PHC MEDICAL STAFF RULES

Approved by PHC Board of Directors – December 2017

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MEDICAL STAFF RULES

1. DEFINITIONS

1.1. Name of Organization

The organization to which these Rules pertain shall be known as the Medical Staff of Providence Health Care (PHC).

1.2. Definitions

For personnel, the use of the following terms within PHC is to be restricted to individuals who meet the following definitions and should not be applied to others. In these Medical Staff Rules:

"Affiliation Agreement" means the "Master Affiliation Agreement" between the Providence Health Care Society and University of British Columbia (2004)

"Appointment" means the permit to practice Medicine, Dentistry, or Midwifery within the facilities of PHC, and includes re-appointment except where the context of these Rules requires otherwise.

"Associate/Assistant Department Head" means a member of the Medical Staff appointed by the Vice President of Medical Affairs in consultation with the Department Head, to be in charge of, and responsible for the fulfillment of departmental leadership responsibilities at specific sites within PHC under the direction of the Department Head.

"Board of Directors" or "the Board" means the governing body of PHC.

"Bylaws" means the specific regulations concerning the organization and function of the Medical Staff of PHC, as endorsed by the Minister of Health of British Columbia, approved by the PHC Board of Directors, and supported by the Medical Advisory Committee.

"Chief Executive Officer" (CEO) means the person engaged by the Board to lead PHC in accordance with the Board's Bylaws, Rules and Policies.

"Clinical Fellow" means a physician, dentist, or midwife temporarily working in the facilities owned or operated by PHC for the educational purpose of gaining additional experience in a medical, dental, midwifery or scientific discipline.

"Consultant" means a member of the Medical Staff who has been asked to give an opinion on the diagnosis, investigation, care or treatment of a patient or resident.

"Consultation" means the formal provision of an opinion regarding the diagnosis, investigation, care or treatment of a patient or resident, conducted by a consultant at the request of a Medical Staff Member.

"Credentials Officer" means a member of the Medical Staff appointed by the Medical Advisory Committee to review, assess and make recommendations with regard to qualifications of Medical Staff, or a deputy duly approved by the MAC.

"Dean, Faculty of Dentistry" means the Dean of the Faculty of Dentistry of the University of British Columbia.

"Dean, Faculty of Medicine" means the Dean of the Faculty of Medicine of the University of British Columbia.

"Director, Midwifery Program" means the Director of Midwifery Program of the Department of Family Practice, Faculty of Medicine of the University of British Columbia.

"Dentist" means a member of the Medical Staff who is duly registered with the College of Dental Surgeons of British Columbia and who is entitled to practice dentistry in British Columbia.

"Department" means a major subsection of the Medical Staff composed of members with common specialty, clinical or research interests.

"Department Head" means the Head of a clinical Department as described in Section 7.4.1. of these Rules. The Medical Staff member appointed by the Board of Directors and responsible to the Vice President, Medical Affairs, to be in charge of, and responsible for, the operation of and quality of care within a medical Department. This term may be used interchangeably with "Department Chair".

"Division" means a subsection of a Department with clearly defined sub-specialty interests.

"Division Head" means the Head of a clinical Division as provided in Section 7.4.3. of these Rules. The Medical Staff member appointed by the Department Head to be in charge of, and responsible for, the operation of a Division under the direction and supervision of the Department Head.

"Facility" means a health care facility owned or operated by PHC and includes, but may not be limited to: Holy Family Hospital; Mount Saint Joseph Hospital; St. Paul's Hospital; St. John Hospice; Youville Residence; St. Vincent's: Brock Fahrni, Langara, Honoria Conway – Heather; Crosstown Clinic; Community Dialysis Clinics: Sechelt, Richmond, Powell River, Squamish, North Shore, Vancouver, and East Vancouver.

"Hospital" means, collectively, all facilities owned and operated by PHC.

"Medical Advisory Committee (MAC)" means the senior medical committee referred to in Section 9 of these Rules, and in Article 9 of the PHC Medical Staff Bylaws.

"Medical Coordinator, Residential Care" means a Medical Staff Member with administrative responsibility to co-manage a clinical program as part of PHC's program-based care-delivery model.

"Medical Staff" means the physicians, dentists, and midwives who hold a permit from the Board of Directors to practice medicine, dentistry or midwifery in the facilities owned or operated by PHC.

"Medical Staff Rules" (Rules) means the rules approved by the Board of Directors governing the day-to-day management of the Medical Staff in the facilities and programs operated by Providence Health Care.

"Medical Students" means undergraduate students of the Faculty of Medicine of UBC who spend a portion of their clinical rotations in different facility settings for the purpose of receiving practical clinical experience, under the direction of

the University, as described in the Affiliation Agreement between the University and PHC.

"Midwife" means a member of the Medical Staff who is duly registered with the College of Midwives of British Columbia and who is entitled to practice midwifery in British Columbia.

"Most Responsible Provider (MRP)" formerly "Attending Physician", means the attending physician, dentist or midwife who has the overall responsibility for the management and coordination of care of the patient or resident at any given time.

"Nominating Committee" means the committee established pursuant to Section 8.2. hereof, to nominate candidates for election as officers of the Medical Staff.

"Nurse Practitioner" means a member of the nursing staff who is duly registered as a nurse practitioner with the College of Registered Nurses of BC.

"On Call" means the availability to promptly respond to patient need and directly provide service on an urgent or emergent basis depending on patient need including overnight, on a weekend, or recognized holidays. Medical Staff Members providing on-call coverage must have appropriate privileges to be able to provide the services that otherwise would be provided by the Medical Staff Member for whom they are providing coverage on an urgent basis.

"Patient/Resident" means a person who attends Providence Health Care for investigation and/or care.

"Physician" means a member of the Medical Staff who is duly registered with the College of Physicians and Surgeons of British Columbia to practice medicine in British Columbia.

"Physician-in-Chief" means the position appointed by and reporting to the Vice President of Medical Affairs which provides strategic advice to the most senior levels of Providence Health Care, notably the Senior Leadership Team, on all matters concerning the use and operations of non-surgical resources, and matters which primarily concern all specialty medical related disciplines.

Physician Program Director" means a physician leader with administrative responsibility to co-manage a clinical program as part of PHC's program-based care-delivery model.

"Podiatrist" means a member of the Associate, Non-Medical Staff who is duly registered with the College of Podiatry of British Columbia and is entitled to practice podiatry in BC*.*

"President of the Medical Staff Association" means the chief elected representative of the Medical Staff.

"Primary Department" means the Department to which a member of the Medical Staff is assigned and within which the member delivers the majority of care to patients or residents.

"Privileges" refers to the specific duties or cluster of duties the practitioner or consultant of medicine, dentistry or midwifery is permitted to practice in the facilities owned or operated by PHC, granted by the Board of Directors to a

member of the Medical Staff, as set forth in the Hospital Act Regulations.

"Procedure Specific Privileges" means a permit to practice specific procedures in the facilities owned or operated by PHC, granted by the Board of Directors to members of the Medical Staff, based on proven competency and ongoing expertise in these procedures.

"Provider" means a physician, dentist or midwife who is a member of the Medical Staff and is a duly qualified licensee in good standing with their regulatory college.

"Provincial Privileging Dictionaries" means the discipline-specific competencies in procedures and procedure volumes that must be satisfied in order to be privileged to practice medicine in a health authority in BC which were developed by expert panels and are maintained by the BC Medical Quality Initiative (BCMQI) office.

"Psychiatrist-in-Chief" means the position appointed by and reporting to the Vice President of Medical Affairs which provides strategic advice to the most senior levels of Providence Health Care, notably the Senior Leadership Team, on all matters concerning the use and operations of mental health and related resources.

"Regional Department Head" (RDH) means the Head of a medical Regional Department as described in Section 7.5. of these Rules. The member of the Provisional or Active Medical Staff of VCH and PHC appointed by the Board of Directors of VCH and PHC and responsible to the Vice Presidents of Medicine of VCH and PHC and to their respective Boards, through the Vancouver Coastal Health Authority Medical Advisory Committee (HAMAC), and the PHC MAC, for the activities of the Regional Department and its members.

"Reserved Act" means an act identified as such in the *Health Professionals Act.*

***"*Resident*"* the** term Resident shall mean a doctor of medicine employed temporarily by the Hospital who is participating in a training program approved by the Royal College of Physicians and Surgeons of Canada, or the College of Family Physicians of Canada, and is registered with the College of Physicians and Surgeons of British Columbia, or is a doctor of Dentistry appointed to a training Program offered by the Hospital. Residents are appointed through the University of British Columbia. For purposes of these Rules, "Resident" also includes physicians enrolled in the International Medical Graduate Program of British Columbia.

"Search Committee" means the committee established pursuant to Section 7.4. hereof, to recommend the selection of a Department Head.

"Senior Leadership Team" (SLT) means the highest ranking executive committee of PHC, which is headed by the Chief Executive Officer and includes all the Vice Presidents. SLT is responsible for all operational issues at Providence.

"Senior Medical Director" (SMD) means the position appointed by and reporting to the Vice President of Medical Affairs which provides operational leadership, in particular quality and safety, patient and family-centered care at PHC.

"Signature" means an authentic signature or electronic sign-off.

"Solid Organ" includes but is not limited to: lung, heart, kidney, bowel and pancreas.

"Specialist" means a physician with Fellowship or Certificate status with the Royal College of Physicians and Surgeons of Canada.

"Staff" means the Medical, Dental and Midwifery Staff of the Hospital as provided for in these Rules but does not include Departmental Assistants, Fellows, Residents or Paramedical personnel.

"Student" means an undergraduate medical, dental or midwifery student assigned to the facilities owned or operated by PHC for the educational purpose of gaining practical clinical experience during a specified rotation.

"Surgeon-in-Chief" means the position appointed by and reporting to the Vice President of Medical Affairs which provides strategic advice to the most senior levels of Providence Health Care, notably the Senior Leadership Team, on all matters concerning the use and operations of surgical resources, and matters which concern all surgical related disciplines.

"Temporary Privileges" means a permit to practice medicine, dentistry or midwifery in the facilities owned or operated by PHC and granted for a specified period of time, not to exceed twelve (12) months, to Medical Staff in order to provide a specific service (e.g. organ retrieval).

"Vice President" means the Vice President, Medical Affairs of PHC, the physician responsible for the coordination and direction of the activities of the Medical Staff, or for purposes of appointments to Medical Staff, a deputy approved by MAC.

"Vice President Acute Clinical Programs" means the SLT member responsible for most clinical programs delivered in the acute care hospital setting.

"**Vice President Research"** means the SLT member most responsible for academic and research matters.

"Vice President of Medical Staff Association" means the representative of the Medical Staff Association elected to that office.

"Working day" means every day of the week except Saturday, Sunday or a Statutory Holiday (as defined in the Interpretation Act).

Words importing the singular only where used in these Rules shall also include the plural, and vice versa, as the context may imply.

Words importing the masculine gender shall also include the feminine and neuter genders and vice versa as the case may be and the context may imply.

2. PURPOSE OF THE MEDICAL STAFF ORGANIZATION

2.1. Purpose

In addition to the General Purpose, as outlined in Article 2.1 of the Medical Staff Bylaws, the purpose of the organization is to apply the regulatory authority of the Board to all members of the medical, dental and midwifery professions who are granted privileges annually by the Board to practice their disciplines within PHC. The objective is to ensure that PHC provides high-quality patient care; education of medical, dental, and allied health professionals; and research in the health disciplines.

The organization described herein, consisting as it does of Departments and Divisions, the Medical Advisory Committee and the Medical Staff Association, allows the Medical Staff to provide advice to the Board in order to achieve the Mission, Vision, Values and Strategic Directions of PHC.

A further purpose of the organization is to maintain and support the rights and privileges of the Medical Staff as provided herein.

3. CREDENTIALLING, MEMBERSHIP AND PRIVILEGES

3.1. Conditions of Appointment

3.1.1. The Board shall appoint all members of the Medical Staff.

3.1.2. No physician, dentist, or midwife shall be eligible for appointment to the Medical Staff, nor to remain a member of the Staff, unless such physician, dentist, or midwife is fully or temporarily registered by the College of Physicians and Surgeons of British Columbia, the College of Dental Surgeons of British Columbia, or the College of Midwives of British Columbia respectively and subscribes to their respective Code of Ethics.

3.1.3. All Medical Staff appointments, including the appointments of Department and Division Heads, shall be consistent with any affiliation agreement in effect between PHC and UBC.

3.1.4. This rule shall only apply to new appointments and shall not be applied retrospectively, or to reappointments to the Medical Staff.

3.1.4.1. An appointment to the Active Medical Staff of PHC will normally be accompanied by a concurrent appointment to the appropriate Division and/or Department of the Faculty of Medicine, UBC. In order to ensure that an appropriate appointment has been sought, the PHC Department Head will satisfy the MAC that the UBC Department or Division Head has been consulted prior to recommending an appointment to the PHC Medical Staff.

3.1.4.2. Any dispute between PHC Department or Division Heads and their UBC counterparts regarding a clinical or academic appointment to the UBC Faculty of Medicine will be referred for review and resolution to the Joint Liaison Committee of the Faculty of Medicine and PHC.

3.1.5. An appointment to the Medical Staff entitles the staff member to utilize hospital resources as determined, from time-to-time, by the appropriate Department Head, the relevant Physician Program Director, and Program Director (also see Appendix II: "Dispute Resolution and Resources Allocation Guidelines")

3.1.6. No person shall be permitted to apply for appointment to the Medical Staff unless he/she has and maintains a principal office within the boundaries of the greater Vancouver area, unless specifically invited to do so by the CEO on behalf of the Board of PHC.

3.2. Term of Appointment

3.2.1. Appointments to the Medical Staff for the ensuing year shall be made by the date prescribed in the Hospital Act Regulation, and Medical Staff Bylaws, or by the thirtieth (30th) day of June annually, whichever is the earlier. Vacancies may be filled and additional appointments may be made at other times during an appointment year.

3.2.2. All appointments shall end on the next thirtieth (30th) day of June or earlier if so determined upon review.

3.3. Process of Appointment

3.3.1. The Head of the Department, in cooperation with the Regional Department Head, is responsible for human resource planning, recruitment and retention. Accordingly, the Head of the Department normally in conjunction with the Regional Department Head in which the appointment is sought must support, in writing, all appointments to the Medical Staff.

3.3.2. All applications for appointment must be submitted through the prescribed PHC Medical Staff appointment process. Pursuant to PHCs Medical Staff Bylaw Article 4.1.2, the Chief Executive Officer delegates responsibility for receipt and processing of all applications to the Vice President, Medical Affairs and his/her office.

3.3.3. Supporting documentation as requested on the BC Provincial Application form must include, but is not necessarily limited to, the following:

- copies of all degrees; diplomas and certificates pertinent to professional practice;
- evidence of appropriate licensure by the College of Physicians and Surgeons of British Columbia, BC College of Dentistry, or BC College of Midwives; a certificate of professional conduct from the appropriate BC College;

- evidence of appropriate malpractice insurance;
- completion of Medical Staff impact assessment materials by the applicant and relevant Department Head;
- three (3) professional references with whom the applicant has worked in the past three (3) years. In the case of physicians, dentists, or midwives who have just completed training, one (1) reference must come from the Post Graduate Program Director of the program completed. In the case of established Medical Staff Members, one (1) reference must come from the Chief of Staff or Senior Medical Administrator of the organization in which the applicant most recently practiced. Applicants requesting privileges/practice activities requiring special skills must include at least one (1) reference specifically addressing recent training and/or experience in these areas. Additional references may be requested. Each reference must be reviewed and signed off by the Department/Division Head or equivalent;
- completion of any relevant educational modules necessary for their requested privileges;
- completion of the Provincial Privileging Dictionary relevant to the specialty and specific procedures for which privileges are being sought. Each dictionary must be reviewed and signed off by the Department/Division Head or equivalent;
- current photo; and
- current curriculum vitae

3.3.4. At the recommendation of the PHC Department Head and normally supported by the Regional Department Head, if the applicant is currently a member in good standing of the VCH Medical Staff and has been so for a minimum of one (1) year, a letter of reference from the Senior Medical Director may be accepted in lieu of the three (3) letters of reference required in Section 3.3.3. Applicants who have been on the VCH Medical Staff for less than one (1) year must apply for appointment to the PHC Medical Staff as outlined in Section 3.3.3.

3.3.5. Upon the signature of the Credentials Officer and the Vice President, Medical Affairs, privileges are granted to the applicant conditional on the approval of the MAC and the Board at their next meeting.

3.3.6. After reviewing the recommendations of the Credentials Officer/Vice President, Medical Affairs and Department Head concerning appointments to the Staff, the Medical Advisory Committee shall forward its written recommendations to the Board within the times prescribed in the Hospital Act Regulation and the Bylaws.

3.3.7. The Board shall make the final decision regarding appointment. This decision shall be communicated to the MAC.

3.3.8. Within six (6) months following the granting of a provisional appointment of a physician, dentist, or midwife to the Medical Staff of Providence Health Care, the provisional member must attend the Medical Staff

Orientation Workshop.

3.3.9. At six (6) months following the granting of a provisional appointment of a physician, dentist, or midwife to the Medical Staff of Providence Health Care, the provisional member will undergo an assessment by the Medical Department/Division Head with a formal report to the Vice President, Medical Affairs, regarding competence and professional behaviour. If any problems are identified, these must be corrected over a further period of six (6) months before a recommendation can be made to the MAC that Active Staff privileges be granted.

3.3.10. On the advice of the appropriate Department Head, an extension of Provisional privileges for up to one (1) additional year may be recommended prior to reconsideration of appointment to Active Staff. The Department Head must be prepared to identify the relevant situational or operational concerns, or concerns in relation to the practice of the individual. During this time, for concerns in relation to the practice of the individual, assessments will be carried out at six (6) month intervals and if at the end of one (1) year progress is not acceptable to the MAC, the individual will not be recommended for further privileges.

3.3.11. The Board, at any time, may refuse to appoint or reappoint a person to the Medical Staff, or may modify, suspend, or cancel appointments and privileges to practice in the Hospital of any member of the Staff on such grounds as may be specified by the Board including but not limited to: the lack of, or unavailability of resources; professional incompetence; unprofessional or unethical conduct (see Appendix I: “Medical Staff Professional Conduct Policy”, Section 1.1. Providence Health Care); inadequacy of professional liability insurance; breach of these Rules; failure to comply with all relevant Acts or Bylaws or with orders, directions and requests of the Board or the CEO; or conduct disruptive to the functioning of PHC. The Board may renew any appointment cancelled or suspended by it after considering the recommendations of the Medical Advisory Committee.

3.3.12. In considering an appointment or reappointment to the Medical Staff and the granting of Privileges under the Bylaws, the Department Heads will use the following in making their recommendations to the Board:

3.3.12.1. The fitness, competence and capability of the applicant,

3.3.12.2. The strategic plan, resources and staffing of the relevant Department or Division,

3.3.12.3. The applicant’s plans relating to retirement or other changes in the nature of their practice,

3.3.12.4. The recruitment of new personnel,

3.3.12.5. The development of new technologies and clinical programs,

3.3.12.6. The allocation of facility resources,

3.3.12.7. The recommendations of the relevant Department Head and Physician Program Director,

3.3.12.8. The need to encourage academic and research excellence and renewal, and

3.3.12.9. The need for mentoring of junior Medical Staff members.

3.4. Re-Appointment

3.4.1. All members of the Medical Staff must complete the invitation for re-appointment to the Medical Staff using the provincial credentialing and privileging system. Documentation required in support of an application for reappointment will be as identified by MAC from time-to-time (e.g., see previous Section 3.3., "Process of Appointment"). The review process for re-appointment will be determined as per Article 4.5 of the Bylaws: "Process for Review".

3.4.2. To be re-appointed, all members of Medical Staff must complete the training modules required as identified by MAC and the Vice President of Medical Affairs.

3.4.3. At least once every three (3) years, all members of the Medical Staff will undergo an in-depth review. The review will be conducted by the respective Department Head or delegate with the assistance of the Credentialing and other relevant senior medical administrators, as applicable. The in-depth review may consist of the following domains:

1. Interpersonal and communication skills
2. Professionalism
3. Psycho-motor skills
4. Cognitive skills
5. Patient outcomes
6. Review of clinical documentation
7. Input from patients
8. Review of CV and personal goals and objectives
9. Complications and mortality review
10. Review of incidents reports and complaints
11. CME and additional competence training
12. Direct observation of procedural and assessment skills
13. Utilization/quality assurance information
14. Currency
15. Competency
16. Multisource feedback

3.5. Senior Staff Sub-Category

3.5.1 Only members of the Medical Staff who had previously been appointed to the Senior Staff sub-category before September of 2016 may retain

that designation. The Senior Staff sub-category has henceforth been eliminated.

3.6. Procedure Specific Privileges

All privileges are granted on the basis of the specific privileges for which application is made pursuant to the Provincial Privileging Dictionaries. Determinants in the granting of these privileges will include specific competencies in the procedures, procedure volumes necessary to maintain currency, and available resources in relation to the procedures. All such privileges are granted by the Board of Directors upon consideration of the recommendations of the Medical Advisory Committee and the Department Head.

3.6.1. Granting of Procedure Specific Privileges

Procedure specific privileges for each member of Medical Staff will be reviewed at the time of reappointment. The Department Head, in consultation with the appropriate Head of the Division in which privileges are requested, will determine and evaluate the training and experience of an applicant to support a request for specific procedural privileges in light of currency and other requirements as set out in the Provincial Privileging Dictionary for the applicant's medical specialty and the specific privileges requested.. Procedural privileges may be limited by the ability of PHC to provide appropriate facilities, equipment, supplies and staff resources.

3.6.2. Conflicts

Where there are conflicts between Division Heads and Department Heads on what procedural privileges should be granted, the matter will be referred first to the Physician-in-Chief, the Surgeon-in-Chief, or the Psychiatrist-in-Chief as appropriate. If the conflict remains unresolved, the matter may be then referred to the Medical Advisory Committee for a recommendation to the Board.

3.7. Urgent Time-Limited Privileges

3.7.1. In extraordinary circumstances, and at the request of a Department Head, the Vice President of Medical Affairs may grant urgent time-limited privileges where immediate patient care is required.

3.8. Observers & Trainees

3.8.1. Physicians, midwives or dentists and trainees without privileges at PHC may attend a patient interaction as Observers for training purposes only in accordance with the requirements set out in Appendix IV, "Trainee Positions at PHC".

3.9. Facility Privileges & Cross Coverage

3.9.1. Unless otherwise stated in the Rules, all appointments to the Medical Staff must specify the site(s) at which the member may practice.

3.9.2. A member of the Medical Staff may provide care at any PHC site when such care is provided within an 'on-call' rota approved by the appropriate Department Head or Division Head (see Section 5.9.3., "On Call Coverage").

3.10. Termination, Modification, Suspension or Non-Renewal of Privileges

3.10.1. Emergency Process

3.10.1.1. Emergency Suspension

The Vice President of Medical Affairs, delegated by the CEO, or in his/her absence, the Department Head may, in an emergency, summarily suspend or restrict the privileges in the Hospital of any member of the Medical Staff whose behavior or actions appear to jeopardize the safety of patients or residents, or to threaten the safety or security of any member of the hospital staff or the public. In the event that such action is taken, the CEO shall be notified of such action with a full explanation within twenty-four (24) hours. The Registrar of the appropriate College shall be notified as per Article 11 of the PHC Bylaws.

3.10.1.2. Assignment of Most Responsible Physician (MRP)

The appropriate Department Head or delegate shall appoint another member of the Medical Staff to undertake care of patients in the Hospital who were under the care of the Medical Staff member at the time of suspension.

3.10.1.3. Meeting

3.10.1.3.1. The Medical Advisory Committee shall, within fourteen (14) days of the suspension or restriction, hold a special meeting to hear the case unless otherwise agreed with the Medical Staff member. The Medical Staff member concerned shall be given not less than ten (10) days' notice in writing of the time and place of the meeting, and shall have the right to be heard at the meeting.

3.10.1.3.2. On the recommendation of the Medical Advisory Committee, Hospital Counsel shall also attend the hearing. The suspended Staff member shall be entitled to reasonable notice of such and may have counsel present at the hearing. In the event the suspended Staff member intends to be represented by counsel, he shall so inform the Chair of the Medical Advisory Committee within three (3) working

days of receipt of notice of the time and place of the hearing.

3.10.1.3.3. The Medical Advisory Committee will make recommendations to the Board of Directors with respect to cancellation, suspension, restriction, or non-renewal of privileges as appropriate after giving the member of the Medical Staff an opportunity to be heard.

3.10.2. General (Non-Emergency) Process

For non-emergency suspension, modification, restriction, or non-renewal of privileges, the Department Head shall advise the Vice President of Medical Affairs and the Chair of the Medical Advisory Committee, all of whom shall meet to review the circumstances of the case.

3.10.2.1. Notification of Staff Member

If suspension, modification, restriction, or non-renewal is determined to be warranted, the Department Head, together with the Vice President of Medical Affairs, shall meet with the Staff Member to provide verbal and written notice of such. If the member is unavailable or refuses to meet, written notice shall be delivered to the Staff Member's address by registered mail or courier.

3.10.2.2. No Dispute of Change to Privileges

If the Staff Member accepts, in writing, the proposed suspension, modification, restriction, or non-renewal of the privileges, the MAC shall be so advised at its next scheduled meeting. At that meeting, the MAC shall consider the proposed change to the Staff Member's privileges, and shall forward its recommendation to the Board of Directors for approval. Should the MAC recommend a course of action other than that proposed the member must be so notified as per Section 3.10.2.1.

3.10.2.3. Dispute of Change to Privileges

In the case where a Staff member does not accept the proposed suspension, modification, restriction, or non-renewal of privileges, the process outlined in Appendix II, "Dispute Resolution and Resources Allocation Guidelines" should be followed.

If resolution of the issue has not been achieved after following the process outlined in Appendix II, the Chair of the MAC shall call a special meeting of the MAC within fourteen (14) days of receiving written notification from the Staff member requesting such a meeting. The sole purpose of this meeting shall be to review and make recommendations

on the proposed suspension, modification, restriction or non-renewal.

3.10.2.3.1. Notice of Special Meeting of the MAC

The Staff Member in question shall be given no less than ten (10) days' written notice of the time and place of the Special MAC meeting. Such notice shall set forth the reasons for the Department Head's recommendation.

3.10.2.3.2. Right to Appear

The Department Head and the Staff Member involved have the right to appear in person before the special meeting of the MAC and to provide a written submission if they so wish.

3.10.2.3.3. Failure to Appear

In the event the Staff Member or Department Head fails to appear at the time and place arranged for the special MAC meeting, the MAC may proceed in their absence if it is satisfied that proper notice has been given.

3.10.2.3.4. Procedure

The MAC shall determine the time, place, and manner of the hearing, and shall be entitled to determine the procedure and manner in which recommendations are brought and heard before it. The MAC may determine what evidence or representation of materials as evidence, the MAC, in its sole discretion, shall review in adjudicating such recommendations, provided always that the MAC affords the Staff Member an unbiased and fair hearing in accordance with the principles of natural justice. Without limiting the generality of the foregoing, the MAC shall, in formulating recommendations to the Board, consider only such evidence as is brought before it, as a matter of record, and the Staff Member shall be entitled to review the evidence brought forward in support of the proposed suspension, modification restriction or non-renewal of privileges.

3.10.2.3.5. Written Report

A written report, including the MAC's recommendations and a summary of the

findings and reasons upon which those findings were based, shall be forwarded to the CEO of the Hospital and to the Board of Directors within thirty (30) days of the MAC's decision. A copy of this report shall be forwarded at the same time to the Staff Member concerned.

3.10.2.4. Consideration of MAC Recommendations by the Board

3.10.2.4.1. If the privileges of a member of the Medical Staff have been recommended for cancellation, suspension, restriction, or non-renewal, the Board of Directors must consider the recommendation of the MAC and the CEO at its next meeting.

3.10.2.4.2. The member of the Medical Staff must be given at least seven (7) days' notice in writing of any recommendation of the CEO, or the MAC to the Board of Directors, and of the date and time at which the recommendation will be considered in-camera by the Board of Directors.

3.10.2.4.3. The member of the Medical Staff has the right to be heard at this meeting.

3.10.2.4.4. All documentation provided to the Board of Directors must be made available to the member of the Medical Staff as soon as it is made available to the Board of Directors.

3.10.2.4.5. The Board of Directors must convey its decision to the member of the Medical Staff in writing within seven (7) days of reaching that decision.

3.10.2.5. Department Head Review: Responsibility for Enactment

In the foregoing, when the privileges of a Department Head may be restricted, modified, suspended, revoked, or not renewed, the Vice President of Medical Affairs shall bring the matter before the MAC.

3.11. Leave of Absence (LOA)

3.11.1. Leave for Education or Medical Reasons

The MAC, on the advice of the appropriate Department Head, may grant a leave of absence for a definite term not to exceed one (1) year for educational or medical reasons. The MAC may grant an extension of the LOA after reviewing the circumstances and considering the advice of the appropriate Department Head.

3.11.2. Leave for Non-Education or Non-Medical Reasons

The MAC, on the advice of the appropriate Department Head, may grant a leave of absence for non-educational, non-medical reasons for a defined term not to exceed one (1) year. The LOA may not be extended beyond this time period.

Where a leave of absence is granted to a member of the Medical Staff by the MAC, the appropriate Department Head, in consultation with the relevant Physician Program Director, shall reassign temporarily that Staff Member's clinical workload and allocation of hospital resources.

3.12. Retirement, Departure and Resignation

3.12.1. Notice of Retirement, Departure or Resignation

To ensure continued provision of service in PHC facilities, a member of Medical Staff must provide appropriate notice to the Department Head prior to retirement, departure or resignation. Normally this notice period would be a minimum of one (1) year.

4. Appointment Categories Not Clearly Outlined in the Medical Staff Bylaws

4.1. Locum Tenens

4.1.1. The relevant Articles of the Medical Staff Bylaws govern the appointment of a locum tenens.

4.1.2. A Locum Tenens replaces a specific individual member of the medical staff generally in all their duties and responsibilities temporarily and for a defined period.

4.1.3. The granting of a locum tenens appointment provides no preferential access to a Provisional, Active, or other Medical Staff appointment at some later time.

4.1.4. The Medical Staff Member who will be replaced by the locum tenens must assure the Department Head that the locum tenens is suitably qualified to cover all aspects of the requesting Medical Staff Member's practice.

4.1.5. The development of locum tenens pools is permitted with the understanding that annual privileges are awarded and that the specific duties and time periods during which they are active is determined by the relevant Department Head.

4.1.6. All locum tenens and temporary appointments expire annually on June 30th consistent with all other appointment categories.

4.2. Dental Staff

4.2.1. The procedures for appointment and granting of privileges for dentists are the same as for physicians, except assignment is to the Department of Surgery.

4.2.2. Members of the Dental Staff do not have admitting privileges.

4.3. Midwifery Staff

4.3.1. The procedures for appointment and granting of privileges for midwives are the same as for physicians, except assignment is to the Department of Midwifery.

4.3.2. Members of the Active, Provisional or Locum Midwifery Staff can admit patients and write orders appropriate to the practice of midwifery in the facility.

4.4. Associate Staff – Non-Medical Staff

4.4.1. General

In accordance with Section 7.7 of the Hospital Act Regulation (2009) persons with appropriate qualifications whose services are required by PHC, and include, but are not limited to, podiatrists, psychologists, and paramedical personnel may be authorized to serve as Associate – Non-Medical Staff.

They may render health care to patients at the request of a member of the Active or Provisional Medical Staff and provide services within the scope of the standards, limits and conditions of their professional body.

They may not admit patients or write independent orders, nor may they perform surgical or investigational procedures for which additional procedure-specific privileges may be required.

Any such authorization is subject to annual review.

4.4.2. Nurse Practitioners (NPs)

Nurse Practitioners (NPs) may not admit or discharge patients, or act as the most responsible provider. However, once a Medical Staff Member has admitted a patient, he or she may designate a NP to attend or treat patients by writing an order on the chart, “NP to treat.” Once designated, NPs may, in consultation with the responsible physician, and, within the limits of their competence, scope of autonomous practice, and in accordance with any applicable article of the PHC Medical Staff Bylaws or these Rules:

- take histories and perform physical examinations,
- order diagnostic tests and referrals,
- diagnose diseases, disorders or conditions,
- order drugs or other therapies

4.4.3. Podiatrists

4.4.3.1. At the request of a member of the Medical Staff, Podiatrists in good standing with their College who have demonstrated appropriate training and competency may be authorized to render health care to patients and perform specific procedures. Such authorization shall be determined annually by the Head, Department of Orthopedics and with the

approval of the Vice President of Medical Affairs. Podiatric procedures shall be subject to peer review and performance assessment under the oversight of the Department of Orthopedics.

4.5. Retired Staff

4.5.1. Physicians, dentists, and midwives who have retired from the Medical Staff but wish to maintain an association with PHC may be named to the Retired Staff. The Medical Advisory Committee may grant Retired Staff privileges on the recommendation of the Department Head. Members of the Medical Staff may request Retired Staff privileges by writing to the appropriate Department Head. Retired Staff are not required to reapply each year; however, their appointment must be confirmed annually. Retired Staff may attend Academic Rounds, and Department meetings only at the invitation of the Head. They may not vote or hold office. Retired Staff may not provide care to patients or residents in PHC facilities. If Retired Staff wish to participate in teaching at the bedside or with simulated and/or volunteer patients they should adhere to the College of Physicians and Surgeons of British Columbia policy on Registration and Licensure of Retired Physicians in the Administrative class for the purpose of teaching at the UBC Faculty of Medicine. Annual confirmation of appointment of Retired Staff who wish to teach medical students requires evidence of this licensure and appropriate medical liability coverage.

5. RESPONSIBILITY FOR PATIENT CARE

5.1. Admission, Discharge, and Transfer of In-Patients and Short-Stay Patients

5.1.1. Pre-Admission

For elective patients and residents, the most responsible Medical Staff Member is responsible for pre-admission requirements, which include the patient's medical history, physical examination, diagnosis, laboratory investigations, appropriate consultations, special tests, documentation of special precautions, and patient consents, as well as demographic and insurance information. This may be delegated to trainees, Fellows or colleagues, although the ultimate responsibility falls to the Medical Staff Member listed as MRP.

5.1.2. Admission

5.1.2.1. Patients and residents shall only be admitted to the facility upon the order of a member of the Medical Staff who holds the requisite appointment and privileges.

5.1.2.2. Where two (2) or more Medical Staff Members are involved with the care of the patient, one (1) Medical Staff Member must be identified as the Most Responsible Practitioner (MRP).

5.1.2.3. Unless otherwise clearly indicated on the physician order sheet, the admitting Medical Staff Member shall be deemed to be the Most Responsible Practitioner (MRP). This also applies to admission by an Emergency Physician to the Diagnostic and Treatment Unit (DTU).

5.1.2.4. The admitting Medical Staff Member shall request admission of the patient and provide the admitting diagnosis, an outline of the history, investigations/treatment for which hospitalization is required, and an estimated date of discharge.

5.1.2.5. For emergency admissions, the admitting Medical Staff Member will certify the severity of the patient's condition and any circumstances necessitating special consideration.

5.1.2.6. The admitting Medical Staff Member shall comply with all necessary admitting documentation including medical records, allergies, etc. In addition, special precautions regarding the care of the patient must be noted on the patient's health record. Precautionary notes are required for, but not limited to, chemical dependency, potential suicide, violence, epileptic seizures, psychiatric conditions, communicable infections, drug reactions, and allergies.

5.1.2.7. All patients and residents must have a note sufficiently detailed to effect good patient care immediately on admission, and a record of their history and physical examination placed on the patient/resident health record within twenty-four (24) hours of admission (see Section 5.5.1., “Admission History”).

5.1.2.8. All patients and residents admitted for surgery must have a history and physical examination recorded on the patient/resident health record before surgery takes place (see Section 5.5.3., “Operative Notes or Procedural Notes”).

5.1.3. Transfer

When a patient is transferred between service(s) or sites during the course of stay in PHC facilities, the transferring service must complete a transfer note at the time that the patient’s responsible service or site location changes. The transfer summary will include diagnoses, comorbidities, complications, and a summary of care while the patient was on service.

5.1.4. Dental and Podiatry Admissions

A Medical Staff Member, who will be the MRP, must admit patients and residents admitted for dental or podiatry treatment. The attending dental surgeon or podiatrist shall be responsible for the patient’s dental or podiatry care.

5.1.5. Discharge

The Attending Medical Staff Member may authorize discharge of patients from the Hospital personally, or delegate this responsibility to a member of their call group or a Nurse Practitioner. Residents and Fellows, who are acting on the advice of the attending Medical Staff Member, may also provide discharge orders.

5.1.5.1. Discharge planning begins at the time the patient is admitted. The attending Medical Staff Member is responsible for identifying the Estimated Date of Discharge (EDD), which should be included in the initial orders and updated regularly throughout the stay.

5.1.5.2. Medical Staff Members shall make reasonable effort to flag the planned discharge on the day prior to discharge. When this is not possible, patients and residents shall have their discharge order written by 10:00 hours on the day of discharge. All discharged patients and residents should normally leave the Facility by 11:00 hours.

5.1.5.3. Any alterations to the discharge plan following the discharge order must be documented on the health record, including new discharge orders.

5.1.5.4. Should a patient demand to be allowed to leave the Hospital against the attending Medical Staff Member's advice, the patient shall be asked to sign a release on the prescribed form. Refusal to sign this release must be noted in the medical record. Patients who have been absent without a pass for greater than six (6) hours past the end of an official pass period, are deemed "Discharged Against Medical Advice" (DAMA).

5.1.5.5. A discharge summary shall be dictated ideally at the time of discharge and always within seventy-two (72) hours of a patient's discharge by the Most Responsible Practitioner (MRP) at the time of discharge. The report shall be dictated in accordance with the PHC Health Records discharge template. Issues significant to the patient's immediate follow-up shall be communicated by the MRP at the time of discharge directly to all relevant health care professionals who will be involved in care pending receipt of the Discharge Report.

5.2. Medical Consultations

5.2.1. Consultation Process

5.2.1.1. Consultation may be initiated by the attending Medical Staff Member, or any Medical Staff Member involved in the care

of the patient. The Consultation request should note the reason for consultation and level of urgency. For urgent consultation, Medical Staff Member to Medical Staff Member contact is required.

5.2.1.2. The Consultation request should be responded to primarily based upon patient need and always within twenty-four (24) hours.

5.2.2. Consultation Record

The consultant physician shall examine the patient and record findings, opinions, and recommendations in a consultation record, which shall be dictated or written, and appended to the patient health record. When a Resident performs the consultation, the findings, opinion, and recommendations may be recorded on the consultation record or in the progress notes of the patient health record. The consultant physician must confirm agreement by signing the plan outlined in the consultation record or notes completed by the Resident.

5.3. Emergency Care

5.3.1. In an emergency, any Medical Staff Member is expected to provide and document medical care until a patient's attending Medical Staff Member can assume responsibility.

5.4. Post-operative/Post-procedural Care

5.4.1. The operating or procedural physician or surgeon is responsible for the post-operative/post-procedural care (including care of the patient returning to the Emergency Department post discharge with a surgical or other post-procedural complication) and completion of the health record of the patient unless otherwise indicated on the order sheet of the patient's health record and confirmed, in writing, by the Medical Staff Member or Nurse Practitioner assuming this responsibility.

5.5. Health Records

The attending Medical Staff Member shall be responsible for the completion of the medical component of the health record for each patient. The record shall include the following items, where applicable:

5.5.1. Admission History

Except in extreme emergency, the attending Medical Staff Member shall ensure that every patient admitted to PHC has an adequate clinical history, physical examination, and provisional diagnosis recorded in the health record within twenty-four (24) hours of admission and prior to every delivery or operation.

5.5.2. Progress Notes

The progress notes shall:

5.5.2.1. Describe a treatment plan, changes in the patient's condition, response to treatment, reasons for change of treatment, and outcome of treatment.

5.5.2.2. Be updated as often as the patient's condition warrants, and provide sufficient detail to convey to others key indicators such as stability, treatment changes, plans and anticipated action, typically daily for acute care patients.

5.5.2.3. Be timed, dated, and signed.

5.5.3. Operative Notes or Procedural Notes

5.5.3.1. In elective or urgent surgical cases, a documented history and physical examination report and the indication for surgery or procedure correctly completed consent for surgery shall be submitted to the booking clerk before an operation will be scheduled.

5.5.3.2. A completed consent must be done prior to surgery or a procedure, or the reason for its absence documented.

5.5.3.3. Prior to any anesthetic procedure, the anesthetist must record a pre-anesthetic assessment on the anesthetic sheet. The anesthetic record must be completed before the patient leaves the recovery room.

5.5.3.4. A written or electronic note summarizing the operation or invasive procedure, the operative findings and any complications, together with post-operative orders must be placed on the chart by the surgeon before the patient leaves the Post-Anesthetic Recovery unit.

5.5.3.5. The Procedural surgeon, Physician or Resident delegate shall provide a complete operative report within twenty-four (24) hours of surgery.

5.5.4. Prenatal Record

The prenatal record is considered an integral part of the health record, and this information must be placed on the health record in accordance with the BC Reproductive Care Program guidelines.

5.5.5. Completion of Health Records

5.5.5.1. All health records must be completed in accordance with the Medical Staff Rules and Department of Health Records policies. If the attending physician is no longer available to

complete the patient health record, the record will be signed off by the appropriate Department Head, Assistant Department Head, or Division Head.

5.5.5.2. The attending Medical Staff Member is responsible for notifying the Health Records Department of planned absences prior to their occurrence. Following appropriate notification, the Medical Staff Member will be responsible for the completion of outstanding health records within five (5) working days of return from such absence.

5.5.5.3. The patient's health record should be completed at the time of discharge, as outlined in Appendix III, "Completion of Health Records Policy – Records Management Procedure Manual" of the Department of Health Information Management.

5.5.5.4. If the health records are not completed within twenty-eight (28) working days following receipt of such notification, Medical Staff privileges are automatically canceled and privileges will be reinstated only on completion of the health records.

5.5.5.5. Medical Staff Members who are suspended more than three (3) times in a consecutive twelve (12) month period will be interviewed by the appropriate Department Head, Assistant Department Head or Division Head. This will result in an automatic letter of conduct to the Chair of the MAC and to the Medical Staff Member's personnel file. Repeated suspensions may be grounds for discipline including revocation of membership on the Medical Staff.

5.5.5.6. Medical Staff Members granted Locum Tenens privileges are responsible for completion of their health records; failing completion by the Locum Tenens, the Medical Staff Member arranging for the Locum Tenens is responsible for completing any outstanding records.

5.5.6. Ownership and Access

5.5.6.1. Patient encounters registered in a PHC patient care information system and reside in the patient's health records are the property of PHC and may not be removed from PHC except as ordered by the courts or by consent of the PHC Department of Health Information Management (HIM).

5.5.6.2. Access to and copying of the health record or information contained therein is governed by the policies of PHC.

5.5.6.3. Medical Staff who have private offices within PHC retain ownership of their office records as described by the College of Physicians and Surgeons of BC.

5.5.7. Storage of Records

Health records will be retained in the Department of Health Information Management and/or in an electronic format unless otherwise approved by the CEO or delegate.

5.6. Informed Consent

5.6.1. Informed Valid Consent

Examination, treatment, procedure, or operation, other than in the case of urgent or emergency health care, may not be carried out on any patient in PHC unless informed, valid consent from the patient or the substitute decision maker has been obtained, as per appropriate PHC policy and governing legislation.

5.6.2. Medical Staff Member Responsibility for Obtaining Consent

The Medical Staff Member responsible for performing a procedure is responsible for obtaining valid informed consent prior to carrying out that procedure, and will not proceed until the appropriate signed PHC consent form has been placed on the patient health record. The consent process is outlined in PHC Corporate Policy Manual, CPF0500 – Consent.

5.7. Quality Improvement Processes and Information

5.7.1. Participation in Quality Improvement Activities

Quality improvement (QI) activities are an integral component of the Medical Staff function and responsibility. All members of the Medical Staff will participate as required by the Hospital Act and requested by their Department or Division Head in QI activities including, but not limited to: critical incident reviews; mortality and morbidity rounds and specific Departmental or program related activities; QI activities and policies.

5.7.1.1. All members of the Medical Staff are required to comply with PHC's quality improvement and safety policies.

5.7.1.2. Failure to comply with Section 5.7.1.1 will initiate a letter to the member of the Medical Staff from the Vice President of Medical Affairs or the Senior Medical Director detailing the specific non-compliance. A copy of this letter will be forwarded to the appropriate Department/Division Head.

5.7.1.3. A Medical Staff member receiving a second letter for the same act of non-compliance for failure to comply with Section 5.7.1.1., will meet with the relevant Department Head and Vice President of Medical Affairs within seven (7)

working days. The meeting will be documented and a summary will be added to member's personnel file. This letter will remain on the member's file for five (5) years.

5.7.1.4. A Medical Staff member receiving a third letter for the same act of non-compliance will be automatically suspended from the Medical Staff for a period not less than one (1) week. An automatic letter of conduct will be added to the Medical Staff member's file, which will remain in the file for five (5) years, and a copy will be forwarded to the Chair of the MAC. Notice will be forwarded as well to the College of Physicians and Surgeons of BC as required by the Health Professions Act.

5.7.1.5. Medical Staff receiving a fourth letter for the same act of non-compliance will be referred to the MAC and the Board for revocation of privileges. This letter will remain on the Medical Staff member's file for five (5) years. Reinstatement of privileges will require reapplication and is not assured.

5.7.1.6. For reoccurring offences after Section 5.7.1.5:

5.7.1.6.1. Physicians receiving any letters for the same act of non-compliance will be dealt with by the process outlined in Section 5.7.1.4.

5.7.1.6.2. Physicians receiving a letter of warning after a five (5) year period with no warning letters issued to them will be dealt with in the process as outlined in Section 5.7.1.2. to 5.7.1.6.

5.7.2. Confidentiality of Quality Improvement Information

The Freedom of Information and the Protection of Privacy Act (FOIPPA) govern access to documentation within PHC. Medical Staff quality assurance and improvement activities within PHC facilities are conducted under the overall supervision of the Medical Advisory Committee (MAC) and the MAC Council for Excellence (MAC CfE), and are protected under Section 51 of the Evidence Act provided they are in compliance with Section 5.7.3. Section 51 of the Evidence Act overrides FOIPPA.

5.7.3. Hospital Quality Improvement Integration

Major interdepartmental recommendations and findings from Morbidity and Mortality (M&M) rounds and the quality improvement activities of Departments, Divisions, and Programs are to be recorded on a form that will be communicated to the MAC Council for Excellence (MAC CfE). A summary of quality improvement initiatives will be forwarded from MAC CfE to the MAC.

5.8. Medical Staff Orders

5.8.1. Orders in General

All orders must be in accordance with the scope of practice established for the applicable group (i.e., physicians, midwives, dentists,) under the *Health Professions Act.* All orders by Medical Staff require printed practitioner name, signature, and relevant BC College number.

5.8.2. Admitting Orders

The admitting Medical Staff Member shall provide orders necessary for the patient's care at the time of admission. The attending Medical Staff Member shall comply with medication order policies.

5.8.3. Orders for Treatment

5.8.3.1. Written Orders for Treatment

All notations in the medical record are to be dated, accurate, using clear and unambiguous language, legible, signed, and dated. All orders for diagnostic procedures, medication, treatment, or discharge of a patient must be signed by a member of the Medical Staff or Nurse Practitioner, and include:

- date and time stamp;
- the printed name of the person ordering;
- the signature of the person ordering; and
- the appropriate BC College license number of the person ordering

5.8.3.2. Telephone Orders for Treatment

If necessary, a Medical Staff Member may give orders for treatment via telephone to another Medical Staff Member or to a Registered Nurse. In such instances all of the requirements in Section 5.8.3.1. must be met at the time the order is received except for the signature of the person ordering. The person receiving the order must read back the order and confirm it is correct, and as well to the list in Section 5.8.3.1. add the following:

- name of the person receiving the order;
- professional designation (e.g. nurse) of the person receiving the order;
- professional college number of the person receiving the order; and
- signature of the person receiving the order.

Such orders shall be countersigned by the ordering Staff Member or designate as soon as possible, but no later than

twenty-four (24) hours after the event.

5.8.3.3. Verbal Orders for Treatment

Wherever possible, orders should be written. Verbal orders for treatment are generally for urgent-emergent situations where failure to do so may compromise patient care. Verbal orders are verified with a read-back process and co-signed by the prescribing professional with indication of role responsibilities and timelines. Verbal orders are not accepted for chemotherapy.

5.8.3.4. Orders for Treatment: Failure to Comply

5.8.3.4.1. Failure to comply with Sections 5.8.3.1., 5.8.3.2. or 5.8.3.3. will initiate a letter to the member of Medical Staff detailing the non-compliance. A copy of this letter will be forwarded to the appropriate Department/Division Head.

5.8.3.4.2. A member of Medical Staff receiving a second letter will receive a warning from the Department Head.

5.8.3.4.3. A member of Medical Staff receiving a third letter for failure to comply with Sections 5.8.3.1., 5.8.3.2. or 5.8.3.3. will need to complete the online Safe Prescribing module and meet with the Department Head and Vice President of Medical Affairs. The meeting will be documented and a summary will be added to his/her personnel file. The letter will remain on the Medical Staff member's file for five (5) years.

5.8.4. Residents Orders

Residents may write orders and prescribe controlled drugs according to PHC guidelines.

5.8.5. Pre-Printed Orders

A Department or Division may establish pre-printed orders for patients and residents under the care of members of the Department. Pre-printed orders shall be approved by the Department Head, Assistant Department Head, or Division Head in consultation with the Health Records Department. All pre-printed order forms must be approved by the PHC Forms Committee before implementation. The attending Medical Staff Member must sign the pre-printed order for each patient.

5.9. Responsibility for Provision of Medical Care of Patient

5.9.1. Continuous Care

5.9.1.1. Each member of the Medical Staff has a duty to comply with the Medical Staff Bylaws including the responsibility to ensure that the patient is continuously under appropriate and available care of a member of the Medical Staff. The admitting or attending Medical Staff Member shall not withdraw services prior to the patient's discharge without proper transfer of the patient's medical care in writing.

5.9.1.2. Any member of the Medical Staff who is away from practice (notwithstanding normal evening and weekend leaves) or who has transferred responsibility of care to another Medical Staff Member shall indicate the name(s) of the Medical Staff Member(s) assuming responsibility for the patient's care on the order sheet of the patient's health record. The receiving Medical Staff Member shall acknowledge acceptance of the transfer in writing on the order sheet. Where a pre-determined process exists that schedules and designates the MRP (e.g., on-call schedules and routine transfers of care for scheduled turnover of Medical Staff), the scheduled Medical Staff Member shall be considered the MRP.

5.9.1.3. If a Medical Staff Member wishes to withdraw from involvement in a patient's care when services are still required, the Medical Staff Member shall inform the patient and must arrange for another Medical Staff Member of appropriate qualification to assume responsibility for the care of the patient. This must be documented by both Medical Staff Members on the order sheet of the patient's health record.

5.9.1.4. In the event that an attending Medical Staff Member intentionally fails to attend upon a patient for whom he/she is responsible, the Department Head or delegate concerned shall designate an appropriate member of the Provisional, Active, or Locum Staff to be responsible for the patient and shall report the matter in writing to the Vice President of Medical Affairs, and to the Medical Advisory Committee.

5.9.1.5. A competent patient has the right to request a change in the attending Medical Staff Member. The attending Medical Staff Member shall cooperate in transferring responsibility for care to a new Medical Staff Member acceptable to the patient. If the attending Medical Staff Member fails to find an acceptable alternative Medical Staff Member, the Department Head shall appoint a Medical Staff Member who will continue to provide care to the patient until such

responsibility is transferred. If the Department Head is the attending Medical Staff Member, then the Vice President of Medical Affairs will be the alternate and appoint a Medical Staff Member who will continue to provide care to the patient until such responsibility is transferred. The transfer of care must be documented on the order sheet of the patient's health record.

5.9.1.6. When a patient requires transfer to another facility, the attending Medical Staff Member shall ensure that there is an appropriately qualified Medical Staff Member on staff at the receiving site who is fully informed about the patient's condition and is prepared to assume responsibility for the patient's care. The attending Medical Staff Member shall identify relevant documentation from the patient's health record to be photocopied and sent or electronically transferred to the receiving facility, in accordance with principles outlined in the Freedom of Information and Protection of Privacy Act.

5.9.2. Daily Care of Patients

5.9.2.1. A hospitalized patient admitted to an acute care bed must be seen by the attending Medical Staff Member or a Resident, appropriate on-call covering Medical Staff Member, or Nurse Practitioner as frequently as required, typically daily. Stable patients awaiting transfer procedures or surgery may not require daily visits although they must be seen as needed and at the request of nursing or allied health care staff.

5.9.2.2. A progress note shall be written after each patient visit and more frequently if necessary, by the attending Medical Staff Member, a Resident, appropriate on-call covering Medical Staff Member or Nurse Practitioner. The note shall provide sufficient detail to allow the formulation of a reasonable picture of the patient's clinical status at the time of observation and shall reflect the involvement of the attending Medical Staff Member in the patient's care.

5.9.3. On-Call Coverage

5.9.3.1. Each Department and/or Division shall ensure that an on-call Medical Staff Member is available to provide care twenty-four (24) hours per day, seven (7) days per week.

5.9.3.2. The Department Head or delegate, if applicable, shall assign each member to a reasonable on-call schedule.

5.9.3.3. All members of the Medical Staff shall participate in departmental on-call rosters, except in special

circumstances approved by the Department Head and the MAC.

5.9.3.4. Each Department and/or Division shall ensure a rotation of members to provide emergency coverage at all times and shall routinely provide a list of such rotation to the Emergency Departments, Medical Affairs, and the PHC Call Centre (Switchboard). The list must be updated as changes occur.

5.9.3.5. On-call Medical Staff Members will be expected to maintain acceptable levels of availability. Those Departments, whose Medical Staff Members deal with life-threatening emergencies, shall delineate the method of obtaining the assistance of another member of the Medical Staff when the first Medical Staff Member on-call cannot respond within these timeframes.

5.9.3.6. Physicians, dentists, or midwives holding appropriate PHC privileges may provide on-call services for physicians, dentists, or midwives within a facility operated by PHC, including admitting and caring for patients under the name of the colleague for whom call is being provided. Where the individual is primarily appointed at VCH or another non-PHC site, a cross-appointment to PHC will be arranged through Medical Affairs at the request of the Department Head.

5.9.4. Delegated Functions

Members of the Medical Staff may delegate certain functions that have been approved by Senior Management. Medical functions may be delegated to a variety of health professionals, following the process outlined below.

A delegated medical function is a medical act that, with the agreement of the relevant Department, has been formally transferred to another health care professional in the interest of good patient care and efficient use of health care resources. The process of delegation to other health professionals must be consistent with the Health Professions Act.

5.9.4.1. Delegation is required for reserved actions that fall outside the scope of practice of the receiving health professional.

5.9.4.2. Delegated medical functions are identified by mutual agreement among the representatives of the Medical Staff and the Professional Practice Council.

5.9.4.3. Delegated medical reserved acts are recommended to the Chief of Professional Practice and Nursing and approved to go forward through the external process by the Medical Advisory Committee.

5.9.4.4. The request for delegation of the reserved action is then forwarded to both the College of Physicians and Surgeons of BC and the regulatory body of the receiving discipline for approval that the reserved action is appropriate for delegation.

5.9.4.5. Even when the two (2) regulatory bodies agree that the reserved action may be delegated, the decision to delegate remains with the individual delegating physician and the decision to accept the delegation remains with the individual receiving health professional.

5.9.4.6. A delegating physician with relevant expertise must ensure that the required knowledge and skills are appropriately taught, and confirm that the receiving health professional has the competence to perform the reserved action.

5.9.4.7. Written instructions must be provided for the delegated action.

5.9.4.8. The delegating physician and the receiving health professional are jointly responsible for ensuring that ongoing competence is maintained through mechanisms such as continuing education, experience, re-evaluation and retraining.

5.9.4.9. Professional Practice Leaders must ensure that records of health professionals qualified to perform delegated medical actions are maintained.

5.10. Organ Donation and Retrieval

(With the establishment of a Provincial Donor Registry and the Human Tissue Gift Act, amendments to this rule concerning the process for organ donation and removal should be updated regularly to reflect provincial policy.)

5.10.1. Privileges for Organ Retrieval

Temporary privileges may be granted by the Vice President of Medical Affairs, or in their absence a delegate, to physicians for situations such as organ retrieval.

5.10.2. Consent

Consent for solid organ donation shall be obtained from the next-of-kin (the hierarchy of the next-of-kin is specified by the Human Tissue Gift Act) after the declaration of neurological death, on the appropriate consent form by a member of the Medical Staff or a Resident. Telephone consent requires two (2) witnesses (nurse or physician).

In the event of eye or non-solid organ tissue donation only, consent shall be obtained from the next-of-kin after cardiac death, by a member of

Nursing Staff, Medical Staff or a Resident, or an employee of the Eye Bank or the Tissue Bank of British Columbia. The physician and the nurse collaboratively decide who is most appropriate to obtain consent for eye donation. The Eye Bank requires two (2) members of the Nursing Staff to witness telephone consent.

5.10.3. Determination of Death

5.10.3.1. In the declaration of neurological death for organ donation, consultation shall be held with a neurosurgeon or neurologist, or the medical practitioner with the highest level of neurological skills available at the health care facility.

5.10.3.2. In the case of solid organ donation, the criteria for the diagnosis of neurological death published by the Canadian Congress of Neurological Sciences (1986), and available from the Organ Retrieval Team, will be followed in accordance with Part 2, Section 7 of the Human Tissue Gift Act.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1491995/pdf/cmaj00134-0115.pdf

5.10.4. Physiological Maintenance of Organ Donor

5.10.4.1. In the event of solid organ donation, responsibility for the physiological maintenance of the solid organ donor after the declaration of neurological death may be transferred, at the discretion of the attending physician, to a member of the Organ Retrieval Team.

5.10.4.2. In the case of solid organ donation, after the declaration of neurological death, and in the event that the attending physician has transferred responsibility of care to the Organ Retrieval Team, standing orders (available from the organ retrieval team) may be followed, and verbal orders may be given to a registered nurse or a respiratory therapist for the physiological maintenance of the donor. Any deviation from standing orders protocol will be discussed in consultation with the attending physician.

5.11. Pronouncement of Death, Autopsy and Pathology

5.11.1. Pronouncement of Death

In expected death, the decision as to who is the appropriate person to pronounce death is made collaboratively between the physician and nurse.

5.11.2. Medical Certificate of Death

The MRP physician or delegate who is a fully licensed physician shall

complete the medical certificate of death or the medical certificate of stillbirth within forty-eight (48) hours of death.

5.11.3. Report to the Coroner

As stated by the Coroners Act, anyone who believes the deceased fits the criteria for reporting outlined in the Coroners Act can notify the Coroner or a peace officer.

http://www2.gov.bc.ca/gov/content/safety/public-safety/death-investigation

5.11.4. Autopsy

No autopsy shall be performed without order of the Coroner or written consent from the appropriate next-of-kin or legally authorized agent of the patient.

5.11.5. Permission for Autopsy

In appropriate cases the attending physician shall make all reasonable efforts to obtain permission for the performance of an autopsy.

5.11.6. Diagnostic Material

All tissue or material of diagnostic value shall be sent to the Department of Pathology, except as noted below.

Autologous or non-autologous specimens removed during an operation, but do not require pathologic evaluation and will not be sent to the laboratory, must be recorded in operative record. The following specimens removed during an operation will not be sent to the Laboratory:

- Old Prosthesis (hip and knee)
- Orthopedic hardware
- Ureteral stents
- Tissue Expanders
- Breast implants
- Penile implants
- Groshong catheters
- Peritoneal dialysis catheters
- Mesh for sealing abdominal hernias
- Gastric bands from obesity surgery
- Liposuction fluid
- Intrauterine contraceptive devices
- Vaginal mucosa from anterior and posterior repairs
- Normal placentas

- Benign asymptomatic scars from previous surgery (not oncology surgery)
- Anal/rectal foreign bodies removed under anesthesia
- Teeth
- Cataracts
- Arthroscopic meniscectomy tissue
- Joint surface bone and femoral heads from joint replacement and hip fractures
- Orthopaedic devices and implants that have been analyzed
- Skin Graft

A Pathology report will be generated with gross description only for the following specimens:

- Any foreign material that may subsequently lead to criminal/medicolegal investigation (e.g., bullets, other objects used in assaults, certain types of breast implants or faulty prostheses, such as stents, pacemaker catheters)
- Other material for identification purposes (e.g., ureteral stones for biochemical analysis, varicose veins, scars, bones from hip and knee replacements)

5.11.7. Pathology Specimens

Pathology specimens including body tissues, organs, materials, and foreign bodies shall not be released without due authorization of the Head of the Department of Pathology and Laboratory Medicine or delegate.

5.12. Residential Care

Medical care of residents in PHC's Residential Care facilities differs in many aspects from medical care provided to patients in an acute-care setting. Those differences are recognized in this section.

5.12.1. Moving into Residential Care

5.12.1.1. Every resident shall be assessed and attended by a member of the Medical Staff who has appropriate privileges and who has primary responsibility for the care of the resident.

5.12.1.2. No resident can move in without a complete and current medical record as outlined in Section 5.12.3.

5.12.1.3. No resident can move in without first having been assessed for the risk of tuberculosis. This assessment (and any subsequent initial management) should be undertaken by

the community or acute care MRP in line with Provincial guidelines.

5.12.2. Resident Care and Treatment

5.12.2.1. Orders (including general, medical and therapeutic orders) written by the previous (community or acute) MRP and in effect at time of moving in will be reviewed by the designated Residential Care MRP either on-site (in person) or by phone, or by fax as appropriate. The MRP will confirm, reject, or modify said orders, which will then become the initial Residential Care orders. Documentation will occur as per Section 5.12.3.3. and 5.12.3.4. Medication orders on admission will be reviewed through a formal medication reconciliation process involving pharmacy, nursing and the MRP.

5.12.2.2. The Residential Care MRP shall visit the new resident within seven (7) days and thereafter at appropriate intervals as clinically indicated. Timing and/or urgency of initial and subsequent visits will take into consideration information from appropriate sources. These sources may include: contact with previous MRPs or consultants, contact with the nurse practitioner, relevant submitted historical documentation, recent clinical instability, nursing staff concerns, or family concerns.

5.12.2.3. Advance Directives for care (level of intervention and resuscitation orders) shall be completed in a timely manner, preferably while still in the acute care or community setting, and then updated as clinically indicated within Residential Care.

5.12.2.4. Medical Staff Members holding appropriate privileges within Providence Health Care may provide on-call services for PHC physicians or dentists.

5.12.2.5. The MRP, Medical Coordinator or physician delegate shall carry out a Drug Review at least every one hundred and eighty (180) days in collaboration with the pharmacist or nurse, as appropriate.

5.12.2.6. If, in the opinion of the nurse, the condition of a resident changes significantly, the MRP or delegate shall be informed and shall act promptly according to the urgency of the situation.

5.12.2.7. If, in the opinion of the Medical Coordinator, the condition of a resident is such that it poses a risk to other residents or to staff, and appropriate consultation, referral or transfer has

not been arranged by the MRP, such consultation, referral or transfer may be arranged by the Medical Coordinator.

5.12.2.8. In instances where transfer of care to another Medical Staff Member outside the Residential Care facility becomes necessary (e.g. ER), then the Residential Care MRP will facilitate communication with the intended care-provider as appropriate. Said communication may consist of nursing notes or chart documentation only, but often will include physician to nurse contact. The degree and urgency of contact will depend on the clinical context and complexity, and may also take into account family issues or levels of intervention.

5.12.2.9. The MRP, NP, or delegate shall obtain a consultation when appropriate. Where a consultation is required urgently and the MRP, NP, or delegate is not available, the Medical Coordinator or delegate may authorize a consultation.

5.12.2.10. Consultants requested to see patients shall be members of the PHC Medical Staff and shall provide a written report on the resident's chart.

5.12.2.11. The MRP shall be invited to attend interdisciplinary conferences to discuss and plan resident care. In the absence of the MRP, the Medical Coordinator or delegate shall make recommendations regarding care to the multidisciplinary team and the MRP.

5.12.2.12. Although the pronouncement of death may be done by a registered nurse, the completion of the Certificate of Death remains the responsibility of the MRP or properly licensed delegate in all circumstances.

5.12.2.13. The MRP, or delegate, shall notify the Coroner of deaths that require notification under the Coroners Act.

5.12.3. Health Records

5.12.3.1. Any resident moving in from Acute Care shall have a complete residential health record documented by the Hospital MRP. Any Resident moving in from the community shall have a complete residential Health record documented by the community-based MRP. The residential health record shall include:

- A list of current diagnoses and problems
- A past medical history, including significant past illnesses, surgeries, and diagnostic tests

- Allergies and drug sensitivities
- A record of a physical examination performed within the previous three (3) months
- A mental or mini-mental status assessment, as appropriate
- Results of relevant current laboratory tests or other diagnostic investigations
- A management plan including drug orders, particular dietary restrictions, activity restrictions, precautions, etc.
- A summary or copies of relevant consultant reports
- Relevant functional assessments
- Special precautions (e.g. infectious diseases, emotional or behavioural disturbances, etc.)

5.12.3.2. All orders for medical treatment shall be in writing and signed by a practitioner with Medical Staff privileges or Nurse Practitioner.

5.12.3.3. Orders in effect when a resident moves in, written by the prior acute or community MRP, may become de facto residential care orders on countersigning by the residential care MRP or as per Section 5.12.3.4.

5.12.3.4. An order for medical care may be dictated over the telephone to a registered nurse. An order dictated over the telephone shall be "read back" by the person receiving the order to confirm that it is correct, written over the name of the ordering practitioner and be signed by the person to whom it is dictated. Orders may be faxed if first signed by a medical practitioner or Nurse Practitioner.

5.12.3.5. An appropriately comprehensive and updated "history and physical shall be completed by the residential care MRP or designate within thirty (30) days of moving in, using the standard "history and physical template".

5.12.3.6. Dated and legible progress notes shall be documented at the time of each visit. Progress notes should describe any significant changes in the resident's condition, list reasons for significant changes of treatment, and document outcomes of treatment as appropriate.

5.12.3.7. All orders for controlled drugs and antibiotics shall be written with a stated limit as to the number of doses, or the hours or days of administration. Telephone orders for controlled drugs shall be countersigned by the ordering practitioner

within seven (7) days. For drug orders written without such dosage or time limit, an automatic stop order shall be implemented.

5.12.3.8. A comprehensive assessment or care conference summary, which includes end of life discussion of the resident, shall be documented annually.

5.12.3.9. The MRP shall complete and sign the resident's discharge summary stating the significant contributory diagnoses and presumed terminal event(s), within thirty (30) days following discharge of said resident.

5.12.3.10. Physicians pronouncing death shall record the time, date, and cause of death (if known) in the progress notes.

5.12.3.11. Immediately following the provision of care, dentists, podiatrists or other health professionals treating residents shall enter into the resident's health record a description of the treatment or procedure performed.

6. CLINICAL FELLOWS, RESIDENTS AND STUDENTS

6.1. Categories

6.1.1. Clinical Fellows

Clinical Fellows shall consist of those physicians who:

6.1.1.1. Have applied directly to and have been accepted by a Department of PHC for ongoing clinical training.

6.1.1.2. Have been approved as Clinical Fellows by the appropriate faculty of the University of British Columbia.

6.1.1.3. Have adequate liability insurance and are licensed by the College of Physicians and Surgeons of BC, The College of Dentistry of BC, or the College of Midwifery of BC.

6.1.1.4. Appointment of Clinical Fellows shall be made as appropriate during the course of the year by the Vice President of Medical Affairs on the recommendation of the appropriate Department Head or the Director of Medical Education.

6.1.1.5. Duties and Responsibilities

Clinical Fellows may attend patients and residents under the direct supervision of a member of the Active or Provisional

staff who is responsible to the Department Head and PHC for the work performed. They:

6.1.1.5.1. May carry out such duties as are assigned them by the Head of the Department or Division to which they have been appointed

6.1.1.5.2. May not admit patients and residents to the facility except under the direction of a member of the Medical Staff

6.1.1.5.3. Should attend Departmental clinical conferences and rounds regularly

6.1.1.5.4. May not vote at Medical Staff meetings and are not eligible to be officers of the Medical Staff Association.

6.1.2. Residents

Residents (see earlier definition) may hold office in Resident personnel organizations in the Hospital and may vote on committees to which they are appointed.

6.1.2.1. Duties and Responsibilities

Residents:

6.1.2.1.1. may attend patients and residents under the direct supervision of a member of the Active or Provisional Medical, Dental, or Midwifery Staff who is responsible to PHC for the work performed

6.1.2.1.2. may carry out such duties that are assigned them by the Head of the Department or Division to which they have been assigned

6.1.2.1.3. should attend Departmental clinical conferences and rounds regularly

6.1.2.1.4. may not admit patients and residents to the facility except under the direction of a member of the Medical Staff

6.1.2.1.5. may not vote at Medical Staff meetings and are not eligible to be officers of the Medical Staff

6.1.2.1.6. may not sign birth or death certificates unless fully licensed by the College of Physicians and

Surgeons of BC (CPSBC)

6.1.2.1.7. a Resident who is providing clinical services outside of his/her current UBC resident rotation (i.e., a "moonlighting resident"), and is therefore functioning outside of his/her educational program, will be subject to the same process for appointment to the PHC Medical Staff as outlined in Section 3.3. Such appointments to Medical Staff would normally be made at the Associate level.

6.1.3. Medical Students

6.1.3.1. Appointments

Medical students (see earlier definition) are undergraduate students of the UBC Faculty of Medicine.

6.1.3.2. Duties and Responsibilities

Medical students who attend patients and residents must do so under the direct supervision of a member of the Active or Provisional Medical Staff who is responsible to PHC for the work performed. A medical student:

6.1.3.2.1. must ensure orders are approved by the MRP or Resident

6.1.3.2.2. shall not sign certificates of birth or death

6.1.3.2.3. may not discharge any patient without appropriate review by a qualified physician

7. ORGANIZATION OF THE MEDICAL STAFF

7.1. General Organization

7.1.1. Regional Department, Department, Divisions, and Sections

After considering the recommendations of the Medical Advisory Committee, the Board shall, from time-to-time:

7.1.1.1. organize the Staff or any part thereof into such Departments/Regional Departments, Divisions, and Sections as it may see fit, as provided herein

7.1.1.2. appoint the Heads thereof

7.1.1.3. assign all members of the Staff to a Department, Division, or Section according to the qualifications of each member

7.1.2. Department Structure

Each PHC Department forms part of the corresponding VCH and PHC Regional Department. Each Division shall form part of a Department. A Division Head will report to the appropriate Department Head. The Department Head reports to the MAC and has dual accountability to the PHC Vice President of Medical Affairs as well as the VCH and PHC Regional Department Head.

7.1.3. Cross-Appointment

A member of the Medical Staff may be cross-appointed in more than one Department or Division, but must identify a primary appointment.

7.2. Departments and Divisions

7.2.1 The Board, after considering the recommendations of the Medical Advisory Committee, shall establish Departments and Divisions. The currently established Departments and Divisions are:

DEPARTMENT	DIVISION
Anesthesia	Acute & Interventional Pain Management Cardiac Anesthesia
Emergency Medicine	
Family Medicine	Palliative Care Residential Care Addiction Medicine FP Obstetrics
Medicine	AIDS/HIV Cardiology Critical Care Dermatology Endocrinology Gastroenterology Geriatric Medicine Hematology Immunology Infectious Diseases Internal Medicine Nephrology Neurology Rehabilitative Medicine Respiratory Medicine Rheumatology
Midwifery	

DEPARTMENT	DIVISION
Obstetrics & Gynecology	
Ophthalmology	
Orthopaedics	
Paediatrics	New Born Care (Neonatology)
Pathology and Laboratory	
Psychiatry	Geriatric Psychiatry Youth Psychiatry
Radiology	Nuclear Medicine
Surgery	Cardiovascular & Thoracic Surgery General Surgery Otolaryngology Plastic Surgery Urology Vascular Surgery

7.3. Department and Division Meetings

7.3.1. Each Department and Division shall meet at least ten (10) times per year and more frequently if required to conduct its administrative affairs, quality of care reviews, teaching, and service commitments. Records of the meetings shall be kept and attendance shall be recorded.

7.3.2. Members of the Provisional and Active Staff shall attend at least seventy percent (70%) of Departmental business meetings, and fifty percent (50%) of Department and Division quality-of-care meetings appropriate to their specialty. The Department Head concerned may modify this rule in the case of a member of the Medical Staff who is actively contributing to the Medical Staff organization in some other way, such as through committee service. Failure to attend the requisite number of meetings may be grounds for suspension from the Medical Staff.

7.3.3. A Quorum at Department and Division meetings shall consist of twenty-five percent (25%) plus one (1) member of the eligible voting members.

7.3.4. An Executive Committee shall be struck by the Department Head. The Executive Committee could be comprised of the Department Head, Assistant Department Head, Division Heads, and other members at the discretion of the Department Head.

7.3.5. Under the direction of the Department Head, the Department Executive Committee shall review, investigate, and evaluate matters concerning manpower planning, appointments, quality of medical care, Mortality and Morbidity, education and discipline. They shall coordinate, with the Department Head and the relevant Program Directors, the planned and efficient use of PHC resources by the Department.

7.3.6. Voting on all motions shall be by a show of hands, or by secret ballot, as directed by the Department Head, or by a majority of those present. In cases of a split vote, the presiding officer shall cast the deciding vote.

7.4. Appointment of Department and Division Heads

7.4.1. Department Head

Department Heads are appointed by the Board to set goals for their respective Departments, to manage physician professional practice within their Departments, to direct departmental academic activities, and to participate in fulfilling the obligations and responsibilities of the MAC. Appointments are subject to the Affiliation Agreement between the Faculty of Medicine of the University of British Columbia and PHC and, where the Department Head is also a University Department Head, subject to the terms of reference for Joint Faculty of Medicine/Hospital Department Heads.

7.4.1.1. Search Committee

When a Department Head is vacant or about to become vacant, the Medical Advisory Committee shall appoint a Search Committee in accordance with the Affiliation Agreement. Membership on the Committee shall include:

- The Chair or Vice Chair of the Medical Advisory Committee, who shall chair the Search Committee
- The Regional Department Head, who shall co-chair the Committee
- The Head of the University Department concerned, or delegate
- The Assistant Department Head, if any
- Representatives from PHC Administration, including the Vice President of Medical Affairs, and the most appropriate Clinical Vice President
- At least two (2) representatives from the Department concerned
- At least one (1) other Department Head appointed by the Medical Advisory Committee
- One (1) member of the elected Medical Staff Association
- Other Members as deemed appropriate

The Search Committee shall make its recommendations to the Medical Advisory Committee and to the Vice President of Medical Affairs.

7.4.1.2. Appointment of Department Head

The Board of Directors shall appoint a Head of each established Department for a term not exceeding five (5) years, in accordance with the Affiliation Agreement, after receiving the recommendation of the President and CEO, the Vice President of Medical Affairs, and the Medical Advisory Committee. A Department Head may be appointed for a maximum of two (2) consecutive five (5) year terms.

In extraordinary circumstances, it may be appropriate for an individual to serve beyond their second five (5) year term. In any such circumstance, this must be considered by the MAC, which will either make a recommendation to the Board on an annual basis to extend the individual's appointment(s), or recommend a specific term for extension.

7.4.1.3. Review of Department Head

7.4.1.3.1. As the end of each five (5) year term approaches, a review of the Department's clinical, academic and leadership performance shall be conducted. This review is normally conducted by up to two (2) reviewers, depending on the size and complexity of the respective Department, and shall be mutually agreed upon by the Vice President of Medical Affairs and the Chair of the MAC, with input from the Department Head. The reviewers are typically recognized leaders in their discipline, and considered free of conflict.

7.4.1.3.2. Disposition of Review

The final report of the reviewer(s) is provided to the Department Head who shall have an opportunity to provide a written response. The report and the response shall be provided to the MAC and any search committee, if applicable. The recommendations of the report and the response of the Department may be made available to others as appropriate, including SLT and the Board.

7.4.1.4. Joint Appointments of Department Heads for PHC and the University of British Columbia

7.4.1.4.1. The appointment shall be approved by the Board of Directors of PHC and the Board of Governors of the University of British Columbia, under the

provisions of the Affiliation Agreement.

7.4.1.4.2. The jointly-appointed Head of a Department shall hold a University Faculty appointment and shall be a member of the Provisional or Active Medical Staff of PHC, selected on the basis of training, experience and demonstrated ability in clinical, teaching and administrative activities.

7.4.1.4.3. The Department Head may be reappointed for a second five (5) year term, as outlined in the Affiliation Agreement, after review by a committee appointed by and co-chaired by the Chair of the Medical Advisory Committee and the University Department Head.

7.4.1.4.4. A Department Head who is also the Head of a University Department may hold a similar office in another facility.

7.4.1.5. Accountability of the Department Head

The Department Head shall be accountable to the Board of Directors, through the Vice President of Medical Affairs, and shall report at meetings of the Medical Advisory Committee.

7.4.1.6. Responsibilities and Duties of Department Heads

The Department Head is responsible for the organization of the Medical Staff for a designated department and all issues related to professional practice and performance of the Department's Medical Staff. The Head must ensure that the standard of medical practice within Providence Health Care complies with policies established by the Board, the College of Physicians and Surgeons of BC (and the College of Midwives of BC, the Board of Examiners in Podiatry of BC, or the College of Dental Surgeons of BC if appropriate), and professional societies such as the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada. The Head shall also ensure that education and research objectives are met in accordance with the Master Affiliation Agreement between PHC and the University of British Columbia. General responsibilities are outlined in the PHC Department Head position description. These duties are carried out in collaboration with the Head of Regional Department for Vancouver Coastal Health and Providence Health Care and the relevant Department of the University of British Columbia.

Specific responsibilities and duties of the Department Heads are as follows:

7.4.1.6.1. To ensure that all Department Medical Staff understand the Mission, Vision, Values and Strategic Directions, goals and objectives of PHC.

7.4.1.6.2. To develop and implement Departmental goals and objectives consistent with the Mission, Vision, Values and Strategic Directions, goals and objectives of PHC.

7.4.1.6.3. To develop and implement a PHC-wide Medical Staff human resources plan for the Department to ensure that the organization has the necessary Medical Staff to achieve its strategic directions and fulfill its mission, in collaboration with the Regional Department Head and appropriate Program and academic leaders.

7.4.1.6.4. To allocate access to PHC resources for the Department in a fair and objective manner in collaboration with the Program Leadership.

7.4.1.6.5. To direct the planning of all medical teaching and research activities within and related to the Department.

7.4.1.6.6. To develop as necessary a Departmental budget and establish mechanisms to monitor and control costs so that the Department operates within that budget.

7.4.1.6.7. To evaluate and make recommendations concerning persons wishing to be appointed to the Medical Staff, including making recommendations regarding admitting and other privileges, where appropriate, consistent with the needs of the PHC department.

7.4.1.6.8. To make recommendations regarding appointment of all categories of Medical Staff and Fellows to the Department.

7.4.1.6.9. To oversee the Medical Staff working in their departments and ensure a high standard of patient care is delivered by such Medical Staff members.

7.4.1.6.10. To call to account, when necessary, Medical Staff members of the department regarding patient care they have delivered.

7.4.1.6.11. To make recommendations where necessary regarding cancellation, reduction, or curtailment of privileges in PHC, following the process outlined herein and pursuant to the Hospital Act and its Regulation.

7.4.1.6.12. To summarily suspend or limit the privileges to practice in the hospital, when necessary, of any Medical Staff member whose behaviour appears to be contrary to the well-being of the patients or PHC, and to appoint another Medical Staff to undertake care of the patients in PHC who were the responsibility of the suspended Medical Staff member.

7.4.1.6.13. To designate a Medical Staff member to be responsible for the patient of any Medical Staff member who fails to render adequate care.

7.4.1.6.14. To assign duties and responsibilities to members of the department in keeping with the goals and objectives of PHC.

7.4.1.6.15. To implement appropriate educational and research activities in alignment with PHC's Strategic Plan and the needs of the UBC undergraduate and postgraduate programs.

7.4.1.6.16. To arrange and chair Department meetings as required in these Rules.

7.4.1.6.17. To ensure that members of the department attend Departmental meetings as required by these Rules.

7.4.1.6.18. To Review deaths occurring within PHC, statistics regarding the progress of patients, methods of treatments, results of surgery, patient safety and all cases of abnormal length of stay of patients in PHC, and make such recommendations as may be appropriate.

7.4.1.6.19. To meet annually with the Vice President of Medical Affairs to make recommendations concerning the reappointment of each Medical

Staff member in the Department.

7.4.1.7. Interim Department Head

In circumstances where a Department Head relinquishes his/her role or has his/her appointment revoked, an Interim Department Head may be appointed by the Board of Directors on the recommendation of the President and CEO, the Vice President of Medical Affairs, and the Chair of the MAC, for a period of six (6) months. An interim appointment may be renewed as necessary until the position can be filled through the Search and Selection process outlined in Sections 7.4.1.1. and 7.4.1.2. above.

7.4.2. Assistant Department Heads

7.4.2.1. Appointment of Assistant Department Head

The Vice President of Medical Affairs, in consultation with the Department Head, may appoint an Assistant Department Head.

7.4.2.2. Responsibilities of the Assistant Department Head

The Assistant Department Head shall generally fulfill the same responsibilities for the functioning of the Department at the sites he/she is responsible for as does the Head for the entire Department, as outlined in Section 7.4.1.4. The Assistant Head shall be responsible to and work in collaboration with the Department Head. Major responsibilities are outlined in the PHC Assistant Department Head job description. Assistant Heads are normally appointed for a five (5) year term, renewable once.

7.4.3. Division Heads

A Division Head shall be a member of the Provisional or Active Medical Staff selected on the basis of qualifications by training, experience and demonstrated ability in clinical, teaching and administrative activities. A Division Head may, with the approval of the Dean of the Faculty of Medicine and the PHC Department Head, hold a similar office in another facility.

7.4.3.1. Appointment of Division Head

The Board of Directors, after receiving the recommendation of the appropriate Department Head, shall appoint a Division Head for each established Division, for a term not exceeding five (5) years, renewable once.

In extraordinary circumstances, it may be appropriate for an individual to serve beyond their second five (5) year term. In any such circumstance, this must be considered by the MAC, which will either make a recommendation to the Board

on an annual basis to extend the individual's appointment(s), or recommend a specific term for extension.

7.4.3.2. Review of Division Head

Following the end of each five (5) year term, the Department Head shall conduct an internal review of the Division's clinical, academic and leadership performance. The Vice President of Medical Affairs and the Department Head shall mutually agree to the selection of reviewer(s), following input from the Division Head.

7.4.3.3. Disposition of Review

The final report of the reviewer shall be provided to the Division Head who shall have an opportunity to provide a written response. The final report, together with the Division Head's response shall be considered during the appointment/reappointment process for Division Heads. The review and response will be available to other relevant parties including Division Members, SLT and the Board.

7.4.3.4. Reappointment of Division Head

Following the review outlined in Section 7.4.3.2., and any other review process deemed appropriate by the Department Head and the Vice President of Medical Affairs, the Department Head may recommend the appointment of a Division Head to a second term, or the appointment of a new Division Head.

At any time the Board of Directors, after receiving the recommendation of the Medical Advisory Committee and the Department Head, may:

7.4.3.4.1. Withdraw such an appointment

7.4.3.4.2. Appoint an Interim Division Head

7.4.3.4.3. Appoint the Department Head as Division Head of one (1) or more Divisions of the Department

7.4.3.5. Authority of Division Head

The Division Head shall oversee the professional practice of members of the Division and shall be responsible to the Department Head. A Division Head shall assist the Department Head in the management of the Division on the authority delegated by the Department Head.

7.4.3.6. Responsibilities of the Division Head

The Division Head shall generally fulfill the same

responsibilities for the management of the Division as does the Head for the Department, as outlined in Section 7.4.1.6, but shall be responsible to the Department Head. General responsibilities are outlined in the PHC Division Head Position Description.

7.4.3.7. Interim Division Head

An Interim Division Head may be appointed by the Board of Directors on the recommendation of the Medical Advisory Committee and the appropriate Department Head for a period of six (6) months. An interim appointment may be renewed as necessary until the position can be filled through the Search and Selection process outlined in Section 7.4.3.1. above.

7.5. Appointment of a Regional Department Head

7.5.1. The Board of Directors of VCH and PHC shall appoint a Head of each established Regional Department for an initial term not exceeding five (5) years, in accordance with applicable Affiliation Agreements, after receiving the recommendation of their respective Presidents, Vice President of Medicine, and Medical Advisory Committees.

7.5.2. Each Regional Department Head shall be a member of the Provisional or Active Medical Staff of VCH and PHC.

7.5.3. The Regional Department Head shall report and be accountable to the Vice Presidents of Medicine of VCH and PHC and to their respective Boards, through the Vancouver Coastal Health Authority Medical Advisory Committee (HAMAC), and the PHC MAC, for the activities of the Regional Department and its members.

7.5.4. All members of the Medical Staff of VCH and PHC with membership in a Regional Department are eligible to hold the position of Regional Department Head.

7.5.5. The Regional Department Head shall be remunerated at a rate agreed upon by VCH and PHC.

7.5.6. The appointment and remuneration for the position of Regional Department Head shall be detailed in a contract outlining the purpose, responsibilities, accountabilities and objectives of the role.

7.5.7. The VCH and PHC Boards may reappoint the Regional Department Head for a second term upon recommendation from the Vice Presidents of Medicine, HAMAC, and the PHC MAC. A Regional Department Head may be appointed for a maximum of two (2) consecutive five (5) year terms.

7.5.8. In recommending re-appointment of the Regional Department Head, the Vice Presidents of Medicine shall consider the results of annual performance reviews. The process for performance reviews shall be described in the Regional Department Head's contract.

7.5.9. Selection Process for Regional Department Heads

7.5.9.1. Where a vacancy exists or following the resignation of a Regional Department Head, a search for a Regional Department Head shall be conducted.

7.5.9.2. HAMAC and the PHC MAC shall appoint a Search and Selection Committee in accordance with their respective Affiliation Agreements. Membership on the Committee shall include:

7.5.9.2.1. The Chairs or Vice Chairs of HAMAC and the PHC MAC (maximum of one (1) from each committee), one (1) of whom shall chair the Search Committee, and the other of whom shall act as Co-Chair.

7.5.9.2.2. The Chair of the appropriate University Department, or delegate.

7.5.9.2.3. The Associate Regional Department Head, if any, and all Associate (Site) Heads of that Department.

7.5.9.2.4. Representatives from VCH and PHC Administration, including the respective Vice Presidents of Medicine.

7.5.9.2.5. At least two (2) representatives from the Department concerned.

7.5.9.2.6. At least one (1) other Department Head appointed by the Chair and Co-Chair.

7.5.9.2.7. Other Members as deemed appropriate.

7.5.10. The Search and Selection Committee shall make its recommendations to the Vice Presidents of Medicine, HAMAC, and the PHC MAC.

7.5.11. The Search and Selection Committee shall only recommend for approval a Regional Department Head candidate who is supported by the majority of Associate (Site) Heads.

7.5.12. The process used by the Search and Selection Committee shall comply with relevant VCH and PHC corporate policies.

7.5.13. HAMAC and the PHC MAC shall review and, if in agreement, approve the recommendation of the Search and Selection Committee prior to the recommendation of a candidate for Regional Department Head to their respective Boards.

7.6. Joint Appointments of Regional Department Heads for VCH, PHC and the University of British Columbia (UBC)

7.6.1. The appointment shall be approved by the VCH and PHC Boards of Directors, as well as the UBC Board of Governors under the provisions of their respective Affiliation Agreements.

7.6.2. The jointly-appointed Regional and UBC Department Head shall hold a University Faculty appointment and shall be a member of the Provisional or Active Medical Staffs of VCH and PHC, selected on the basis of training, experience and demonstrated ability in clinical, academic and administrative activities.

7.6.3. The joint Regional and UBC Department Head may be reappointed for a second five (5) year term, as outlined in the Affiliation Agreements, after review by a committee appointed and co-chaired by the Chairs of HAMAC and the PHC MAC together with a representative of the Dean of the Faculty of Medicine, UBC.

7.6.4. A Regional Department Head who is also the Chair of a University Department may hold a similar office in another facility.

7.7. Direction of Board

7.7.1. Nothing set forth in this Section 7 shall be construed to limit the Board's right and authority to change, modify, delete and add to each or any of the foregoing duties and obligations in such manner and to such extent as the Board may deem necessary or appropriate.

7.8. Suspension or Termination

7.8.1. Notwithstanding anything to the contrary in this Section 7, the Board may, in its sole discretion, at any time, suspend or terminate the appointment of any VCH and PHC Regional Department Head, Department Head or Division Head. In the event the Board intends to consider the suspension or termination of a VCH and PHC Regional Department Head, Department Head or Division Head, the Medical Staff member involved shall be given reasonable notice of such and shall have the right to appear before the Board to make representation.

8. Medical Staff Association Structure

8.1. Officers of the Medical Staff Association

8.1.1. Officers of the Medical Staff Association

The officers of the Medical Staff Association shall be the President, Vice President, Secretary-Treasurer, and up to four (4) members-at-large who shall constitute the Medical Staff Executive Committee (MSEC). Five (5) members of the MSEC shall be voting members of the Medical Advisory Committee.

8.1.2. Election Procedure

The elections will be by acclamation or by a simple majority vote by all Active Staff Members present and eligible to vote. Up to seven (7) positions for the MSEC shall be elected at an annual meeting of the Medical Staff Association, following a process led by the Nominating Committee to solicit candidates. MSEC members shall hold office for a term of up to two (2) years, renewable once, contingent upon maintenance of appointment to the Provisional or Active Staff. The second term would be only one (1) year consistent with the Bylaws.

For continuity, a recently retired member of the Medical Staff may be elected for up to one (1) term.

8.1.3. Selection of the President, Vice President and Secretary-Treasurer

The individuals who will serve in the positions of President, Vice President and Secretary-Treasurer will be determined through a process internal to the MSEC. These positions may be held for more than one (1) term, to a maximum of three (3) consecutive years in office.

8.1.4. Duties of the President

The President of the Medical Staff Association shall:

8.1.4.1. Call and preside at all meetings of the Medical Staff Association

8.1.4.2. Be a voting member of the Medical Advisory Committee

8.1.4.3. Promote collegiality amongst members of the Medical Staff

8.1.4.4. Promote effective engagement of the Medical Staff in PHC in general

8.1.4.5. Represent the Medical Staff in general and speak for the individual Medical Staff member in particular

8.1.4.6. Be a non-voting member of all Medical Staff departments and committees to which he or she has not been assigned as part of his/her normal duties

8.1.4.7. Bring before the Medical Advisory Committee any resolution duly passed at a meeting of the Medical Staff

8.1.4.8. Be responsible for reporting to the MAC and CEO issues that arise from the Medical Staff and for participating in the subsequent follow-up of these issues

8.1.5. Duties of the Vice President

The Vice President shall:

8.1.5.1. Fulfill the duties and responsibilities of the President in his/her absence

8.1.5.2. Perform such duties as are delegated by the President

8.1.6. Duties of the Secretary-Treasurer

The Secretary-Treasurer shall:

8.1.6.1. Give notice and keep minutes of all meetings of the Medical Staff Association and the Nominating Committee for Medical Staff Executive Committee officers

8.1.6.2. Attend to all correspondence of the general Medical Staff Association

8.1.6.3. Direct the preparation of a financial statement of the Medical Staff Association funds for presentation at the Annual meeting

8.1.6.4. Ensure that an audit of Medical Staff funds is conducted at least annually

8.1.6.5. Perform any other duties pertaining to the office of Treasurer

8.1.7. Duties of the Members-at-Large

The Members-at-Large shall:

8.1.6.1 Promote collegiality amongst members of the Medical Staff

8.1.7.1. Promote effective engagement of the Medical Staff in PHC in general

8.1.7.2. Represent the Medical Staff in general and speak for the individual Medical Staff member in particular

8.1.8. Recall, Removal and Filling of Vacant Offices

8.1.8.1. Upon receipt of a petition seeking recall of an elected officer signed by ten percent (10%) of Medical Staff members eligible to vote, the President shall call a special meeting to be held within thirty (30) days of receipt of the petition. If at this meeting, with a quorum present, two-thirds (2/3) of eligible voters present vote in favour of recall, the office shall be declared vacant. An election to fill the vacant office may be held at the same meeting.

8.1.8.2. In the event of death, removal or resignation of an elected officer during the term of office, another Medical Staff member may be elected at a regular or special meeting to fill the balance of the expired term. Otherwise, the duties of that office shall be assumed by the remaining officers.

8.2. Meetings and Committees of the Medical Staff Association

8.2.1. Annual Meeting

8.2.1.1. The annual meeting shall be the fourth quarterly meeting of each academic year, at which time officers shall be elected to fill vacant positions for the ensuing term of office effective July 01. The President shall notify members of the Medical Staff thirty (30) days prior to the annual meeting, announcing the time and place of the meeting.

8.2.1.2. The President and Secretary Treasurer reports will be circulated prior to, or reviewed at, the annual meeting.

8.2.1.3. Representatives from the Board of Directors shall be invited to attend.

8.2.2. General Meetings

8.2.2.1. General meetings of the Medical Staff Association shall be held quarterly on such dates as deemed appropriate by the President and Officers of the Medical Staff. Each meeting will be chaired by the President.

8.2.2.2. The President shall notify members of the Medical Staff thirty (30) days prior to a general meeting, announcing the time and place of the meeting.

8.2.2.3. The Chief Executive Officer and the Vice President, Medical Affairs shall be given notice of all meetings of the Medical Staff, and shall provide a report.

8.2.2.4. The Chair of the MAC, or delegate, shall be given notice of all meetings of the Medical Staff Association, and shall provide a report of the work of the MAC.

8.2.2.5. Department and committee reports may be presented at these meetings.

8.2.3. Special General Meetings

8.2.3.1. A special meeting may be called by the Board of Directors, Chief Executive Officer, President of the Medical Staff Association, Medical Advisory Committee or by the written request of ten percent (10%) of the members of the Medical

Staff eligible to vote, and shall be held within ten (10) working days of receipt of the request.

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

8.2.3.3. A notice shall be posted by the President at least seven (7) days before the special meeting and shall describe the purpose of the meeting.

8.2.4. Written Notice

Any motion for presentation at a General Meeting of the Medical Staff Association shall be delivered, in writing, to the President at least ten (10) working days prior to that meeting. Any motion not duly presented may be deferred to a future meeting especially if, in the opinion of the President, it may have significant impact on the management or resources of PHC.

8.2.5. Notice to President

Notwithstanding anything to the contrary contained in these Rules, the President of the Medical Staff Association shall be given at least ten (10) days written notice of any meeting of the Medical Staff.

8.2.6. Minutes

The President of the Medical Staff Association shall ensure that full and complete minutes of all meetings of the Medical Staff are kept.

8.2.7. Attendance

8.2.7.1. General Medical Staff Meetings

Members of the Active, Provisional and Associate Medical Staff are required to attend at least fifty percent (50%) of the General Medical Staff Association Meetings in a calendar year.

8.2.7.2. Failure to Attend

A Staff Member's attendance at Medical Staff Association meetings will be considered at the time of re-appointment. Failure to attend the requisite number of meetings may be grounds for suspension from the Medical Staff.

As required by the Hospital Act Regulation, any member who, without reasonable excuse, fails to attend meetings or to participate in the performance of the duties of the Medical Staff shall be identified to the Board.

8.2.8. Quorum

8.2.8.1. A Quorum for General Medical Staff Association meetings shall consist of fifty (50) members of the Medical Staff members eligible to vote.

8.2.8.2. A Quorum for any Medical Staff Association committee, unless otherwise specified in these Rules or the committee's Terms of Reference, shall consist of fifty percent (50%), plus one (1) member of the voting members.

8.2.9. Medical Staff Association Executive Committee

8.2.9.1. Composition

- President of the Medical Staff (Chairperson)
- Vice President of the Medical Staff (President-elect)
- Secretary-Treasurer of the Medical Staff
- Up to four (4) members-at-large

8.2.9.2. The committee shall meet at the call of the Chair.

8.2.10. Nominating Committee

8.2.10.1. The purpose is to nominate candidates for election as Officers of the Medical Staff.

8.2.10.2. This committee is responsible to the Medical Staff.

8.2.10.3. Composition

- President of the Medical Staff Association
- Secretary-Treasurer of the Medical Staff Association
- Past President of the Medical Staff Association (Chair)

8.2.10.4. Meetings

8.2.10.4.1. The committee shall meet regularly to nominate candidates for election at annual meetings of the Medical Staff.

8.2.10.4.2. The committee shall meet at the call of the Chair to nominate a candidate or candidates for a vacated position.

8.2.10.5. Duties

8.2.10.5.1. To prepare a slate of candidates (at least one person per position) for the elected positions of Officers of the Medical Staff for annual meetings of the Medical Staff.

8.2.10.5.2. To invite nominations from the members of the Medical Staff through notice provided to each member at least one (1) month prior to voting.

8.2.10.5.3. To ensure a fair and equitable system of voting

on the slate of officers by members of the Medical Staff.

8.3. Medical Staff Fund

8.3.1. Each member of the Medical Staff shall pay a yearly subscription, as determined by the Medical Staff Association at the annual meeting, to an association to be known as “PHC Medical Staff Fund”. This subscription is due and payable with return of the Application for Reappointment each year.

8.3.2. Exemptions to the payment of the yearly subscription are granted to the following: members of the Medical Staff in the Senior Staff subcategory, the Associate Medical Staff category, the Temporary Staff category, the Locum Tenens category, the Scientific and Research staff category, and those members of the PHC Medical Staff whose primary site is not PHC as per reciprocal agreements with identified health authorities or hospitals.. Other exceptions may only be granted by a member of the Medical Staff Executive and notification of exceptions shall be made to the Medical Staff Association.

9. THE MEDICAL ADVISORY COMMITTEE (MAC)

9.1. Purpose

The Medical Advisory Committee (MAC) is the senior medical administrative body for all Medical Staff in the organization. The MAC is established by the Board of Directors and reports to the Board of Directors, and provides advice to the Board and CEO. The Chair of MAC attends Board meetings.

9.1.1. To provide advice to the Board of Directors and the CEO on the quality of medical care provided within all facilities operated by PHC, and to provide medical advice to inform administrative and Board decision-making.

9.1.2. To assure the Board of Directors and the CEO that the safety and quality of medical care in PHC facilities is continually being evaluated, and advise regularly of steps being taken to improve medical practice in PHC. This work will be conducted under the protection of Section 51 of the Evidence Act.

9.1.3. To provide advice to the Board of Directors and the CEO on the adequacy of medical staff resources.

9.2. Composition/Appointment

The Board shall appoint a Medical Advisory Committee, which shall consist of:

9.2.1. Voting Members

- The Chair
- The Vice Chair
- Up to five (5) members of the Medical Staff Association Executive
- The VCH and PHC Regional Department Heads

- The PHC Department Heads
- MSJ representatives from Medicine, Surgery and Family Medicine
- One (1) Physician Program Director from each clinical program.
- Vice President, Medical Affairs (whose office provides secretariat support)
- The Senior Medical Director
- The Dean of the Faculty of Medicine or designated representative.

9.2.2. Non-voting Members

- The CEO
- Vice President, Research
- One other Vice President, selected by MAC to foster communication between Medical Staff Acute and the Senior Leadership Team
- Director, Medical Affairs

9.2.3. Alternates

Each voting member may designate an experienced Medical Staff Member as an "alternate" who shall attend and vote in that member's absence.

9.3. Officers

9.3.1. Chair

9.3.1.1. The Chair shall be selected from amongst the members of the MAC

9.3.1.2. The Chair shall be appointed by the Board of Directors after considering recommendations from the MAC, the Vice President of Medical Affairs, and the CEO.

9.3.1.3. The appointment of the Chair will be for a two (2) year term, which may be renewed once, following a review by the MAC Executive and re-appointment by the Board of Directors

9.3.2. Vice Chair

9.3.2.1. The Vice Chair shall be selected from amongst members of the MAC

9.3.2.2. The Vice Chair shall be appointed by the Board of Directors after considering recommendations from the MAC, the Vice President of Medical Affairs, and the CEO.

9.3.2.3. The appointment will be for a two (2) year term, which may be renewed once following a review by the MAC Executive.

9.3.2.4. The Vice Chair shall assume the responsibilities of the Chair in the Chair's absence.

9.3.2.5. The Vice Chair is anticipated to assume the role of Chair of the MAC upon the incumbent's retirement under normal circumstances.

9.4. Authority and Duties of the MAC

9.4.1. To appoint Chairs and members to Standing and Ad Hoc Committees of the MAC., and to help set direction of committees.

9.4.2. To make recommendations to the Board of Directors with respect to the awarding, maintenance, restriction, modification, suspension, revocation, or non-renewal of a Staff Member's permit to practice, or other disciplinary action as the committee may feel appropriate.

9.4.3. To require any Medical Staff Member to appear before the MAC to present information in order to assist the committee in carrying out its responsibilities.

9.4.4. To make recommendations concerning the supervision of clinical practice; establishment and maintenance of professional standards across facilities; compliance with the Hospital Act and its Regulation, PHC Bylaws, Rules, and policies of the Medical Staff and relevant corporate policies; and continuous improvement in the quality of medical care.

9.4.5. To report to the Board of Directors and CEO on all medical, dental and midwifery matters including Medical Staff organization, new and existing clinical, and medical education activities and research conducted across facilities, as well as disciplinary matters

9.4.6. To consider and make recommendations on such matters as may be referred to it by the Board of Directors and/or CEO

9.4.7. To receive, study and act upon reports from Heads, Departments, Divisions and Committees.

9.4.8. To ensure effective processes are in place to review, analyze, investigate and evaluate the clinical practices of the Medical Staff to determine the quality of medical care delivered within PHC

9.4.9. To submit recommendations to the Board of Directors concerning appointments and reappointments of Medical Staff members and delineation of specific clinical privileges

9.4.10. To make recommendations regarding Medical Staff resource requirements to meet the needs of patients and residents in PHC facilities

9.4.11. To ensure professional and ethical conduct on the part of all members of the Medical Staff

9.4.12. To make recommendations regarding the appointment of PHC Department Heads and VCH and PHC Regional Department Heads

9.4.13. To make recommendations regarding changes and amendments to the Medical Staff Rules

9.5. Reporting

9.5.1. The MAC reports to the Board of Directors.

9.6. Meetings

9.6.1 Meetings shall be held monthly and at the call of the Chair. A minimum of ten (10) meetings shall be held annually.

9.6.2 A quorum shall consist of the voting members or their delegates present at a duly-called meeting of the committee.

9.6.3 Motions require a vote and a majority must vote in favour in order for the motion to pass.

9.6.4 Votes may not be made in absentia or by proxy.

9.6.5 Agenda items shall be submitted in writing to the Chair at least five (5) working days prior to a meeting of the MAC Executive.

9.6.6 The agenda will be distributed to all MAC members four (4) working days prior to the MAC.

9.6.7 The minutes of meetings will be distributed to members of the committee in advance of the next scheduled meeting.

9.6.8 Minutes shall be kept in the office of the Vice President of Medical Affairs.

9.6.9 Administrative support for the committee will be provided by the office of the Vice President of Medical Affairs.

9.7. Committees of the MAC

9.7.1. Definitions

9.7.1.1. Standing

Those Committees formed at the request of the Board, the MAC, or outside agencies to perform regular functions of the MAC. Standing Committees include:

- MAC Executive Committee
- Credentials Committee or Officer
- MAC Council for Excellence
- Pharmacy & Therapeutics Committee
- Medical Education Council
- Transfusion Committee
- Infection Control Standards Committee

9.7.1.2. Ad Hoc

Those Committees formed to address specific issues or problems. Ad Hoc Committees are disbanded after reporting their conclusions to the MAC.

9.7.2. Creation of Standing Committees

A Standing Committee may be created and may be delegated duties by the Medical Advisory Committee after receiving approval from the Board for the proposed terms of reference, purpose, and composition of the Committee. Once a Standing Committee has been created, the Medical Advisory Committee shall not disband it without the approval of the Board.

9.7.3. Function

Committees shall report to the Medical Advisory Committee on such matters as shall be specified in their respective terms of reference, which may be modified from time-to-time by the Medical Advisory Committee with the approval of the Board.

9.7.4. Membership

The Chairs of all committees of the Medical Advisory Committee shall be appointed by the MAC. Except in instances where membership is restricted by these Rules, membership on committees of the Medical Advisory Committee shall be determined by the respective Committee Chair in consultation with the Chair of the Medical Advisory Committee.

9.7.5. Meetings of Standing Committees

Unless otherwise stated in its terms of reference, each committee shall meet as required. All members of standing committees shall have voting privileges. The minutes, or a report of each meeting, together with recommendations, if any, shall be submitted in writing to the Medical Advisory Committee.

9.8. MAC Executive Committee

9.8.1. Responsibility

9.8.1.1. To assist the Chair of the MAC in setting the agenda for the MAC

9.8.1.2. To provide advice on how the business of the MAC will be conducted

9.8.1.3. To advise the Chair of the MAC on any other matters so requested by the Chair

9.8.1.4. To conduct a review of the performance of the Chair and Vice Chair of the MAC for the purposes of making a recommendation for a second term

9.8.2. Composition

- Chair of MAC (Chair)
- Vice Chair of MAC
- Past Chair of MAC (so long as remains a member of MAC)
- President Medical Staff Association
- Two (2) representative Department Head(s) to be appointed by the MAC (reviewed annually)
- One (1) representative Physician Program Director to be appointed by the MAC (reviewed annually)
- Vice President, Medical Affairs
- Senior Medical Director
- Director, Medical Affairs
- Chief Executive Officer

9.8.3. Frequency of Meetings

Meetings are held approximately one (1) week prior to the MAC meeting and at the call of the Chair.

9.8.4. Quorum

A quorum shall be the attending members at a duly called meeting.

9.9. Credentials Committee or Officer

9.9.1. Purpose

To review the training, qualifications, licensure, good standing, references, and malpractice coverage of all applicants for appointment to the Medical Staff and to report on these to the Medical Advisory Committee.

9.9.2. Selection of Committee or Officer

The Committee or Officer will be chosen from among the membership of

the MAC, and duly appointed by the MAC. If the MAC chooses to appoint an Officer rather than a Committee, a Deputy must be appointed to carry out this role in the absence of the Officer.

9.9.3. Term of Appointment for Credentials Officer

Two (2) years (renewable).

9.10. The MAC Council for Excellence

9.10.1. Purpose

9.10.1.1. To support the quality improvement of medical care and medical organization at Providence Health Care

9.10.1.2. To assist the MAC to improve the quality and performance of its work

9.10.2. Responsibilities

9.10.2.1. Support the MAC to improve the quality and performance of its work, including the following accountabilities:

- Advising the Board
- Improving the safety and quality of medical care
- Mitigating risk
- As appropriate, make recommendations to develop better Medical Staff management processes, including credentialing, privileging, appointments and reappointments, and for making improvements to the Medical Staff Rules and Policies

9.10.2.2. Recommend improvement priorities to the MAC

9.10.2.3. Direct improvement initiatives delegated by the MAC

9.10.2.4. Establish and monitor relevant performance indicators

9.10.2.5. Recommend process improvements, policies, and guidelines to the MAC

9.10.2.6. Ensure that regular quality assurance and quality improvement activities occur in each Department. This, at a minimum, will include review of the following:

- Deaths occurring in the hospital
- Statistics regarding patient progress in hospital
- Methods of treatment of patients in hospital
- Results of surgery performed in hospital

- Medical Staff Member-related issues referred from Programs or the Senior Leadership Team
- Complaints, either from patients or staff
- Issues identified through the Patient Safety Learning System (PSLS)

9.10.2.7. Provide support and assistance to Department Heads in fulfilling their specific quality and performance improvement responsibilities and mandate

9.10.2.8. Work with and support the committee responsible for the quality of medical records

9.10.2.9. Ensure alignment of activities with PHC Strategic Directions and related improvement initiatives

9.10.2.10. Link, liaise, participate, present and provide a report to PHC Quality, Care Experience, Patient Safety & Clinical Risk Management Committee (the “Alphabet Committee”)

9.10.3. Membership

9.10.3.1 The committee is chaired by the Vice Chair of the MAC. The term of the Chair is two (2) years, renewable.

9.10.3.2 Membership shall be comprised of at least four (4) MAC members and must have representation from the following:

- Department of Surgery
- Department of Medicine
- Department of Family Medicine
- Department of Emergency Medicine
- Department of Psychiatry
- Chair, MAC
- Director, Health Records
- Director, Medical Affairs
- Director, Risk Management and Patient Safety
- Vice President, Medical Affairs or Senior Medical Director
- Other members as required

9.10.4. Team Support (as needed)

Director, Performance Improvement & Measurement.

9.10.5. Quorum

Attending members shall constitute a quorum.

9.10.6. Frequency of Meetings

Meetings will be held ten (10) times per year and at the call of the Chair. All activities will be conducted under the protection of Section 51 of the Evidence Act.

9.11. Pharmacy & Therapeutics Committee

9.11.1. Purpose

The primary purposes of the Pharmacy and Therapeutics Committee are:

9.11.1.1. Advisory – The Committee recommends the adoption of, or assists in the formulation of, broad professional policies regarding evaluation, selection, and therapeutic use of drugs within Providence Health Care.

9.11.1.2. Educational – The Committee recommends or assists in the formulation of programs designed to meet the needs of the professional staff (physicians, nurses, pharmacists and other health care practitioners) for current knowledge on matters related to drugs and drug use in Providence Health Care.

9.11.1.3. Evaluative – The Committee assists in the monitoring of the quality of drug therapy by an ongoing review of drug use with emphasis on appropriateness, safety, and cost consciousness.

9.11.2. Composition

This Committee is composed of no less than three physicians, a pharmacist, and representatives from nursing. Cross-site representation is preferable whenever possible.

A physician serves as chairperson and a pharmacist as secretary. The Committee may invite to its meetings persons from within or outside the hospital, who can contribute from their specialized knowledge or experience to determine the best use of drugs within the institution. Members must declare conflicts of interest prior to discussion on any matter placing them in potential conflict.

9.11.3. Term of Chair

Two (2) years (renewable).

9.11.4. Frequency of meetings

Meetings will be held at least nine (9) meetings per year, and at the call of the Chair.

9.11.5. Responsibilities

9.11.5.1. To serve in an advisory capacity to the medical staff and hospital administration in all matters pertaining to the use of

drugs (including investigational drugs, intravenous fluids and therapy).

9.11.5.2. To develop a formulary of drugs accepted for use in the hospital and provide for its constant revision. The selection of items to be included in the formulary will be based on objective evaluation of their therapeutic merits, safety and cost. The committee should minimize duplication of the same basic drug type, drug entity or drug product.

9.11.5.3. To regularly assess the appropriateness and adequacy of medication-related policies.

9.11.5.4. To review medication incidents and their causes and to make recommendations regarding their prevention to medical, nursing and pharmacy staffs.

9.11.5.5. To initiate, promote and/or direct drug use review programs and studies, and review the results of such activities. The appropriateness of prophylactic, empiric and therapeutic use of antibiotics is to be included.

9.11.5.6. To evaluate the effectiveness of the drug distribution system and to advise the Pharmacy on the need for contemporary drug distribution and control procedures.

9.11.5.7. To make recommendations concerning drugs to be stocked in hospital patient care

9.11.5.8. To review medication costs and medication related economics.

9.11.5.9. To develop and/or review protocols for programs such as I.V. Therapy, Parenteral Nutrition, Investigational Drugs and Self-Medication.

9.11.5.10. To periodically review and assess Providence Health Care's drug usage patterns.

9.11.5.11. To make recommendations to the institution on methods to maximize patient safety

9.12. Medical Education Council

9.12.1. Purpose

To advise the MAC on education matters in PHC relating to Medical Staff, Clinical Fellows, Residents, and Medical Students.

9.12.2. Composition

The committee shall be co-chaired by the Vice President of Medical Affairs, the Vice President of Research, and a senior representative of the UBC Faculty of Medicine, and include one (1) representative from each Department responsible for resident training and three (3) representatives of the residents. The Director of Medical Education shall be a voting member. Membership may be increased to include appropriate interested representatives at the discretion of the Co-Chairs.

9.12.3. Term of the Co-Chairs

The terms of the Co-Chairs on this committee shall coincide with the terms of the positions they hold.

9.12.4. Responsibilities

9.12.4.1 To advise the MAC on matters relating to Medical Education

9.12.4.2 To advise on all matters relating to Clinical Fellows, Residents and Medical Students, including their welfare, on-call facilities, appointments, educational programs, evaluations, and discipline

9.12.4.3 To advise clinical departments, divisions and programs on educational activities for Medical Staff, Clinical fellows, Residents and Medical Students within PHC and the community

9.12.4.4 To advise the Director of Medical Education of rounds, clinical conferences, lectures and symposia being given in each department

9.12.4.5 To assist departments, divisions and programs in setting policies for continuing education

9.12.4.6 To provide representation to the PHC Health Services Library Committee in accordance with the University Affiliation Agreement

9.13. Transfusion Committee

9.13.1. Purpose

To provide consultative and support services relating to Transfusion Medicine practices and activities.

9.13.2. Composition

The Committee shall have representation from the following Departments/programs:

- Anesthesia and pre-operative assessment
- Surgery – General Surgery, Cardiothoracic, Vascular, Trauma and/or other key Divisions
- Emergency
- Medicine – Hematology, other key Divisions
- Nursing Leaders (key areas and as designated by Nursing Administration)
- Hemophilia Home Care (Clinical Nurse Specialist)
- Medical Director of the Transfusion Medicine Laboratory
- Technical Leader of the Transfusion Medicine Laboratory
- Other key individuals as interest or issues arise
- Minutes to: Risk Management

9.13.3. Term of the Chair

The Chair is appointed by MAC for three (3) years, renewable.

9.13.4. Responsibilities

9.13.4.1. Help define blood transfusion policies as appropriate to local clinical activities

9.13.4.2. Ensure that regular evaluations of blood transfusion practices are conducted

9.13.4.3. Set criteria for the evaluation of ordering practices, usage (including discard of blood and blood components), administration policies, and the ability of services to meet recipient needs

9.13.4.4. Recommend corrective measures, if necessary

9.13.4.5. Disseminate transfusion medicine information and education

9.13.4.6. Evaluate reports of adverse transfusion events and all transfusion errors within the facility, as well as relevant federal and provincial or territorial reports on adverse transfusion events.

9.13.4.7. Review suitable alternatives to allogenic blood transfusion and make appropriate recommendations on their use

9.13.4.8. Maintain liaison with the Provincial Blood Coordinating Office (PBCO) and its relevant committees

9.13.5. Reporting Responsibility

9.13.5.1. The Committee reports regularly to the Medical Advisory Committee and the PHC Quality, Care Experience, Patient Safety & Clinical Risk Management Committee (the "Alphabet Committee")

9.14. Infection Prevention and Control Committee (IPACC)

9.14.1. Purpose of Committee

The Infection Prevention and Control Committee (IPACC) and its members are advocates and role models for the Infection Prevention and Control (IPAC) program at Providence Health Care (PHC).

PHC IPACC is responsible for:

- endorsing of standards, and guidelines for all matters pertaining to Infection Prevention and Control (IPAC) at Providence Health Care;
- reviewing quarterly IPAC surveillance data and development of appropriate improvement action plans;
- reviewing and addressing the results of outbreak management, audits, and investigations;
- endorsing of annual goals and objectives of IPAC
- enabling compliance or progress to achieve Accreditation Canada standards and practices.

9.14.2. Specific Objective & Responsibilities

The committee is responsible for:

9.14.2.1 reviewing and endorsing goals and objectives of the IPAC program;

9.14.2.2 evaluating the results of the activities developed to meet those goals;

9.14.2.3 reviewing, revising, and recommending, standards and guidelines

9.14.2.4 advocating for resources necessary to accomplish the goals of the program; and

9.14.2.5 supporting Clinical Programs in the implementation of Infection Prevention and Control standards and guidelines set by:

- IPAC Department
- B.C. Ministry of Health
- Public Health Agency of Canada
- Accreditation Canada

9.14.3. Membership and Member Responsibilities:

Members are multidisciplinary, and include:

- Physician Leader of a Clinical Program (Chairperson)
- Vice President, Seniors Care and Chief Quality, Safety & Performance Improvement Officer
- Medical Director, Infection Prevention and Control
- Leader, Infection Prevention and Control
- Infection Control Practitioner – IPAC Department
- Infection Control Practitioner – Crothal Healthcare
- Director, Occupational Health & Safety
- Medical Microbiologist
- Infectious Diseases Physician
- Medical Health Officer & Medical Director of Communicable Disease Control, VCH
- Program Director, Elder Care and Palliative Services
- Operations Leaders for Medicine, Surgery, Emergency
- Nurse Educator – ICU Program
- Clinical Nurse Leader – Renal Program
- IPAC LINK – Heart/Lung Program
- Director, Risk Management and Patient Safety
- Director, Support Services, PHC
- Professional Practice Consultant
- Operations Leader, Medical Device Reprocessing
- Pharmacist, Antimicrobial Stewardship Program
- IPAC LINK
- Patient Partners (2)
- IPAC Epidemiologist
- IPAC Physician

Membership is reviewed annually. Responsibilities of members include:

- Participating in regular meetings
- Reporting on committee decisions to those whom they represent
- Bringing forward concerns from the population they represent
- Identifying a delegate to attend in his or her absence

9.14.4. Meeting Frequency and Quorum

The committee will meet every two (2) months or at the call of the IPACC Chair. Quorum shall consist of those members present at a duly-called meeting.

All members have voting privileges.

9.14.5. Accountability

The IPACC is a Standing[1] Committee of the PHC Medical Advisory Committee.

9.14.6. Minutes

The minutes, or a report of each meeting, together with recommendations, if any, shall be submitted in writing to the Medical Advisory Committee.

Minutes of each meeting are forwarded to:

- IPACC standing members
- Vice President, Medical Affairs
- Chair, MAC
- Members, IPAC department
- Technical Leader, Microbiology
- PHC Program Directors: Quality, Patient Safety & Clinical Risk Management Steering Committee

10. RELATIONSHIP OF THE MAC WITH THE HEALTH AUTHORITY

10.1. The President of the Medical Staff Association, Chair of the MAC, and Vice President of Medical Affairs shall be members of the HAMAC and shall attend its meetings.

10.2. The Chair of the MAC, or delegate, shall provide a regular informational update on the activity of the MAC to the HAMAC.

10.3. The Chair of the MAC or his/her delegate shall regularly report on relevant activities of the HAMAC to the MAC.

10.4. Recommendations from the PHC MAC requiring the attention of the HAMAC shall be forwarded by the Chair of the MAC to the Chair of the HAMAC.

11. DISCIPLINE AND APPEAL

11.1. The specific processes and procedures concerning discipline and appeal matter are outlined in Article 11 of the PHC Medical Staff Bylaws.

12. AMENDMENTS

Amendments to the Medical Staff Rules shall be recommended from time-to-time by the Medical Advisory Committee (MAC) and approved by the Board of Directors.

12.1. Regular Review of Medical Staff Rules

The rules of the Medical Staff shall be reviewed at least every three (3) years, revised as necessary, and dated accordingly.

12.2. Powers of Board

Notwithstanding anything to the contrary contained herein, the Board may, at any time and from time-to-time, modify or change these Rules.

APPENDICES

APPENDIX I

Medical Staff Professional Conduct Policy

1.1. Providence Health Care (PHC)

The PHC Medical Staff are health-care professionals whose standards of practice, professional deportment and ethical behaviour are described and mandated by their respective Provincial Colleges and National Associations. As highly regarded professionals who are looked to for leadership in Providence Health Care members of the Medical Staff have a responsibility to lead through example by conducting themselves with a high degree of personal integrity and a high standard of professional deportment. This influence of Medical Staff conduct is more important in the academic environment of PHC because students observe, and are influenced by, the behaviour of their mentors.

The Mission and Values Statement of PHC declares that, *"our staff, physicians and volunteers are dedicated to service and to the support of one another. In this environment of service, support and respect, we meet the physical, emotional, social and spiritual needs of those served through compassionate care, teaching and research"*. The Values of "S*pirituality, Integrity, Stewardship, Trust, Excellence and Respect"* clearly identify the principles that govern Medical Staff behaviour in fulfilling the Mission. This is the foundation of conduct expected not only of the Medical Staff but also from staff and colleagues with whom the Medical Staff works.

The Medical Staff governs its professional actions and interactions in accordance with the PHC Medical Staff Bylaws and Rules (PHC Public Folders>Medical Staff Information), PHC's Policy on Guidelines for Addressing Discrimination, Harassment or Inappropriate Behaviour in the Workplace (PHC Public Folders>Human Resources>Employee Services>Guidelines), the College of Physicians and Surgeons of BC guidelines and policies, the CMA Code of Ethics and the Catholic Health Association of Canada's "Health Ethics Guide".

In addition, those who are appointed to the Faculty of Medicine (including Midwifery) or Dentistry, UBC, agree to conduct based on "Professional Standards for Faculty Members and Learners in the Faculties of Medicine and Dentistry".

Behaviour which violates accepted rules of civil behaviour and professional etiquette or which violates legal standards of conduct or professional ethics can interfere with the cooperation and free exchange of information that is necessary for the health care team to provide safe and effective patient care. Other potential negative effects include undermining staff morale; making it difficult to recruit and retain qualified staff; harming the hospital's reputation; and, exposing the hospital and practitioner to legal liability. In order to maintain the confidence of the community, and enable PHC to fulfill its legal obligation to provide a safe

and professional work environment, it is necessary that all practitioners abide by high standards of conduct, and that PHC take reasonable actions to correct inappropriate conduct.

The members of the Medical Staff will not accept a work environment that tolerates unprofessional conduct or disruptive behaviour. Disruptive behaviour is defined as "a consistent pattern of unprofessional, uncooperative and contentious behaviour which creates a hostile working environment and interferes with the ability of others to deliver quality patient care". Upon witnessing such behaviour the member(s) will make their expectations of appropriate conduct known directly and respectfully to each other. It is important to remember that disruptive behaviour, especially if it is out of character for the individual can often be a response to stress and initial feedback should be given privately and tactfully. The Medical Staff expect our Leaders to deal directly, consistently, fairly and effectively with unprofessional conduct or disrespectful behaviour.

The primary responsibility of the Medical Staff is, and always will be, the health and well-being of their patients. The Medical Staff must therefore be unencumbered in their ability to respectfully and constructively challenge any hospital policy that, in their view, is potentially deleterious to their patients.

Merely expressing contrary opinions is not disruptive conduct, nor is expressing constructive criticism of inappropriate policies or procedures or unacceptable performance or conditions, if it is done in good faith, in an appropriate time, place and manner, and with the aim of improving the environment of care rather than personally attacking any individual. Except as otherwise required by their legal or ethical duties, practitioners are requested to first express their concerns or constructive criticism through appropriate Medical Staff, administrative or governing board channels, and seek an internal resolution prior to publicly expressing their concerns or constructive criticism.

1.2. Process to Deal with Unprofessional Conduct or Disruptive Behaviour

The primary goal of this policy is to help practitioners conform their behavior to reasonably expected standards of conduct. Therefore, the initial approach should be collegial and educational. If this approach is not successful or is not appropriate based upon the nature and severity of the disruptive conduct, the hospital may take additional steps of progressive discipline including corrective action under the PHC Medical Staff Bylaws. At each step in the process, all of those involved should consider whether the disruptive conduct could possibly be caused by a medical, psychological, or substance abuse problem. If so, it may be appropriate for the physician to be referred to the Physicians' Health Program, or other medical or mental health professionals, for a "fitness for duty" evaluation, recommended follow-up, and possible monitoring agreement, with the goal of restoring the practitioner to safe and healthy practice, if possible.

1.2.1. Step 1: Informal Conversation

Wherever possible, a member of the Medical Staff who has been the recipient of, or who has witnessed, unprofessional or disruptive behaviour from another member of the Medical Staff or employee of

Providence Health Care is encouraged to engage directly in a respectful, informal conversation with that person in an effort to resolve the issue.

Members of the Medical Staff, who are the objects of these informal conversations, whether from other members of the Medical Staff or Providence Health Care employees, should attempt to receive the criticisms objectively and respond in a way to achieve resolution of the conflict.

If the member of the Medical Staff has been the recipient of, or has witnessed unprofessional or disruptive behaviour in a Medical Staff Leader and is unable to have this conversation directly with the Leader, they should contact the person to whom that Leader directly reports. This person would facilitate the conversation between the parties and should consider attending the meeting.

1.2.2. Step 2: Division or Department Head Involvement

If concerns cannot be resolved informally, the matter should be referred to the appropriate Division or Department Head(s) for resolution. The Division or Department Head(s) should take the following steps:

1. Meet separately with the individuals involved to review the concern.

2. Meet together with the individuals involved to facilitate the conversation between them with the aim of clarifying and resolving the issue.

3. With reference to this policy, review the expectations of professional conduct of the Medical Staff.

4. Seek a commitment from the involved Medical Staff member that their conduct will be above reproach in the future.

5. Follow up and monitor the conduct of the involved Medical Staff member to ensure that this commitment is being honoured.

6. Document the steps taken in trying to achieve a resolution.

1.2.3. Step 3: Formal Resolution

If a resolution cannot be achieved through Steps 1 and 2, the Medical Staff member who has been the recipient of, or who has witnessed, unprofessional or disruptive behaviour in another member of the Medical Staff may seek a formal resolution of the issue. This will require a written complaint to the appropriate Division or Department Head. The complaint should include the following information:

1. When and where the incident occurred.

2. The name(s) of the individual(s) involved.

3. An outline of the complaint.

4. The names of any witnesses to the incident.

5. How the incident may have impacted patient care or the complainant's well-being.

The process will proceed as follows:

1. A Division Head upon receiving a formal complaint will involve the appropriate Department Head.

2. A Department Head, who receives the complaint directly or from a Division Head, will investigate the complaint through interview of the parties involved and any known witnesses. This process may be delegated to the appropriate Division Head.

3. The Department Head will document the findings of this investigation.

4. The Department Head may involve the Vice President Medical Affairs at any point in this process.

5. The Department Head, upon review of the findings of the investigation, will determine whether this policy has been breached.

6. The determination will be documented in a written summary, a copy of which will be made available to the parties involved.

    a. The Department Head will keep a copy of the documentation in case further steps in this process are required.

    b. If the Department Head determines that the member of the Medical Staff has committed a breach of this policy, a copy of the documentation will be forwarded to the Vice President Medical Affairs who will place it in the Medical Staff member's personal file.

    c. Upon the determination that a breach of this policy has been committed, the Department Head will write to the involved Medical Staff member expressing the expectation of compliance with the policy by the Medical Staff member and a plan outlining the follow-up necessary to assure that compliance has been obtained.

    d. The Department Head will request that the Medical Staff member sign the copy of the letter and return it to the Department Head signifying agreement with the expectation of compliance with the policy and the follow-up plan. This letter will be placed in the Medical Staff member's personal file. The Department Head may request the assistance of

the Vice President, Medical Affairs in the drafting of this letter requiring compliance with this policy and appropriate follow up.

e. Follow up plans may include strategies to help the Medical Staff member such as a referral to the *Physician Health Program of BC* or other appropriate agencies.

f. The involved Medical Staff member may appeal the outcome of this process to the *Providence Health Care Medical Advisory Committee (MAC)*.

g. If the involved Medical Staff member respondent fails to comply with the follow-up plan or the requirement that professional conduct and behaviour be beyond reproach, the matter will be referred to the *Medical Advisory Committee* for further action.

h. Complaints referred to the MAC regarding the professional conduct or disruptive behaviour of a member of the Medical Staff will be investigated and managed in accordance with the PHC Medical Staff Bylaws and Rules.

At any time during this process the member of the Medical Staff may seek assistance and advice from the Medical Staff Executive Committee. If mediation is necessary, a mediator who is acceptable to both the member of the Medical Staff and the administration of Providence Health Care may be asked to enter the process of conflict resolution. The mediator could be a respected member of the medical staff or an outside appointee. The cost of such mediation will be borne by Providence Health Care. The member of the Medical Staff is free to ask any individual or agency of their choosing to participate in the process.

APPENDIX II

Dispute Resolution and Resources Allocation Guidelines

Providence Health Care values its positive relationship with the members of its Medical Staff. This positive relationship has been underpinned by the recognition of the hospital that it is critically dependent on the engagement, input, and commitment of its Medical Staff and the recognition of the Medical Staff that access to the facilities, resources, and support of the hospital facilitates both care of patients and the ability to do research.

Occasionally, conflict has emerged concerning the ability of the Hospital or its Department or Division Heads to allocate access to resources, call, operating time, etc. When these disputes arise, it is helpful to have a framework of stated values and process to help resolve the dispute.

Providence Health Care and the Medical Staff acknowledge:

1. The commitment of both parties to deliver the best medical care possible within the available resources.

2. The commitment of both parties to honour the spirit and letter of the arrangements to provide services, access to services, and support of programs as long as those services and programs meet or exceed the standard of care and can be continued with the resources available.

3. The commitment of both parties to promoting a high quality environment conductive to teaching and training, and supportive of scholarly research.

4. The obligation to consult with, understand, and to the fullest extent possible, accommodate the needs/desires of the other when it is determined that a major change in provision of services, access to services, and support of programs is necessary.

5. The need for adequate notification of intent to significantly modify existing provision of services, access to services or support of programs.

6. The principles of natural justice such that decisions to modify existing provision of services, access to services or support of programs will be principled, transparent, fair and not arbitrary.

7. The need to limit provision of services to those with advanced training or expertise. All recognized medical professional training will be accepted if conferred by the appropriate regulatory bodies (such as the Royal College of Physicians and Surgeons of Canada and the BC College of Physicians and Surgeons). Although holding appropriate credentials is necessary, this alone does not automatically lead to an individual being granted access to specific hospital resources.

8. If those currently providing the services no longer meet the standard of practice, it is expected that a mutually acceptable transition period will be negotiated.

9. The need for orderly transitions to retirement. It is expected that a mutually acceptable plan will be negotiated.

In accordance with the principles outlined above, each Department will maintain an appropriate quality improvement process. Access to hospital resources will be contingent upon each Department's continued commitment to such a quality improvement process.

Should a dispute arise, in order to honour these values, the following dispute resolution process is suggested.

The Scope

In scope:

- Disputes relating to access to hospital resources including, but not limited to:
  - OR or procedure room allocation Scheduling related to work duties
  - Bed allocations
  - Access to equipment
  - Access to reporting of diagnostic tests

- Disputes over restriction of privileges based upon currency, not competency. (*Currency* relates to the volumes of exams, procedures, tests being performed and also referred to as the level of *current experience*).

Out of scope:

- Disputes relating to Ministry or Health Authority mandates or other issues reasonably beyond the control of Providence Health Care

- Routine scheduling disputes (call, days, clinic schedules) that do not have a fundamental relationship to remuneration or compensation under normal circumstances

- Disputes relating to competency/performance which are otherwise covered under separate procedures in the Medical Staff Rules

The Process

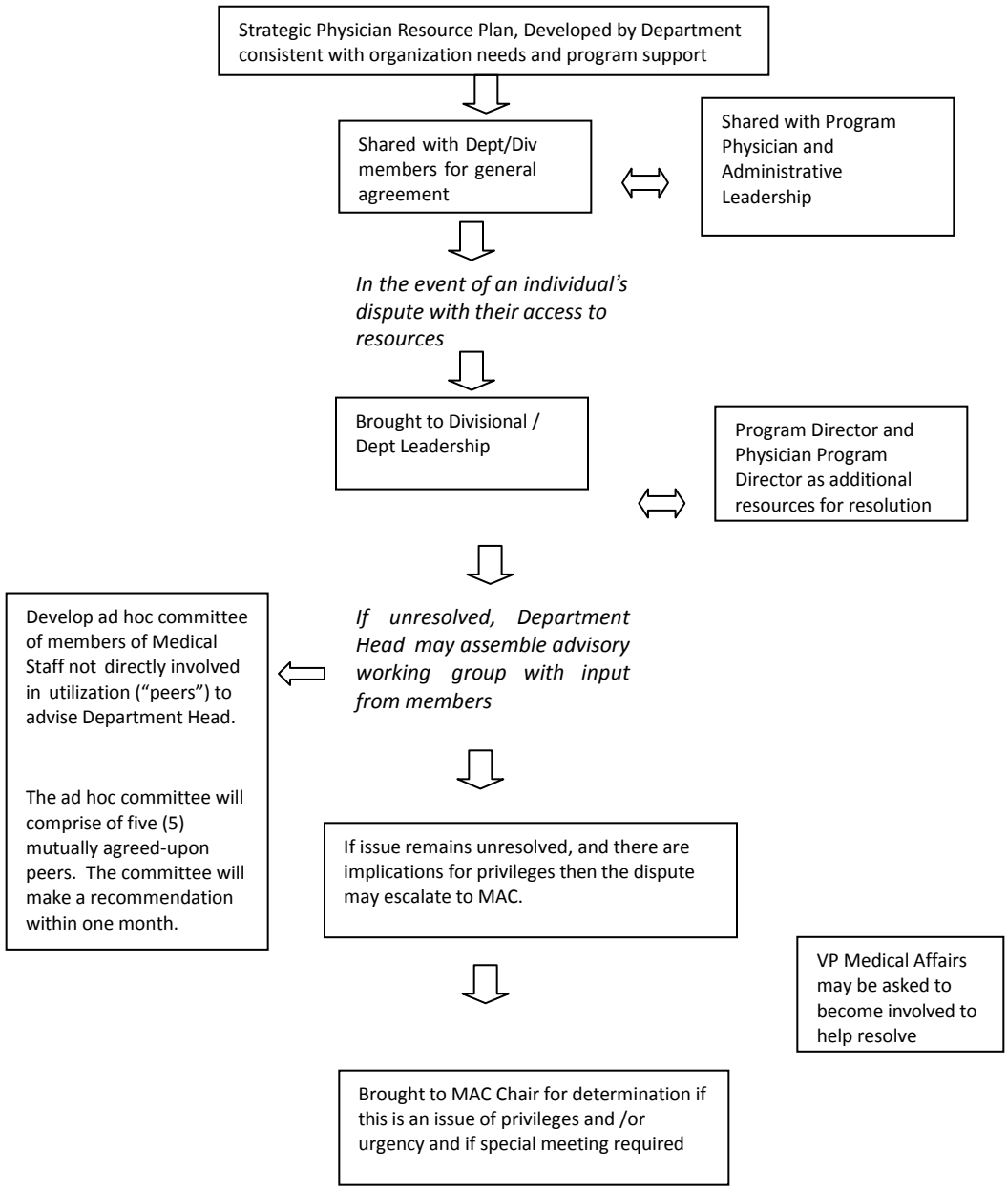
In accordance with the Medical Staff Rules including Appendix II (Principles to Guide the Allocation of Medical Staff Access to PHC Resources), it is the joint responsibility of the Departments (and Divisions) and the Programs within which the resources are operated to determine Medical Staff access to resources.

Members of the Medical Staff are related to SPH through the privileges recommended by the Department/Division structure. Department/Division Heads should consult with members in the development of resource planning.

Department/Division Heads hold the responsibility for Physician Resource Planning, which is done with the following considerations:

- The needs of the patients Providence provides care for;
- Program priorities and strategic plans, determined in collaboration with Medical Departments;
- current staff capacities, capabilities and career transitions;
- succession planning;
- available resources & future resource expectations;
- “currency” of procedural practice;
- external influences (regionalization, funding, MoH priorities);
- teaching and training requirements;
- research mandate and opportunities;
- on-call coverage requirements.

The integrity of the physician leadership relies on general support for the leader and the plan, however it is understood that 100% agreement, support or consensus among the members of any group is difficult to achieve. While consensus is not always possible, the Department/Division head holds authority to use his/her leadership skills, knowledge and experience to determine plans that meet the needs of patients. In the event of a dispute over resources, the following shall apply:



The MAC shall hear the matter at a regular or, if required, extraordinary meeting of the MAC. Ordinarily, only disputes that have a direct implication for an individual's privileges will be addressed by MAC. The decision of the MAC will be provided as a recommendation to the parties involved, and shall not be binding upon the organization.

At the discretion of the Chair of the MAC, guests (including those who may have served on an ad hoc committee) may be invited to the MAC meeting to provide context or opinions. These guests shall not be present during any deliberations.

At any proceeding, individuals will be asked to declare any conflicts of interest. Ordinarily an individual with a significant conflict of interest will be asked for his/her

opinion and then be absent from the final deliberation of the MAC, consistent with the conflict guidelines contained in the Medical Staff Rules.

Guidelines will be reviewed in one (1) year for effectiveness and appropriateness.

APPENDIX III

Completion of Health Records Policy - Records Management Procedure Manual

Procedure # 3.5

Subject:	**Record Completion System**	
Section:	Records Management – Health Records	Page: 1 of 3
Approved by:	Director, Records Management and Registration, LMHIM	Original Date: Jan 10/06 Revision Date: May 30/16
References:	VCH and PHC Medical Staff Rules - Section 5.5.5 Completion of Health Records FH Medical Staff Rules – Section 5.25 Health Records PHSA Medical Staff Rules – Section 3.3.5 Completion of Health Records	

The Intent:
To outline the procedure to be followed to ensure completion of health records.

This procedure outlines the steps to be followed by the Records Management areas throughout Vancouver Coastal Health (VCH), Providence Health Care (PHC), Fraser Health (FH) and PHSA (Children's & Women's). Each site may need to augment this procedure with site and/or system specific procedures in order to meet these guidelines.

This procedure is based on the VCH and PHC Medical Staff Rules sections 5.5.5 Completion of Health Records, the FH Medical Staff Rules section 5.25 Completion of Health Records, and PHSA 3.3.5 Completion of Health Records.

Definitions:

QA – Quantitative Analysis

PHSA – for this document, PHSA refers to Children's & Women's and Sunnyhill Health Centre.

Incomplete Record Notice – Notice sent to each Provider by Records Management on a monthly basis notifying them that they have records that require completion (see attached template).

Suspension Pending Notice – Letter sent to each Provider by Records Management, fourteen (14) days following the issuance of the Incomplete Record Notice, on behalf of Medical Administration, notifying them that their hospital admitting privileges will be

suspended if their records are not completed within a further seven (7) days (see attached template).

Suspension Letter – Letter sent to each Provider by Records Management, seven (7) days following the issuance of the Suspension Pending Notice, on behalf of Medical Administration, notifying them that their hospital admitting privileges are suspended (see attached template).

Deficiencies – Missing or incomplete documentation on a record as identified through the Quantitative Analysis Procedure.

Allocation Date – The date a deficiency is assigned to a Provider.

Subject:	**Record Completion System**	
Section:	Records Management – Health Records	Page: 2 of 3
Approved by:	Director, Records Management and Registration, LMHIM	Original Date: Jan 10/ 06 Revision Date: May 30/16
References:	VCH and PHC Medical Staff Rules - Section 5.5.5. Completion of Health Records FH Medical Staff Rules – Section 5.25 Health Records PHSA Medical Staff Rules – Section 3.3.5 Completion of Health Records	

Procedure:

1. All health records must be completed according to the Medical Staff Rules. If the Provider is no longer available to complete the record, the health record will be reviewed by the appropriate VCH/PHC/FH/PHSA Medical Lead.

2. The Provider is responsible for notifying Records Management of planned absences prior to their occurrence. Following notification, the Provider will be responsible for the completion of incomplete health records within five (5) calendar days of return from such leave or absence for PHC/VCH/PHSA and within fourteen (14) calendar days of return from such leave or absence for FH.

3. The patient's health record should be completed at the time of discharge or within 24 – 48 hours, as per the Medical Staff Rules. If the patient's health record is not completed at the time of discharge, the following steps will be taken.

4. An Incomplete Record Notice will be sent to all Providers on a monthly basis. These notices will alert the Providers that they have health records with deficiencies. A listing of their patient's health records requiring completion may be provided.

5. Following notification via the Incomplete Record Notice the Provider is responsible for completion of the incomplete health records within a further fourteen (14) calendar days.

6. Failure to comply with #5 above will result in a Suspension Pending Notice being issued to the Provider by Records Management staff on behalf of Medical Administration. A copy is sent to Medical Administration and the appropriate Medical Leads. Following notification via the Suspension Pending Notice, the Provider is responsible for completion of the incomplete records within a further seven (7) calendar days.

7. Failure to comply with #6 above will result in the suspension of the Provider's admitting privileges at the site. A Suspension Letter will be issued to the Provider by Records Management staff on behalf of Medical Administration. A copy is sent to Medical Administration and the appropriate Medical Leads.

8. Upon suspension, PHC Providers must arrange transfer of care to patients within a PHC facility to an appropriate member of the Medical Staff. VCH/FH/PHSA Providers will be permitted to treat those patients already in hospital under their care until the time of discharge or those patients already in the system and booked for surgery. Admission of patients (using the name of another Provider), use of the operating rooms, or the use of any other hospital facilities will not be available.

Subject:	**Record Completion System**	
Section:	Records Management – Health Records	Page: 3 of 3
Approved by:	Director, Records Management and Registration, LMHIM	Original Date: Jan 10/06 Revision Date: May 30/16
References:	VCH and PHC Medical Staff Rules - Section 5.5.5 Completion of Health Records FH Medical Staff Rules – Section 5.25 Health Records PHSA Medical Staff Rules – Section 3.3.5 Completion of Health Records	

9. Upon suspension, and where required, Records Management staff will notify involved Departments of the Provider suspension. This can be done via email or by a deficiency system notification to the intake departments

10. Once records are completed, Records Management staff will ensure that all completed records have their deficiencies removed from the system and that admitting/ordering privileges are reinstated the next business day. Records Management staff will immediately notify involved departments, where required, when the Provider's privileges are reinstated.

Timetable Example

DATE	LETTER/NOTICE TYPE	ALLOCATION DATES	DISCHARGE DATES
May 04, 2011	Incomplete Record Notice	Apr 08 to May 03, 2011	Apr 01 to Apr 26, 2011
May 18, 2011	Suspension Pending Letter		
May 25, 2011	Suspension Letter		
Jun 01, 2011	Incomplete Record Notice	May 04 to May 31, 2011	Apr 27 to May 24, 2011
Jun 15, 2011	Suspension Pending Letter		
Jun 22, 2011	Suspension Letter		
Jul 06, 2011	Incomplete Record Notice	Jun 01 to Jul 05, 2011	May 25 to Jun 28, 2011
Jul 20, 2011	Suspension Pending Letter		
Jul 27, 2011	Suspension Letter		
Aug 03, 2011	Incomplete Record Notice	Jul 06 to Aug 02, 2011	Jun 29 to Jul 26, 2011
Aug 17, 2011	Suspension Pending Letter		
Aug 24, 2011	Suspension Letter		

APPENDIX IV
Trainee Positions at PHC (as of Nov 2016)

Eligibility for Applicants

	Observer I	Observer II (licensed)	Electives	Clinical Trainee	Clinical Fellow I (non-UBC)	Clinical Fellow II (non-UBC)	Fellow (UBC)	Clinical Associate	Research Associate
Medical Students									
• Visiting	✓	x	*	x	x	x	x	x	x
• Canadian Accredited Schools	✓	x	*	x	x	x	x	x	x
Medical Graduates									
• IMG	x	✓	*	✓	✓	✓	**	✓	✓
• Canadian Accredited Schools	x	✓	*	✓	✓	✓	**	✓	✓
Post-Graduate Training									
• Canadian Accredited Schools	x	✓	*	x	✓	✓	**	✓	✓
• Fully licensed physicians	x	✓	*	x	✓	✓	**	✓	✓

* Please refer **all** elective requests to UBC Visiting Student Electives. PHC **does not accept** direct applications for electives.

** UBC processes all the UBC Fellowship applications and are only sent to PHC to obtain signatures from the Division Head, Department Head, and Vice President of Medical Affairs.

MEDICAL STUDENTS are only permitted to OBSERVE.

APPENDIX IV
Trainee Positions at PHC (as of Nov 2016)

Category	Reason	Supervision	Licensing/Documents	Appointment
1. Observer I	Observing new procedures; learning about Canadian medical system; exploring options for specialty training; can be visiting Medical Students	• Directly supervised by an ACTIVE member of the Medical Staff, with absolutely NO direct patient care • May be present with patients when attending and has sought patient consent and documents in notes	• Must hold clinical credentials or be enrolled in a recognized training program ***other non-medical staff only by exception**** • Support/confirmation letter from school must be included; if observer is a physician, a copy of their MD license must be included • Letter to VP Medical Affairs from mentor, co-signed by Division and Department Heads with: exact start and end dates; purpose/scope of activities; supervisor name(s); and areas where they will be visiting (ORs, clinics, wards, etc.); and any Rounds or other CME events • Signed confidentiality agreements by all parties • License from College only required if observing longer than one (1) month	Observerships are approved for a **maximum of one (1) month. If seeking a longer term, a license will be required from the College** No hospital privileges, ID badges, or computer access given to observers Non-credit (UBC)
2. Observer II	Observing new procedures; learning about Canadian medical system; exploring options for specialty training; licensed physician	• Directly supervised by an ACTIVE member of the Medical Staff, with absolutely NO direct patient care • May be present with patients when attending and has sought patient consent and documents in notes	• Must hold clinical credentials • Support/confirmation letter from hospital or current workplace must be included • a copy of their MD license must be included • Letter to VP Medical Affairs from mentor, co-signed by Division and Department Heads with: exact start and end dates; purpose/scope of activities; supervisor name(s); and areas where they will be visiting (ORs, clinics, wards, etc.); and any Rounds or other CME events • Signed confidentiality agreements by all parties • License from College only required if observing longer than one (1) month	Observerships are approved for a short term (generally less than one week) No hospital privileges, ID badges, or computer access given to observers Non-credit (UBC)

APPENDIX IV
Trainee Positions at PHC (as of Nov 2016)

Category	Reason	Supervision	Licensing/Documents	Appointment
3. Electives (Requests from Visiting Medical Students & Residents)	Exploring Canadian Health Care and options for specialty training		E-mail: visiting.electives@ubc.ca	Please refer **ALL** elective requests to UBC Visiting Student Electives. **PHC does not accept direct applications for electives**
4. Clinical Trainees	Exploring Canadian Health Care; seeking additional experience and training while awaiting CaRMS match or assessment IMGs & Canadian Medical graduates	• License allows them to train under supervision at level of 4th year medical student • This rotation is **unpaid** per CPSBC license	• CPSBC Clinical Trainee license which requires endorsement from the Vice President of Medical Affairs • CMPA Code 13 • verification letter from school must be included • copy of their MD degree • Letter to Vice President, Medical Affairs from mentor, co-signed by Division and Department Heads with: exact start and end dates; purpose/scope of activities; supervisor name(s); and areas where they will be visiting (ORs, clinics, wards, etc.), and any Rounds or other CME events • Signed confidentiality agreements by all parties • Copy of College license must be sent to Medical Affairs • Supervisor must provide evaluation (please use the UBC evaluation form for now and send back to Medical Affairs)	Appointed via Vice President, Medical Affairs for **less than a three (3) month rotations** on various services; normally **not to exceed one (1) year** Non-privileged; network and clinical systems access granted if required (contact Liz Andrichuk); ID badge given to those who are here longer than one (1) month Non-credit (UBC)

APPENDIX IV
Trainee Positions at PHC (as of Nov 2016)

Category	Reason	Supervision	Licensing/Documents	Appointment
5. Clinical Fellow I (non-UBC)	Short-term trainees seeking additional special interest training (e.g. PoC, ultrasound, Addictions, IDC) Fully licensed physicians	• Directly supervised • Unable to bill MSP or APP for this training	• CPSBC license to practice in BC • copy of their CV • copy of their MD degree • Letter to Vice President, Medical Affairs from mentor, co-signed by Division and Department Heads with: exact start and end dates; purpose/scope of activities; supervisor name(s); and areas where they will be working (ORs, clinics, wards, etc.) • Signed confidentiality agreements by all parties NOTE: **Non-UBC Fellows may not be recognized as receiving UBC Fellowship training**	Appointed as time-limited Clinical Fellow, **normally less than one (1) month** No hospital privileges; network and clinical systems access granted as needed; should be using ID from visiting site if available.
Category	**Reason**	**Supervision**	**Licensing/Documents**	**Appointment**
6. Clinical Fellow II (non-UBC)	Sub-specialty or specialized training upon completion of recognized Royal College specialty training Longer term than Clinical Fellow I Cannot be working in the same specific area they are being trained in	• Supervising attending is responsible for care delivered by Fellow	• CPSBC Clinical Trainee license which requires endorsement from Vice President, Medical Affairs • May apply for privileges if appropriately licensed for independent practice following approval of Vice President, Medical Affairs • copy of their CV • copy of their MD license • Letter to Vice President, Medical Affairs from mentor, co-signed by Division and Department Heads with: exact start and end dates; purpose/scope of activities; supervisor name(s); and areas where they will be working (ORs, clinics, wards, etc.) • Signed confidentiality agreements by all parties **NOTE: Non-UBC Fellows may not be recognized as receiving UBC Fellowship training**	PHC will provide a letter of support to CPSBC only after a completed package is submitted. **Approval can be up to two (2) years max.** Hospital privileges not automatically granted. May apply for exception. Network and clinical systems access granted as needed. Non-credit (UBC)

APPENDIX IV
Trainee Positions at PHC (as of Nov 2016)

Category	Reason	Supervision	Licensing/Documents	Appointment
7. Fellow – UBC	Sub-specialty training upon completion of recognized Royal College specialty training including CCFP & Royal College specialty training	• Supervising attending is responsible for care delivered by Fellow	• CPSBC trainee license required • May apply for privileges if appropriately licensed for independent practice following approval of Vice President, Medical Affairs • Department/Division Head to sign application form, with sign-off by Vice President, Medical Affairs for CPSBC Trainee license. If working at both sites (VCH & PHC), both site Department Heads must sign **<u>NOTE</u>: funding source cannot be from a PHC Department cost centre and are not permitted to bill MSP.**	PHC does not process these applications as they are processed through UBC and sent to PHC for signatures Fellowship documentation entered into CACTUS through PHC Medical Education Hospital privileges not automatically granted. May apply for exception.
8. Clinical Associates	Moonlighting Residents / Fellows providing afterhours patient care	• Working under the supervision of the attending/service that hires them • residents and fellows on a trainee license	• Must hold license to practice from CPSBC; CMPA Code 14 • May not bill MSP; paid through other means • Authorization of program/site Training Director • Must submit a copy of their CPSBC license and CMPA • Signed confidentiality undertaking **<u>NOTE</u>: Upon submission to Medical Affairs, MA will provide written acknowledgement and record moonlighting permit to practice as extension of trainee license.**	No hospital privileges

APPENDIX IV
Trainee Positions at PHC (as of Nov 2016)

Category	Reason	Supervision	Licensing/Documents	Appointment
9. Research Associates	Seeking Research experience Exploring options for areas in Research IMGs, Canadian Medical graduates, and fully licensed physicians	• Working under the supervision of the principal investigator	• License from College – varies, depending on what they are doing. If no patient contact, a license will no longer be required if less than one (1) month • Must hold clinical credentials or be enrolled in a recognized Medical training program • If observer is a physician, a copy of their MD license must be included • Letter to Vice President, Medical Affairs from principal investigator, co-signed by Division and Department Heads with: exact start and end dates; purpose/scope of activities; supervisor name(s); and areas where they will be visiting (ORs, clinics, wards, etc.); and any Rounds or other CME events • Signed confidentiality agreements by all parties • A copy of the College license must be sent to Medical Affairs	Research associates are approved for **normally one (1) year; renewable** No hospital privileges or ID. Network access granted if required.

Required Documents to be Completed and Signed

A – Observers I & II & Researchers	B – Clinical Trainees	C – Clinical Fellows (non-UBC) I & II	D – UBC Fellows	E – Clinical Associates
Support letter A1a (Observers  template letter for observerships - Mar 2 **Support letter A1b (Researchers)**  Support letter - Research Associate.d	**Support letter B1**  template letter for clinical trainees - Mar	**Support letter C1**  template letter for non-UBC Clinical Fello	**Fellowship Application form D1** (usually comes to PHC after UBC Head has signed) • Signatures required from (1) Division Head, (2) Department Head, (3) VP Medicine. Please attach separate signature page if required  Postgrad Fellow Application.pdf	**Forms to be signed** **E1**  Clinical Associates - Program Director sign **E2**  ED-Resident-Clinical-Associate - Health-Au
Pledge of Confidentiality A2  PLEDGE OF CONFIDENTIALITY - (	**Pledge of Confidentiality B2**  PLEDGE OF CONFIDENTIALITY Cl	(same as B2)	N/A – confidentiality documents should already been covered through UBC	
Observer Agreement A3  Observer Agreement PHC Apr 2016.pdf	**Agreement B3**  Clinical Trainee-Fellow-Medic	(same as B3)	N/A – confidentiality documents should already been covered through UBC	
Additional documents required A4 • CV • Copy of MD degree • If applicable, copy of license from College	**Additional documents required B4** • CV • Copy of MD degree • Copy of license from College	(Same as B4)	(Same as A4)	**Additional documents E3** MA will provide confirmation of moonlighting permit to practice as extension of trainee license & term engagement letter