeness of the clinical material in the patient's record, that the final

Medical Staff Rules and Regulations

Page 4

diagnosis has been stated, and that all records have been duly signed within thirty (30) days of discharge.

9. In the case of the readmission of a patient, all previous records on file shall be made available for the use of the attending psychiatrist and other members of the treatment team. This shall apply whether the patient is being attended by his/her previous psychiatrist or another.
10. All members of the Medical Staff shall familiarize themselves with and adhere to the Health Information Management service guidelines for timeliness of completion of required documentation.
11. Abbreviations that have been approved by the Medical Staff shall be the only abbreviations used in the progress notes. Symbols and abbreviations shall have only one meaning. Only standard abbreviations as approved by the Medical Staff shall be used when writing medication and other orders. An official legend of approved abbreviations shall be kept on file. Each physician shall be given a copy of the hospital's abbreviations list. The only exception shall be generally accepted English abbreviations such as for the months of the year, days of the week, etc.
12. Diagnostic nomenclature shall be that used in the Diagnostic and Statistical Manual of Mental Disorders- IV (DSM-IV) or future revisions published by the American Psychiatric Association; and the latest edition of the International Classification of Diseases published by the United States Public Health Service.
13. A progress note shall be entered in the medical record by the appropriate Licensed Independent Practitioner (attending psychiatrist, on-call physician, Ambulatory Care Services physician or APRN) whenever a patient is discharged, sent to or returned from another hospital or hospital ER clarifying the rationale for the assessment, diagnostic evaluation received, therapeutic interventions rendered, and recommendations provided for follow-up care.

ARTICLE: V. PHYSICIAN ORDERS

1. All orders for medication and treatment shall be recorded in the medical record on the physician's order sheet.
2. Except for Schedule II Drug orders (narcotics), orders may be given verbally to a Registered Nurse by a Licensed Independent Practitioner (LIP) [physician or advanced practitioner registered nurse] or physician assistant (PA). Telephone/verbal orders should be reserved for appropriate situations and not merely used for staff convenience (either MD or nursing).
3. Telephone or verbal orders given to a Registered Nurse shall be signed by the nurse with the name of the LIP/PA who gave the order duly noted. LIP/PAs must sign and date all telephone and verbal orders within 24 hours. Failure to sign and date verbal or telephone orders in a timely fashion may result in the loss of ability to give such orders. Physicians may countersign verbal/telephone orders of other LIPs. Please note that

Medical Staff Rules and Regulations

Page 5

orders for seclusion or restraint have specific requirements as stipulated in the Operational Policy and Procedure Manual (OP&P), Policies 3.17.1; 3.17.2; 3.17.3.

4. All LIP/PA orders shall be legible and written in ink and shall include the date and time of the order. Orders that are illegible or improperly written will not be carried out until rewritten or understood by the nurse.
5. All medication orders written by on-call physicians shall expire on the next business day.
6. All medication orders must be reviewed and renewed at least every 30 days.

ARTICLE VI: MEDICATION

1. Drug use shall meet the standard of the U.S. Pharmacopeia, National Formulary, or New and Non-Official Drugs, with the exception of drugs used in bona fide clinical investigations approved by the Research Committee. The Hospital formulary is a listing of drugs and dosage forms selected by the Pharmacy and Therapeutics Committee and considered most useful therapeutically at this Hospital from among the numerous medicinal agents available. The formulary indicates to the Medical Staff, the nursing staff and the pharmacy staff the therapeutic agents officially approved for use in the Hospital, together with the composition, strengths, and routes of administration. Drugs listed in the formulary are also listed by generic name. The Hospital Pharmacy is given permission by the Medical Staff to dispense the generic preparation whenever a staff member prescribes by the proprietary title, unless concurrently with the writing of the medication order, the physician indicates that the brand name product only shall be dispensed. The Pharmacy and Therapeutics Committee shall approve every drug to be used at Connecticut Valley Hospital, subject to the final approval of the Medical Staff. A copy of the Hospital formulary shall be maintained in the Hospital's pharmacy and at each nursing station and by each physician. Non-formulary medications may be ordered in accordance with policies established by the Pharmacy and Therapeutics Committee.
2. Psychotropic medications shall be used only when clearly indicated, at the lowest dosage producing the desired effect, and only as long as clinically indicated. Each patient, and/or conservator, if applicable, will be fully informed about all medications and must participate in discussion concerning medications.
3. Each patient receiving antipsychotic medication should be regularly observed for tardive dyskinesia, as well as more familiar complications of such therapy. If early signs of tardive dyskinesia occur, the risk benefit ratio for continuing use should be considered and appropriate steps taken. Clinical benefits versus risks of the continued use of antipsychotic medication in the face of signs of tardive dyskinesia, whenever occurring should be clearly documented in the medical record. Consultation from a peer may be requested if any question of risk/benefit exists.
4. An examination for the presence of abnormal involuntary movements (AIMS) will be performed at the initiation of treatment with an antipsychotic medication, or at the time of admission for those newly admitted patients already prescribed an antipsychotic agent, and will be repeated every six months thereafter until thirty (30) days subsequent to the discontinuation of the medication.

Medical Staff Rules and Regulations

Page 6

5. Weekly or biweekly (after six months of documented normal WBC counts) blood monitoring is required for all patients prescribed clozapine. Orders for clozapine shall include the most recent WBC (white blood cell count) and the date the WBC was completed.
6. To implement the Controlled Substances Act of 1970, and its Amendments, Schedule II, narcotic drugs, (e.g. morphine, codeine, etc.) shall be ordered for not longer than seventy-two (72) hours. If the drug is required beyond this time, the order must be rewritten.
7. Schedule II, non-narcotic drugs, (e.g. stimulants such as amphetamine, and methylphenidate, and sedatives such as amobarbital, secobarbital, pentobarbital,) and Schedule III drugs (such as paregoric, combinations of opioids/non-opioids, some short acting barbiturates) shall be ordered for a period up to seven (7) days, and be reordered in increments of seven (7) days if needed.
8. Orders for antibiotic medications will be recorded on an order form for that purpose and instructions for that form will be followed.
9. Birth control tablets shall be reordered every cycle.
10. Orders for medications other than those specifically mentioned in sections 2-6 above will terminate after thirty (30) days, at which time the order must be rewritten to be continued.
11. Medications ordered on a PRN basis shall be valid for 30 days unless the prescribing physician indicates a shorter duration.
12. All adverse drug reactions (ADR's) must be reported by the ordering LIP as per pharmacy protocol. Adverse drug reactions shall be reviewed by the Pharmacy & Therapeutics Committee.
13. Where more than one medication in the same pharmacological class is used, the ordering physician must provide clear and sufficient documentation of the rationale in the progress notes.
14. Orders for new medications shall be accompanied by a progress note that shall include the following: reasons for the medication, target symptoms, dosage and schedule, indication of when the medication's effectiveness shall be assessed as per the Monitoring the Effectiveness of Medication Policy.
15. All follow-up progress notes shall document the patient's response to the medication ordered, any changes in dosage or schedule, whether the medication shall be continued, any side effects or adverse drug reactions noted and an indication of when the next assessment regarding effectiveness of the medication shall be made.

ARTICLE VII: EMERGENCY CARE

1. In life-threatening situations, personnel on the scene, if appropriately trained, will initiate life-sustaining treatment pending the arrival of the emergency team. A physician will

Medical Staff Rules and Regulations

Page 7

assume responsibility for the assessment and treatment until the paramedics arrive or the emergency ends.

2. Connecticut Valley Hospital provides Level IV emergency care, offering reasonable care in determining whether an emergency exists, rendering lifesaving first aid, and making appropriate referral to the nearest facility capable of providing the required services.

ARTICLE VIII: SPECIAL OBSERVATION STATUS

1. Special observation status (e.g. one to one observation or q 15 minute checks) requires physician's order. These orders shall be renewed every 24 hours. Discontinuation of special observation status also requires a physician's order.
2. Restrictions on smoking, use of the telephone, confinement to room, etc. all require a physician's order and must be in accordance with statutory requirements for patients' rights.
3. For all patients on special observation status, the minimum requirement is for an assessment of the patient's condition and documentation in the progress note every 24 hours.

ARTICLE IX: SPECIAL PROCEDURES

1. Electroconvulsive therapy is provided to CVH patients through the services of a contracted vendor. CVH patients are transported to the vendor's facility when the treatment is provided through the vendor's ECT service. CVH patients are registered as outpatients at the vendor's facility. Scheduled appointments are arranged directly with the vendor's ECT Service by the attending psychiatrist or his/her designee. A copy of each ECT treatment session is provided by the vendor for inclusion in the patient's medical record.

Electroconvulsive therapy necessitates the informed consent of the patient or legal guardian, when applicable. If the informed consent by the patient and/or guardian is denied, administration of electroconvulsive therapy can only be ordered by the Probate Court as stipulated in Section 17a-543(d) of the Connecticut General Statutes.

Pre-ECT studies must be current and the blood work must be done no earlier than one week prior to ECT. These studies must include physical examination, lumbosacral spine films if indicated, EKG, CBC with differential, SMAC-24 and chest x-ray if indicated. (See OP&P #3.18)

2. The use of restraint and seclusion shall be in accordance with Connecticut Valley Hospital policies and procedures. The use of restraint and seclusion shall be in strict conformity with relevant Connecticut General Statutes, Federal regulations and the DMHAS Commissioner's Policies on restraint and seclusion.
3. The use of behavior modification procedures that use painful stimuli shall not be employed at Connecticut Valley Hospital.

Medical Staff Rules and Regulations

Page 8

4. Surgical procedures, except for certain minor medical and dental surgical procedures, are not performed at Connecticut Valley Hospital. Arrangements for patients to undergo surgery shall be made with the appropriate community-based facilities.
5. Psychosurgery is not performed at Connecticut Valley Hospital.
6. Every member of the Medical Staff is expected to be actively interested in securing an autopsy when the death of a patient occurs. No autopsy shall be performed without the written consent of a relative or legally authorized agency. Autopsies shall be performed by a pathologist on the staff of one of the community hospitals or by the Medical Examiner's office.

ARTICLE X: MEDICAL CARE OF PATIENTS

1. Non-psychiatric physicians responsible for the ongoing medical (Axis III disorders) care of the patient, dentists, optometrists, podiatrists, Physician's Assistants (PA's) and Advanced Practice Registered Nurses (APRNs) are members of Ambulatory Care Services and receive professional supervision from the Medical Director of Ambulatory Care Services.
2. Connecticut Valley Hospital has a contractual relationship with Middlesex Memorial Hospital (MMH). MMH provides the services of a hospitalist who is available for telephone consultation twenty-four hours a day/seven days a week.
3. In the case of life-threatening emergencies, the evaluating physician shall call the MMH Emergency Department and discuss the situation with the physician on duty.
4. Transfers to the Emergency Department of MMH for non-emergency treatment or evaluation shall be arranged through consultation with the hospitalist as per Ambulatory Care Services protocol.
5. A special consent form is required for initial HIV (Human Immunodeficiency Virus) testing. This form must be completed by the ordering LIP and signed by the patient or his/her conservator. Progress notes must document that the patient has given informed consent for such tests.
6. The admission/annual medical history shall include (see form CVH-341):
 - Chief Complaint
 - Present Illness
 - Past Surgical History
 - Past Medical History
 - Gynecological History (if applicable)
 - Family History
 - Present Medications
 - Allergies and Adverse Drug Reactions
 - Life Style (e.g., tobacco, alcohol, and illicit drug usage)
 - Review of Systems (including major body systems and pain assessment)

Any information unobtainable will be documented as such.

Medical Staff Rules and Regulations

Page 9

7. The admission/annual medical physical examination shall include (see form CVH-341):
 - General Appearance
 - Vital Signs and Height/weight
 - Skin
 - Head
 - Neck
 - Breasts
 - Lungs
 - Heart and circulatory system
 - Abdomen
 - Genitourinary and rectal
 - Extremities
 - Neurological examination

Any information unobtainable will be documented as such.

8. A patient who refuses his/her admission medical history and physical examination shall be approached again at least monthly thereafter, until such time as the patient consents to such an examination. Documentation of the initial refusal shall be written in the margins of the Medical History and Physical Examination form; subsequent refusals shall be documented in the Physical Health Progress Notes at the time of the monthly medication renewals. Competency to consent to or refuse needed medical examinations and/or treatments is a question to refer to Attending Psychiatrist for potential referral to the Probate Court.
9. All patients shall receive an annual physical examination during the anniversary month of their admission (as defined by CVH policy). The Ambulatory Care Service LIP must document patient refusals of the annual physical examination at the time of the monthly medication renewals.
10. All admission/annual Medical History and Physical Examination(s) shall outline assessments, additional diagnostic testings, consultations, and/or treatments for all non-psychiatric (medical) physical problems.
11. Physician's Assistants are each assigned a primary supervising physician as stipulated in Connecticut General Statute 20-12a-g and the Hospital's OP&P #3.3.2. Each physician assistant is supervised by a designated physician, in compliance with applicable State regulations and CVH policy. They function at all times under the supervision of a physician and in accordance with written protocols.
12. Each APRN is assigned and works with a collaborating physician, in compliance with applicable State regulations and CVH policy.
13. Pain assessments are completed in accordance with the Hospital's OP&P #2.5.

Medical Staff Rules and Regulations

Page 10

14. Chest X-rays will be performed based upon physical findings and/or clinical symptomatology. Chest X-rays are not part of Connecticut Valley Hospital's routine admission or annual medical assessments.

ARTICLE XI: PATIENT DEATHS

1. In the event of a patient death, a LIP shall pronounce the deceased as soon as possible but no later than four hours following the initial discovery of the body. The body shall not be released until an entry has been made and signed by the physician in the medical record of the deceased.
2. Post mortem care is not initiated until the patient has been examined and pronounced dead, and the family has been notified. Policies with respect to the release of dead bodies shall conform to state law. (See OP&P, Policy 3.3)
3. All LIPs shall secure meaningful autopsies whenever possible. An autopsy, unless required by the Medical Examiner's Office, may be performed only after obtaining written consent in accordance with state law and Hospital policy. (See OP&P, Policy 3.3)

ARTICLE XII: CONFIDENTIALITY

The Medical Staff complies with the relevant Section of the General Statutes of Connecticut (CGS Chapter 99) concerning the confidentiality of patient records and Federal Confidentiality Regulations (CFR 42, Part 2) concerning confidentiality of alcohol and drug dependency records.

ARTICLE XIII: LABORATORY SERVICES

Clinical laboratory services shall be provided by an approved clinical laboratory as per present and service contracts.

ARTICLE XIV: RULES AND REGULATIONS REVIEW AND REVISION

1. The Medical Staff of Connecticut Valley Hospital shall review its Rules and Regulations at least biannually, and shall review and/or modify them whenever the results of Performance Improvement activities or changes in the accepted standards of care suggest such a need. Any member of the Medical Staff may propose a review of the By-Laws and Rules and Regulations during a regular Medical Staff meeting or by a written request to the Executive Committee of the Medical Staff.
2. The Executive Committee of the Medical Staff shall, from time to time, review Hospital policies and procedures that pertain to medical care and shall review and/or suggest modifications of them whenever the results of Performance Improvement activities or changes in the accepted standards of care suggest such a need. Any member of the Medical Staff may propose a review of the Hospital policies and procedures during a regular Medical Staff meeting or by a written request to the Executive Committee of the Medical Staff.

Medical Staff Rules and Regulations

Page 11

ARTICLE XV: PROFESSIONAL DEVELOPMENT

1. There shall be a working medical library and journal file.
2. All members of the Active Medical Staff shall be encouraged to continue their professional development through in-house training opportunities, recognition and pay incentive for passing specialty boards, and an opportunity to receive additional training in areas found deficient through peer review mechanisms. Additionally, all members are encouraged to attend courses and conferences related to clinical or administrative work. It is expected that each Medical Staff member earn one hundred (100) continuing education credits per two-year period, at least forty (40) credits being category one credits. The Continuing Medical Education Committee shall arrange for appropriate educational opportunities to be held at the Hospital.
3. All LIPs other than consultants are expected to maintain current certification in Cardiopulmonary Resuscitation (CPR), and all physicians must be CPR certified prior to performing direct patient care. Acceptable CPR certification courses must include *at minimum* CPR skills for adult, child and infant victims; two-man CPR; use of resuscitation devices (BVM and other masks); and obstructed airways procedures for all victims. The following certifications shall meet this requirement: Advanced Cardiac Life Support (ACLS), Basic Life Support (BLS) American Red Cross CPR for the Professional Rescuer (ARC CPR FPR) and Healthcare Providers Course (AHA). Successful completion of these courses satisfies the Medical Staff requirement for a one-year period, except that ACLS satisfies the requirement for two years.

ARTICLE XVI: IMMUNITY FROM LIABILITY

Section 4-165, Immunity of State Officers and Employees from Personal Liability, of Connecticut State Statutes, reads as follows: "No State officer or employee shall be personally liable for damage or injury, not wanton, reckless or malicious, caused in the discharge of his duties or within the scope of his employment. Any person having a complaint for such damage or injury shall present it as a claim against the state under the provisions of this chapter. For the purposes of this section "scope of employment" shall include, but not be limited to, representation by an attorney appointed by the public defender services commission as a public defender, assistant public defender or deputy assistant public defender or any attorney appointed by the court as a special assistant public defender of an indigent accused or of a child on a petition of delinquency, representation by such attorneys, referred to in section 4-141, of state officers and employees, in action brought against such officers and employees in their official and individual capacities, the discharge of duties as a trustee of the state employees retirement system, the discharge of duties of a Commissioner of Superior Court hearing small claims matter or acting as a fact-finder, arbitrator or magistrate or acting in any other quasi-judicial position, and the discharge of duties of a person appointed to a committee established by law for the purpose of rendering services to the judicial department; provided such actions arise out of the discharge of the duties or within the scope of employment of such officers or employees..."

ARTICLE XVII: DISASTER PLAN

The Hospital maintains at all times an external and internal disaster plan in which members of the Medical Staff actively participate. Members of the Medical Staff are required to be familiar with their duties and roles in the event of a disaster. Selected members of the Medical Staff participate on the Connecticut Valley Hospital Management of the Environment of Care Committee. This committee periodically updates the plan.

ARTICLE XVIII: SELECTION OF NEW MEDICAL STAFF

1. When a position for a physician becomes available, either through vacancy or through the creation of a new position, the Medical Staff shall play an active role in the selection of new members of the Medical Staff. The Executive Committee of the Medical Staff shall have the right to interview any applicant for membership on the Medical Staff and to make recommendations about the appropriateness of candidates for membership and for particular clinical positions. The names of approved applicants will be sent to the administration of the Hospital for further consideration and personnel action.
2. Once approved for hiring, the physician's completed application file will be forwarded to the Credentialing and Privileging Committee of the Medical Staff for review of credentials and privileges. Recommendations are forwarded to the Executive Committee of the Medical Staff. The Executive Committee, through the President of the Medical Staff, recommends the applicant for privileges sought to the Chief Executive Officer (CEO). The CEO and the Hospital's Governing Body determine final approval of employment, appointment to the Medical Staff, and approval of delineated privileges.
3. No physician shall practice at Connecticut Valley Hospital in a clinical capacity without the Executive Committee of the Medical Staff first recommending appointment to the Medical Staff. When necessary, interim clinical privileges may be granted and renewed by the Chief Executive Officer at the request of the President of the Medical Staff (or designee) based on the recommendation of the Chair of the Credentialing and Privileging Committee (or designee) for up to sixty (60) days.

ARTICLE XIX: PROFESSIONAL CONDUCT

1. Medical Staff members agree to conform to the requirements of professional dignity in their conduct and attire.
2. Professional staff members recognize their obligation to report to their Service Medical Director or Medical Director, the Chief of Professional Services, Chief Executive Officer, or the Executive Committee of the Medical Staff any act(s) of unethical conduct, or any case(s) of gross negligence or professional incompetence on the part of any clinician.
3. Members shall not exert pressure on their co-workers or subordinates on behalf of a part or organization, be it political, cultural, religious or charitable.
4. All Medical Staff members agree not to exceed the privileges granted to them by the Governing Body except necessitated by a life-threatening emergency.

Medical Staff Rules and Regulations

Page 13

5. As participating and voting members of a democratic organization, members of the medical staff agree to be bound by decisions of the duly constituted meetings of the Total Medical Staff or the Executive Committee of the Medical Staff.
6. Medical Staff members may not engage in outside private practice while on duty time at the Hospital. Any such outside practice shall be in accordance with applicable policies of the Department of Mental Health and Addiction Services and the State Personnel Policy Board.
7. It is improper for a Medical Staff member to promote one's own private practice among patients at the Hospital.
8. Medical Staff members may hold college or university appointments.

ARTICLE XX: REVIEW, EVALUATION AND MONITORING OF MEDICAL STAFF PRACTICE

1. All members shall participate and cooperate in review, evaluation and monitoring activities of the Medical Staff and the Hospital.
2. Permanent records shall be maintained of all review functions. When important problems in clinical care and clinical performance or opportunities to improve care are identified, there shall be documentation of all actions taken. The effectiveness of the actions taken shall be evaluated and reported to the appropriate committees, Service Medical or Medical Director, the Chief of Professional Services, or the Chief Executive Officer.
3. The Medical Staff shall participate and cooperate with the Hospital's Performance Improvement Plan.

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