

Revised

UNIVERSITY OF MINNESOTA HOSPITALS

RULES AND REGULATIONS

1. The meetings of the medical staff shall be held every Friday noon of the nine-month academic school year or as directed by the Dean of the College of Medical Sciences.
2. Patients seen at the University of Minnesota Medical Center must be referred by the private physician who has been caring for the patient. Obstetrical patients without a referring physician, emergency patients, and selected patients referred by courts and community agencies are exceptions to this rule.
3. Physicians admitting patients are responsible for giving information to protect the patient from self-harm and to assure the protection of other patients from those who are a source of danger from any cause whatsoever.
4. Standing orders are permissible, subject to the approval of the Joint Conference Committee. They can be changed only by mutual consent of the medical staff and administrator, and the latter shall notify all personnel concerned. These orders shall be signed by the attending physician.
5. All orders for treatment must be written in the Doctor's Order Book and signed. Verbal orders may be given only to the night nursing supervisor and are accepted only at her discretion. All such orders should be written within 24 hours.
6. Drugs used shall be those listed in the United States Pharmacopeia, National Formulary, New and Non-Official Remedies, British Pharmacopeia, Canadian Formulary, or University Hospital Formulary, with the exception of drugs for bonafide clinical investigations. Exceptions to this rule shall be approved by the Pharmacy Committee. Use of generic names of drugs is recommended. In writing prescriptions, the use of the Metric System is required.
7. The attending physician shall be held responsible for the preparation of a complete medical record for each patient. This record shall include identification data; complaint; personal history; family history; history of present illness; physical examination; special reports such as consultations, clinical laboratory, x-ray, and others; provisional diagnosis; medical or surgical treatment; operative report; pathological findings; progress notes; final diagnosis; condition on discharge; summary or discharge note; follow-up and autopsy report when applicable. No medical record shall be filed until it is complete, except on order of the Medical Records Committee.
8. As complete a history as is compatible with the patient's condition and a physical examination shall in all cases be written within 24 hours after admission of the patient.
9. When such history and physical examinations are not recorded before the time stated for operation, the operation shall be cancelled unless the attending surgeon states in writing that such delay would constitute a hazard to the patient.
10. All hospital chart records are the property of the hospital and shall not be taken away or information therein disclosed without the written consent of the patient. In case of readmission of a patient, all previous hospital

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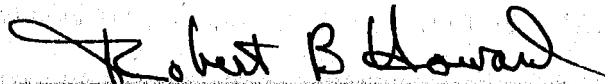
chart records shall be available for the use of the attending physician. This shall apply regardless of the financial classification of the patient and whether he be attended by the same physician or by another.

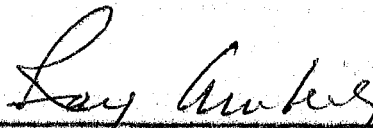
11. Except in emergencies, a surgical operation shall be performed only on consent of the patient or his legal representative.
12. All operations performed shall be fully described by the operating surgeon. All tissues removed at operation shall be sent to the hospital pathologist who shall make such examination as he may consider necessary to arrive at a pathological diagnosis, and he shall sign his report.
13. Patients shall be discharged only on written order of the attending physician. At the time of discharge, the attending physician shall see that the record is complete, state his final diagnosis, and sign the record.
14. Medical staff standing committees are provided for in Article V, Section 1 of the Bylaws. These committees are Intern, Medical Records, Professional Standards, and Pharmacy.
15. Every member of the medical staff is expected to be actively interested in securing autopsies. No autopsy shall be performed without proper consent of a relative or legally authorized agent. All autopsies shall be performed by the hospital pathologist or by a physician delegated this responsibility.
16. All staff members who have full-time academic appointments in the College of Medical Sciences may have patient treatment responsibility. Interns and residents may treat patients under supervision of a staff physician. Visiting clinicians may treat patients in connection with their teaching responsibilities, but do not have admission privileges or responsibility for continuing care of the patient, except under unusual circumstances and with permission of the department head.
17. Medical Staff Disaster Assignments: All physicians shall be assigned in accordance with the Medical Center Disaster Plan.
18. Free access to all medical records of all patients shall be afforded to staff physicians in good standing for bonafide study and research, consistent with preserving the confidentiality of personal information concerning the individual patients. Subject to the discretion of the administrator, 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 attended such patients in the hospital.

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19. Rules and regulations not specifically covered by the above are listed in the University of Minnesota Hospitals Information and Reference Manual for Interns and House Staff, 9th Edition, dated 1960. Questions or requests for changes are to be submitted to the department concerned and/or the Joint Conference Committee.

Adopted at a regular meeting of the active medical staff.

  
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Dean, College of Medical Sciences

  
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Director, University Hospitals

DATE: October 11, 1961