ARTICLE I, MEDICAL STAFF MEMBERSHIP
SECTION 7. RESPONSIBILITIES OF EACH MEMBER

A. Each staff member must provide appropriate, timely, and continuous care of his/her patients. He/She is not responsible for the actions of other staff members, Allied Health Professionals (unless under his/her supervision), or health system employees.

B. Each staff member must participate, if assigned, in quality/performance improvement activities and in discharging other staff functions as may be required from time to time.

C. Each staff member must participate in the coverage of the emergency service and other coverage programs as determined by the Medical Staff Executive Committee.

D. Each staff member must abide by the bylaws, rules and regulations and other policies and procedures of the health system and the medical staff including but not limited to paying required fees and/or dues.

E. Each staff member must notify the Chief of Staff or Vice President of Medical Affairs (VPMA) immediately upon the occurrence of any of the following:

   1. The revocation, suspension, restriction, curtailment, probation, or limitation, whether voluntarily or involuntarily, of the staff member's professional license by any state licensing agency for reasons relating to the staff member's professional competence or professional conduct; or

   2. The revocation, suspension, restriction, curtailment, probation, or limitation, whether voluntarily or involuntarily, of a staff member's practice privileges at any hospital or other healthcare institution that adversely affects his/her practice privileges for a period of more than 30 days.

F. Each staff member must continually meet their medical records responsibilities as outlined in the Medical Staff General Policy & Procedures Manual. Failure to do so will result in consequences as described in the manual up to and including an enhanced re-credentialing fee and voluntary resignation from the medical staff.

G. A History and Physical examination shall be completed and documented in iSparrow EMR for each patient no more than 30 days prior to, or 24 hours after, admission or registration, but prior to surgery or a procedure requiring anesthesia services or intravenous sedation.

   When the History and Physical examination are completed within 30 days prior to admission or registration, an updated interval History and Examination shall be completed and documented in the iSparrow EMR within 24 hours after admission or
registration, but prior to surgery or a procedure requiring anesthesia services or intravenous sedation.

If an updated interval History and Examination is performed, it shall include documentation that the patient was examined, the history reviewed, and the presence or absence of changes.

A regular History and Physical Examination (as opposed to the “update” described above) shall include the chief complaint, history of present illness, including when appropriate an assessment of the patient's emotional, behavioral, and social status, relevant past medical, surgical, social and family histories, allergies, current medications (including dose, route and frequency), special diets and treatments, technological support, and a Review of Systems. The physical examination shall reflect a comprehensive, current physical assessment. A Principal Diagnosis shall be recorded in a structured manner on the iSparrow EMR Problem List; any additional problems or diagnoses related to the hospitalization should also be entered in the Problem List. An assessment and plan of care for the patient during the Hospital stay drawn from the admission history and physical examination shall be included.

In cases of an emergency, a patient may be taken to surgery without the taking and recording of a full history and physical examination present and on the chart. In this case, a preoperative note must be entered into the EMR by the surgeon; the note shall include a preoperative diagnosis, summary of physical findings and the proposed surgical procedure.