Sections of the Rules and Regs pertaining to 'Admitting Physician', 'Attending Physician' and 'Physician of Record'

1.1.1 Admitting Physician.

The Medical Staff Member who orders a patient's admission into the Medical Center. The Admitting Physician must have admitting privileges.

1.1.2 Attending Physician.

The Medical Staff Member who is responsible for oversight of a patient's care during an inpatient, outpatient or Emergency Department visit. The Attending Physician may transfer this responsibility to another member of the Medical Staff, after contacting and obtaining his or her consent, by updating this designation in our Clinical Information System. The Attending Physician must be a member of the Medical Staff with appropriate clinical privileges, regardless of Medical Staff category.

1.1.3 Allied Health Professionals.

Those health care professionals who provide patient care services at the Medical Center pursuant to the provisions of the Cedars-Sinai Medical Staff Rules and Regulations for Allied Health Professionals.

1.1.4 Assistant Surgeon.

The Medical Staff Member who is responsible for providing surgical assistance to the Primary Surgeon.

1.1.8 Consultant.

A Medical Staff Member who is requested by the Attending Physician to participate or confer in the diagnosis, treatment plan development and/or actual treatment of a given patient as evidenced by Documented progress notes, orders, or reports.

1.1.24 Pediatric Patients.

Patients aged birth to thirteen (13) years old (on admission) shall be admitted to or cared for in spaces approved for pediatric beds. Patients beyond the age of thirteen (13) may only be admitted to or cared for in spaces approved for pediatric beds in unusual circumstances, and only if approved by the attending pediatrician and the reason Documented in the patient's medical record. Medical Staff Members must have appropriate Privileges to provide care to pediatric patients. Except as provided above, patients aged fourteen (14) to twenty-one (21) years old (on admission) should be placed in adult unit beds, but may be treated by either the patient's attending pediatrician or other members of the Medical Staff privileged to provide such care.

1.3 Medical Staff Member for Family Members.

1.3.1 Except in an emergency or to treat a minor condition, a Medical Staff Member should not be the Admitting Physician, Attending Physician , Primary Surgeon, Assistant

Surgeon, Anesthesiologist or Consultant for any member of his or her family including spouse, domestic partner, common law spouse, same-sex partner, children, parents, siblings, grandchildren, grandparents, great-grandparents, inlaws (including parents-in-law, siblings-in-law, and grandparents-in-law), or any of these in a step relationship or through legal adoption. For the purposes of this Section1.3.1, an “emergency” exists where an individual is apparently experiencing severe suffering, or is at risk of sustaining serious bodily harm if medical intervention is not properly provided, and a “minor condition” is a non-urgent, non-serious condition that requires only short-term, routine care and that is not likely to be an indication of, or lead to a more serious condition.

2.1.10 House Physician.

2.1.10.1 Physicians (who are not otherwise eligible for any other Medical Staff category) may be appointed to the House Physician category for the purpose of providing inpatient care for emergent and urgent problems until a Medical Staff Member on the patient care team is able to provide onsite inpatient care. House Physician category members may be permitted to provide such emergent or urgent care for inpatients subject to the recommendation of Clinical Privileges by the Department of Medicine, as approved by the Credentials Committee, the Executive Committee and the Board of Directors. The House Physician member must hold a License, but may still be working towards specialty board eligibility. The House Physician’s membership and privileges are limited in scope, and as with all newly appointed Medical Staff Members, House Physician members are appointed to the Medical Staff on a probationary or “Provisional” basis. In this regard, all initial determinations of Clinical Privileges granted to House Physicians shall be subject to review by the Department of Medicine. In addition, appointment to the House Physician category shall not create a presumption regarding suitability for other Medical Staff categories, and a House Physician member must submit a new Application to the Medical Staff to obtain any other category of membership or Privileges. The House Physician seeking a change in either membership category or Privileges has the burden of proof (by a preponderance of the evidence) that he or she is qualified for the Medical Staff category requested. All Applications for House Physician category shall require the approval of the Chairman of the Department of Medicine.

2.1.10.3 The House Physician shall provide the following kinds of emergent or urgent care services to inpatients:
(a) Emergent Care. The House Physician Service will be available to provide emergent care for patients not on the teaching service. Nurses should attempt to reach the Attending Physician first. If the Attending Physician requests assistance from the House Physician, or if the Attending Physician cannot be reached in a reasonable timeframe, nurses may call the House Physician for assistance. Excepting Subsection (b) below, the House Physician should only be called for: (1) Potentially emergent issues, when a delay in patient evaluation may endanger patient safety; (2) Assistance in the evaluation of patient with complaints of acute chest pain, sudden shortness of breath, or acute

abdominal pain; and (3) Assistance in the evaluation of patients likely to need transfer to a higher level of care.
(b) Urgent Care. The House Physician will also assist in the evaluation of patients that have fallen from bed.

3.2 Admission Order.

Admission shall be initiated by an order that specifies the Admitting Physician, the Attending Physician, and whether the patient is being admitting as an inpatient or placed in observation. Unless clearly documented elsewhere in the medical record, this order should also define the patient's provisional diagnosis on admission. The order to admit a patient may be entered by a Medical Staff member who does not have admitting privileges, or by a Physician-in-Training, providing he or she identifies the Admitting Physician at the time of admission.

3.4 Transfer or Discharge To or From the Medical Center.

Transfer or discharge will not be carried out if, in the opinion of the patient's Attending Physician, such transfer or discharge would create a medical hazard. No patient will be transferred or discharged for purposes of effecting a transfer from the Medical Center to another health facility or from another health facility to the Medical Center unless arrangements have been made in advance for admission, pursuant to applicable laws, and Medical Center Policies and Procedures pertaining to patient transfers, as amended from time to time.

3.6 Critical Burns.

Patients with critical burns will be transferred to an appropriately licensed and permitted burn center, unless transfer of the patient to the burn center is contraindicated in the judgment of the Attending Physician.

3.8 Cancellation.

3.8.1 The Admitting Physician shall notify the Admitting Office if a scheduled admission is to be canceled.

4.5.3 Completion of History and Physical for Hospitalized Patients.

(a) Every hospitalized patient (inpatient) must have a history and physical examination that is Documented either:
(i) no more than twenty-four (24) hours after admission, or
(ii) no more than thirty (30) days prior to admission.

(b) If the history and physical examination was completed within thirty (30) days prior to admission pursuant to the above, a Medical Staff Member or a Physician-in-Training must review the history and physical examination, see the patient, and conduct an assessment to determine if there have been any changes since the history and physical examination was completed. A note must then be Documented:
(i) within twenty-four (24) hours after admission;
(ii) to summarize all additions and changes to the patient's history and physical examination; and
(ii) to confirm that the necessity for the admission or treatment is still present.(c) The lack of a History and Physical meeting these requirements shall be treated as a "delinquent medical record" subject to the provisions of Section 4.22 below, except that such medical record delinquency shall immediately result in the Admitting Physician's automatic administrative suspension without prior notification to the Medical Staff Member. A Medical Staff Member on administrative suspension for such medical record delinquency will retain all current Clinical Privileges except that he or she shall not be allowed to make bed reservations for his or her patients or schedule elective outpatient or inpatient surgery for his or her patients.

4.7 Assuring Appropriate Documentation.

The Operating Room staff shall be responsible for assuring that all required documentation is present in the medical record prior to starting surgery. In the event information, including the pre-procedure assessment or an appropriate assessment or history and physical examination, is not evident, the procedure or surgery will be canceled or postponed until such time as all required documentation is available, unless the Attending Physician or Primary Surgeon states in writing that such a delay incurred for this purpose would constitute a hazard to the patient.

4.10 Progress Notes.

Legible, pertinent and sufficient progress notes shall be Documented at or near the time of observation. Whenever possible each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatments. Progress notes shall be Documented at least daily (i.e., either on any given calendar day or within twenty-four (24) hours of the last progress note) on all patients by the Attending Physician, or his or her delegate, based upon the Medical Staff Member's direct observation of the patient, as provided by the applicable Departmental Rules and Regulations. Notwithstanding the foregoing, progress notes shall only be required to be Documented for healthy newborn patients in the Medical Center's Newborn Nursery within twenty-four (24) hours of admission and within twenty-four (24) hours prior to the patient's discharge. All progress notes must be authenticated by signature and dated by the Medical Staff Member.

4.15 Obstetrical Record.

The Attending Physician shall ensure that the current Obstetrical record includes a complete Prenatal record, which may be a legible copy of office records transferred to the Medical Center before or at the time of admission. In such instances, an interval admission note must be Documented that includes pertinent additions to the history and any subsequent changes in the physical findings.

4.16 Final Diagnosis.

The Attending Physician is responsible for assuring that a Medical Staff Member documents the Final Diagnosis within twenty-four (24) hours of a patient's discharge. If the Final Diagnosis is not recorded in full, the patient's medical record shall be treated as a "delinquent medical record" subject to the provisions of Section 4.21, below.

4.20.2 Authentication of Verbal and Telephone Orders.

(a) **Generally.** All in-patient diagnostic and therapeutic telephone and verbal orders must be authenticated electronically using the appropriate Clinical Information System(s) by the ordering Medical Staff Member, Physician-in-Training, or Attending Physician within forty eight (48) hours.
(b) **Restraint and Seclusion Orders.** Notwithstanding Subsection 4.20.2(a) above, restraint and seclusion orders must be authenticated electronically by the ordering Medical Staff Member, Physician-in-Training, or Attending Physician within twenty-four (24) hours.
(c) **Do Not Resuscitate ("DNR") Orders.** Notwithstanding Subsection 4.20.2(a) above, Do Not Resuscitate ("DNR") orders must be authenticated by the ordering Medical Staff Member or Attending Physician within twentyfour (24) hours.

4.21.1 Birth Certificates and Death Certificates.

(a) **General.** Unless otherwise provided herein, medical records not completed within fourteen (14) calendar days of a patient's discharge will be considered delinquent.
(b) **Birth Certificates.** Birth certificates that remain unsigned by the Attending Physician for fourteen (14) consecutive days will be deemed delinquent medical records.
(c) **Death Certificates**.
(i) Non-coroner cases. Death certificates in non-coroner cases that remain unsigned by the Attending Physician (who was last in attendance at the patient's death) for fourteen (14) consecutive days from the date of the patient's discharge or autopsy report, whichever is later, will be deemed delinquent medical records.
(ii) Coroner cases. Death certificates in coroner's cases shall never be considered delinquent (as the coroner has the responsibility to complete the death certificate).

6.1 Medical Staff Member or Physician-in-Training Responsibility in CPR.

The Medical Staff Member or Physician-in-Training with the highest level of expertise as evidenced by Board Certification or current Heart Association CPR certification will have the ultimate responsibility in all CPR procedures at the Medical Center. In the event that two (2) or more physicians hold the same level of certification, the most senior physician will be responsible. If other than the Attending Physician, this person will communicate and act with the input of the Attending Physician.

9.6 Consulting Privileges in Closed Service Departments.

If a member in good standing of the Medical Staff seeks to avail himself or herself of the consulting services, in a Closed Service Department, but by a Consultant, who is not a member of the Closed Service Department, prior to the occurrence of any such consultation, he or she shall: (i) complete and sign a written statement to such effect on an approved form ("the Request Form"); and (ii) Document in the patient's medical record that the Attending Physician has advised the patient (or the patient's legal representative if the patient is not competent) that the consultation shall be provided by a

physician who is not a member of the Closed Department and whether the consultation shall result in an additional charge to the patient.

9.6.3 Senior Vice President for Medical Affairs & Chief Medical Officer Review and Approval.

The Senior Vice President for Medical Affairs & Chief Medical Officer shall promptly review the Request Form and shall consider the recommendation of the Department Chair. The Senior Vice President for Medical Affairs & Chief Medical Officer shall approve the request unless in his or her judgment: (i) the Consultant lacks the professional qualifications to perform the requested consultation; (ii) other circumstances exist which render it medically inadvisable or inappropriate for the Consultant to perform the requested consultation; or (iii) if the Consultant in question has previously had repeated violations of the administrative requirements contained in this Article IX, Section 9.6. If the request is approved, the Senior Vice President for Medical Affairs & Chief Medical Officer shall promptly so advise the Consultant, in writing, and initiate such administrative procedures as may be customarily employed to complete the temporary appointment. If the request is disapproved, the Senior Vice President for Medical Affairs & Chief Medical Officer shall promptly notify the Attending Physician and so advise the Consultant, indicating the reasons for such action.

9.6.5 Prior Consultation History.

Nothing in this protocol shall require the Senior Vice President for Medical Affairs & Chief Medical Officer to approve requests by any Consultant to provide consulting services when requested by the Attending Physician, when in his or her judgment the Consultant has consistently demonstrated that he or she is unwilling or unable to provide such services in a manner consistent with the standards of the Medical Center in the course of prior consultations.

9.6.6 Limitation on Consulting Services.

All consulting services performed by the Consultant pursuant to any given request by the Attending Physician shall be performed within the time specified on the "Consulting Services Request Form." Such services shall not exceed the bounds of consultation as the term is customarily used. Such services shall not entail use of any staff or equipment of the Medical Center. The Consultant shall not be authorized to write any orders or perform any procedure. He or she shall be permitted to examine such records as are customarily made available to a consulting physician; examine and interview the patient with respect to whom the Privileges are granted, subject to the consent of the patient; and confer with diagnostic specialists in Medical Center Service Departments.

10.11 Phone Call(s) to Medical Staff Members Regarding a Patient Care Issue.

10.11.1 Phone Call(s) to Medical Staff Members.

A Medical Staff Member shall respond to a phone call(s) regarding a patient care issue made by any member of the patient care team, a member of Care Management, or a Department Chair or Clinical Chief in a timeframe consistent with the acuity of the clinical circumstances, but in no event more than four (4) hours from receipt of the call. If the phone call is regarding an urgent issue or a patient who requires admission from the Emergency Department, a response is required within thirty (30) minutes of a Medical Staff Member's receipt of the phone call. For the purposes of this Section 10.11.1, "urgent" shall mean any situation that requires an immediate action in order to avoid an adverse outcome; this includes an acute change of vital signs, critical test results, a new physical finding or a symptom that is reasonably perceived as requiring immediate attention.

10.11.2 Urgent and Critical Results.

The Attending Physician is responsible for handling urgent or critical results when the Medical Staff member, or Physician-in-training, who ordered a lab test or imaging study cannot be reached.

10.11.3 Discharge Planning.

When the Physician of Record fails to assist in discharge planning for his or her patient, the Department Chair, Clinical Chief, Division Clinical Chief or Director for the respective service will be contacted and requested to intervene.

16.2 Consultations.

Consultations with another physician on the Medical Staff, who is Privileged to provide such consultations, are advised in cases on all services in which, according to the judgment of the Attending Physician, the patient is seriously ill, the diagnosis is obscure, and there is a question as to the best therapeutic measures. All consultations at the Medical Center will be arranged for by the Attending Physician who will directly call the Consultant or his or her office. The following exceptions may apply:

(a) Request for imaging procedure consultation;

(b) The Attending Physician specifically delegates authority for requesting a consultation to a Physician-in-Training; and

(c) In an emergency, the Attending Physician may delegate a nurse or a Physician-in-Training to request a consultation.

16.3 Triage Duty of Critical or Intensive Care Unit Directors.

The Director of a Critical or Intensive Care Unit ("Unit"), or his or her delegate (who shall be an Attending Physician), shall perform a daily triage of all patients hospitalized in the Unit, including all patients eligible for admission to and/or discharge from the Unit. Such daily triage shall be performed in consultation with the patients'Attending Physician. Notwithstanding the foregoing, the decision to admit and/or discharge a patient from the Unit shall reside solely with the Director of the Unit, or his or her Attending Physician delegate, and such decision shall be final.