# MEDICAL STAFF RULES

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Provincial Health Services Authority

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## Article 1 — DEFINITIONS

Affiliation Agreement — An agreement with the University of British Columbia or other educational entity to facilitate teaching and practicum activities within a Facility or Program.

Appointment — The process by which a Clinical Scientist, Dentist, Midwife, Nurse Practitioner, or Physician becomes a member of the PHSA Medical Staff.

Associate Department or Program — A second Department or Program, other than the Primary Department or Program, to which a member of the Medical Staff is appointed.

Associate Physician — A Physician who holds an Associate Physician licence, as defined by the College of Physicians and Surgeons of BC. They are not members of the Medical Staff.

Attending Midwife, Attending Nurse Practitioner or Attending Physician — The Midwife, Nurse Practitioner Physician who cares for a patient admitted to or treated in a PHSA Facility or Program.

Best Possible Medication History (BPMH) — A "snapshot" of the patient's current medication, obtained through a systematic process of interviewing the patient and family, if available, and review of at least one other reliable source of information. The BPMH attempts to document all current prescription and non-prescription medication, including drug name, dose (amount or volume), route, frequency, and duration.

Board of Directors (the Board) — The governing body of the Provincial Health Services Authority appointed by the Minister of Health for British Columbia.

Chief Executive Officer (CEO) — The person engaged by the PHSA Board to provide leadership and to carry out the management of the Facilities and Programs operated by the PHSA in accordance with the Health Authority Bylaws, Rules and policies.

Clinical Fellow — An educational-licensed Physician, temporarily working in a PHSA Facility or Program to gain additional experience in a health-care discipline under the supervision of a member of the Medical Staff. They are not members of the Medical Staff.

Clinical Associate Staff — Appropriately qualified, Credentialed and Privileged Medical Staff working in highly-specialized areas under the direction of a Department or Division Head, or a senior member of a Department

or Division. Clinical Associate Staff provide services in a clinical academic centre affiliated with the Faculty of Medicine, UBC. They are not to be interpreted as Associate Physicians as defined by the College of Physicians and Surgeons of BC.

Clinical trainees — A Practitioner with a temporary educational license temporarily engaged by the facilities for the purpose of training in a medical discipline and who are supervised by a member of Medical Staff. Clinical trainees are not members of the Medical Staff.

Clinical Scientists — Members of PHSA Medical Staff responsible for laboratory medical operations and patient care, including confirming diagnoses, and providing test interpretation and consulting across molecular genetics, biochemical genetic, clinical chemistry, and cytogenetic clinical services. They are Credentialed and Privileged, fulfilling similar clinical roles as Physicians within that scope of practice. Those in active practice are certified and in good standing with a national academic college, society, or equivalent e.g. Canadian Academy of Clinical Biochemistry, Canadian College of Medical Geneticists, Canadian College of Microbiologists or Canadian Society of Clinical Chemists.

Computerized Provider Order Entry (CPOE) — The process of order placement into the Electronic Health Record by a health-care Provider or designated Medical Staff member, employing either single electronic orders or groups of orders (electronic clinical order sets).

Consultant — A member of the Medical Staff who has been asked by another Medical Staff member to provide an opinion related to the investigation, diagnosis, treatment, or ongoing care of a patient within a PHSA Facility or Program.

Continuous Quality Improvement (CQI) — a structured organizational process that involves Medical Staff and others in planning and implementing ongoing proactive improvements, in processes of care to provide quality health care outcomes, used by hospitals to optimize clinical care by reducing variability and reducing costs, to help meet regulatory requirements, and to enhance customer-service quality.

Corporate Medical Affairs Department — The administrative branch of PHSA, structured to assist the HAMAC, LMACs, Departments and Programs fulfill their obligations regarding Medical Staff governance.

Credentialing — The process of screening and evaluating Medical Staff qualifications, including appropriate training, licensure, experience, references, professional college requirements and practice insurance necessary for appointment to the PHSA Medical Staff. The Credentialing process requires, in part, Medical

Staff compliance with competency expectations outlined in the Provincial Privileging Dictionaries for the province of British Columbia.

Dentist — A member of the Medical Staff who is duly registered with the BC College of Oral Health Professionals and who is entitled to practice dentistry in BC.

Department — An organizational unit, which may consist of Division(s), to which Medical Staff with a similar practice or specialty have been assigned, including a Program.

Department Head — A Medical Staff member in the Active Medical Staff category, appointed by the PHSA to lead a Department's clinical, academic, quality improvement and governance activities. Reports directly to the Senior Medical Administrator or Senior Nursing Administrator (or delegate, as appropriate). For the purposes of these Rules, a Department Head may be responsible for a single Department across Health Authority Facilities or Programs or could be a Provincial Lead who oversees and responsible for a group of Departments or Programs. For specifics based on Programs, see Appendix B.

Division — A component of a Department composed of members with a clearly defined sub-specialty interest.

Division Head — A Medical Staff member in the active Medical Staff category, who has been appointed by the Department Head to lead a Division's clinical, academic, quality improvement and governance activities. Reports directly to a Department Head.

Elders/Knowledge Keepers- First Nations, Inuit, and Métis Peoples who carry traditional knowledge in different cultural and spiritual practices. Elders are often acknowledged and respected by their communities through a lifetime of learned teachings, experiences, and defined ceremonies to become an Elder. Gender and age are not factors that determine or define Elder status.

Electronic Health Record (EHR) — A comprehensive digital health history, provided through a secure, integrated, computerized collection of a patient's encounters with the health-care system.

Executive Leadership Team (ELT) — The primary planning, strategic management and decision-making team that supports the CEO of the Health Authority.

Facility — A patient care site operated by PHSA where Practitioners hold privileges.

Provincial Health Services Authority

Freedom of Information and Protection of Privacy Act (FOIPPA) — A provincial act that regulates the information, and privacy practices of public bodies such as government ministries, local governments, crown corporations, police forces, hospitals, and schools.

General Practitioner in Oncology (GPO)- A Family Physician who has completed formal, BC Cancer approved training to support aspects of cancer care for local patients and their families.

- Nurse Practitioner in Oncology (NPO) is a Nurse Practitioner who has completed formal, BC Cancer approved training to support aspects of cancer care for local patients and their families.

Health Authority Medical Advisory Committee (HAMAC) — The senior medical advisory committee to the PHSA on Medical, Dental, Midwifery and Nurse Practitioner matters, including quality of care issues, as described in Article 8 of the Medical Staff Bylaws.

Health Authority Medical Advisory Committee Chair — The Medical Staff member appointed by the Board to lead the HAMAC.

Health Record — A digital or hard copy version of the patient medical chart.

House Staff — Those Clinical Scientists, Dentists, Midwives, Nurse Practitioners and Physicians temporarily engaged by or attached to a Facility for the purpose of obtaining postgraduate training in a medical, dental, or scientific discipline and who are supervised by a member of Medical Staff. They are not members of Medical Staff.

Interdisciplinary-Care Team — Integrated group of Medical Staff members, nurses and allied health professionals involved in the care of a patient.

Learner — A person in a Dental, Midwifery, Nurse Practitioner or Physician Training Program. They are not Medical Staff members.

Local Medical Advisory Committee (LMAC) — The medical advisory committee of a Program or Facility, which reports to the HAMAC on local Clinical Scientist, Dental, Medical, Midwifery, and Nurse Practitioner matters, as described in Article 9 of the Bylaws.

Medical Care — In these Rules, medical care includes clinical services provided by Clinical Scientists (within scope of practice), Dentists, Midwives, Nurse Practitioners and Physicians to PHSA patients and clients.

Provincial Health Services Authority

Medical Staff — Clinical Scientists, Dentists, Midwives, Nurse Practitioners and Physicians who have been appointed to the Medical Staff and granted privileges by the PHSA Board of Directors to practice in the Facilities and Programs operated by PHSA.

Medical Staff Association (MSA)(s) — The component(s) of the Medical Staff organization, established by Article 10 of the Bylaws, to represent and advocate for the Medical Staff and to bring matters of general concern to the LMACs and to the HAMAC, as appropriate. All members of the Medical Staff must belong to, and fulfill the responsibilities of, the Medical Staff Association.

Medical Staff Bylaws (the Bylaws) — Bylaws approved by the HAMAC, PHSA Board and B.C. Minister of Health, that outline the organization, structure, function, governance, and accountability of the PHSA Medical Staff working at PHSA Facilities and Programs designated under the Hospital Act.

Medical Staff Association President — The elected representative of the Medical Staff who leads, manages, and advocates for the Medical Staff, as per Article 12 of the Medical Staff Bylaws.

Medical Staff Rules (the Rules) — The Rules, promulgated as per Article 12 of the Medical Staff Bylaws and approved by the Board, governing the day-to-day management of the Medical Staff in the Facilities and Programs operated by PHSA.

Medical Students — Undergraduate Medical Students temporarily attached to a Facility to gain practical clinical experience during a specified clinical rotation and who are supervised by a Medical Staff member. They are not members of the Medical Staff. See Article 4 for specifics.

Midwife — A member of the Medical Staff duly licensed by the BC College of Nurses and Midwives, and who is entitled to practice midwifery in B.C.

Most Responsible Provider (MRP) — The Physician, Oral and Maxillofacial Surgeon, Midwife or Nurse Practitioner who has the overall responsibility for the management and coordination of care of the patient admitted to or being treated in a Facility or Program operated by PHSA. A Dentist who is not an Oral and Maxillofacial Surgeon cannot be MRPs. An MRP may delegate the Medical Care of a patient to an appropriately qualified member of the Medical Staff or a Resident/Fellow.

- At BC Cancer, Oncology Lifetime Provider (OLP) is defined as the medical staff who has overall responsibility for the management and overall care of the patient for a specific cancer diagnosis, when the patient is admitted to that medical staff member’s service. Other medical staff may act as

MRP, depending on which medical service the patient is admitted to that physician's service. Other oncologists may act as MRP, depending which medical service the patient is admitted to. Additionally, patients with more than one cancer diagnosis may have more than one OLP. Note that Cerner only allows for one OLP to be documented in the electronic medical record at a time.

Nurse Practitioner — A member of the Medical Staff duly licensed by the BC College of Nurses and Midwives, and who is entitled to practice as a Nurse Practitioner in B.C.

Oral and Maxillofacial Surgeon — A Dentist who holds a specialty certificate from the BC College of Oral Health Professionals authorizing practice in oral and maxillofacial surgery in B.C.

Patient-Centred Care — Care that places the patient and those personally significant to the patient and are concerned with their care (family members, partners, caregivers, legal guardian, and substitute decision-makers) at the centre of clinical decision making to ensuring that the patient's voice, wishes, and well-being are fundamental to the plan of care.

Physician — A member of the Medical Staff duly licensed by the College of Physicians and Surgeons of British Columbia and who is entitled to practice medicine in BC.

Practitioner — A Physician, Dentists, Midwife, Nurse Practitioner or Clinical Scientist who is a member of PHSA's Medical Staff.

Primary Department or Program — The Department or Program to which a Medical Staff member is assigned, according to his or her training, and where the member delivers the majority of care to patients.

Privileges — A permit to practice Medicine, Dentistry, Midwifery or Nursing as a Nurse Practitioner in the Facilities and Programs operated by PHSA and granted by the PHSA Board to a member of the Medical Staff. Privileges describe and define the scope and limits of the Practitioner's permit to practice in the Facilities and Programs of PHSA.

Procedural Privileges — A permit to practice specific medical or surgical interventions in PHSA Facilities or Programs, as granted by the Board to Medical Staff members, based on patient need, proven Practitioner competency, and ongoing expertise in those procedures.

Program — A care delivery structure, focused on co-ordinating and delivering a specific type of patient care under the jurisdiction of PHSA.

Provincial Privileging Dictionaries— Province-wide privileging standards for Medical Staff practicing in British Columbia Health Authority Facilities.

Regulatory College — The discipline-specific provincial regulatory body for a member of the Medical Staff.

Resident — A physician-in-training who has received a medical degree, and who is undertaking additional specialty training at a PHSA Facility or Program. Residents are employees of a Health Authority and are not considered members of the Medical Staff. As such, their training is governed by their university training program.

Section — A component of a Division comprised of members with clearly defined sub-specialty interests.

Section Head — A member of the active Medical Staff category appointed by, and accountable to, a Division or Department Head to lead the clinical, academic, quality improvement and governance activities of a Section.

Section 51: Evidence Act of British Columbia — A section of the B.C. Evidence Act applying to PHSA Facilities and Programs designated under the Hospital Act, that operates to protect: (a) records prepared by or for a quality committee, as defined under the Act, from being introduced in civil proceedings; and (b) witnesses or members a quality committee from being compelled to testify in civil proceedings. These protections allow participants the freedom to discuss or critique patient care events for quality-of-care purposes, free from the concern that one's thoughts, opinions or recommendations could be entered into evidence in any possible legal proceeding. This is meant to ensure that hospitals and healthcare professionals can constantly review and improve services and procedures without fear of reprisal.

Senior Medical Administrator (or delegate) — The Physician, appointed by the Chief Executive Officer (CEO), responsible for the coordination and direction of the activities of the Medical Staff.

Senior Site Medical Administrator (or delegate) — The Senior Administrative Physician of a PHSA Program or Facility.

Senior Nursing Administrator — The nurse or nurse delegate engaged by PHSA to provide leadership for nursing practice across Facilities and Programs.

Senior Operational Administrator — The person engaged by PHSA to provide leadership to a PHSA Facility or Program, and to oversee its day-to-day operations and management.

Signature — A person's name written by hand by that person in a distinctive way, or electronic facsimile thereof, to signify the person's authorization of a part of the Health Record or other document requiring a Medical Staff member's authorization.

Specialist — A Physician or Dentist who has been granted a Fellowship or Special Certificate by the Royal College of Physicians and Surgeons of Canada/Royal College of Dentists of Canada, or its equivalent in a non-Canadian jurisdiction; or a Physician/Dentist with relevant clinical experience, licensed to practice as a Specialist by the College of Physicians and Surgeons of British Columbia/BC College of Oral Health Professionals.

Subcommittee — In the context of these Rules, a special group established by the LMAC or HAMAC to fulfil specific aspects of the respective committee's mandate.

Substitute Decision Maker — An individual with legal authority to make decisions in the event of patient incapacity. The individual must meet specific legal requirements to be the designated substitute decision maker. If those requirements are not met, then by law the public guardian may become the substitute decision maker.

Temporary Privileges — A permit to practice in the Facilities and Programs operated by PHSA, granted to a member of the Medical Staff for a specified period to meet a specific service need.

University — Unless otherwise specified, the University of British Columbia and its affiliates.

Unprofessional Behaviour — Behaviour that contravenes the code of professional conduct of a practitioner's regulatory college, professional association, or the policies of PHSA.

# Article 2 — MEMBERSHIP CATEGORIES, APPOINTMENT AND PRIVILEGES

## 2.1 Membership

**2.1.1** Terms and criteria for Appointment and membership are detailed in Article 3 of the Bylaws. Procedures for application, Appointment, and review are outlined in Article 4 of the Bylaws. PHSA supports consistency and transparency in these processes.

**2.1.2** Medical Staff categories

a. Medical Staff categories are identified and defined in Article 6 of the Bylaws. These Rules provide further details about some of these categories. The Medical Staff categories are as follows:

    i. Provisional staff
    ii. Active staff
    iii. Associate staff
    iv. Clinical Associate staff
    v. Consulting staff
    vi. Temporary staff
    vii. Locum Tenens staff
    viii. Scientific and Research staff
    ix. Honorary staff

b. Temporary staff

    i. The purpose of an Appointment to the temporary Medical Staff is to fill a time limited-service need. General details are outlined in Article 6.6 of the Bylaws.

    ii. Appointment to the temporary staff conveys no preferential status or privilege in seeking a future Appointment to any category of the Medical Staff.

    iii. Under normal circumstances, a temporary staff Appointment must follow the policies and procedures used for any other Medical Staff Appointment. In special or urgent circumstances however, where temporary Medical Staff may need to be appointed quickly, the Senior Medical Administrator (or delegate), on the authority of the CEO, may grant interim temporary privileges for a specified purpose and period, up to 12 months.

    Examples include:

    - Privileges required for organ retrieval.

- Demonstrating equipment or new procedures.
- Providing care during mass casualties.
- Meeting a time limited clinical need that temporarily overwhelms a Department's capacity to provide adequate coverage.

The PHSA Board must ratify or terminate the Appointment at its next scheduled meeting.

iv. The renewal of Temporary Staff privileges may be considered upon review.

v. Nurse Practitioners and Midwives who are granted a provisional licensure with the BC College of Nurses and Midwives will be appointed to the temporary Medical Staff until they fulfill the qualifications for a practicing licensure with the BC College of Nurses and Midwives.

c. Locum Tenens Staff

i. Article 6.7 of the Bylaws defines the Locum Tenens staff category and scope of practice. For better clarity, these Rules define privileges activation or de-activation, maintenance of privileges and responsibilities for Locum Tenens staff, as well as the role of provisional, active, or consulting staff members seeking a Locum Tenens.

ii. Members of the Locum Tenens staff are appointed for a specified time period, not to exceed 12 months, for the purpose of replacing a member of the provisional, active, or consulting staff during an absence.

iii. Locum Tenens staff members may only replace an absent member of the provisional, active, or consulting Staff. "Absent" means being away from a Facility or Program-based practice for vacation, educational leave, illness, or Board-approved leave of absence.

iv. Locum Tenens staff members may cover on-call shifts only when they are providing Locum coverage for an absent member for the specified period of the absence.

v. The Senior Medical Administrator (or delegate) approve any request for Locum Tenens staff for a period of less than 48 hours only in urgent circumstances.

vi. While Locum Tenens staff privileges may be granted for up to 12 months, each period of active Locum coverage must be approved in advance. When the approved period of

coverage concludes, Locum Tenens staff cannot continue to exercise their privileges. For each subsequent Locum Tenens coverage period, a provisional, active, or consulting staff member must submit a completed Locum scheduling form to the Credentialing and Privileging Office of the Corporate Medical Affairs Department. The Department or Division Head must approve coverage dates prior to Locum Tenens staff exercising their privileges.

vii. Locum Tenens should not be used to fill what should be a regular staff position. If a Locum is used repeatedly for the same position, or for an extended period of time, the Department Head should assess the situation to determine if the position should be filled by a regular Medical Staff member.

viii. Any provisional, active or consulting staff members must submit their requests for Locum coverage to their Department or Division Head for approval before they can advise the Corporate Medical Affairs Department of the specific dates of coverage.

ix. Minimum lead times for Locum Tenens category privileges are:
   - New applicants: six (6) weeks
   - Current Locum Tenens staff requesting additional site privileges: two (2) weeks

x. In situations requiring urgent Locum Tenens Appointment, the Senior Medical Administrator (or delegate) may grant temporary privileges while the application is being processed.

xi. The Corporate Medical Affairs Department shall provide an application for new Locum Tenens privileges to any applicant who has not previously held PHSA Medical Staff privileges. The completed application package must be approved by the Department or Division Head, following which it shall be forwarded to the HAMAC for a recommendation to the Board for approval.

xii. Responsibilities of a Medical Staff member requesting a Locum Tenens:
   - The Medical Staff member shall notify the Corporate Medical Affairs Department of an upcoming Locum Tenens arrangement by forwarding the completed Locum scheduling form, indicating start and end dates, within the required minimum lead-time.
   - The Medical Staff member must arrange for their Locum Tenens to attend an orientation of the applicable Facility or Program, including orientation to Program policies and procedures as required to support provision of care to patients. If the

Medical Staff member is unavailable to fulfil these responsibilities, the Department or Division Head shall assign the responsibility to another member of the Medical Staff.
- In Facilities where the EHR has been implemented, the Department shall facilitate timely PHSA-approved EHR competency training and advise the Locum Tenens of this requirement. The Locum Tenens must complete training before receiving access to the EHR and excludes Locums who have previously completed training.

xiii. The Medical Staff member is responsible for the completion of any Health Records the Locum Tenens fails to complete while providing Locum coverage.

xiv. Responsibilities of the Locum Tenens
- Locum Tenens privileges are granted to a specific Medical Staff member for a defined time period.
- In facilities where the EHR has been deployed, the Department shall facilitate timely PHSA-approved EHR competency training, and advise the Locum Tenens of this requirement, unless this training has already been recently completed in another health authority. The Locum Tenens must complete training before receiving access to the EHR.
- Locum Tenens are responsible for the completion of all Health Records of patients for whom they have been caring. Failure to complete Health Records shall result in a review of privileges by the Division or Department Head, which may influence the Locum's ability to obtain future Locum Tenens privileges.
- Locum Tenens may not assign their Locum coverage to another Practitioner with Locum Tenens privileges.
- The term of the Locum ends automatically when the regular Medical Staff member returns to their practice. Any requests to provide future Locum Tenens coverage must be submitted to the Credentialing & Privileging Office of the Corporate Medical Affairs Department for approval.

d. Clinical Associate Staff

i. Clinical Associates are appropriately qualified, credentialed and Privileged Medical Staff who work in highly specialized areas under the direction of either a Department or Division Head, or a senior member of a Department, Division (or equivalent), who acts as their sponsor and is responsible for their work. The supervising staff member shall define their scope of practice.

ii. Clinical Associates provide clinical services and are not part of a Clinical Training Program.

iii. Clinical Associates are assigned to a Primary Department, and may attend, investigate, diagnose, and treat patients within the scope of their privileges. They are not authorized to admit patients.

iv. Unless specifically exempted by the HAMAC, Clinical Associates are required to participate in fulfilling organizational and service responsibilities, including on-call responsibilities as described in the Rules.

v. Clinical Associates are required to participate in Medical Staff-related administrative and educational activities and are required to attend at least 70 per cent of Primary Departmental or Divisional meetings.

vi. Appointment to the Clinical Associate staff conveys no preferential status or Privilege in seeking a future appointment to any category of the Medical Staff.

## 2.2 Credentialing and Privileging

The procedures for application and Appointment to the Medical Staff are set out in Article 4.3 of the Bylaws. The applicant must complete the Credentialing and Privileging process on or before the applicant's start date unless the Senior Medical Administrator (or delegate) specifically waives this requirement.

2.2.1 Appointment to the Medical Staff

a. Appointments to PHSA Medical Staff are Facility-specific.

b. Privileges define the scope and location of a Practitioner's permit to practice in Facilities and Programs operated by PHSA.

c. Facility-specific privileges convey no preferential status for privileges in any other PHSA Facility or Program.

d. All members of the Medical Staff may apply for privileges in another PHSA Facility or Program. The Board may grant additional privileges after considering the recommendation of the HAMAC.

e. Each Practitioner shall be assigned to a Primary Department. The LMAC shall consider requests for cross-Appointment to other Departments on the advice of the Department Heads involved. The LMAC will determine cross-appointments based on the Practitioner's ability to fulfill membership responsibilities in each Department to which the Practitioner is assigned.

2.2.2 References

Specific references are required upon application for a Medical Staff Appointment, as follows:

a. Newly qualified Family Physician or General Dentist
   i. One reference from the dean or the dean's representative from the medical school where the applicant graduated.
   ii. One reference from the applicant's residency program director.
   iii. One reference from a teaching member in the facility where the applicant completed their family medicine residency.

b. Established Family Physician or General Dentist
   i. One reference from the Department Head, Senior Medical Administrator (or delegate) at the last hospital where the applicant practiced.
   ii. At least two references from Physicians familiar with the applicant's current practice.

c. Newly qualified Midwife
   i. One faculty reference from the dean or director at the school or program from which the Midwife graduated.
   ii. At least two references from teaching members of the program where the applicant trained.

d. Established Midwife
   i. One reference from the Department Head, Senior Medical Administrator (or delegate) at the last hospital where the applicant practiced.
   ii. At least two references from Physicians or Midwives familiar with the applicant's current practice.

e. Newly qualified Specialist
   i. One reference from the applicant's residency training program director.
   ii. One reference from a Medical Administrator (or delegate) at the hospital where the applicant trained.

   iii. At least two references from faculty members who taught the applicant during their residency training program.

f. Established Specialist
   i. One reference from the Department Head, Senior Medical Administrator (or delegate) at the last hospital where the applicant held privileges.
   ii. At least two references from Physicians (or Dentists for Specialist Dentists) familiar with the applicant's current practice.

g. Newly qualified Nurse Practitioner
   i. One faculty reference from the dean, director or faculty of the school or program where the applicant trained.
   ii. At least two references from teaching members at the program or clinical preceptors where the applicant trained.

h. Established Nurse Practitioner
   i. One reference from the Department Head, Senior Medical Administrator (or delegate), Senior Nursing Administrator (or delegate) at the last hospital where the applicant practiced.
   ii. At least two references from Physicians, Midwives or Nurse Practitioners familiar with the applicant's current practice.

i. Indigenous Applicants
   i. An Indigenous applicant for any category of Medical staff may, at their own election, provide an additional reference from and Elder or Knowledge Keeper.

2.2.3 Procedural Privileges

a. Procedural privileges are a permit to perform specific operations or procedures in designated PHSA Facilities and Programs. Procedural privileges are assessed using specialty-specific B.C. Provincial Privileging Dictionaries and are granted by the Board on the recommendation of the LMAC and HAMAC after the Department Head's affirmative review of a Practitioner's training, experience and competency. An affirmative review is also dependent upon PHSA's service needs as well as the requisite available resources in a specific Facility or Program.

b. Physicians, Dentists, Midwives, Clinical Scientists or Nurse Practitioners Appointed to the Medical Staff may apply for procedural privileges. All procedural privileges require documentation of training and experience.

c. The HAMAC defines certain procedural privileges as “basic privileges,” and may be granted automatically to all Medical Staff members with Privileges.

d. The Department Head (or delegate) shall re-evaluate procedural privileges during the reappointment process to confirm the Practitioner’s maintenance of competence, the ongoing service needs of PHSA and the requisite available resources in a specific PHSA Facility or Program.

e. Procedural privileges may be granted based on adequate documentation provided by another Facility where the applicant has previously held such privileges.

f. Where specific procedural privileges have been granted, the Board in consultation with the HAMAC, on the advice of the appropriate Department Head, may specify the frequency at which such a procedure shall be performed for the applicant to retain their privileges.

g. Procedural privileges require an individual application in the following situations:
   i. The introduction of new technology for which training has not previously been available to the specialty.
   ii. A request for privileges outside the Practitioner’s specialty area.
   iii. A request for specialty-specific privileges by a non-Specialist Practitioner.

2.2.4 Procedure to address application requests when no Medical Staff vacancy exists:

a. The procedures for application, Appointment and review are set out in Article 4 of the Bylaws.

b. Unsolicited letters of intent to apply for Medical Staff membership where a vacancy does not exist should be forwarded expeditiously to the Corporate Medical Affairs Department for appropriate review and management.

c. An unsolicited letter of intent to apply for Medical Staff membership does not constitute an application in accordance with Article 4.1.3 of the Bylaws.

2.2.5 Infant and maternal transport teams and organ retrieval teams

a. Members of transport and organ retrieval teams shall be granted temporary privileges, without application for the purpose of stabilizing patients, and preparing them for transport to another Facility.
b. The Attending Medical Staff may transfer responsibility to a member of the transport team for the physiological maintenance of the patient while the patient remains under the care of the sending Facility. The transport team members are authorized to give verbal orders to a registered Nurse or respiratory therapist to ensure optimum physiological maintenance of the patient during preparation for transport.

## 2.3 Medical Staff evaluation

Quality assurance (QA), quality improvement (QI) and in-depth review are Processes, which can be utilized to ensure professionalism; appropriate standards and patterns of Medical Care are established and maintained. Under the aegis of the HAMAC and the Safety and Quality of Medical Care Subcommittee(s), each Medical Staff Department or Program is responsible for establishing an adequate system for QA, QI, and in-depth review.

### 2.3.1 Review at reappointment

Members of the Medical Staff seeking re-appointment shall comply with the requirements outlined in Articles 4.4 and 4.5 of the Medical Staff Bylaws. The review shall include at a minimum, a review of the quality of the member's contribution to PHSA and its Facility or Program, compliance with PHSA Bylaws, Rules, policies, and procedures; quality and consistency of Health Record documentation; completion of continuing professional development objectives, professional conduct, and the establishment and review of personal goals and objectives.

### 2.3.2 In-depth review

An in-depth review is an evaluation of a Medical Staff member's practice and performance, which occurs every four (4) years in addition to, or in conjunction with, the member's review at reappointment. The intent of the in-depth review is professional development and quality-of-care improvement. The process involves an achievement review, which provides reviewees with feedback about their clinical practice through the eyes of those with whom they work and serve. The review also includes a self-assessment, which is designed to be educational, and where opportunities for improvement exist, potentially corrective. For in-depth reviews of

Medical Staff working at Facilities and Programs designated under the Hospital Act, the in-depth review shall be performed in compliance with disclosure safeguards found in Section 51 of the Evidence Act.[1]

In-depth review procedure:

a. Provisional and Active Medical Staff members shall participate in the in-depth review process. This must be completed prior to Appointment to the Active Medical Staff, and every fifth year thereafter.
b. The review can be initiated by a Department Head, Department Subcommittee, the HAMAC, the LMAC, Senior Medical Administrator (or delegate), Senior Nursing Administrator or other appropriate body of the Medical Staff.

c. The in-depth review shall be conducted by Medical Staff as appointed by the Division Head, Department Head, the LMAC, the HAMAC, the Senior Medical Administrator (or delegate), the Senior Nursing Administrator (if applicable), or other appropriate body of the Medical Staff. The review process shall be coordinated through the Department Head and the Corporate Medical Affairs Department.

d. The in-depth review shall include input from non-Medical Staff co-workers, medical colleagues, and members of clinical or academic teams, who shall assess attributes of the Medical Staff member's performance in relation to clinical knowledge and skills, communication skills, psychosocial management, office management and collegiality.

e. The Medical Staff member will select reviewers who will provide input. The Medical Staff member may request assistance selecting reviewers from their Department Head (or delegate).

f. In addition, the in-depth review may include any or all the following:
    i. A review of inpatient and outpatient clinical documentation including an assessment of the quality, accuracy, and timeliness of reports.
    ii. Input from patients to determine their view of the Medical Staff member's professional attitude and communication skills.
    iii. Review of current curriculum vitae and a personal statement from the Medical Staff member outlining goals and objectives, including successes and challenges.

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[1] Section 51, *Evidence Act*, [RSBC 1996] Chapter 124, Health Care Evidence - https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96124_01

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iv. Clinical complications and mortality review.
v. Review of incident reports and complaints.
vi. Continuing professional development, including the completion of maintenance of certification hours required by the relevant professional college, additional specific competence training completed since the last review, as well as any updates specific to Departmental or Program requirements.
vii. Procedural Privilege evaluation, including frequency of procedures done.
viii. Direct observation of procedural and clinical-assessment skills.
ix. Interviews or communication with members of affiliated organizations and regulatory bodies.
x. Resource utilization and quality assurance information.

g. The results of the Medical Staff member's in-depth review shall be presented to the Department Head (or delegate), Senior Medical Administrator (or delegate) and/or the Senior Nursing Administrator (if applicable), who shall review them. The Department Head (or delegate) shall discuss the results with the Medical Staff member, and where necessary, assist the member to develop and implement a plan for either a correction of deficiencies or ongoing performance improvement.

h. The Medical Staff member shall acknowledge in writing receipt of the completed review, including the follow-up discussion with the Department Head (or delegate), and shall confirm agreement with any plan to address areas for improvement. The Medical Staff member shall complete and deliver this document to the Department Head, Senior Medical Administrator (or delegate) and/or Senior Nursing Administrator (as applicable) within two weeks of review completion.

i. Documentation of the in-depth review shall include the review report, any corrections of factual errors, the Medical Staff member's response, recommendations, implementation plan and reports on the implementation of recommendations. Discussions among the Department Head, Senior Medical Administrator (or delegate), Senior Nursing Administrator (as applicable) and the Medical Staff member shall be documented and included.

j. Documentation of the in-depth review process will become part of the Medical Staff member's confidential Credentialing file.

**2.3.3** Comprehensive Review

a. In circumstances where serious concerns arise from the Medical Staff member's in-depth

review, the Senior Site Medical Administrator (or delegate), Senior Medical Administrator (or delegate), and in the case of the Nurse Practitioners, the Senior Nursing Administrator, shall be informed, and a decision shall be made in consultation with the Department Head to undertake a comprehensive review by a Review Committee consisting of:

i. The Staff Member's Department Head (or delegate) or, if the Medical Staff member is cross appointed, both Department Heads.
ii. A medical staff member from the Medical Staff Department of the member being reviewed.
iii. A member of the team with whom the member works regularly.

b. The Comprehensive Review Committee shall undertake a further in-depth review, which shall include all criteria outlined in item 2.3.2 d and f.
   i. The Comprehensive Review Committee shall report to the Department Head(s), the Senior Medical Administrator (or delegate) and Senior Nursing Administrator (if applicable) on the results of the in-depth review, in accordance with the Medical Staff Bylaws Articles 4.5 and 4.6 and shall provide written recommendations to the Department Head regarding requirements for corrective action.
   ii. After the in-depth review, the LMAC, the HAMAC and PHSA Board shall be notified in writing of recommendations requiring action.

# Article 3 — RESPONSIBILITY FOR PATIENT CARE

## 3.1 Inclusive and Respectful Workplace Free of Indigenous Specific Racism and Other Forms of Discrimination

**3.1.1** PHSA and its Medical Staff are committed to creating a workplace where everyone feels respected and valued (patients, clients, visitors, clinical trainees, learners, staff, and colleagues). **The In Plain Sight Report** states:

- *"Addressing systemic racism requires coherent, systematic action. Uprooting Indigenous-specific racism in health care requires shifts in governance, leadership, legislation and policy, education, and practice."*
- *"Stereotyping and discrimination lead to mistrust and avoidance of the health system by Indigenous people, and anticipatory behaviours and strategies to avoid discriminatory treatment (including fear/lack of trust in doctors and the medical system)."*
- *"Indigenous health care workers believe that racism is a problem in their workplaces and organizations, and over half of Indigenous respondents to the Health Workers' Survey have experienced workplace discrimination themselves"*.

Our shared vision of an equitable, anti-racist, and culturally safe health system begins with a foundation of mutual respect and inclusivity in the workplace; ensuring all individuals are treated with respect, free from discrimination, racism, and harassment; and are supported in the respectful management of workplace conflict.

**3.1.2** Commitments to these concepts are highlighted by the Colleges regulating Medical Staff at PHSA:

- College of Physicians and Surgeons of BC: Indigenous Cultural Safety, Cultural Humility and Anti-Racism
- BC College of Nurses & Midwives: Indigenous Cultural Safety, Cultural Humility, and Anti-Racism
- BC College of Oral Health Professionals: Indigenous Cultural Safety and Humility

**3.1.3** PHSA endeavours to address and eliminate inequities and barriers impacting the rights of members of the Medical Staff to an equitable, inclusive, respectful anti-racist and culturally safe workplace. To this end, members of the Medical Staff conduct themselves, and expect to be treated, in accordance with PHSA's three interrelated policies:

- The Fostering a Culture of Respect policy

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- [The Indigenous-specific Racism and Discrimination for PHSA Staff policy]
- [The Anti-Racism and Anti-Discrimination policy]

## 3.2 Admission, discharge, and transfer of patients

Admission to PHSA can encompass admission to an inpatient PHSA Facility or an outpatient PHSA Program. Clinical documentation needs to be completed in a timely way throughout the patient journey, starting at admission, through to transfer and/or discharge.

**3.2.1** Every patient shall be admitted by a member of the Medical Staff who has admitting privileges, and who has primary responsibility for the management and coordination of care for the patient. This Practitioner shall be designated the Most Responsible Provider (MRP).

a. The MRP is established based on whose scope of practice is best suited to treat the most responsible diagnosis at the time of admission.

b. The MRP is determined either prior to the admission for planned surgical admission or subspecialty intervention and treatment, or at the time a decision to admit is made in the Emergency Department.

c. The MRP works within a multi-professional team to deliver care and treatment to the patient. For Indigenous patients, to support culturally safer care, the MRP ensures involvement of on-site Indigenous Patient Navigators or the Indigenous Health team at the Program (or Corporate) level during multi-professional team discussions.

d. If the patient's medical condition warrants consultation with other members of the Medical Staff, the MRP coordinates and facilitates that care.

e. During a patient's admission, the role of MRP may be transferred, based upon the changing acuity, and nature of the patient's medical condition.

f. The MRP is only established at sites where the Hospital Act is applicable. MRP process is not required for outpatient ambulatory care settings.

g. The MRP duties:

i. Accept patients for admission from the community, the Emergency Department (ED) or from another Practitioner.
ii. Complete and document a full assessment for admission, including a full history, physical examination, and orders for ongoing care.
iii. Work collaboratively with health-care team members, including the development of a Best Possible Medication History (BPMH), complete medication reconciliation, and order appropriate medications.
iv. Provide or oversee provision of daily ongoing care for acute patients, and care at least weekly for Alternate Level of Care (ALC) patients, complete progress notes and oversee the patient's Medical Care, either directly or through an on-call group.
v. Communicate with the patient and the patient's team members, including the patient's Primary Care Practitioner, regarding medical conditions, tests, and planned consultations. This information shall be shared with other parties at the patient's request, with the patient's written consent, or as required by law.
vi. Clarify and resolve apparent treatment or manage conflicts among the patient's health-care team.
vii. Facilitate and coordinate discharge to the community and communicate with the Primary Care Practitioner where possible, as well as with community support teams.

h. MRP for admissions from the Emergency Department:
   i. When a patient requires admission from the ED, the Emergency Physician (EP) shall request an MRP either directly or through that Practitioner's on-call group, to assume the role of MRP. This request shall be based on selecting the Practitioner or service that customarily manages patients with the most-responsible diagnosis necessitating the admission.
   ii. A Practitioner with admitting privileges must be available personally or through an on-call service to accept the MRP role. Once a patient has been accepted, the MRP assumes primary responsibility for the patient's care and coordination of services up to the time that transfer-of-care is accepted by another Practitioner, or the patient is discharged back to the community.
   iii. If, prior to accepting MRP, but after personally assessing the patient, the Practitioner does not believe he/she is the most appropriate MRP, the Practitioner shall liaise directly with an alternate service, or with the referring EP regarding appropriate choice to fill the MRP role.
   iv. Where an admission disagreement persists, the EP shall contact the Division(s) or Department(s) head(s) to which the Practitioners in dispute are assigned. If this is not possible or unsuccessful, the EP shall contact the Senior Site Medical Administrator (or delegate), who shall make an immediate service assignment. At the earliest opportunity during regular

working hours, the appropriate Department or Division Head(s) shall review the incident and determine next steps to prevent a similar situation in the future.

v. MRP for care in outpatient Facilities or Programs:
   - Practitioners, as well as postgraduate Learners such as Residents and Fellows, with appropriate privileges shall write orders or enter orders electronically for patients who require medical treatment in out- patient Facilities or Programs operated by PHSA.
   - A Practitioner wishing to treat a patient in an outpatient Facility or program shall be designated as the MRP and shall maintain responsibility for all subsequent care ordered and carried out in the Facility or Program, whether or not the MRP is physically present at the site.

**3.2.2** Admission documentation

a. Clinical documentation needs to be completed in a timely way. Admission documentation is required for all patients receiving inpatient care at the time of admission. Admission documentation includes:
   i. A recorded history and physical examination, including the presenting problem, the history of the presenting illness, significant past medical and surgical history.
   ii. Social history.
   iii. Any Known allergies and sensitivities.
   iv. Current medications.
   v. Review of systems including any deviation from norma.
   vi. Physical examination relevant to the presenting problem.
   vii. Results of pertinent diagnostic investigations.
   viii. Active problem list.
   ix. The Provisional diagnosis and management plan, including resuscitation status where it is documented as full code if there has not been a discussion between the Physician and patient (or legally authorized Substitute Decision Maker), and the Physician has not implemented a different Physician-determined code status.

b. Admission orders including, at a minimum, diet, activity level, frequency of vital-signs measurement, required investigations and diagnostic tests, and any treatment to be initiated.

**3.2.3** Pre-admission requirements for elective patients include the patient's medical history, physical examination, diagnosis, appropriate laboratory tests and imaging studies, required consultations, special tests, documentation of special precautions and evidence of patient procedural and

transfusion consents.

**3.2.4** In circumstances requiring an emergency admission, where a Practitioner other than the MRP has provided holding orders, the MRP shall provide complete admission orders within 24 hours of the admission.

**3.2.5** The MRP shall note any special precautions regarding the patient's care on the patient's Health Record. Precautionary notes are required for, but not limited to, chemical dependency, elevated risk for suicide, elevated risk for violence, history of epileptic seizures, current infections, known drug reactions and allergies.

**3.2.6** Surgical Admissions: The operating Physician, Surgeon or Dentist is responsible for the post-operative care of the patient. Where a post-operative patient has medical co-morbidities requiring management by another Medical Staff member, the parameters of that care shall be clearly described in the Health Record.

**3.2.7** Dental Admissions: For patients admitted for dental treatment, the Medical Staff member who admitted the patient shall be the MRP for any required Medical Care. The Attending Dental Surgeon shall be responsible for the patient's dental care.

**3.2.8** Readmissions: All readmissions require a full history and physical. For unplanned readmissions, special attention should be paid to any factors, including cognitive or functional issues that may have contributed to an unsuccessful discharge.

**3.2.9** Discharge

a. Clinical documentation needs to be completed in a timely way. The MRP on-call shall provide a discharge order and complete a discharge summary using a HAMAC-approved electronic discharge template or a written template for those Facilities still using a paper Health Record. The discharge summary shall conform to the EHR documentation policy in Facilities where the EHR has been deployed. Incomplete or inaccurate discharge summaries can impact the ability to extract accurate patient data for improvement purposes.

b. All patients shall have their discharge order written on paper or electronically as early as possible on the day of discharge. For planning purposes, the MRP should note the discharge on the patient's Health Record order sheet the day prior to discharge.

c. A required component of the discharge process includes provision of follow-up instructions and a specific post-discharge plan to the patient, caregivers, the patient's relevant providers and Primary Practitioner if there is one. These instructions should include a list of all appointments made with consultants, any pending outpatient investigations, outstanding tests and any home and community care supports arranged or needing to be arranged.

d. A discharge summary is required for all in-patient discharges, all deaths and all obstetrics and newborns cases, except for those patients with:
   i. An uncomplicated day care or short-stay surgery or procedure.
   ii. An uncomplicated obstetrical delivery.
   iii. An uncomplicated neonatal admission.
   iv. A short admission where the HAMAC has approved an abbreviated discharge documentation process.

e. For uncomplicated obstetrical admissions, the B.C. Antenatal Record Part 1 and 2, or electronic equivalent, shall become an integral part of the patient's Health Record. The B.C. Labour and Birth Summary Record or electronic equivalent, together with the B.C. Newborn Record Part 1 and 2 shall be completed and placed in the Health Record by the MRP and shall form the discharge summary in uncomplicated deliveries.

f. A single report combining the operative report and discharge summary, including follow-up plans, is permitted for uncomplicated admitted surgical cases with a length of stay of less than 48 hours.

g. To ensure continuity of care and patient safety, the discharge summary should be dictated or electronically transcribed at the time of discharge but shall be completed within two weeks of the discharge.

**3.2.10** Transfer of patient care

a. The MRP shall ensure continuous coverage for their admitted patients.

b. Where a duty-of-care has been established, an MRP wishing to withdraw from patient care while services are still required shall inform the patient, and document on the Health Record the name of another MRP. A Practitioner who cannot find another qualified Practitioner willing to assume the role of MRP shall meet with the appropriate Department or Division Head to arrange ongoing coverage. If alternate coverage cannot be arranged, the MRP shall continue to provide ongoing care. Failure to do so constitutes patient abandonment.

c. A capable patient or, if incapable, the legal representative, has the right to request a change of Practitioner. The MRP shall cooperate in transferring responsibility for care of that patient to another Practitioner with appropriate privileges who is acceptable to the patient. If the MRP cannot find an acceptable Practitioner, the Senior Medical Administrator (or delegate) and/or Nurse Administrator, and if required, the Patient Care Quality Office (PCQO), shall assist the patient in finding another Practitioner to assume the MRP role. If a willing Practitioner cannot be found, the appropriate Department Head, Division Head (or delegate) shall discuss options with the patient. Until an alternate Practitioner has accepted responsibility for the patient, the MRP providing current care shall continue to do so for the patient.

d. Clinical documentation needs to be completed in a timely way. The transfer of care shall be documented in the patient's Health Record. This section does not apply to patients certified under the Mental Health Act, where the Act outlines a patient's rights related to altering treatment provision.

e. When a patient is to be transferred to another Facility, the current MRP shall ensure that there is an appropriately qualified Medical Staff member available at the receiving site who is fully informed about the patient's condition and has agreed to assume the receiving MRP role. The sending MRP shall identify to the staff member arranging the transfer all relevant documentation from the patient's Health Record to be sent to the receiving Facility. The transfer of care must be documented in the patient's Health Record.

f. Where a patient is transferred to another Facility or Program for administrative rather than medical reasons (e.g. lack of available beds), the MRP must speak to the receiving Medical Staff directly, if not assuming the MRP role at the new Facility or Program. The receiving MRP must be given all information regarding the plan of care. The administrator-on-call at the receiving site shall coordinate this conversation to ensure safe and timely access to necessary services. The transfer of care must be documented in the patient's Health Record.

g. Repatriation from a Higher-Level-of-Care Facility or Program back to a referring Facility or Program.

**3.2.11** Before a patient is repatriated to a referring Facility or Program, clinical, operational, and administrative preparation, including required documentation, must be completed.

**3.2.12** Where repatriation occurs between two acute care Facilities or Programs, verbal communication between the sending MRP and the receiving MRP is required. Acknowledgment of this conversation and acceptance of the transfer shall be documented in the patient's Health Record by the sending and receiving MRPs.

**3.2.13** At a minimum, a transfer note, but preferably a discharge summary completed by the sending MRP shall accompany the patient upon transfer either as a legible, signed, and dated hardcopy delivered with the patient or, where both sites have deployed the EHR, by entry into the EHR.

**3.2.14** Medication reconciliation and review is a required element of the accompanying documentation delivered with the patient undergoing repatriation.

**3.2.15** The receiving MRP shall work with Medical Staff to provide adequate notification to enable operational planning for the repatriation at the receiving site.

## 3.3 Medical Consultations

Preamble: Consultation is a process whereby the MRP or another Consultant asks a colleague for advice or help in managing the care of a patient. Those consulted are expected to collaborate expeditiously in providing this assistance or directing the admitting service to the best available source of care.

**3.3.1** The MRP shall make a written Consultation Request to the Consulting Practitioner in the medical record. In the case of an urgent or emergent situation, if the MRP is engaged in ongoing care, another health-care professional may request the Consultation.

**3.3.2** Where necessary, a Consultation may also be requested by the Department Head, Senior Medical Administrator (or delegate) or applicable Senior Nursing Administrator.

**3.3.3** The Consultant shall provide an in-person or virtual evaluation of the patient, a review of all necessary documentation, and the provision of a timely, electronically entered or dictated report. The evaluation should provide a clinical opinion, recommendations for management, including treatment, and the basis for the advice given.

**3.3.4** Following Consultation, the Consulting Practitioner should record all findings, opinions, and recommendations on the Consultation Record. The Consultant shall then directly communicate with the MRP in a timely and mutually acceptable manner.

**3.3.5** A Consultation may result in an opinion only or an expectation of continued management in the specialized knowledge being sought. This shall be determined through an acceptable form of communication between the MRP and the Consultant. If the Consultant agrees to provide direct and continuing care to the patient for those aspects of care related to the Consulting Practitioner's expertise, this shall be documented directly in the patient's Health Record. Direct care includes ongoing evaluation and treatment of the patient's condition and communication with the patient, family, MRP, other Practitioners involved in the patient's care and the multidisciplinary team, as appropriate.

**3.3.6** To ensure timely treatment and intervention, urgent Consultation or emergent Consultation requests must be made by direct Practitioner-to-Practitioner contact. The required response time is context dependent.

**3.3.7** All medical orders resulting from a consultation request must be documented in the medical record.

## 3.4 On-call

**3.4.1** On-call coverage for admitted patients:

a. The MRP has a professional obligation to ensure continuous availability to meet the medical needs of their admitted patients.

b. Groups of Practitioners with a similar scope of practice may join in call groups to share requirements of their patients' care. These Practitioners shall create an on-call rota to ensure 24-hour coverage for the group's in-patients in a manner acceptable to their Department or Division and the Senior Medical Administrator (or delegate) and/or the Senior Nursing Administrator.

c. Unless specifically excluded, all Departments, Divisions and Sections are required to provide continuous on-call coverage to manage:
   i. Emergency Department (ED) patients who require urgent Consultation or inpatient admission.
   ii. Patients already admitted to hospital whose condition necessitates urgent intervention or Consultation by a Practitioner other than their MRP.

d. Unless specifically excluded by the Board on advice from the HAMAC and the applicable Department Head, all Medical Staff are required to contribute equitably in fulfilling the on-call responsibilities of the Department.

e. Department members may request access to finite Health Authority resources to practice. Access to these resources shall be allocated on an equitable basis, taking into consideration the members' contributions to their Department and PHSA. Such contributions include, but are not limited to, the provision of on-call coverage.

f. The Department Head (or delegate) shall develop a list of Practitioners belonging to each call group within the Department and maintain an on-call rota that shall be provided in advance to PHSA and Facility switchboards.

g. Wherever possible, call-group members should possess equivalent qualifications to ensure consistency of patient care.

h. Where community size or Practitioner numbers necessitates a call group whose Practitioners have different skillsets, the call group members shall establish a group on-call strategy to ensure all medical needs of the patient are met.

i. Where call group members practice in different communities, the members may establish a cross-community on-call rota, provided a clinical service-delivery model is established to ensure patients have local access to an on-call Practitioner as required. A cross-community on-call rota requires Department Head approval after consultation with the applicable Division Head(s).

j. The method of Practitioner compensation, whether through fee-for-service, alternate payment contract or sessional payment, has no bearing on the individual or collective requirement to provide continuous on-call coverage.

k. The availability, or lack thereof, of a Medical On-call Availability Program (MOCAP) contract has no bearing on the individual or collective requirement to ensure continuous on-call coverage.

**3.4.2** On-call scheduling:

The establishment of an on-call schedule shall be mandatory for each call group and shall:

a. Provide a Practitioner available to assess and treat patient(s) at all times.

b. Be maintained in up-to-date fashion at all times.

c. Identify each Practitioner by name, including up-to-date contact information.

d. Identify the Practitioner responsible for maintaining the on-call list, including contact information.

e. Be made available in a manner, time, and format acceptable to PHSA in order to distribute it to necessary recipients.

f. Department Heads, Division Heads (or delegates), will submit the on-call schedule at least 14 days prior to the date on-call will be provided. They will also ensure that all necessary recipients receive changes to the call schedule in advance of their shifts.

Patients' needs and size of the call group will determine the frequency of call scheduling. Consideration shall be given to the intensity of call responsibilities to ensure that the combination of frequency and intensity of call does not compromise the safety of patients or Medical-Staff members and the sustainability of the call group. In the event of an unresolved dispute of call frequency, the matter shall come before the LMAC and potentially HAMAC for review and resolution.

On-call Practitioners shall maintain availability dictated by the patient's condition and clinical requirements.

**3.4.3** On-call exemptions:

a. A Practitioner may be exempted from providing on-call coverage in accordance with Department policies only when continuous coverage can be assured by the Department.

b. In an urgent situation, or in an emergency, the Senior Medical Administrator (or delegate) may grant a temporary exemption from providing on-call coverage. In this circumstance, the Department Head, Division Head (or delegate) shall exercise all means available to find a replacement.

c. The Department Head, in consultation with applicable Division Heads and Department members, shall establish written criteria for requesting an exemption by its members from on-call responsibilities. A Department or Division shall only request an exemption for a member if the other Department or Division members are prepared to fulfil that member's on-call obligations.

d. Criteria for partial or full exemptions may include, but are not limited to a Medical Staff member's:

i. Age.
ii. Health concerns.
iii. Extraordinary personal circumstances.
iv. Other offsetting contributions to their Department or Division.

e. The Department Head shall provide the LMAC and potentially the HAMAC with reasons for a proposed exemption, any changes to an already existing exemption, or potential consequences of an exemption, which shall assist the LMAC or HAMAC in providing an appropriate recommendation to the Board.

## 3.5 Health Records

The MRP involved in the patient's care shall be responsible for the preparation of the medical component of the Health Record for each patient. The record shall include the following items, where applicable:

### 3.5.1 Admission history

The MRP shall ensure that every patient has all admission documentation outlined in Article 3.2.2 above on the chart within 24 hours of the admission and, except in extreme medical emergency, prior to every delivery or operation.

### 3.5.2 Progress notes:

a. MRPs shall document progress notes for acute-care patients at least daily, and more frequently if warranted.

b. Progress notes shall be written in the patient’s Health Record or entered electronically where an EHR exists, and shall include:
   i. The date and time of assessment or intervention.
   ii. Any material change in the patient’s condition.
   iii. Active monitoring, investigation, and treatment, including the management of a problem list.
   iv. Any revision to the anticipated date of discharge, discharge plan or prognosis.

c. Within 24 hours, the MRP shall review the admission documentation, and where appropriate, add additional history regarding the present illness, a revised problem list, a revised management plan and a discharge plan.

3.5.3 Operative and Procedural reports:

a. In elective or urgent surgical cases, the history and physical examination report, as well as a signed consent for surgery, shall be submitted to the operating room booking clerk before an operation is scheduled.

b. If the history and physical examination are not recorded before the time an operation is scheduled, the operation shall be cancelled unless the MRP writes in the patient's Health Record that a delay would result in mortality or significant morbidity. The Surgical Committee or other appropriate body of the Medical Staff Association must review such cases at the next regular meeting.

c. Prior to any anaesthetic procedure, the anaesthesiologist must document a pre-anaesthetic assessment on the anaesthetic record. The anaesthetic record shall be completed before the patient is discharged from the post-anaesthetic recovery room.

d. Prior to the patient leaving the post anaesthetic recovery unit, a written or electronic note outlining the operative procedure, complications and post-operative orders shall be placed in the patient's Health Record to provide pertinent information to the next care provider(s).

e. An operative report is required for all invasive procedures except those excluded by the HAMAC. The report shall be dictated, written, or electronically entered within 24 hours of completion of an operative or other high-risk procedure, but preferably immediately post-procedure. If the operative report is not placed in the Health Record immediately after dictation, then a progress note shall be entered in the Health Record immediately after the procedure. The operative report shall contain, at a minimum:

   i. Patient's name and health record number.
   ii. Names of the primary surgeon and assistant(s).
   iii. Names of Practitioners who should receive a copy of the report.
   iv. Date and time of admission.
   v. Date of procedure.
   vi. Pre-operative and post-operative diagnosis.
   vii. Proposed procedure(s) and indications.
   viii. Operative procedure(s) performed.
   ix. Operative complications, if any.
   x. The patient's condition before, during and immediately after the operation.
   xi. Estimated blood loss.

xii. Specimens removed and their disposition (e.g. to pathology).

f. A procedure note must be filed after medical-imaging and laboratory-medicine procedures, or where the HAMAC has deemed an operative report is not required.

g. Operative and procedural reports shall be documented in a HAMAC-approved template or format. Where the EHR is in use, the report shall be completed in the EHR.

3.5.4 Prenatal record
The prenatal record shall be an integral part of the patient's Health Record, and the information shall be submitted in accordance with B.C. Reproductive Care Program guidelines.

3.5.5 Completion of Health Records:

a. All Health Records shall be completed by all involved Practitioners and validated by the MRP in compliance with the Health Information Management (HIM) policy. All Practitioners must comply with PHSA HIM clinical documentation requirements, and EHR requirements outlined in the Vancouver-Coastal-Health / Providence-Health Care / PHSA Clinical-Systems-Transformation clinical-documentation policies, as relevant.

b. If the MRP member is no longer available to sign orders, the appropriate Department or Division Head shall complete the Health Record.

c. The MRP is responsible for coordinating preparations for planned absences before their occurrence. Prior to a planned absence, the MRP shall complete all outstanding Health Records as per HIM policy.

d. The patient's Health Record should be completed at the time of discharge, and must be completed within 14 days of discharge from the Facility.

e. If a patient's Health Record is not completed at the time of discharge, the following policy shall apply:
   i. The Medical Staff member is notified of incomplete charts every two weeks.
   ii. Following notification, the Medical Staff member shall be responsible for completion of the charts within 14 days.
   iii. Failure to comply with this notification will trigger the Health Records Department to send a notice imposing an administrative suspension of admitting privileges until all outstanding

Records have been completed. However, the Medical Staff member shall continue to provide ongoing care for all patients admitted prior to the suspension and shall continue to fulfil all previously scheduled Departmental or Divisional on-call obligations.

iv. The suspension of admitting privileges is automatically reversed once the outstanding Health Records are complete.

v. Medical Staff members suspended three or more times in a consecutive 12-month period shall attend an interview with the appropriate Department or Division Head to plan remedial action. If administrative suspensions continue following this meeting, the Medical Staff member shall be required to appear before the LMAC, which shall recommend disciplinary action up to and including permanent revocation of Medical Staff membership.

vi. Locum Tenens Medical Staff shall be responsible to complete the Health Records of all patients for whom they have been MRP, performed procedures or written orders during the locum period; the Medical Staff member whom the locum replaced shall be responsible to complete any Health Record left incomplete by the Locum Tenens.

**3.5.6** Ownership and access:

a. Ownership — The Health Record pertaining to a patient of the PHSA, including records maintained in a Medical Staff member's office in a PHSA Facility or Program, are the property of PHSA and shall not be removed from the Facility or Program except by court order.

b. Access to originals or copies of a patient's Health Record, or any information contained therein, shall only be obtained by:

i. PHSA Medical Staff members directly involved in providing care to the patient in question.

ii. House Staff and clinical trainees, under the supervision of Medical Staff members, who have a clinical reason to access the patient's information.

iii. Medical Staff members engaged in research approved by PHSA's Research Review Committee (or delegate).

iv. Medical Staff members carrying out authorized medical quality assurance, medical audits, or utilization reviews approved by the manager of health information Management and subject to Section 51 of the Evidence Act.

v. Medical Staff members, or House Staff and clinical trainees seeking information from Health Records for the purposes of clinical education or academic rounds, upon written authorization from the appropriate Department Head, Division Head (or delegate).

vi. Written request from a Department Head or a member of the Department of Quality, Safety and Risk Management, for review purposes.

vii. Written request by the patient's MRP to facilitate transfer of medical treatment and patient care.
viii. A coroner's request.
ix. A patient, or legally authorized representative, requesting a copy of his or her own record.
x. A court order or subpoena.
xi. A written request from a PHSA legal representative.
xii. A written request from a Medical Staff member's professional college, in accordance with applicable legislation.

**3.5.7** Storage and transfer of records:

a. The Health Records Department retains all patient Health Records unless otherwise authorized and approved by the CEO (or delegate).

b. When the transfer of a patient's Health Record is requested, in compliance with provincial legislation, or PHSA policy, a photocopy of the Record shall be made available through a process consistent with the Freedom of Information and Protection of Privacy Act.

## 3.6 Informed consent

**3.6.1** Except in the case of a health emergency, examination, investigation and medical or surgical intervention shall not be performed on any patient in a PHSA Facility until informed consent has been obtained from the patient or legally authorized representative. Consent should be sought in a culturally safe and trauma informed manner.

**3.6.2** The MRP is responsible for obtaining the informed consent of the patient, or authorized representative prior to performing any procedure and shall not undertake any procedure until a signed and witnessed PHSA consent form has been completed.

## 3.7 Confidentiality of quality management information

Medical Staff quality assurance activities are protected under Section 51 of the Evidence Act, when undertaken at a PHSA Facility or Program designated under the Hospital Act. Section 51 of the Evidence Act, when properly implemented, overrides FOIPPA.

**3.7.1** Access to quality assurance and quality improvement information — professional staff who access quality assurance data for projects or preparation of papers shall comply with requirements regarding

ownership of and access to the information that shall adhere to the requirements of FOIPPA and Section 51 of the Evidence Act.

**3.7.2** Access by other users — The Chair of the appropriate Safety and Quality of Medical Care Subcommittee(s) can authorize access in Consultation with the Senior Medical Administrator (or delegate), in accordance with FOIPPA.

**3.7.3** All written communication among Quality of Medical Care Subcommittees shall be identified specifically as being for the purpose of quality assurance and quality improvement.

**3.7.4** In all circumstances, the communication of quality assurance data shall avoid any personal identifiers of those whose care has been reviewed, and shall avoid identifying any staff, Medical Staff or other personnel who were involved with the case.

## 3.8 Emergency care

**3.8.1** In an emergency, any Medical Staff member is expected to provide Medical Care until a patient's MRP assumes responsibility.

## 3.9 Orders

**3.9.1** All orders for treatment shall be written and signed (electronically where applicable) by a registered and licensed member of a College, as defined in the Health Professions Act (1996), in accordance with the standards and scope of practice for members of that College.

**3.9.2** In an emergency, a Medical Staff member may give verbal orders for treatment to a Registered Nurse, Respiratory Therapist, Perfusionist or Pharmacist, who shall transcribe the order onto the chart under the Medical Staff member's name per the writer's name. Such orders shall be counter-signed by the Medical Staff member (or delegate) as soon as possible but no later than 24 hours after the order has been given.

**3.9.3** The MRP shall provide orders necessary for the patient's care at the time of admission.

**3.9.4** The MRP shall comply with the PHSA's safe prescribing guidelines.

**3.9.5** House Staff and Clinical Fellows may write orders and prescribe controlled drugs provided they comply with PHSA's safe prescribing guidelines, as outlined in the PHSA Safe Medication Order Writing course.

## 3.10 Standard orders

**3.10.1** Members of a Department or Program may establish Standard Order Sets for their patients. The appropriate Department Head shall approve Standard Order Sets and arrange for the review of Standard Order Sets at least biannually. The Medical Staff member shall sign Standard Order Sets for each patient. Standard Order Sets shall comply with PHSA's safe prescribing guidelines, as well as standards set by the Medical Staff member's professional College.

## 3.11 Delegation of a Medical Act

**3.11.1** A Delegated Medical Act is a restricted activity or aspect of practice that, with the agreement of the transferring and receiving Service or Program, has been formally transferred from one Medical Staff member to staff that are Regulated Health Professionals or Unregulated Care Providers. Medical Acts are delegated in the interest of improved patient care and efficient use of health-care resources. A Delegated Medical Act becomes part of the specialized skills inventory of the accepting staff.

**3.11.2** The legal authority to delegate a medical act is defined under the Health Professions Act. As such, the delegation of a medical act does not alter the Medical Staff member's responsibility for the care of the patient, but rather widens the circle of responsibility for the safe performance of the procedure. The delegating Medical Staff member and the staff that perform the Delegated Medical Act are jointly responsible for the safe and ethical care of the patient.

**3.11.3** Medical acts may only be delegated from a named Medical Staff member and not from a job title (e.g. Department Head). A Delegated Medical Act ceases to be in effect when the named Medical Staff member leaves PHSA.

**3.11.4** The delegating Medical Staff member may revoke the Delegated Medical Act at any time.

**3.11.5** Staff receiving the Delegated Medical Act cannot delegate performance of the Act to another staff.

**3.11.6** The Delegated Medical Act must be clearly defined and circumscribed by the degree of medical supervision required.

**3.11.7** Staff identified to perform the Delegated Medical Act must demonstrate initial and ongoing competence to perform the Act. Competency, skill, and training requirements to perform the Delegated Medical Act shall be determined in collaboration with the delegating Medical Staff member, the PHSA Scope of Practice and Regulation Review Collaborative, and other relevant key partners they identify (e.g. Learning & Development teams).

**3.11.8** Education for Delegated Medical Acts, activities required to demonstrate competency, and the mechanism for certifying competence and assessing skills will be developed by the delegating Medical Staff member in collaboration with the PHSA Scope of Practice and Regulation Review Collaborative and other relevant key partners they identify. Education for Delegated Medical Acts shall include:

i. Written policy (posted to the Shared Health Organizations Portal SHOP) that identifies the Delegated Medical Act & any limitations associated with it.
ii. Prerequisite skills required to meet objectives.
iii. Objectives that are achievable, measurable and time limited.
iv. Knowledge, theory, and competence required for safe practice.
v. An evaluation plan that demonstrates theoretical knowledge of the Act, and competence in its performance.
vi. Specified date for re-assessment where applicable.
vii. The monitoring process for assuring continued effective performance of the Delegated Medical Act.

**3.11.9** The delegating Medical Staff member is accountable for ensuring the required knowledge and skills are taught appropriately. Non-Medical Staff individuals and teams may carry out the education.

**3.11.10** Records of those qualified to perform the Delegated Medical Act shall be collaboratively maintained by the delegating Medical Staff member and PHSA Scope of Practice and Regulation Review Collaborative. Re-evaluation and, if necessary, retraining all staff who perform the Delegated Medical Act, as required to maintain professional competency and an acceptable standard of care, shall be conducted at a regular basis agreed to by the delegating Medical Staff member and the PHSA Scope of Practice and Regulation Review Collaborative.

**3.11.11** Once the delegating Medical Staff member and PHSA Scope of Practice and Regulation Review Collaborative have developed, reviewed, and endorsed the required components stipulated in 3.11.7, 3.11.8, and 3.11.10, the Delegated Medical Act will be reviewed as follows:

i. Endorsed by either the Local MAC (if the PHSA Program has a Local MAC) or HAMAC (if the delegating Medical Staff is delegating the medical act to staff in multiple PHSA Programs).
ii. Shared with HAMAC.
iii. Shared with the PHSA Executive Leadership Team as consent.
iv. Reviewed by the PHSA Board Quality and Safety Subcommittee and approved by the PHSA Board.

**3.11.12** Delegated Medical Acts may only be made in accordance with the Bylaws of the delegating Medical Staff's regulatory College. A Delegated Medical Act must be approved by the respective regulatory Colleges representing the delegating Medical Staff member; the College of Physicians and Surgeons of BC, the College of Oral Health Professionals, BC College of Nurses and Midwives, and when applicable the regulatory College of the Regulated Health Professional receiving the delegation.

**3.11.13** Delegated Medical Acts must also align with rules outlined in PHSA's Delegation of Restricted Activities Policy.

**3.11.14** Assuming all of the requirements outlined in Section 3.11 have been satisfied, the final decision to delegate and to accept a delegation rests with the delegating Medical Staff and the staff that would receive the delegation.

## 3.12 Organ donation and retrieval

**3.12.1** Membership and Appointment

PHSA Medical Staff shall cooperate with BC Transplant to support the provincial Program for organ donation and retrieval. Members of the organ retrieval team shall be granted temporary privileges by the Senior Medical Administrator (or delegate), without application for the purpose of organ recovery.

**3.12.2** Responsibility for patient care:

a. Transfer of responsibility —The MRP may transfer responsibility for the physiological maintenance of an organ donor after the declaration of neurological death to a member of the organ recovery team.

b. Identification of potential donors — In accordance with the Human Tissue Gift Act,[2] all deaths or impending deaths of infants born at or after 39 weeks gestation, children, or adults up to and

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[2] *Human Tissue Gift Act*, [RSBC 1996] Chapter 211 - www.qp.gov.bc.ca/statreg/stat/H/96211_01.htm

including 75-years of age, must be reported to BC Transplant for the determination of medical suitability for organ donation.

c. In accordance with the PHSA “Identification of Donor-Death Registration” policy, the MRP shall contact the BC Transplant Donor Referral Line. BC Transplant shall determine the appropriateness for organ donation in conjunction with the referring individual. All ventilated patients with an impending or determined diagnosis of brain death shall be evaluated as potential solid-organ donors.

d. Designated requestor — if BC Transplant determines that the patient is medically suitable for donation, a designated requestor specifically trained in accordance with PHSA policy, shall approach the next-of-kin, or individual(s) with power-of-attorney for consent. A requestor may be a Physician, Nurse Practitioner, nurse, social worker, or other trained individual.

e. Matters requiring consent — Consent for organ donation shall be obtained after the declaration of neurological death on the appropriate consent form by a member of PHSA staff, or if requested and logistically possible, by a member of the Organ Retrieval Team.

f. Eye or Other Tissue Donation — In the event of eye or other tissue donation only, consent shall be obtained after cardiac death, by a member of the PHSA staff, or by an employee of the Eye Bank or the Tissue Bank of British Columbia.

g. Physician orders — After the declaration of neurological death, and if the MRP has transferred responsibility of care to the organ retrieval team, the team may give standing and verbal orders to a Nurse Practitioner, Registered Nurse, or a Respiratory Therapist, in order to maintain the physiological status of the donor. Any deviation from the protocol outlined in the standing orders shall be discussed in consultation with the MRP.

h. Pronouncement of death, autopsy, and pathology — In the case of organ donation, the criteria for the diagnosis of neurological death published in the most recent iteration by the Canadian Council for Donation and Transplantation shall be followed, in accordance with Part 2 Section 7 of the Human Tissue Gift Act.

## 3.13 Pronouncement of Death, Autopsy and Pathology

**3.13.1** Only a Physician or Nurse Practitioner shall pronounce death.

**3.13.2** The MRP shall seek autopsy permission for all deaths including stillborn deaths.

**3.13.3** A Medical Staff member, who attended the death of a child or attended a child during the child's past illness, shall report the death to the Chief Coroner's Office through the pediatric coroner. If a child dies in circumstances described in 3.12.4 below, the MRP shall immediately report to the duty coroner, in the format required by the chief coroner, the facts and circumstances relating to the child's death. Stillbirths do not require a report to the coroner.

**3.13.4** The MRP shall immediately report the case to the coroner if there is reason to believe that the death of an adult or child death occurred within these parameters outlined in the BC Coroner's Act:

a. As a result of violence, misadventure, negligence, misconduct, or malpractice.
b. As a result of a self-inflicted illness or injury.
c. Suddenly and unexpectedly, when the person was apparently in good health, and not under the care of a Medical Practitioner or Nurse Practitioner.
d. From disease, sickness, or unknown cause, for which the person was not treated by a Medical Practitioner or Nurse Practitioner.
e. During pregnancy or following pregnancy in circumstances that might reasonably be attributable to pregnancy.
f. If the chief coroner reasonably believes it is in the public interest that a class of deaths be reported, and issues a notice in accordance with the regulations in the circumstances set out in the notice.
g. While a patient in a designated Facility or private hospital within the meaning of the Mental Health Act, whether on the premises or in actual detention.

**3.13.5** An autopsy or post-mortem examination of a foetus shall not be performed without a coroner's order or written consent from the patient's next-of-kin or legally authorized agent; or without consent received by telephone from the next-of-kin or legally authorized agent of the patient, which shall be documented in the Health Record.

**3.13.6** All tissue or material of diagnostic value shall be forwarded to the Department of Pathology. From time to time, the LMAC or HAMAC may determine that certain materials may be excluded from routine examination by the Department of Pathology.

**3.13.7** Pathology specimens including body tissues, organs and foreign bodies shall not be released without written authorization from the Head of the Department of Pathology or delegate, in accordance with PHSA policies.

**3.13.8** The MRP shall complete the Medical Certificate of Death or the Medical Certificate of Stillbirth.

**3.13.9** Deaths shall be reported to the Coroner in accordance with the requirements of the Coroner's Act.[3]

## Article 4 — CLINICAL TEACHING AND RESEARCH

Preamble: PHSA has entered into affiliation agreements with UBC and other educational institutions that define processes for placement, and responsibilities for training health-discipline students, clinical trainees, Residents and Fellows within its Facilities and Programs.

The College of Physicians and Surgeons of BC and the BC College of Nurses and Midwives shall define both undergraduate and postgraduate Learner categories.

### 4.1 Medical Staff preceptors and supervisors

The UBC affiliation agreement stipulates that the Faculty of Medicine shall provide suitable Appointments for those Medical Staff members who are involved in teaching Programs at the University and are subject to the University's policies and procedures.

**4.1.1** Since an Appointment to PHSA Medical Staff includes teaching UBC students and Residents, Practitioners shall apply for and maintain a clinical faculty appointment in an appropriate UBC Department or other University (in BC) for Nurse Practitioners.

**4.1.2** All Medical Staff members shall participate in teaching as a condition of their Appointment.

**4.1.3** Medical Staff members shall not be responsible for onboarding or verifying that learners have met all the onboarding requirements as mandated by UBC and PHSA.

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[3] *Coroners Act*, [RSBC 1996] Chapter 72 – https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/00_07015_01

4.1.4 Medical Staff involved in teaching activities shall be responsible for ensuring that all learners and clinical trainees are engaged in activities appropriate to their level of training. learners and clinical trainees shall not be placed in situations that may compromise safety.

4.1.5 Medical Staff members shall advise patients (or their delegates) when Residents or clinical trainees may be involved in their care.

4.1.6 Supervisors and preceptors shall be available by phone or pager when not available in person to respond in a timely manner and shall be available to attend to the patient in an emergency. When not immediately available, they shall ensure that an appropriate alternate Medical Staff member is available and has agreed to provide supervision.

4.1.7 Supervisors and preceptors shall assess, review and document Learner and Clinical Trainee competence in accordance with UBC policies or other affiliated University for Nurse Practitioners.

4.1.8 Supervisors and preceptors shall comply with relevant policies of the affiliated Universities as well as PHSA when involved with learners and clinical trainees.

## 4.2 Undergraduate Learners

4.2.1 Undergraduate learners are not members of the Medical Staff.

4.2.2 Undergraduate learners include Medical Students, Midwifery Students and Dental Trainees.

4.2.3 Medical Students training through PHSA shall have an educational licence from the College of Physicians and Surgeons of BC.

4.2.4 Nurse Practitioner Students at a PHSA Facility or Department are graduate learners, requiring an undergraduate degree and RN licence from the BC College of Nurses and Midwives.

4.2.5 Midwifery Students in PHSA Facilities and Programs must have an educational licence and register as Trainees through the BC College of Nurses and Midwives.

4.2.6 Midwifery Students may complete clinical placements during years two, three and four under the direct supervision of a Midwife Medical Staff member.

**4.2.7** Midwifery Students may attend antenatal or postnatal encounters. These can be clinic, home, or hospital encounters, including participation in intra-partum and perioperative care.

**4.2.8** Undergraduate learners may participate in the care of patients under the direct supervision of a Medical Staff member, or under the direct supervision of a Fellow or Resident who is under the supervision of a Medical Staff member.

**4.2.9** Undergraduate learners, after undergoing adequate training, may perform Procedures under supervision, and in compliance with the regulations of their training institution.

**4.2.10** Undergraduate learners shall advise all patients of their Trainee status.

**4.2.11** Undergraduate learners shall ensure that they discuss orders in advance, with their supervisor(s). It is a supervisor(s) responsibility to countersign the orders.

**4.2.12** Undergraduate learners shall not discharge, on their own, a patient from a ward in the hospital, from the Emergency Department, or the Outpatient Department. Patients shall only be discharged once approval has been given by the MRP.

**4.2.13** Undergraduate learners shall not sign birth and death certificates, mental health certificates or other medico-legal documents.

**4.2.14** Undergraduate learners shall not sign prescriptions.

**4.2.15** Undergraduate learners shall not dictate final versions of discharge summaries or consultation letters.

**4.2.16** Undergraduate learners are expected to be on call but must be directly supervised at all times.

**4.2.17** Undergraduate learners may attend Division, Department, or general Medical Staff meetings, at the discretion of their supervisors.

**4.2.18** Undergraduate learners shall participate in clinical and academic rounds, as well as relevant clinical training sessions.

## 4.3 House Staff

**4.3.1** House Staff are not members of the Medical Staff as defined in the Bylaws.

**4.3.2** House Staff are qualified Dentists, Midwives, Nurse Practitioners or Physicians who are undergoing further training, and who are temporarily attached for educational purposes to a Facility or Program operated by PHSA.

**4.3.3** Appointments of House Staff shall be made annually, and shall be recommended by the Department Head concerned, the LMAC, the HAMAC, and approved by PHSA's Board of Directors.

**4.3.4** House Staff may attend patients under the supervision of a member of the Active or Provisional Medical Staff, who shall be responsible for the work they perform.

**4.3.5** Categories of House Staff:

a. Are Clinical Fellows or Residents engaged in post-graduate training.
b. Have applied directly to and have been accepted by the UBC Program affiliated with the Facility where the clinical training takes place.
c. Have adequate approved professional liability insurance.
d. Are appointed by the University.
e. Are licensed by the College of Physicians and Surgeons of BC, BC College of Oral Health Professionals or BC College of Nurses and Midwives.

**4.3.6** Duties and responsibilities

The House Staff shall:

a. Carry out those duties assigned to them by the Department or Program Head, to which they have been appointed.
b. Not admit patients to the Facility under their name.
c. Attend Medical Staff meetings, if so requested.
d. Regularly attend Department or Program clinical conferences and rounds.

## 4.4 Clinical trainees

**4.4.1** Clinical trainees are not members of the Medical Staff as defined in the Bylaws.

**4.4.2** Clinical trainees shall consist of those Physicians, Dentists, or Midwives who:

a. Are engaged by the Facility for the purposes of training.

b. Have applied directly to and have been accepted by the Facility.
c. Have adequate approved professional liability insurance.
d. Are licensed by the College of Physicians and Surgeons of BC, BC College of Oral Health Professionals or the BC College of Nurses and Midwives.

**4.4.3** Clinical trainees may attend patients under the supervision of a member of PHSA's Active or Provisional Medical Staff, who shall be responsible for the work they perform.

**4.4.4** Duties and responsibilities
The Clinical trainees shall:
a. Carry out those duties assigned to them by the Department or Program Head, to which they have been Appointed.
b. Not admit patients to the Facility under their name.
c. Attend Medical Staff meetings, if so requested.
d. Regularly attend Department or Program clinical conferences and rounds.

## 4.5 Dentists, Midwives, Nurse Practitioners or Physicians attached to a Facility for the purposes of clinical upgrading

**4.5.1** These shall be persons who:
a. Are practicing Dentists, Midwives, Nurse Practitioners, and Physicians who wish to complete upgrading in a specific clinical discipline.
b. Are licensed by the College of Physicians and Surgeons of BC, BC College of Oral Health Professionals or BC College of Nurses and Midwives.
c. Have qualifications commensurate with the level of training required.
d. Have applied directly to the appropriate Department and have been accepted by the Facility.
e. Have adequate approved professional liability insurance.

**4.5.2** Duties and responsibilities
Dentists, Midwives, Nurse Practitioners, and Physicians attached to a Facility for the purposes of clinical upgrading shall:
a. Carry out such duties that are assigned to them by the Department Head within their appointed Program.
b. Not admit patients to the Facility.
c. Attend Department or Program clinical conferences and rounds.

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## 4.6 Observership

Observers are practicing who wish to observe the provision of care or procedures at a PHSA Facility. All observers, prior to their start date, shall be registered, as appropriate, with the College of Physicians and Surgeons of BC, BC College of Oral Health Professionals or BC College of Nurses and Midwives, as well as with PHSA's Corporate Medical Affairs Department. Observers shall be informed that these requirements must be met prior to any observership at a PHSA Facility. The required Facility documentation for observers shall be available through PHSA's Corporate Medical Affairs Department. Dentists, Midwives, Nurse Practitioners, and Physicians

## 4.7 Research

**4.7.1** PHSA views research as a core component of its mandate and encourages Medical Staff to contribute to the generation and application of evidence that will improve the quality of care provided.

**4.7.2** The requirements for conducting research in PHSA are as follows:

a. Individuals conducting research shall comply with the policies of the research institutes of PHSA, as well as with any other applicable PHSA research policies and procedures. The list of PHSA Research Institutes includes: the BC Cancer Research Institute (BCCRI); BC Centre for Disease Control; BC Children's Hospital Research Institute (BCCHRI); BC Mental Health and Substance Use Research Institute (BCMHSURI); and the Women's Health Research Institute (WHRI).

b. Research conducted through PHSA requires PHSA Research Ethics approval. This includes research involving subjects or their personal health information who are patients of the researcher.

c. Approval must be obtained from all PHSA Departments and Programs involved in the support or conduct of the research project.

d. Individuals conducting clinical research through PHSA, including interventions involving human research participants, must be trained in Good Clinical Practice, as defined by the International Council on Harmonization (ICH).

# Article 5 — ORGANIZATION OF MEDICAL STAFF

Preamble: Article 7 of the Medical Staff Bylaws describes, in general terms, the organization of the Medical Staff, Medical Staff Departments (or equivalent), and the responsibilities of the Department Heads (or delegate). PHSA recognizes that specific names and titles may differ across the organization. For example, in BC Cancer, each Regional Centre has a senior medical administrator, the "Executive Medical Director", to whom the Department Heads for specialty areas report (e.g. medical and radiation oncology). There are no "divisions" or "sections" at BC Cancer.

PHSA maintains a Medical Staff leadership structure in support of governance and clinical operations of the Health Authority. In accordance with Article 7 of the Bylaws, the Board, upon the advice of the HAMAC, shall organize Medical Staff into Departments, Divisions and Sections.

All members of the Medical Staff shall belong to at least one Department and maintain privileges in at least one Facility or Program within PHSA.

## 5.1 Departments

**5.1.1** There is one PHSA-wide Department: the PHSA Department of Nurse Practitioners.

**5.1.2** Departments shall comprise of Medical Staff members who belong to the same medical or clinical discipline.

**5.1.3** Departments shall be responsible for monitoring the quality of patient care and services provided by their members. Department members shall participate in a program of structured quality assurance, including morbidity and mortality rounds and case reviews arising from quality committee activities or complaints regarding the care provided to patients by its members. These Programs shall at minimum encompass:

a. Patient clinical outcomes.
b. Legislatively mandated reviews.
c. Adverse clinical events arising from patient care.
d. Mortality in acute care environments.

## 5.2 Divisions and Sections

**5.2.1.** Individual Departments and Programs may be further organized into Divisions with clearly defined sub-specialty interests.

**5.2.2.** In large Facilities with complex medical sub-specialties, Divisions may be further organized into Sections with clearly defined sub-sub-specialty interests.

## 5.3 Department, Division and Section meetings

**5.3.1** Departments, Divisions and Sections shall meet regularly to conduct administrative affairs, clinical appraisals, teaching, research, and service commitments. Each is responsible for studying, investigating, and evaluating services provided by its members for the purpose of improving care. Department Heads or equivalent shall report regularly on these activities to the appropriate LMAC. When creating meeting agendas, any number of the following items may be included, as applicable:

a. Clinical Program planning
b. Budget submissions
c. Medical human resources
d. Appointments
e. Quality of Medical Care
f. Education and research
g. Discipline
h. Use of Facility or Program resources
i. Cases of mortality and morbidity
j. Clinical audits
k. Quality improvement projects

**5.3.2** Meetings shall be in person, by video or by teleconference.

**5.3.3** Each Department shall meet at least five (5) times per annum, and at the call of the Department Head to discuss matters of importance to PHSA and/or the Department.

**5.3.4** Department Heads shall meet with their Division Heads at least five (5) times per annum, or more often as circumstances dictate.

**5.3.5** Each Division shall meet at least four (4) times per annum, and at the call of the Division Head to discuss matters of importance to PHSA and to the Division.

5.3.6 Each Section shall meet at least three (3) times per annum, and at the call of the Section Head to discuss matters of importance to PHSA and to the Section.

5.3.7 Records of all duly called meetings shall be kept, and attendance shall be recorded.

5.3.8 Provisional and Active Medical Staff members are required to attend 70 per cent of their Primary Departmental and Divisional meetings unless excused by the Department or Division Head. Where this does not occur, during the annual performance meeting, the Medical Staff member and the appropriate Head shall discuss how this requirement shall be fulfilled in the future and establish a process to follow up on attendance compliance.

5.3.9 Records relating to quality assurance and quality improvement at PHSA Facilities and Programs designated under the Hospital Act shall be privileged pursuant to Section 51 of the Evidence Act. These records must be separated from other records and compiled under the Heading: "For Quality Review Purposes Only – Protected under Section 51 of the Evidence Act".

5.3.10 A quorum shall consist of 50 per cent of the voting members in each Department, Division or Section.

## 5.4 Medical Staff leadership

5.4.1. Department, Division and Section Heads provide assurance of public safety by ensuring each Practitioner is duly qualified and appropriately Privileged to provide Medical Care, and that the quality of care meets an acceptable standard.

5.4.2. Medical Staff leadership roles encompass, but are not limited to:

a. Standards of care.
b. Documentation of care.
c. Medical Staff recruitment.
d. Privileging.
e. Resource planning.
f. Performance monitoring and improvement.
g. Education and research.
h. Professional competence and behaviour.
i. Maintenance of respectful learning and work environments.
j. Individual provider quality of care.

k. Medical Staff wellness.
l. Effective, timely and thorough communication of organizational issues, decisions and policies affecting the Medical Staff.

**5.4.3.** Department, Division and Section Heads

Department Heads:

a. Department Heads shall be appointed by the Board, on the recommendation of the Senior Medical Administrator (or delegate), Senior Nursing Administrator (as appropriate), after receiving advice from the LMAC, HAMAC and appropriate University Department or Program Head. Selection Committee should ensure appropriate Indigenous representation and thought leadership.

b. The term of appointment for each Department Head shall not exceed five (5) years. The PHSA Board of Directors may reappoint a Department Head for an additional term. The functioning of the Department or Program and past performance of the Head shall be reviewed prior to a decision regarding reappointment.

c. The Department Head shall be selected based on qualifications, training, leadership experience and demonstrated clinical, academic, and administrative ability.

d. The Department Head shall report to and shall be accountable to the Senior Site Medical Administrator (or delegate), the Senior Site Nursing Administrator (as appropriate), the PHSA Senior Medical Administrator (or delegate) and/or PHSA's Senior Nursing Administrator.

e. The Department Head (or delegate) shall attend all meetings of the LMAC as a voting member and participate on LMAC Subcommittees at the request of the LMAC Chair.

f. The Department Head shall identify an Assistant Department Head to assume responsibilities whenever absent. In the case where the Assistant Department Head is also absent, the Head will appoint a senior member of the staff to assume temporary responsibilities.

Division Heads:

a. Division Heads shall be appointed by the Department Head for a term determined after obtaining advice and recommendations from the Senior Medical Administrator (or delegate) and/or the Senior Nursing Administrator (as appropriate), and subject to any applicable affiliation

agreement.

b. Division Heads shall be active Medical Staff members, selected based on qualifications, training, experience, and demonstrated leadership ability in clinical, teaching, and administrative activities.

Section Heads:

a. Section Heads shall be appointed by the Division Head for a term determined after obtaining the advice and recommendations from the Department Head, and subject to any applicable affiliation agreement.

b. Section Heads shall be active Medical Staff members selected based on qualifications, training, experience, and demonstrated ability in clinical, teaching, and administrative activities.

**5.4.4.** Responsibilities of the Department Head

In addition to those defined in the Medical Staff Bylaws Article 7.2, the Department Head's responsibilities include:

i. Advising the LMAC and HAMAC (as requested) on matters regarding quality of Medical Care provided to patients, and compliance with professional standards of Medical Care by all Department members.

ii. Ensuring effective assessment, planning, implementation, modification, utilization and evaluation of patients, families, and patient-care processes in selected dimensions of quality, including:
   - Mortality and morbidity reviews, including results and actions taken.
   - Clinical audits.
   - Outcome tracking and monitoring.
   - Annual quality-improvement project.

iii. Advising the Board, through the LMAC and HAMAC structure and the Quality and Access Committee, on the adequacy of resources affecting quality of Medical Care and academic activities.

iv. Coordinating communication to and from the Department or Program and PHSA through the LMAC and HAMAC structure; and updating Department or Program members on Facility, Department or Program objectives, policies, and general activities.

v. Developing standards of clinical practice and behaviour for members of the Department, as prescribed by Facility or Program policies, the Medical Staff Bylaws and these Rules.

vi. Developing annual operating objectives and a budget for the Department.

vii. Ensuring effective and efficient use of applicable PHSA and Department resources by monitoring, evaluating, and reporting on their utilization.

viii. Maintaining the human resource plan for their Department or Program.

ix. Recruiting new members in accordance with their human resource plan.

x. Evaluating persons wishing to be appointed or reappointed to the Medical Staff, and making necessary recommendations, a process which includes completing an impact analysis affecting privileges, where appropriate.

xi. Conducting an annual or in-depth review of Department members' Privileging status and making appropriate recommendations to the Credentials and Human Resource Planning Subcommittee.

xii. Investigating any Medical Staff behavioural or patient-care-delivery concerns, and where appropriate, initiating disciplinary procedures in accordance with the Medical Staff Bylaws, Section 9 of the Rules and applicable PHSA policies.

xiii. Making appropriate recommendations regarding all Medical Staff leave of absence applications.

xiv. Ensure continuous out-of-hours coverage for the Facility and its patients, as appropriate.

xv. Developing and maintaining specific job descriptions for the Head(s) of each Division.

xvi. Supporting professional development of Department staff by facilitating and allocating resources, including professional academic time to encourage and promote participation in mentorship, research, education, teaching, and other developmental activities.

xvii. Creating and sustaining an equitable, inclusive, respectful, anti-racist and culturally safe workplace, related to goals and objectives of PHSA, and its Facilities and Programs.

xviii. Organizing, planning and Chairing Department meetings, as outlined in Section 5.3.

xix. Appointing a senior member of the Department or Program to fulfill these duties and responsibilities in their absence when the Assistant Department Head is also absent.

xx. Appointing and managing Division Head(s).

**5.4.5.** Responsibilities of the Assistant Department Head:

i. Fulfilling all duties and responsibilities during any absence of the Department Head.
ii. Performing other duties as designated by the Department Head.

**5.4.6.** Responsibilities of the Division Head:

i. Fulfilling similar, but subordinate tasks to those of the Department Head, but with focus on specific activities of the Division.
ii. Reporting all pertinent clinical, educational, research and administrative matters within the Division to the Department Head.
iii. Appointing and managing Section Heads within their Division.

**5.4.7.** Responsibilities of the Section Head:

i. Fulfilling similar, but subordinate duties to those of the Division Head, but with a focus on the specific activities of the Section.
ii. Reporting all pertinent clinical, educational, research and administrative matters within the Section to the Section Head.

**5.4.8.** Selection process for Department Head

Where a vacancy exists for the position of Department Head, and the PHSA Board has expressed a desire that the vacant position be filled, the Senior Medical Administrator (or delegate), and/ or Senior Nursing Administrator (as appropriate), shall strike a Selection Committee, advisory to the LMAC, HAMAC and the Board, to recommend a candidate to fill the vacancy. Selection Committee should ensure appropriate Indigenous representation and thought leadership.

a. Suggested composition:

The Department Head Selection Committee may comprise of the following:

i. Chair, who shall be recommended by the LMAC.
ii. UBC Department Head (or delegate).

iii. One member of the Department, elected by that Department. If there are more than 10 members in that Department, two representatives shall represent the clinical and academic staff.
iv. A Department Head, or other senior member of the Medical Staff from the Facility, chosen by the LMAC.
v. Senior Site or Facility Administrator (or appropriate delegate).
vi. Senior Medical Administrator and Senior Nursing Administrator (if applicable, or appropriate delegates).
vii. Senior Facility Medical Administrator of the associated Facility (or delegate).
viii. A senior nurse leader whose job entails frequent interaction with the Department.

b. Process:
The Selection Committee shall:
i. Develop a job description and list of required qualifications and make it available to each member of the Selection Committee.
ii. Advertise the position according to PHSA requirements.
iii. Review candidates and all information submitted in reference to a candidate's application.
iv. Develop a shortlist of candidates for more comprehensive review.
v. Ensure shortlisted candidates have complied with all application process requirements, including Credentialing and Privileging requirements.
vi. Interview shortlisted candidates.
vii. Prepare a written report for the Senior Medical Administrator (or delegate), the Senior Nursing Administrator (as applicable), the LMAC and the HAMAC.

c. The LMAC shall consider the report and make an appointment recommendation to the PHSA Senior Medical Administrator and PHSA Senior Nursing Administrator (as applicable) concerning the appointment.

**5.4.9.** Selection of a Division Head

When a vacancy exists for the Head of a Division comprising 12 or more members, and the Department Head has expressed a desire to fill the vacant position, the Department Head shall strike a Selection Committee, advisory to the Head, to recommend an appropriate candidate. For Divisions comprising less than 12 members, the Department Head will consult with a Head of the corresponding academic discipline to determine an acceptable selection process, as appropriate.

a. Composition:

It is advisable for the Division Head Selection Committee to comprise of the following:

i. Department Head for the applicable Division, to Chair the Committee.
ii. Head of the corresponding academic discipline (if not the same person as the Department Head).
iii. One elected member of the Division involved (for Divisions between three and 10 members); or two elected members (for divisions with more than 10 members).
iv. One Department or Program member whose Division interacts regularly with the Division seeking a new Head (chosen by the Department Head).
v. One Division Head elected by members of their Department or Program.
vi. One representative of the LMAC for the Facility in which the Division provides the majority of its Medical Care.

b. Process:

The Selection Committee shall:

i. Develop a job description and list of required qualifications, and make it available to each member of the Selection Committee.
ii. Advertise the position according to PHSA requirements.
iii. Review candidates and all information submitted in reference to a candidate's application.
iv. Develop a shortlist of candidates for more comprehensive review.
v. Ensure shortlisted candidates have complied with all application process requirements, including Credentialing and Privileging requirements.
vi. Interview shortlisted candidates.
vii. Prepare a written report for the Department Head.

5.4.10. Review of Departments and the Department Head

a. Department Heads are appointed for a term of five (5) years. The Senior Medical Administrator (or delegate) and/or the Senior Nursing Administrator (if applicable), shall lead an annual performance review of each Department Head.

b. In the fourth year of appointment, a Review Committee shall be struck to formally assess the performance of each Department Head and shall report its recommendations to the LMAC and HAMAC (as required).

c. In the case of a UBC Department Head, the review shall use the existing mechanism prescribed by the University.

d. The review report shall include a recommendation regarding the reappointment or non-reappointment of the Department Head for a further five-year term.

e. The purpose of the review is to assess the performance of the Department Head in the following areas:
   i. Departmental and hospital administration.
   ii. Medical Staff management.
   iii. Quality of care provided by the Department.
   iv. Resource utilization and management by the Department.
   v. Fulfilment of academic responsibilities.

f. The Department Head's performance will be measured against the:
   i. Position description.
   ii. Strategic Plans of the PHSA, the Facility and Department.
   iii. Additional relevant documentation provided by the Senior Medical Administrator (or delegate) and/ or the Senior Nursing Administrator (as applicable).

g. The PHSA, UBC and the Selection Committee shall consider the results of the review in the process of recommending the appointment of a new Department Head.

h. Composition of the Review Committee
   The Committee membership shall be specific for each review process. Membership may consist of:
   i. The Chair, who shall be recommended by the Senior Medical Administrator (or delegate), after considering advice from the LMAC.
   ii. UBC Dean of Medicine (or delegate).
   iii. Two members of the Department or Program under review, nominated by that Department or Program's membership; or one representative if there are less than 10 members.
   iv. One additional PHSA Department Head, chosen by the Senior Medical Administrator (or delegate), after considering advice from the LMAC.
   v. At least one external reviewer, selected by the Senior Medical Administrator (or delegate), with input from the Department Head and its members.
   vi. Senior Medical Administrator (or delegate) and/or Senior Nursing Administrator (if applicable)

5.4.11. Review process

A briefing package shall be prepared in advance for the Review Committee. This may include:

i. Terms of Reference, developed by the Senior Medical Administrator (or delegate) and/or Senior Nursing Administrator (if applicable), after receiving the advice of PHSA, and the appropriate UBC Department Head.
ii. The position description.
iii. PHSA, Facility and Department strategic plans and mission statements.
iv. A Department overview prepared by Department members, including a description of all patient-care activities, teaching programs, research activities, funding and issues facing the Department.
v. Curriculum vitae of Department members.
vi. Summaries of recent assessments, such as UBC Faculty of Medicine, Royal College, and accreditation reviews and reports, or other relevant material.

5.4.12. The Review Committee shall meet with the Department Head, Department or Program members, and other relevant members of the PHSA staff. It shall weigh information concerning:

i. Whether the Department or Program's objectives are being or have been achieved.
ii. Whether the Department or Program maintains respectful and constructive working relationships with other Departments and health-care professionals.
iii. The ability of the Department Head to effectively administer matters of the Department.
iv. The leadership ability of the incumbent, as well as the effectiveness of his or her program for the ongoing development of the Department or Program Review Report.

5.4.13. The Review Committee Chair shall prepare and deliver a confidential draft report to the Senior Medical Administrator (or delegate) and/or the Senior Nursing Administrator (as applicable). The Chair shall then forward it to the Department Head for review and to correct any errors of fact. The Senior Medical Administrator (or delegate) and/or the Senior Nursing Administrator (as applicable), shall make confirmed corrections in the draft report and send the report to the Department Head for Departmental or Program response. The final report and corresponding response shall go to the LMAC Chair for further action. This action may be to:

i. Recommend re-appointment.
ii. Recommend re-appointment with specific conditions.
iii. Recommend a transitional appointment for a finite term.
iv. Recommend not to re-appoint.

Confidentiality:

All correspondence and communication with and from the Review Committee shall be held in strict confidence, as shall all Committee deliberations. A specific report on the content and process of these deliberations shall not be issued.

## 5.5 Suspension or termination of the Department Head

The Board may, either on the recommendation of the Senior Medical Administrator and/or the Senior Nursing Administrator (if applicable) or in its sole discretion, suspend or terminate the appointment of any Department Head. Prior to suspension or termination, the Board shall notify the LMAC and the Department Head. If the Board chooses to terminate the Department Head, it shall provide three months' notice to the Department Head and the Department.

# Article 6 — MEDICAL STAFF ASSOCIATIONS

## 6.1 Role and structure

**6.1.1** At PHSA, Medical Staff Associations (MSAs) are Facility or Program specific. PHSA Medical Staff may elect to establish a Health Authority-wide MSA to provide better representation of Medical Staff issues to the LMACs, HAMAC and Board. Some Programs or Facilities have elected to create Medical Staff Engagement Societies (MSESs, which may also be utilised to provide better representation of Medical Staff issues to the LMACs, HAMAC and Board.

**6.1.2** Objectives

i. Promoting and engaging Medical Staff involvement in the provision of PHSA's medical and clinical services.
ii. Representing and advocating for the interests of PHSA Medical Staff.

**6.1.3** The structure and operation of the MSAs shall be guided by these Rules and be determined by their Terms of Reference.

## 6.2 Elected officers of the Medical Staff Associations

**6.2.1** The elected officers of the Medical Staff Associations shall be:

i. President
ii. And additional officers as defined in the MSA Terms of Reference

## 6.3 Election Procedure

**6.3.1** The formation of a Nominating Committee and its composition is defined as per the MSA's Terms of Reference.

**6.3.2** MSA members will elect officers at an annual general meeting.

**6.3.3** Elected officers shall hold office for a period of not more than three (3) years, and may be reappointed for up to three (3) consecutive terms.

**6.3.4** All members of PHSA's active Medical Staff are eligible to vote, stand for election and hold office.

**6.3.5** If there are enough eligible voting members present to achieve quorum, elections shall be by acclamation or by a simple majority vote.

## 6.4 Duties of the MSA President

The MSA President shall:

i. Convene and Chair all meetings of the MSA.
ii. Be an ex-officio member of all MSA Committees.
iii. Be a voting member of the HAMAC and LMAC.
iv. Receive information and directives from the LMAC and HAMAC and disseminate this information to the MSA membership.
v. Communicate matters concerning the MSA to HAMAC/LMAC Chair and PHSA's senior medical leadership, as appropriate.
vi. Effectively perform additional duties outlined in the MSA's Terms of Reference.

## 6.5 Duties of additional officers

The duties of additional elected offices are defined in the MSA Terms of Reference.

## 6.6 Recall, Removal and Filling of Vacant Offices

Officers of the Medical Staff Association may be recalled and removed based on the following principles:

**6.6.1** Upon receiving a petition to recall an officer, signed by at least one-third of the eligible Medical Staff Association voting members, the President of the Medical Staff Association shall call a special meeting to be held within 30 days of receiving the petition. In the event the petition is to recall the President, the elected officers shall call a special meeting to be held within 30 days of receiving the petition.

**6.6.2** If, at this meeting, with quorum established, two-thirds of eligible voters, present in-person or by proxy vote in favour of recall, the office shall be declared vacant. They may hold an election for the vacant office at the same meeting.

**6.6.3** In the event of death, removal, or resignation of an officer during the term of office, another Medical Staff Association member may be elected at a regular or special meeting to fill the balance of the term.

**6.6.4** The remaining officers shall strike an ad-hoc Nominating Committee and present a potential candidate, or slate of potential candidates willing to stand for the position, either at the next regular MSA meeting, or at a special meeting called for this specific purpose. If a special meeting is called, the sole item of business shall be filling the vacant MSA officer position. Until a replacement is found and duly elected, the remaining officers will assume additional duties.

**6.6.5** In the event of a simultaneous removal or resignation of the entire slate of elected officers, the Past President of the Medical Staff Association shall temporarily assume the duties and responsibilities of President, to handle all urgent matters, the first of which shall be to call expeditiously for an election to fill the vacant offices.

# Article 7 — MEETINGS OF THE MEDICAL STAFF ASSOCIATION

## 7.1 Annual general meeting

**7.1.1** The annual general meeting shall be the last meeting before year-end, at which time officers shall be elected for the upcoming year.

**7.1.2** The President of the Medical Staff Association shall post a notice announcing the time and place of the meeting to MSA members at least 10 days prior.

**7.1.3** All MSA officers and Committees shall present an annual report in writing. These reports should be distributed to the MSA membership sufficiently far in advance to allow time for their perusal.

**7.1.4** MSA officers will present an annual report on the MSA's financial affairs for the current year, along with a proposed written budget for the upcoming year.

**7.1.5** Written records will be kept of the meeting.

## 7.2 Regular meetings

**7.2.1** The MSA shall hold regular meetings at least three times per year, or more often if the President and officers of the MSA deem appropriate, in accordance with individual terms of the MSA.

**7.2.2** The MSA President shall post a notice to the membership at least 10 days prior to a regular meeting, announcing the time and place of the meeting.

**7.2.3** The Chief Executive Officer (or delegate), members of PHSA ELT, local senior administrator(s), HAMAC Chair (or delegate), LMAC Chair (or delegate), and/or others as deemed appropriate by MSA Terms of Reference, shall receive notice of and may attend appropriate portions of all regular MSA meetings.

## 7.3 Special Meetings

**7.3.1** The PHSA Board, CEO, MSA President or HAMAC/LMAC Chair may request a special meeting of the MSA. A special meeting may also be called, upon receipt of a written request signed by at least one-third of eligible voting MSA members. Special meetings shall be held within 10 days of request receipt, or at a time mutually agreeable to the parties involved.

7.3.2 At a special meeting, no business shall be transacted except as stated in the written notice of the meeting.

7.3.3 Written notice shall be posted by the MSA President at least two days before the special meeting, and shall describe clearly, with sufficient detail, the purpose of the meeting.

## 7.4 Attendance

7.4.1 Attendance requirements shall be defined within the MSA's individual Terms of Reference.

## 7.5 Quorum

7.5.1 Quorum shall be defined within the MSA's individual Terms of Reference.

## 7.6 Membership dues

7.6.1 The annual amount to be paid for membership dues shall be determined by a vote at the annual meeting on the recommendation of the elected officers of the MSA. An MSA may also vote to not collect dues for an annual fiscal, if deemed appropriate.

Payment of membership dues is required to maintain membership on the MSA. Non-payment of dues within the time specified by the MSA terms of reference may be considered grounds for potential disciplinary action.

## Article 8 — HEALTH AUTHORITY MEDICAL ADVISORY COMMITTEE

The PHSA Board appoints the HAMAC, as defined in Article 8 of the Medical Staff Bylaws.

### 8.1 Purpose

The HAMAC makes recommendations to the PHSA Board, CEO, Senior Medical Administrator (or delegate) and Medical Staff Association with respect to:

a. Appointment and review of members of the PHSA Medical Staff, including the delineation of clinical and procedural privileges.

b. Ensuring quality and safety standards and availability of Medical Care provided within PHSA Facilities and Programs.

c. Establishing and maintaining professional standards in PHSA Facilities, Departments and Programs, ensuring they follow all relevant legislation, Bylaws, Rules, and policies.

d. Ensuring availability and adequacy of resources required by the Medical Staff to provide patient care and meet the needs of the population served by the PHSA.

e. Continuing professional development (CPD) of the Medical Staff.

f. The professional and ethical conduct of members of the Medical Staff.

g. Disciplinary measures for violation of the Bylaws, Rules and policies governing the conduct of PHSA Staff and Medical Staff.

### 8.2 HAMAC composition

The HAMAC membership shall comprise of:

**8.2.1** Voting members:

a. Chair of the HAMAC (if not already a voting member listed herein)
b. Vice-Chair of the HAMAC (if not already a voting member listed herein)
c. Chief Medical Officer, BC Children's Hospital and BC Women's Hospital + Health Centre

d. Chief Medical Officer, BC Cancer
e. Vice President, Public Health & Wellness and Deputy Provincial Health Officer, BC Centre for Disease Control
f. Chief Medical Officer, BC Mental Health and Substance Use Services
g. Chief Medical Officer, BC Emergency Health Services
h. Chief Medical Information Officer, PHSA
i. Regional Department Head, Nurse Practitioners
j. Regional Department Head, Midwifery
k. Regional Department Head, Dentistry
l. Chair, Children's and Women's Health Centre of BC Local Medical Advisory Committee
m. Chair, BC Cancer Local Medical Advisory Committee
n. Chair, Local Medical Advisory Committee for Facilities or Programs not designated as hospitals under the Hospital Act
o. President, Children's and Women's Health Centre of BC Medical Staff Association
p. President, BC Cancer Medical Staff Association
q. One MSA President from Facilities or Programs not designated under the Hospital Act
r. Vice President, Medical and Academic Affairs
s. Vice President, Indigenous Health and Cultural Safety (or delegate)
t. Past-Chair HAMAC

8.2.2 Non-voting members

a. President & Chief Executive Officer, PHSA
b. Executive Vice-President, Clinical Service Delivery, PHSA
c. Executive Vice-President, Provincial Clinical Policy, Planning & Partnerships, PHSA
d. Vice President, Quality, Safety, Clinical Informatics, and Chief of Nursing and Allied Practice, PHSA
e. Dean, or delegate, UBC
f. A patient representative approved to work in PHSA
g. PHSA Chief Information Officer

8.2.3 The HAMAC shall review and ratify its voting and non-voting membership at the annual HAMAC Organizational Planning Meeting. Between Organizational Planning meetings membership may change based on the appointment of new incumbents into voting and non- voting positions.

## 8.3 HAMAC Executive Committee

**8.3.1** The HAMAC Executive Committee shall meet at least two weeks prior to each scheduled HAMAC meeting.

**8.3.2** The Executive Committee shall plan, develop, prioritize, and finalize the agenda items for each regular meeting, and deal with business arising between meetings at the request of the Chair or PHSA Senior Medical Administrator.

**8.3.3** The Executive Committee shall comprise of:

a. HAMAC Chair
b. HAMAC Vice-Chair
c. Chair, BC Children's Hospital and BC Women's Hospital + Health Centre LMAC
d. Chair, BC Cancer LMAC
e. Chair of Local Medical Advisory Committee (LMAC) for Facilities or Programs not designate as hospitals under the Hospital Act
f. One PHSA Facility MSA President
g. The PHSA Senior Medical Administrator
h. Vice President, Quality, Safety, Clinical Informatics, and Chief of Nursing and Allied Practice, PHSA
i. Vice President, Indigenous Health and Cultural Safety (or delegate)
j. Past-Chair HAMAC

## 8.4 Duties of the HAMAC

**8.4.1** Patient care:

a. Determine the quality of care delivered to PHSA patients by studying and making recommendations on reports received from Department Heads, Departments, Programs and Committees concerning the review, analysis, and evaluation of the Medical Staff's clinical practice.
b. Ensure clinical practice standards are developed for and met by all Departments.
c. Ensure the outcomes of surveillance regarding the quality of Medical Care focus on continuous improvement.
d. Liaise with other health-care providers, as required, to help ensure the achievement of the highest quality of patient care possible.
e. Make recommendations to the Board and ELT regarding Medical Staff resources necessary to meet the clinical needs of patients treated by the PHSA.

**8.4.2** Administration:

a. Appoint Chairs and members to standing Committees and ensure these Committees function effectively.
b. Make recommendations to the Board, regarding ongoing development, maintenance, review, and updates to these Rules.
c. Make recommendations to the Board, regarding Appointments, reappointments, evaluations, and reviews of Medical Staff, including the delineation of specific clinical and procedural privileges.
d. Monitor the Medical Staff and report to the ELT and Board on the maintenance of professional standards and conduct of the Medical Staff and, where appropriate, to recommend actions to address deficiencies.
e. Report to the Senior Medical Administrator, ELT, and Board on recommended disciplinary measures for members of the Medical Staff following who have violated the provisions of the PHSA Bylaws, Rules, and policies.
f. To monitor the professional and ethical conduct of all members of the Medical Staff and report any infractions to the Senior Medical Administrator and Board, when required.

**8.4.3** Academic:

a. Receive, study, and make recommendations on reports related to the educational, research and continuing professional development activities of Medical Staff members.
b. To make specific recommendations on the appropriate levels of research and teaching at each PHSA Facility.
c. Ensure implementation of education recommendations continue to advance Indigenous Specific Anti-Racism.

## 8.5 HAMAC membership

**8.5.1** Each HAMAC member shall be appointed for a three-year term (3), unless specified in the PHSA role description for that member.

**8.5.2** Voting members shall attend all meetings of the HAMAC. A voting member's failure to attend at least 80 per cent of meetings annually, in person or by regular delegate, shall be considered at the Annual Organizational Meeting.

**8.5.3** Voting members, who will be absent from an upcoming HAMAC meeting, shall name a regular delegate to attend in their absence, and shall notify the Chair in writing at least 24 hours in advance.

To ensure that the delegate comes prepared to participate effectively in the meeting, the absent member shall provide sufficient information, including giving the delegate authority to vote on all motions before the HAMAC at that meeting.

## 8.6 HAMAC meetings

**8.6.1** Operational protocols:

a. A simple majority of voting members shall constitute a quorum.
b. The HAMAC Executive Committee shall have the authority to take preliminary action on urgent issues in situations where a full HAMAC meeting is not feasible, or quorum cannot be established. The HAMAC executive shall report to the HAMAC at its next regularly scheduled meeting on actions or decisions taken. At this meeting, the HAMAC shall ratify, rescind, or modify the Executive Committee's actions.
c. PHSA's Corporate Medical Affairs Department shall maintain the agendas, meeting packages, minutes, and any other documentation relevant to, or required by the HAMAC.

**8.6.2** Regular meetings:

a. The HAMAC shall conduct regular meetings at least five (5) times per year, in alignment with, and sufficiently in advance of regularly scheduled Board meetings, ensuring that HAMAC decisions and recommendations can reach the Board in a timely manner.

b. The agenda, minutes of the previous meeting(s) and any required meeting materials shall be distributed to members not less than one week prior to any regular meeting.

c. Attendance at regular meetings shall be limited to those members identified in Article 8.2 of these Rules, or at the invitation of the HAMAC Chair, or a simple majority of the HAMAC executive.

d. The Facility Medical Staff Association Presidents shall provide a written report at each HAMAC meeting regarding Medical Staff Association issues. Time to discuss any issues arising shall be allotted on the regular HAMAC agenda.

e. Meetings shall be conducted in compliance with the most recent version of Robert's Rules of Order.

**8.6.3** Special meetings:

a. The HAMAC may meet to address special issues or urgent matters. Special meetings are held at the call of the Chair or at the request of a simple majority of the HAMAC executive members.

b. Special meetings require a minimum of four (4) days' notice. In extraordinary circumstances, the HAMAC Chair, in consultation with the Senior Medical Administrator, may make an exception to this requirement. The rationale for the exception shall be provided to the HAMAC and to the Board at their next regularly scheduled meetings.

c. All members of the HAMAC may attend special meetings provided no conflict of interest exists, but a simple majority of voting members is required for the meeting to proceed. Others may be permitted or encouraged to attend at the request of the Chair or a simple majority of the HAMAC executive.

d. At a special meeting of the HAMAC, the only order of business shall be to address the issue for which the meeting is called.

e. Meetings shall be conducted in compliance with the most recent version of Robert's Rules of Order.

**8.6.4** Annual Organizational Meeting:

a. The HAMAC shall conduct an annual face-to-face meeting, open to all HAMAC members, Chairs of HAMAC Subcommittees, and others at the invitation of the HAMAC Chair or a simple majority of members of the Executive. Participation by video conference shall be construed as face-to-face.

b. Quorum for the organizational meeting shall be a simple majority of the regular HAMAC voting membership.

c. The purpose of the meeting is threefold:
   i. To receive and review annual reports from the Chairs of the HAMAC Subcommittees.
   ii. To confirm the membership of HAMAC and its Subcommittees for the coming year.
   iii. To review HAMAC progress during the past year, and plan for new strategies, or initiatives to improve the operational effectiveness of the HAMAC.

d. Meetings shall be conducted in compliance with the most recent version of Robert's Rules of Order.

## 8.7 HAMAC Chair & Vice Chair

The Chair and Vice Chair of the HAMAC are appointed by the Board of Directors after considering the recommendation of HAMAC.

a. The Chair shall be chosen from the active medical staff at PHSA. The selection process for a new HAMAC Chair will align with the established process used for appointing chairs of other Board committees from a list of preferred candidates provided by the HAMAC.

b. The Vice Chair shall be chosen from the active medical staff at PHSA. The process for selecting a Vice-Chair will be directed by the HAMAC.

c. The Chair and Vice Chair of the HAMAC are appointed for a term of not more than three years and may be reappointed for up to three consecutive terms upon successful review.

d. Once the Chair completes their term, they will continue on HAMAC as an ex-officio member in the role of Past Chair for a term of up to one year.

## 8.8 Authority of the HAMAC

**8.8.1** The HAMAC has the authority to:

a. Ensure Medical Staff Association members comply with the Hospital Act and its regulation (as applicable) and the Bylaws, Rules, and Policies of PHSA.

b. Appoint HAMAC Subcommittees to recommend disciplinary or remedial actions, including reprimands for any Medical Staff member, within and up to the limitations of authority delegated by the Board.

c. Require any member of the Medical Staff Association to appear before it, whenever necessary to carry out its responsibilities.

**8.8.2** The HAMAC also has the authority to make recommendations concerning:

a. Supervision of clinical practice.
b. Establishment and maintenance of professional-practice standards and professional conduct in the Facilities; owned and operated by PHSA.
c. Continuous quality improvement of patient care, including recommendations for resource allocations to facilitate improvement.
d. Meeting PHSA’s provincial mandate and legislative obligations.

e. Meeting PHSA's research and academic mandate.
f. The restriction, modification, suspension, revocation, non-renewal, or maintenance of a Medical Staff member's Appointment or privileges, including other disciplinary or remedial action the HAMAC deems appropriate.
g. Medical Staff performance improvement projects; quality improvement and innovation in care delivery and Medical Staff engagement projects, across PHSA.

## 8.9 Evaluation of the HAMAC

The HAMAC shall conduct a self-evaluation at least biannually to determine whether it is fulfilling its mandate. The HAMAC, with input from PHSA's Senior Medical Administrator, shall determine the evaluation process.

## 8.10 Subcommittees of the HAMAC

### 8.10.1 General

The general principles and relationships among HAMAC and other Medical Staff Committees are outlined in Article 9 of the Medical Staff Bylaws.

The *ad hoc* Subcommittee of the HAMAC will include:

a. Bylaws and Rules Subcommittee (Section 8.11)

The Standing Subcommittees of the HAMAC shall include:

a. HAMAC Executive (Section 8.3)
b. LMACs are essential standing Subcommittees of the HAMAC. Each LMAC shall be accountable, and report directly to the HAMAC (Section 8.12)
    i. BC Cancer Local Medical Advisory Committee.
    ii. BC Centre for Disease Control Local Medical Advisory Committee.
    iii. BC Children's Hospital and BC Women's Hospital + Health Centre Local Medical Advisory Committee.
    iv. BC Mental Health and Substance Use Services Local Medical Advisory Committee.

### 8.10.2 Operational Protocols and Meetings

a. The HAMAC may also establish other Subcommittees with clearly defined functions.

b. Each HAMAC Subcommittee shall have the same authority as the HAMAC to fulfil its purpose and duties.

c. All Subcommittee members have voting rights.

d. A simple majority of each Subcommittee membership shall constitute a quorum.

e. Each HAMAC Subcommittee is recommended to review its terms of reference annually and ~~shall~~ recommend proposed changes to the HAMAC at the Annual Organizational Meeting.

f. The HAMAC may appoint each Subcommittee member to a two-year (2) term, renewable following a satisfactory performance review.

g. Subcommittee appointees do not need to be members of the HAMAC, nor do they need to be PHSA-appointed medical-staff leaders. Appointees shall be members in good standing of the Active Medical Staff.

h. The HAMAC may appoint each Subcommittee Chair to a two-year (2) term, renewable once, for a maximum of two (2) consecutive terms, unless otherwise stated in the "operating protocols" section of the Subcommittee's Terms of Reference, outlined in these Rules. Each Subcommittee Chair shall be a member in good standing of PHSA's Active Medical Staff.

i. Unless otherwise specified in these Rules, PHSA's Corporate Medical Affairs Department shall provide administrative and secretariat support to each HAMAC Subcommittee as required. The Corporate Medical Affairs Department shall be responsible for receiving and maintaining the agendas, minutes and other documentation related to each HAMAC Subcommittee. Minutes shall be recorded at each meeting and shall be submitted to the HAMAC through PHSA's Corporate Medical Affairs Department. Approved minutes shall be available for electronic review from the Corporate Medical Affairs Department upon request.

j. Each Subcommittee Chair shall submit in writing, its Subcommittee's recommendations, decisions and actions to PHSA's Corporate Medical Affairs Department as soon as possible, but at least two (2) weeks prior to the next upcoming HAMAC meeting for inclusion in the meeting package.

k. All quality assurance and quality improvement reports, and other documents prepared regarding standards of care and professional practice designated under the Hospital Act, created by or for

the HAMAC and their Subcommittees, shall be marked "For quality assurance and improvement purposes only – Protected under Section 51 of the BC Evidence Act." These documents shall be prepared in accordance with all appropriate Section 51 requirements.

l. Upon approval of the Subcommittee Chair, Subcommittee members may seek the confidential advice of any Medical Staff member or other staff member as required to fulfil the mandate and duties of the Subcommittee. The Subcommittee Chair has the sole authority to authorize this advice after assuring the HAMAC Chair that no legislative or confidentiality requirements shall be breached through this process.

m. All recorded communications among the HAMAC and its Sub-Committees, and with other committees or persons engaged in the business of the HAMAC, and which relate to patient care provided at PHSA Facilities and Programs designated under the Hospital Act, shall also be marked "For Quality Assurance and Improvement Purposes Only – Protected under Section 51 of the BC Evidence Act".

n. All Subcommittee meetings shall be conducted in compliance with the latest published version of Robert's Rules of Order.

## 8.11 HAMAC Medical Staff Rules Review Subcommittee

**8.11.1** Purpose:

i. This Committee will be struck by the HAMAC and the Senior Medical Administrator as the need arises (at least every three years) for review of the Rules.
ii. This Committee will recommend edits of the Rules to the HAMAC and make recommendations regarding Medical Staff compliance with the Rules.
iii. HAMAC will recommend edits to the Board for consideration.

**8.11.2** Duties:

i. Make recommendations regarding the Medical Staff Bylaws and Rules to the HAMAC.
ii. To review sections of the Medical Staff Bylaws and Rules at the request of the HAMAC or Department(s) and/or Programs.

**8.11.3** Operating protocols:

i. A simple majority shall constitute a quorum.

ii. PHSA's Corporate Medical Affairs Department shall provide administrative support to the Subcommittee.

## 8.12 HAMAC Standing Subcommittees: Local Medical Advisory Committees (LMACs)

The Local Medical Advisory Committees (LMACs) are appointed by the Board of Directors. The LMAC may establish subcommittees with clearly defined functions and reporting to the LMAC (see Article 8.12.3 of the Rules). Quality Assurance reports and documents generated by these committees shall be marked for quality assurance purposes only and shall be prepared in accordance with section 51 of the Evidence Act as appropriate. All written (paper or electronic) communications between the committees and other persons or committees shall be identified specifically as being for the purpose of the committees involved. All committee meetings shall be conducted according to Robert's Rules of Order (newly revised).

### 8.12.1 LMAC Purpose:

To act as a medical resource, provide advice, and report to the HAMAC and the Board of Directors through the Chair of LMAC and the Senior Medical Administrator on:

i. All matters of a medical nature including organizational, clinical, educational and research activities.
ii. The monitoring of the quality, quantity, effectiveness, and sufficiency of medical care provided
iii. The quality of care delivered to patients free of Indigenous-specific racism and other forms of racism and discrimination.
iv. The continuing education of the members of the Medical Staff, research and teaching issues at the Program.
v. The maintenance of professional standards by members of the Medical Staff.
vi. The conduct of the Medical Staff.
vii. Disciplinary and remedial matters relating to Medical Staff.

### 8.12.2 Composition (see Appendix A for composition at the different Programs)

Members of the LMAC shall include, but not be limited to:

i. Chair
ii. Vice Chair
iii. Chair, Safety and Quality of Medical Care Committee(s)
iv. Administrative and Medical Staff as designated by the Program
v. President, Medical Staff Association

vi. Senior Medical Administrator
    a. All voting LMAC members shall attend all meetings of the LMAC. Repeated failure by voting members to meet attendance requirements (less than 80 per cent of meetings) will result in a review of membership.
    b. Regular attendees shall designate delegates to attend in the event of their absence. The designate shall be announced before each meeting. The designate must come prepared for meetings and have sufficient information to be able to participate in discussions.
    c. The term of appointment of each LMAC member is recommended to be a two-year (2) term, unless fixed by other role appointments.
    d. Medical Staff President will inform the LMAC regarding Medical Staff Association issues.

8.12.3 Duties related to Patient Care:

i. To receive, study and act upon reports from Department Heads, departments, programs, and committees concerning the review, analysis and evaluation of clinical practices of the Medical Staff to determine the quality of care delivered to patients.
ii. To ensure medical practice standards are developed and adhered to by all medical Departments, and that the outcomes of surveillance systems regarding the quality of medical care are directed towards its continuing improvement.
iii. To liaise with other health care providers as required to ensure a high quality of care is delivered to patients.
iv. To make recommendations regarding Medical Staff resource requirements to meet the medical needs of patients in the Program, either as a committee of the whole, or as a properly constituted human resource planning committee.

8.12.4 Administration:

i. To appoint chairs and members of standing committees, in consultation with the Medical Staff, and to ensure that these committees' function effectively.
ii. To make recommendations to the HAMAC and Board of Directors on the development, maintenance, and updating of these Rules.
iii. To submit recommendations to the HAMAC and Board of Directors concerning appointments, reappointment, evaluations and review of Medical Staff members and delineation of specific clinical and procedural privileges.
iv. To monitor and report to the Program Senior Operational Administrator(s), HAMAC and Board of Directors on the maintenance of the professional standards and conduct of the Medical Staff and where appropriate to take action to address deficiencies.
v. To report to the Senior Medical Administrator, the Program Senior Operational Administrator(s), the HAMAC, and Board of Directors on disciplinary measures to be applied to members of the

Medical Staff following violation of the provisions contained in the Medical Staff Bylaws, Medical Staff Rules, or Program Policies/Procedures.

vi. To monitor the professional and ethical conduct of all members of the Medical Staff and to report any concerns to the LMAC, HAMAC and to the Board of Directors when required.

vii. To perform rregular self-evaluations to ensure the LMAC is fulfilling its mandate.

8.12.5 Academic

To receive, study, and act upon reports regarding education, research, and continuing education of members of the Medical Staff, and research and teaching in the Program.

## 8.13 LMAC Chair

i. The term of office of the LMAC Chair shall be not more than three (3) years, and may be reappointed for up to three (3) consecutive terms.

ii. The Chair of the LMAC shall be appointed by the Board of Directors upon recommendation of the HAMAC. The nominee for the Chair of LMAC will be selected by the LMAC or the Nomination Committee on behalf of LMAC and brought to the HAMAC for confirmation.

iii. The LMAC Chair shall have the authority to invite any Medical Staff member or anyone of the Program or any other party to attend for specific agenda items as a non-voting participant.

iv. The LMAC Chair or their designate is responsible for attending the HAMAC and/or Board of Directors Quality and Safety Committee meetings and presenting a report of the committee's activities as requested.

## 8.14 LMAC Vice-Chair

i. The Vice Chair of the LMAC shall be appointed by the HAMAC and shared with the Board for information. The nominee for the Vice Chair of LMAC will be selected by the LMAC or the Nomination Committee on behalf of LMAC and brought to the HAMAC for formal appointment.

ii. The term of office of the LMAC Vice-Chair shall be not more than three (3) years. The LMAC Vice-Chair will serve with a view to becoming the LMAC Chair once the term of the LMAC Chair has concluded.

## 8.15 LMAC Operational protocols

i. A simple majority of voting members shall constitute a quorum.

ii. Meetings shall be held monthly or at the call of the Chair. A minimum of 10 meetings shall be held each year.
iii. An executive of the LMAC will be determined by the LMAC. The LMAC executive will have the authority to act on urgent issues when a full LMAC meeting is not feasible. The LMAC executive will report to the LMAC on actions or decisions that are made.
iv. The minutes, agenda and other documentation of the Committee are maintained by the Corporate Medical Affairs Team (where applicable).

## 8.16 LMAC Authority

**8.16.1** The LMAC has the authority:

i. To ensure compliance of Medical Staff members with the Hospital Act and Regulations, Medical Staff Bylaws, Medical Staff Rules and policies of the Medical Staff and the Health Authority.
ii. To appoint Subcommittees of the LMAC.
iii. To exercise discipline or remedial action within and up to the limitations of authority delegated by the Board of Directors on any of its members, including issuing reprimands.
iv. To require any member of the Medical Staff to appear before it whenever necessary to carry out its responsibilities.

**8.16.2** Recommendations

The LMAC has the authority to make recommendations concerning:

i. Supervision of clinical practice.
ii. Establishment and maintenance of professional standards and conduct within the Program.
iii. Continuing improvement in the quality of care delivered to patients, including resource allocation.
iv. The provincial mandate, and research and academic activities within the Program.
v. Restriction, modification, suspension, revocation, non-renewal, or maintenance of a Medical Staff member's appointment or privileges, or other disciplinary action as may be appropriate.

**8.16.3** Evaluation

The LMAC shall conduct a self-evaluation annually to determine if it is fulfilling its mandate. The process for the evaluation will be determined by the LMAC.

**8.16.4** Standing Subcommittees of the LMAC:

If appropriate, the LMAC has the option to form Subcommittees that report directly to the LMAC and to the corresponding HAMAC Subcommittees (as applicable). They may include:

a. Credentials and Medical Staff Human Resource Planning Committee (Article 8.19).
b. Nominations Committee (Article 8.20).
c. Safety and Quality of Care Committee(s) (Article 8.21).
d. Health Records Committee (Article 8.22).
e. Infection Control Committee (Article 8.23).
f. Mortality Review Committee (Article 8.24).

## 8.17 LMAC Subcommittee: Credentials and Medical Staff Human Resource Planning

**8.17.1** Purpose:

i. Make recommendations regarding the Appointment, reappointment, review and delineation of privileges for all Medical Staff Association members, including those applying to or belonging to the scientific and research staff.
ii. Receive and review Department Heads' reports on the professional qualifications, standards of care and professional conduct of their staff, and make corresponding recommendations to the LMAC based on those findings.
iii. Receive reports from Department or Program Heads, and make recommendations to the LMAC and HAMAC (as required) regarding corresponding human resource planning and requirements.
iv. Make recommendations to the Bylaws and Rules Subcommittee regarding changes to policies and procedures related to Credentialing and Privileging.

**8.17.2** Composition:

The Subcommittee may consist of:

i. Three Medical Staff Association members, representing all major clinical disciplines and specialties.
ii. A University of British Columbia representative, who may be an existing member.
iii. A representative of the medical administration appointed by the Senior Medical Administrator.

**8.17.3** Duties:

i. Make recommendations regarding appointing or reappointing Department or Division Heads to the LMAC.
ii. Recommend clinical and procedural privileges for each Medical Staff applicant or member, based on assessments made by the Department, Program or Division Heads.
iii. Make recommendations regarding all applications for the modification of privileges.

iv. Make recommendations to the LMAC concerning the Credentialing process for all PHSA Departments and Programs. This process requires the Active involvement of the appropriate Department or Program Head.

8.17.4 Operating protocols:

i. A simple majority shall constitute a quorum.
ii. The Subcommittee shall meet 10 times per year, and at the call of the Chair for urgent matters, unless otherwise specified in each Subcommittee's operating protocols, as outlined in these Rules.
iii. The Corporate Medical Affairs Department shall receive and maintain the agenda, minutes and all other Subcommittee documentation.
iv. Minutes shall be taken at each meeting.
v. All Credentialing and Privileging files shall be secured in accordance with the requirements of the Freedom of Information and Protection of Privacy Act and, where applicable, Section 46(6) of the Hospital Act.[4]
vi. The Subcommittee shall submit its recommendations, decisions and actions to the LMAC in writing.
vii. The Subcommittee shall obtain the advice from the Department Head, if clarification is required regarding the assessment of an applicant's qualifications, and the delineation of an applicant's privileges.

8.17.5 Evaluation

The Credentials and Medical Staff Human Resource Planning Subcommittee shall conduct a self-evaluation at least biannually.

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[4] *Hospital Act,* [RSBC 1996] Chapter 200, Section 46(6): All information or evidence (a) about an application for a Practitioner's permit to practice in a hospital, or contained in the decision of a Board of management resulting from the application, or (b) received by, or presented to, a hospital appeal Board for an appeal is Privileged and an action must not be brought against a person for it.

## 8.18 LMAC Subcommittee: Nominations

### 8.18.1 Purpose

The Nominations Subcommittee shall:

i. Make recommendations to the LMAC or HAMAC regarding the Appointment of the LMAC or HAMAC Chair and Vice-Chair.
ii. Make rrecommendations regarding the Appointment of other LMAC or HAMAC Committee members when requested to do so by the LMAC or HAMAC.

### 8.18.2 Composition

The Subcommittee may consist of:

i. The President of PHSA, MSA, or in the absence of a Health Authority-wide MSA, a representative from the Facility and Program MSA's.
ii. Six (6) other LMAC or HAMAC voting members.
iii. Two (2) Medical Staff members.
iv. Senior Medical Administrator (or delegate).

### 8.18.3 Duties

i. Clarify the roles and responsibilities of the position and ensure that potential candidates are aware of them.
ii. Seek broad input from PHSA Medical Staff concerning potential candidates.
iii. Establish a list of potential candidates for the vacant position.
iv. Review qualifications of potential candidates.
v. Rank potential candidates and create a shortlist.
vi. Interview shortlisted candidates.
vii. Recommend selected candidate(s) to the LMAC or HAMAC for ratification.

### 8.18.4 Operating protocols

i. The Nominations Subcommittee shall meet as necessary, at the call of the Chair.
ii. LMAC or HAMAC shall appoint members to the Subcommittee, making every effort to ensure cross-Facility representation.
iii. Medical Staff members appointed to the Subcommittee shall be appointed by the MSA President, or in the absence of a Health Authority-wide MSA, a representative from the Facility and Program MSAs. The Subcommittee shall make every effort to ensure cross-Facility representation.

### 8.18.5 Evaluation

The Nominations Subcommittee should conduct a self-evaluation at least biannually, provided the Subcommittee has met.

## 8.19 LMAC Subcommittee: Safety and Quality of Medical Care

### 8.19.1 Purpose

The Safety and Quality Subcommittee shall:

i. Monitor and report on the quality of clinical care provided within PHSA Facilities and Programs.
ii. Socialize awareness of quality-of-care issues within PHSA Facilities and Programs.
iii. Support and create a PHSA-wide culture of safety by raising Medical Staff awareness of patient and safety issues.
iv. Recommend initiation of CQI projects in areas of identified need, using established CQI tools and models for improvement.
v. Promote an integrated, patient-centred clinical care model within PHSA Facilities and Programs.
vi. Establish Facility or Program satellite-Subcommittees and provide them with oversight and direction.

### 8.19.2 Composition

The Subcommittee may consist of:

i. PHSA Medical Staff representative of Facilities and Programs.
ii. A member of the Department of Quality, Safety and Risk Management.
iii. Other members as the LMAC or HAMAC may recommend.

### 8.19.3 Duties

The Subcommittee shall:

i. Make recommendations on the quality of clinical care provided in PHSA Facilities, Programs and Departments.
ii. Recommend quality assurance and CQI initiatives to address the provision of better patient care and health care delivery.
iii. Advise on the development and establishment of clinical quality, utilization and risk-management indicators, for use in PHSA Facilities, Departments and Programs.
iv. Report regularly to the LMAC or HAMAC regarding clinical quality and utilization data, including performance indicators, scorecards, dashboards and reports, and recommend corrective action when necessary.
v. Ensure processes exist to review quality of care issues in all Facilities, Departments and Programs; and make recommendations to the LMAC or HAMAC to address deficiencies, as required.

vi. Make recommendations to the LMAC or HAMAC regarding the investigation into Department / Program morbidity and mortality statistics, whenever outliers are noted.
vii. Establish and maintain effective reporting relationships between the Quality of Care and Safety Subcommittee, its satellite Subcommittees, and all Department and Program Quality Committees.
viii. Receive and review reports from the Infection Control Subcommittee, Mortality Subcommittee, Health Records Subcommittee, and the Priorities and Evaluation Subcommittee; make recommendations to the LMAC or HAMAC, as required.

#### 8.19.4 Operating protocols

i. The Committee(s) shall meet at least 10 times per year, and at the call of the Chair.
ii. The Department of Quality, Safety and Risk Management shall provide secretariat support to the Subcommittee.
iii. The Department of Quality, Safety and Risk Management shall maintain the agenda, minutes and other documentation related to the work of the Subcommittee.

#### 8.19.5 Evaluation

The Safety and Quality of Care Subcommittee shall conduct a self-evaluation at least biannually.

## 8.20 LMAC Subcommittee: Health Records

#### 8.20.1 Purpose

i. Ensure the overall quality of, and appropriate access to, the Health Record, to improve the provision of excellent patient care.
ii. Make specific recommendations to the LMAC on improving the quality of the Health Record.

#### 8.20.2 Composition

The Subcommittee may consist of:

i. Medical Staff members representative of PHSA’s Facilities and Programs.
ii. Nursing Staff and allied health staff representation.
iii. A representative from the Department of Risk Management.
iv. The manager of the Department of Health Information Management (or delegate).
v. Members of the Health Record Subcommittee shall be appointed by the LMAC after receiving advice from the applicable Department Head, Division Head, or Vice President.
vi. Membership shall include representation from as many Medical Staff Specialties as possible, including Nursing and Midwifery.

8.20.3 Duties

The Subcommittee shall:

a. Make recommendations to the LMAC regarding:
   - Policies that facilitate appropriate access to, and storage of, the Health Record while ensuring compliance with FOIPPA legislation.
   - Policies that are consistent with promoting excellent patient care.
   - Policies for expedited Medical Staff completion of the Health Record.
   - Regular maintenance, review and revisions of PHSA policies concerning the Health Record.
   - Processes for quality assurance assessment of the Health Record.
   - Planning, implementing, studying, reviewing and revising Health Record documentation to promote the continuous improvement of patient care.
   - The approval of forms for inclusion in the Health Record.
   - Standards and procedures for creating an Electronic Health Record.

b. Make recommendations on policies regarding Medical Staff completion of incomplete Health Records.
c. To receive, review and make recommendations on results of audits completed by PHSA Health Information Management.
d. To solicit end-user feedback on Health Records and consider that feedback in fulfilling responsibilities of the Subcommittee.
e. To develop a future vision for Health Records that ensures its migration to an EHR.

8.20.4 Operating protocols

a. The Health Record Subcommittee shall meet at least nine times per year, and at the call of the Chair.
b. Adopted minutes, together with meeting attachments, shall be submitted in written and electronic formats to the Quality, Safety and Risk Management Department, in both electronic and paper formats, within seven (7) days of adoption.

8.20.5 Evaluation

The Health Record Subcommittee shall conduct a self-evaluation at least biannually.

## 8.21 LMAC Subcommittee: Infection Control

8.22.1 Purpose

To ensure the safest environment that is practical for the patients, family, visitors and staff of the hospital in all situations involving the transfer of infectious agents.

8.22.2 Composition

a. The Infection Control Committee shall consist of at least five (5) members, including but not restricted to:
   i. Representation from the main medical discipline from the Medical Staff including a member of the Division of Infectious Diseases or equivalent
   ii. Senior Infection Control Nurse
   iii. Infection Control Officer
   iv. Representation from Microbiology
   v. Representation from Nursing
   vi. Representation from Occupational Health and Safety
   vii. Representation from Administration
   viii. Representation from Pharmacy
   ix. Representation from Quality, Safety and Risk Management
   x. Representation from Obstetrics
   xi. Representation from Adult Infectious Disease / Medicine

b. The Chair shall be appointed by the LMAC for a two (2) year renewable term. The Chair will report to the LMAC.
c. All members of the Infection Control Committee shall be appointed for a two (2) year term and all members are voting members.
d. Regular attendees can designate delegates to attend in the event of their absence. Delegates may attend at the discretion of the Chair.
e. A Vice-Chair shall be appointed for a two (2) year term, to serve in the absence of the Chair. In the selection of the Vice-Chair, consideration should be given to the multidisciplinary nature of the programs within the Facility.

8.22.3 Duties:

a. To formulate policies for the maintenance of the safest environment that is practical for the patients, family, visitors and staff of the hospital in all situations involving the possible transfer of infectious agents.
b. To review and approve systems for reporting, evaluating and recording infection statistics developed by the infection control service.
c. To conduct any business delegated by the LMAC.

8.22.4 Operational protocol:

a. A simple majority shall constitute a quorum.
b. The Infection Control Committee shall usually meet monthly, but a minimum of eight (8) times per year, at the call of the Chair.
c. Minutes and an agenda will be circulated to each member of the Committee at least five (5) working days (1 week) before each meeting. Adjusted minutes will be taken at each meeting. An adjustor will be elected from the attendees at each meeting to ensure accuracy of minutes before they are distributed to the group.
d. All action items are to be brought forward at subsequent meetings. It is the responsibility of the secretary of the Committee to maintain an action log. It is the responsibility of the Chair to ensure follow-up takes place for all action items.
e. Administrative support will be provided by the Quality and Safety & Risk Management.

8.22.5 Documentation protocol:

a. Documents prepared for the Committee and at the request of the Committee are protected under Section 51 of the Evidence Act.
b. The maintenance of minutes, agenda and other documentation related to the Committee is the responsibility of the Committee Chair. The original minutes, agenda and other documentation of the Committee are maintained in the Department of Quality, Safety and Risk Management.
c. Minutes of the Committee are submitted to the Chair of the LMAC and the Senior Medical Administrator. Motions, recommendations, actions, and decisions are presented by the Chair to the LMAC as necessary.

8.22.6 Accountability:

a. The Infection Control Committee shall be accountable to and report to the LMAC. The Infection Control Committee shall advise the Senior Medical Administrator of these Facilities of critical concerns.
b. The Committee will be responsive to specific requests from the LMAC for information related to the quality of patient care.

8.22.7 Authority

The Infection Control Committee has the authority to:

a. Advise the LMAC regarding Infection Control Policy updates as established by the Infection Control Committee.

b. Formulate policies for the maintenance of the safest environment that is practical for the patients, family, visitors and staff of the hospital in all situations involving the possible transfer of infectious agents and shall review regularly the effectiveness of these policies.
c. Make changes to the terms of reference of the committee, which must be reviewed and approved by the LMAC, and when appropriate by the HAMAC and Board of Directors.

### 8.22.8 Evaluation

The Infection Control Committee will ensure a self-evaluation consistent with the standards and requirements of the LMAC. This will be done individually on an annual basis.

## 8.22 LMAC Subcommittee: Mortality Review

### 8.22.1 Purpose

To ensure that the mortality review process is functioning thoroughly and in a timely manner. To review the mortality reports of Departments to identify similarities in cause, pathogenesis and/or therapy that may require evaluation. To review the activity of the Code Blue Team related to cardiac resuscitation to identify issues and concerns.

### 8.22.2 Composition

a. Membership will include:
    i. Chairs of Safety and Quality of Medical Care Committee(s)
    ii. Four (4) Medical Staff representatives
    iii. Nursing Administration representative
    iv. Risk Management representative
    v. Decision Support Services representative (non-voting member)
    vi. Representative from the Code Blue Committee (ad hoc member)

b. All members are voting members.
c. Ad hoc members will attend the Mortality Review Committee meetings if cases relevant to their population mandate areas are being reviewed, or at the request of the Chair.
d. Representative members are appointed for two-year (2) terms by their Department Head or Senior Medical Administrator.
e. The Chair shall be appointed for a two-year (2) term by the Chair of the LMAC.
f. Regular attendees can designate delegates to attend in the event of their absence. Delegates may attend at the discretion of the Chair.

8.22.3 Duties

a. To ensure that the mortality review process is functioning thoroughly and in a timely manner.
b. To review the minutes of the committees reviewing all deaths occurring in the facility, outpatient clinics and emergency department.
c. To review all cardiac arrests occurring in the Facility through report by the Code Blue Committee.
d. To survey all deaths for similarities in cause, pathogenesis and/or therapy that may require evaluation.
e. To provide a full review of any death when requested by an individual mortality review committee, the LMAC, or Safety and Quality of Medical Care Committee(s).
f. To follow-up and report on the enactment of its recommendations for all cases investigated, including Coroner's cases.
g. To bring forward to the Safety and Quality of Medical Care Committee(s), LMAC, Program Executive and Board of Directors confirmation that complete mortality reviews are occurring in a timely manner and that actions are taken appropriately.
h. To liaise with the public relations department on matters of a general concern to the community.

8.22.4 Operational protocol

a. A simple majority shall constitute a quorum.
b. The Mortality Review Committee shall meet 10 times per year, or at the call of the Chair.
c. All action items are to be brought forward at subsequent meetings. It is the responsibility of the secretary of the Committee to keep a bring-forward list. It is the responsibility of the Chair to ensure follow-up takes place for all action items.
d. Minutes and an agenda will be circulated to each member of the Committee at least five (5) working days (1 week) before each meeting. Minutes will be taken at each meeting.
e. The Mortality Review Committee shall receive and review reports from departmental/ program mortality committees. The Chair or alternate of the Mortality Review Committee may attend any departmental/program mortality committees or other quality assurance committees where a mortality is being reviewed, as deemed necessary.

8.22.5 Documentation protocol

a. Documents prepared for the Committee and at the request of the Committee are for quality assurance purposes and are protected under Section 51 of the Evidence Act.
b. The maintenance of minutes, agenda and other documentation related to the Committee is the responsibility of the Committee Chair. The original minutes, agenda and other documentation of the Committee are maintained in the Department of Quality, Safety and Risk Management.

c. Minutes of the Committee are submitted to the Chair of the LMAC and the Senior Medical Administrator. Motions, recommendations, actions and decisions are presented by the Chair to the LMAC as necessary.

8.22.6 Accountability and reporting relationships

a. The Mortality Review Committee shall be accountable to the LMAC. The Committee will report to the Safety and Quality of Medical Care Committee(s) at least three (3) times a year.
b. The Committee will be responsive to specific requests from the LMAC for information related to the quality of patient care.

8.22.7 Authority

a. The Mortality Review Committee has the authority to review the minutes of the Departments or the Department committees reviewing all deaths occurring in the hospital, outpatient clinics and emergency department.
b. The Committee has the authority to follow-up and report on the enactment of its recommendations for all cases investigated, including Coroner's cases.
c. Changes to the terms of reference of the Committee must be reviewed and approved by the LMAC and when appropriate, by the HAMAC and Board of Directors.

8.22.8 Evaluation

The Mortality Review Committee will ensure a self-evaluation consistent with the standards and requirements of the LMAC.

# Article 9 — DISCIPLINE AND APPEAL

The specific processes and procedures concerning Medical Staff discipline and appeal are outlined in Article 11 of the Medical Staff Bylaws. Article 11.4.5 of the Bylaws and Article 9.1.2 of the Rules shall apply only to Medical Staff working at a PHSA Facility or Program designated under the Hospital Act.

## 9.1 General considerations

**9.1.1** Medical Staff members shall be informed, in writing and in a timely fashion, of any complaints or concerns involving their clinical care or professional behaviour.

**9.1.2** Where the Board refuses, restricts, modifies, suspends or revokes the privileges of a member of the Medical Staff, the Medical Staff member has the right to appeal to the Hospital Appeal Board as per the Hospital Act and its Regulation.[5]

## 9.2 Managing Unprofessional Behaviour or failure to meet standards of care: Process overview

**9.2.1** When appearing at a formal meeting with the Health Authority regarding respectful workplace and/or disciplinary matters, the Medical staff member shall be informed in advance of their option to have one of the following attend as a support person: a colleague from the Medical Staff, and advocate from their professional association (e.g. Doctors of BC, MABC), legal counsel provided by their insurer (e.g. CMPA, CNPS, MPP), and/or an Elder or Knowledge Keeper.

**9.2.2** Wherever possible, minor behavioural incidents should be dealt with by respectful discussions between or among Medical Staff members before the issue is escalated to a Stage 1 or higher intervention. If the issues are resolved at this point, and there is no recurrence, further action is not required. Documentation may be completed at the discretion of either party involved, but shall be completed in the case of recurrent behaviour. This documentation shall not be placed in the Medical Staff member's Credentialing file unless the issue is escalated to a Stage 1 or higher intervention.

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[5] Section 46, *Hospital Act*, [RCBC 1996] Chapter 200, Hospital Appeal Boards - https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96200_01

9.2.3 The Department Head shall advise the Senior Facility or Program Medical Administrator, the PHSA Senior Nursing Administrator (if applicable), and the PHSA Senior Medical Administrator of any Stage 1, 2 or 3 interventions. Escalation of interventions to level 1, 2, or 3 shall occur only after discussion with the Senior Facility or Program Medical Administrator and the PHSA Senior Nursing Administrator (if applicable), unless immediate action is required (see Article 9.3.4). If there is disagreement with the level of intervention, the LMAC or the HAMAC shall be asked to review the circumstances and make a recommendation.

9.2.4 Interventions have the goal of remediation, and shall generally follow a staged approach, as outlined in Article 9.3, below. These interventions shall be documented in the member's Credentialing file.

a. Stage 1: This stage is warranted for complaints or concerns perceived as being of low severity, and which seek to address Unprofessional Behaviour that cannot be resolved informally, or where Unprofessional Behaviour appears to be part of a recurring pattern. The Division Head, Department Head, Senior Site Medical Administrator, or the Senior Site Nursing Administrator (if applicable), shall organize a formal meeting(s) with the Medical Staff member. At their discretion, the responsible Medical Staff leader may consult with other medical-staff leaders during this process.

b. Stage 2: This stage of intervention is warranted for complaints or concerns that are of moderate severity, or where a Stage 1 intervention has been ineffective. The Division Head or Department Head shall organize a formal meeting(s) with the Medical Staff member. At the medical-staff leader's discretion, consultation with other medical-staff leaders may be appropriate. The process for management of Stage 2 discipline is outlined in Article 9.3.2 of these Rules. The medical-staff leader shall notify the member that another incident could result in a Stage 3 intervention. The Medical Staff leader shall provide a written copy of the documentation to the Medical Staff member and retain a copy on the Medical Staff member's Credentialing file. Where the Medical Staff member does not agree with the findings or remedial plan, the Medical Staff member may appeal within 30 days to the Senior Site Medical Administrator and the Senior Site Nursing Administrator (if applicable), for review. If the Medical Staff member disagrees with the Senior Site Medical Administrators' recommendations, the matter shall be brought before the LMAC for a full review and recommendations.

c. Stage 3: This stage of intervention is reserved for significant Unprofessional Behaviour, or for serious clinical concerns that persist despite a Stage 2 intervention. This will automatically result

in referral to the LMAC to determine further action. When appropriate, the LMAC will escalate and refer reviews to the HAMAC.

d. Crisis Intervention: This stage of intervention is reserved for behaviour or clinical concerns where immediate action is required to prevent harm or potential harm to patients, staff, Medical Staff or the public.

e. Documentation of Stage 1, 2, 3 and Crisis Interventions shall remain in the Medical Staff member's Credentialing file permanently. The Medical Staff member has the right to review this file. Any retributive behaviour by a Medical Staff member against a complainant shall result in immediate escalation of the disciplinary process.

## 9.3 Uniform approach for managing Unprofessional Behaviour and concerns about clinical competence or failure to meet appropriate standards of care

**9.3.1** Stage 1 intervention:

In order to determine whether the complaint or concern has validity and intervention is warranted, the Division Head, Department Head, Senior Facility or Program Medical Administrator, or PHSA Senior Nursing Administrator (if applicable), shall:

i. Meet with the Medical Staff member involved to describe the alleged incident and review any relevant documents or patient charts.
ii. Provide the Medical Staff member with an opportunity to describe events from their perspective.
iii. Describe to the Medical Staff member how others have interpreted or received their behaviour.
iv. Offer advice, guidance, and information on how to access support resources.
v. Following discussion with the Medical Staff member, determine the format and substance of an appropriate resolution, including a response to the complainant.
vi. Prepare the summary documentation of steps I to V.
vii. This process should be completed within four (4) weeks of receiving the complaint or concern.

**9.3.2** Stage 2 intervention:

The Division Head, Department Head, Senior Facility or Program Medical Administrator, or the PHSA Senior Nursing Administrator (if applicable), shall follow the process set forth under Stage 1 Intervention. The Division Head, Department Head, Senior Facility or Program Medical Administrator,

and the PHSA Senior Nursing Administrator (if applicable), shall then work with the Medical Staff member to develop a remediation plan which shall include the following:

i. Method of redress, which may include but is not limited to, education, coaching, counselling, practice supervision, or supervision of practice in another Program with regular reports submitted to the Department Head. At this time, the Medical Staff leader may suggest psychological or other medical testing; suggest substance use therapy; leadership training; written project or tutorial sessions, including referral of the Medical Staff member to an external resource such as a Practitioner Health Program.
ii. A method of monitoring for improvement.
iii. A description of behaviour benchmarks to be assessed for future action.
iv. The time frame within which progress must be demonstrated.
v. The consequences for failure to meet the terms of the remediation plan.

a. The Medical Staff leader and the Medical Staff member shall attempt to reach mutual agreement on the remediation plan. If mutual agreement is not reached within 30 days from the time the Medical Staff leader presents a remediation plan to the Medical Staff member, the Medical Staff leader shall finalize and document the remediation plan, considering feedback provided by the Medical Staff member. The Medical Staff leader will then provide a revised copy of the plan to the Medical Staff member.

b. Failure of the Medical Staff member to meet the terms of the finalized remediation plan shall be grounds for a review by the LMAC. When appropriate, the LMAC will escalate and refer to the HAMAC for review.

c. In the case of clinical concerns, an external review may be obtained, and appropriate remediation shall be considered based on the findings of the review, if feasible.

d. Where a complaint or concern is determined to be substantiated, the Division Head, Department Head, the Senior Facility or Program Medical Administrator, or the PHSA Senior Nursing Administrator (if applicable), shall notify the Medical Staff member in writing that another substantiated incident shall result in review by the LMAC. When appropriate, the LMAC will escalate and refer the matter to the HAMAC. The HAMAC may recommend cancellation, suspension, modification or restriction of the member's privileges.

**9.3.3** Stage 3 intervention:
The Department Head together with the Senior Site Medical Administrator shall involve PHSA's Senior

Medical Administrator, PHSA's Senior Nursing Administrator (if applicable), and the LMAC Chair as soon as the need for a Stage 3 intervention is identified.

a. The Senior Medical Administrator and the Senior Nursing Administrator (if applicable), and the LMAC Chair shall schedule a review of the complaint or concern by the LMAC as soon as conveniently possible. Legal advice should be considered. The Senior Medical Administrator and the Senior Nursing Administrator (if applicable) is responsible to initiate and oversee Stage 3 investigations.
b. The Senior Medical Administrator shall consider conducting an external review to aid in fact-finding and appropriate recommendations at this point.
c. The LMAC shall:
    i. Review the behavioural and/or clinical-care history of the Medical Staff member.
    ii. If appropriate, recommend other rehabilitation strategies or disciplinary action.
    iii. Consider ddisciplinary action including, but not limited to:
        - Modification, suspension, revocation, or refusal to renew a Medical Staff member's Privileges and Appointments to practice within PHSA Facilities and Programs.
        - Setting other conditions that the LMAC deems appropriate.
d. When appropriate, the LMAC will escalate and refer the matter to the HAMAC. The HAMAC may recommend cancellation, suspension, modification or restriction of the member's privileges, in accordance with the Bylaws.

9.3.4 Crisis intervention:

Where behaviour is too egregious, or care is deemed too unsafe to warrant a staged intervention, the Division Head, Department Head, or the Senior Facility or Program Medical Administrator shall request the Senior Medical Administrator (or delegate), and the Senior Nursing Administrator (or delegate), as applicable, to consider summary suspension of privileges as per Article 11.2.1 of the Bylaws. The Bylaws also authorize the CEO to summarily suspend a Medical Staff member. Where the PHSA Senior Medical Administrator or the PHSA Senior Nursing Administrator (if applicable), or CEO is not immediately available, any medical-staff leader has the authority to summarily suspend the member, and shall notify the Senior Medical Administrator or Senior Nursing Administrator (if applicable), or CEO verbally and in writing of the suspension as soon as circumstances permit, but no later than 24 hours after the suspension has occurred.

a. A LMAC hearing will be held within 14 days to review the appropriateness of the summary suspension, unless otherwise agreed by the Medical Staff member or member's legal counsel.
b. The Department Head shall assign the suspended Medical Staff member's clinical duties to other appropriate Department members during the time the member's privileges are suspended. The

LMAC Chair will refer the LMAC recommendation to the HAMAC Chair, for recommendation of the HAMAC pursuant to Article 11.2.1 of the Bylaws.

## Article 10 — AMENDMENTS

The Bylaws and Rules Subcommittee shall review the Medical Staff Rules (at least) every three (3) years and revise as necessary. The Subcommittee shall date the revised Rules accordingly, and submit them through the HAMAC to the Board for approval.

The Board has the authority to approve the amended Rules after receiving advice from the HAMAC.

A member of the Medical Staff, the LMACs, the Bylaws and Rules Subcommittee, the HAMAC, or the Board may request amendments to these Rules.

Provincial Health Services Authority

## Article 11 — APPROVAL OF RULES

These Rules come into effect when approved by the PHSA Board of Directors.

THIS IS TO CERTIFY:

The Medical Staff Rules of the Provincial Health Services Authority were adopted by the Board of Directors on:

Date______________________________

Signatories:

______________________________

Chair, Board of Directors, PHSA

______________________________

President & CEO, PHSA

______________________________

Vice President Medical and Academic Affairs, PHSA

______________________________

Chair, PHSA HAMAC

# Appendix A: Composition of PHSA LOCAL MEDICAL ADVISORY COMMITTEES

## BC Cancer

Voting members

1. Chair, Medical Advisory Committee
2. Vice-Chair, Medical Advisory Committee
3. Past Chair, Medical Advisory Committee
4. President, Local Medical Staff Association
5. Executive Medical Directors (or delegates)
6. Provincial Leads for:
   - Diagnostic Imaging
   - Functional Imaging
   - Medical Oncology
   - Oral Oncology
   - Pain and Symptom Management
   - Pathology and Laboratory
   - Psychiatry
   - Radiation Oncology
   - Supportive Cancer Care
   - Surgical Oncology
     1. Head, Department of Nurse Practitioners.
     2. One elected representative of the Medical Staff from each Cancer Centre.
     3. Four members elected from the Medical Staff to ensure Medical, Radiation, GP Oncology, and one other specialty are represented.

Non-voting members

7. Chief Medical Officer
8. Chief Operating Officer
9. Senior Nursing Administrator, or delegate
10. Senior Executive Director of Operations
11. Senior Executive Director of Clinical Programs
12. Senior Executive Director, Medical Affairs and Quality
13. Director of Risk Management (as required)

## BC Children’s Hospital and BC Women’s Hospital + Health Centre

Voting members

1. Chair, Local Medical Advisory Committee
2. Vice-Chair, Local Medical Advisory Committee
3. President, Local Medical Staff Association
4. Head, Department of Pediatric Anesthesia
5. Head, Department of Obstetric Anesthesia
6. Head, Department of Family Practice
7. Head, Department of Medical Genetics
8. Head, Department of Medicine
9. Head, Department of Midwifery
10. Head, Department of Obstetrics & Gynecology
11. Head, Department of Pediatrics
12. Representative, Department of Pediatrics (appointed by Department Head)
13. Head, Department of Pathology
14. Head, Department of Psychiatry
15. Head, Department of Radiology
16. Chief, Department of Pediatric Surgery (to include Dentistry, Ophthalmology and Orthopaedics)
17. Representative, Department of Pediatric Surgery (appointed by the Chief of Surgery)
18. Head, Department of Pediatric Dentistry
19. Head, Department of Nurse Practitioners

Non-Voting Members

1. Chief Operating Officer, BC Children’s Hospital
2. Chief Operating Officer, BC Women's Hospital + Health Centre
3. Chief Medical Officer, BC Children’s Hospital and BC Women’s Hospital + Health Centre
4. Vice-President, BC Mental Health and Addiction Services
5. Executive Director, BC Children’s Hospital Research Institute
6. Executive Director, Women’s Health Research Institute
7. Senior Nursing Administrator (or delegate)

## BC Mental Health and Substance Use Services

Voting members

1. Chair, Local Medical Advisory Committee
2. Vice-Chair, Local Medical Advisory Committee
3. President/Representative, Forensic Physician Engagement Society
4. President/Representative, Concurrent Disorders Physician Engagement Society
5. President/Representative, Correctional Health Physician Engagement Society
6. Associate Chief Medical Information Officer, BCMHSUS
7. Medical Director, AMHSUS
8. Medical Director, Forensic Psychiatric Hospital
9. Medical Director, Forensic Psychiatric Regional Clinics
10. Medical Director, Correctional Health Services
11. Medical Director, Psychiatry, Correctional Health Services
12. Dental Practice Lead, BCMHSUS
13. IPAC Medical Lead, BCMHSUS
14. Chief Medical Officer, BCMHSUS
15. Medical Lead, Quality, BCMHSUS

Non-Voting Members

1. Chief Operating Officer, BCMHSUS
2. Executive Director, Inter Professional Practice BCMHSUS
3. Director, Lower Mainland Pharmacy Services
4. Senior Director, Medical administration, BCMHSUS
5. Director, Quality, Safety & Accreditation, BCMHSUS
6. Executive Director, Department of Nurse Practitioners
7. Executive Medical Director, PHSA Medical & Academic Affairs

## BCCDC

Voting members

1. Chair, Local Medical Advisory Committee
2. Vice-Chair, Local Medical Advisory Committee
3. President, Local Medical Staff Association
4. Representative, Chee Mamuk
5. Representative, Clinical Prevention Services
6. Representative, Environmental Health
7. Representative, IMMS
8. Representative, Population and Public Health
9. Representative, Public Health Laboratory
10. Representative, Public Health Response
11. Representative, Clinical Scientist
12. Representative, Nurse Practitioner
13. Representative, Drug & Poison Information Centre (DPIC) or Environmental Health

Non-Voting Members

8. Chief Medical Officer, BCCDC
9. LMAC Secretariat Staff
10. Vice President, PHSA Medical & Academic Affairs

# Appendix B: MEDICAL STAFF DEPARTMENTS OF PHSA FACILITIES AND PROGRAMS

## Provincial Health Services Authority

The Departments of the Provincial Health Services Authority

- Nurse Practitioners (primary Department)

## BC Children's Hospital and BC Women's Hospital + Health Centre

The Departments of the BC Children's Hospital and BC Women's Hospital + Health Centre are:

- Paediatric Anaesthesia
- Adult Anaesthesia
- Paediatric Dentistry
- Paediatric Diagnostic Imaging
- Women's Diagnostic Imaging
- Family Practice
- Medical Genetics
- Medicine
- Midwifery
- Obstetrics and Gynaecology
- Paediatric Ophthalmology
- Paediatric Orthopaedics
- Paediatric Pathology
- Paediatrics
- Psychiatry
- Paediatric Surgery
- Women's Health

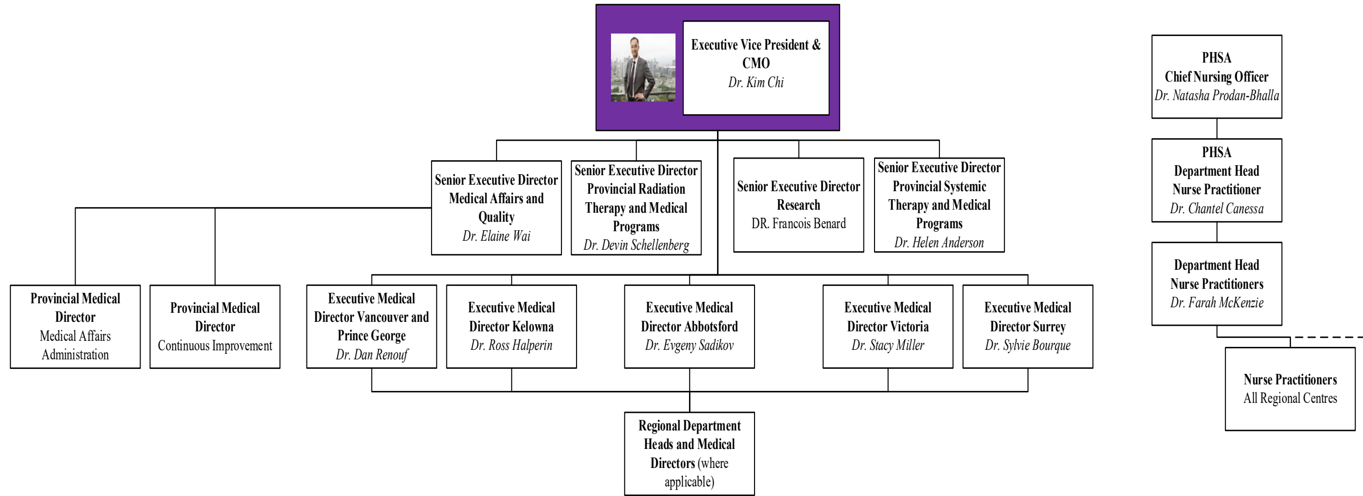
## BC Cancer

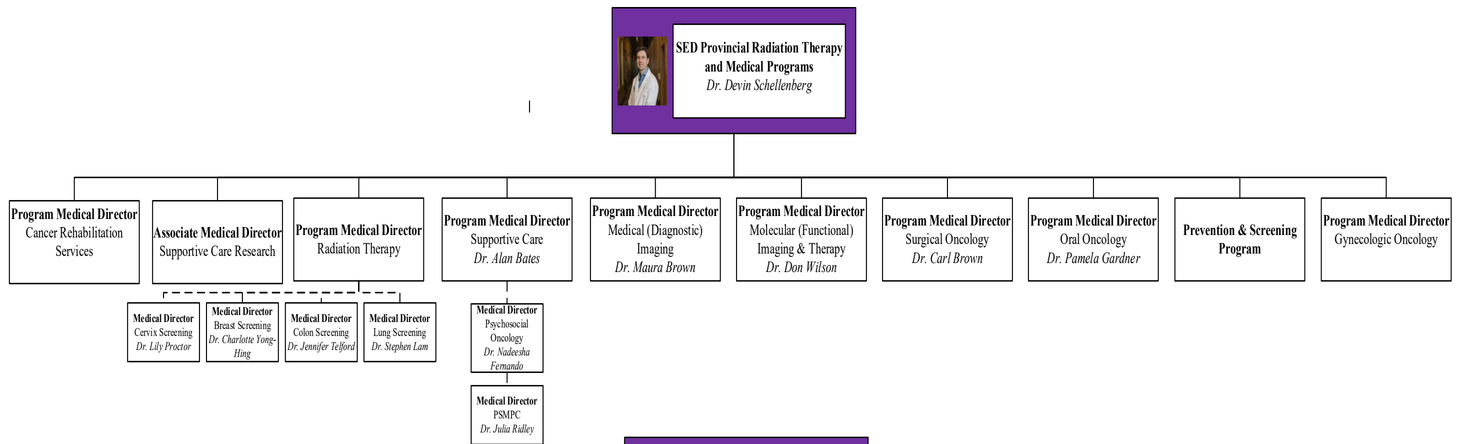
The Departments of BC Cancer are:

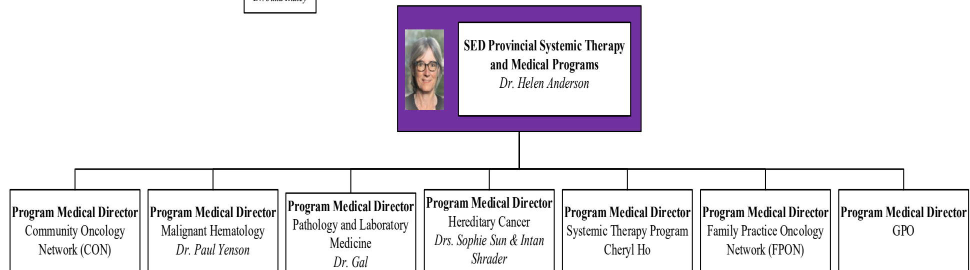
- Bone Marrow Transplant and Hematology
- Diagnostic Imaging
- Molecular Imaging and Therapy
- Gynecological Oncology
- Hereditary Cancer Program
- Malignant Hematology
- Oral Oncology
- Pain and Symptom Management
- Pathology and Laboratory Medicine
- Psychosocial Oncology
- Radiation Oncology
- Surgical Oncology
- Systemic Therapy

Provincial Health
Services Authority

# BC Cancer Overall Structure

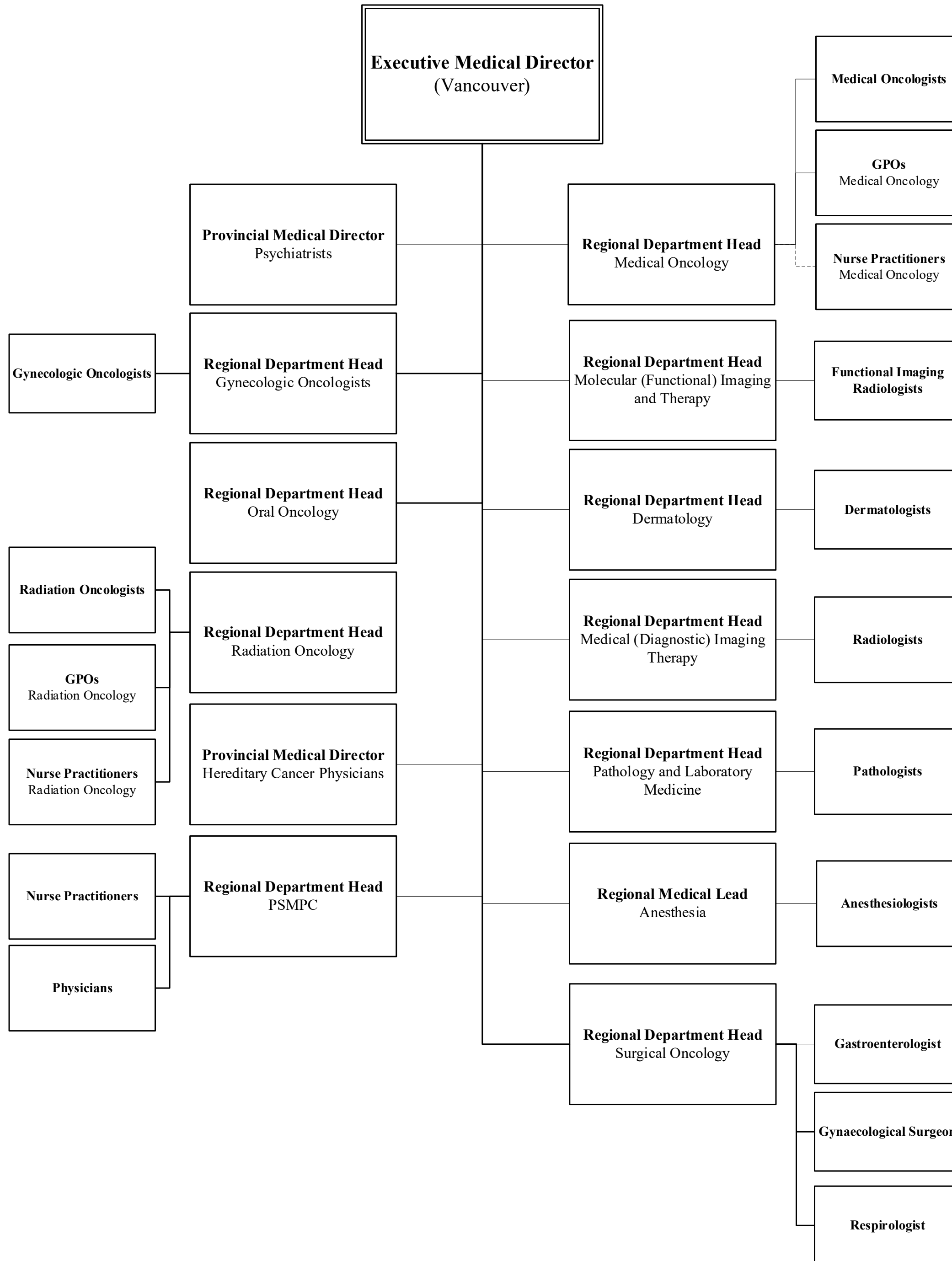


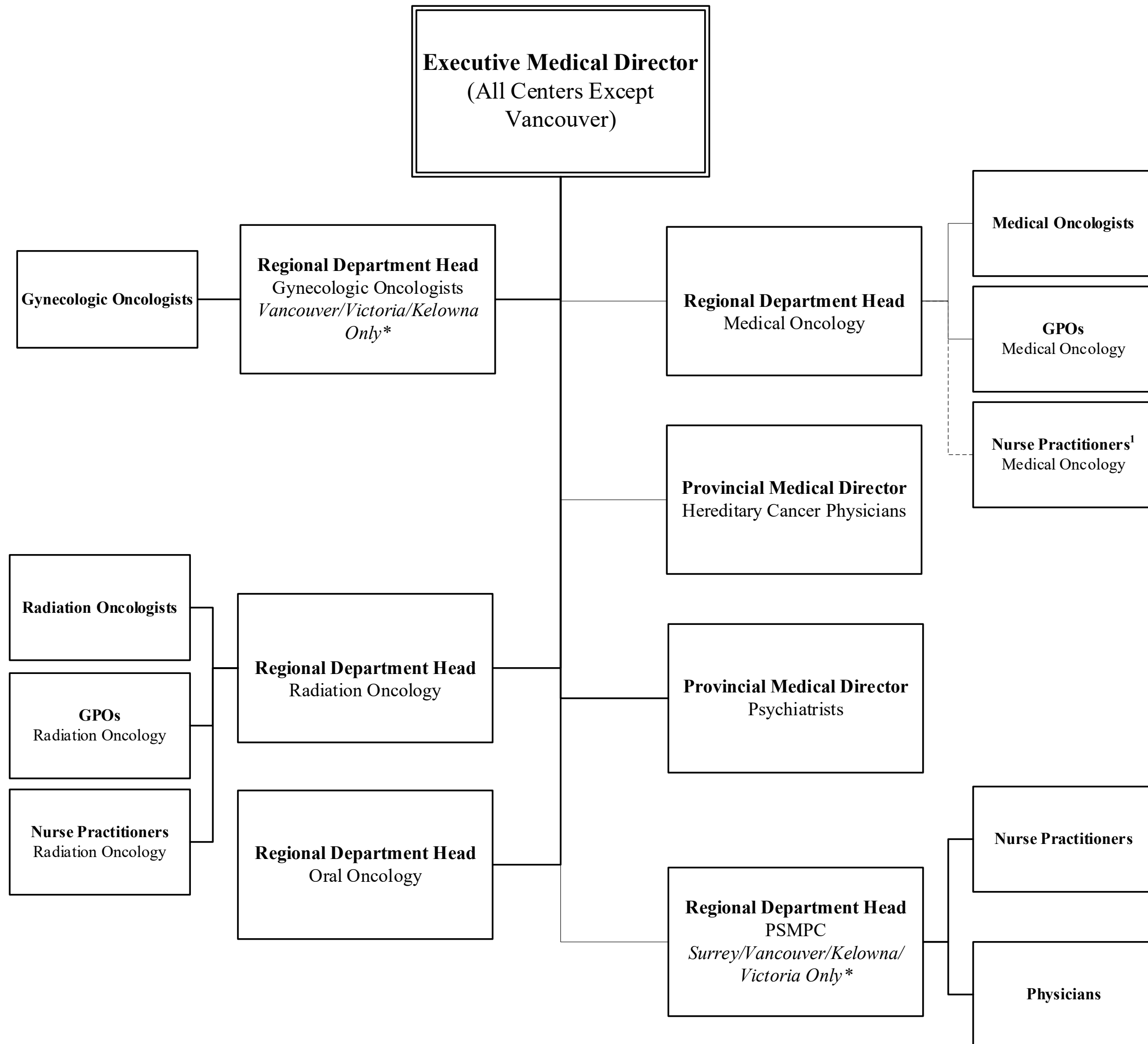
Provincial Health Services Authority

# BC Cancer Centre – Vancouver



Provincial Health Services Authority

## BC Cancer Centre – All Others



Provincial Health Services Authority

## BC Mental Health and Substance Use

The term “Department” and “Department Head” are not generally used at BCMHSUS. For the purposes of these Rules, a Department Head may be responsible for a single Department across Health Authority Facilities or Programs or could be a Provincial Lead who oversees and responsible for a group of Departments or Programs. See below to delineate the medical leadership structure at BCMHSUS.