Medical Staff Rules

Interior Health Authority

Original Draft: November 15, 2006
Board Approved: January 17, 2007

Most Recent Revisions: January 26, 2011; May 27, 2014; May 2, 2025
Current Revision: April 14, 2026

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Preamble

This document comprises the Medical Staff Rules (the "Rules") of the Interior Health Authority (IHA), and applies to all members of its Medical Staff, whether independent practitioners, contracted practitioners or employees. The Rules provide specificity and detail to the articles of the Medical Staff Bylaws[1] (the "Bylaws"). In the case of an inconsistency between these Rules and the Bylaws, the provisions of the Bylaws shall prevail.

The Hospital Act Regulation[2] requires the Board to organize the Medical Staff, through Medical Staff Bylaws and Rules, and in compliance with the IHA's published Bylaws, Policies and procedures. The Board grants Privileges to appropriately qualified Medical Staff members to ensure effective care delivery in the facilities and programs operated by IH.

The Board is ultimately accountable for the quality of care delivered in the Facilities and Programs operated by IHA. This accountability extends to the Chief Executive Officer (CEO), who is the Board's representative, as outlined in Section 3(1) of the Hospital Act Regulation[2]. Members of the Medical Staff are accountable to the CEO and Board, through the Health Authority Medical Advisory Committee (HAMAC), for the quality of medical care they provide in the facilities and programs operated by the IHA. The primary role of the HAMAC is first, to assure the Board that the quality of medical care meets an acceptable standard; second, to recommend Medical Staff appointments to the Board; and third, to govern the Medical Staff based on the Medical Staff Bylaws, Rules and Policies.

The Rules are established by the Board upon the recommendation of the HAMAC pursuant to Article 12 of the Bylaws. Whereas a change to the Bylaws requires approval by the Minister of Health, the Board has the authority to approve or amend the Rules after receiving the recommendation of the HAMAC. As such, the Rules can be adapted to reflect ongoing changes in Medical Staff practice and governance. The Rules amendment process is set out in Article 12 of the Bylaws.

The Rules govern the relationship between IHA and its Medical Staff and address the accountability of Medical Staff for their day-to-day practice within IHA. The Rules assist the Medical Staff to discharge their responsibilities to the Board by establishing standards and processes that define the function and deportment of the Medical Staff.

Members of the Medical Staff are required to adhere to, and are offered the protections of, the B.C. Freedom of Information and Protection of Privacy Act (FOIPPA) and other applicable legislation respecting personal privacy. Further, Medical Staff are afforded the protection of the Public Interest Disclosure Act (PIDA), promoting public accountability and transparency.

1. Medical Staff Bylaws. Interior Health Authority, Board Manual 9.1.
https://www.interiorhealth.ca/sites/default/files/PDFS/medical-staff-bylaws.pdf
2. Hospital Act Regulation.
https://www.bclaws.gov.bc.ca/civix/document/id/crbc/crbc/121_97

ARTICLE 1 – PURPOSE

As outlined in the Bylaws, Article 2, the purpose of the Medical Staff are to act in an advisory capacity to the Board of Directors, being accountable for the quality of medical care provided in the programs and facilities of the IHA. Through a variety of functions (Article 2.2, Bylaws) the Medical Staff can fulfill this accountability. Further, the professional conduct of the members of the Medical Staff are governed by each profession's Code of Ethics, as detailed in Bylaws, Article 2.3.

The Medical Staff are representatives of the strengths and diversity with Interior Health communities, both urban and rural centres. The Medical Staff work cohesively and collaboratively to provide equitable patient- and family-centred care through the Region. As representatives of their communities, the Medical Staff espouse the highest quality medical care and professionalism.

The Medical Staff support the provision of medical care built around the patient and family receiving health care services. The Medical Staff support the Interior Health Framework for Person- and Family-Centred Care, which places individuals at the forefront of their health and care, ensures they retain control over their health care choices, helps them make informed decisions, and value the patient as a partner in health care provision and redesign of services.

The Medical Staff promote diversity, equity, inclusion and belonging, for all Medical Staff, employees, volunteers, patients, and families. The Medical Staff recognize that diversity in the workplace shapes values, attitudes, expectations, perception of self and others and in turn impacts behaviours in the workplace. The dimensions of a diverse workplace includes the protected characteristics under the human rights code of: race, color, ancestry, place of origin, political belief, religion, marital status, family status, physical disability, mental disability, sexual orientation, gender identity or expression, age, criminal or summary conviction unrelated to employment (IHA Policy AU2100).

The Medical Staff are committed to ensuring that all individuals, whether patients, clients, residents, visitors or staff, are treated with dignity and respect, free from discrimination and harassment; and supported in the respectful management of any workplace conflict. To this end, the Medical Staff are required to conduct themselves, and to be treated, in accordance with the IHA Standards of Conduct for Interior Health Employees (IHA Policy AU0100).

The Medical Staff are committed to Culturally Safe care, as defined by Interior region Indigenous peoples. Medical Staff are committed to delivery of health services that are accessible, of high quality, relevant, culturally safe, and provided in a culturally competent manner (IHA Policy AD0200). Further, Medical Staff are committed to addressing Anti-Aboriginal Racism and breaches of Cultural Safety, and activity engaging in Anti-Racism, in alignment with the IHA Anti-Racism Policy (IHA AU 2200).

The Medical Staff are committed not only to high quality clinical care, but to education and research. Medical Staff are committed to the clinical education of medical students, residents, fellows and other clinical trainees in the IHA Facilities and

Programs. Further, Medical Staff strongly support research and improvement activities to further study, enhance and improve the quality of care provided.

The Medical Staff and Interior Health acknowledge their shared commitment to deliver high quality care in a healthy workplace and consequently, our shared understanding of our respective responsibilities. The IHA and the Medical Staff are committed to supporting safe work environments, promoting team-based care and a learning culture for teaching. Further, the IHA and Medical Staff promote the principles and practices of a Just Culture and procedural fairness in both patient safety reviews, individual accountability reviews and disciplinary processes.

ARTICLE 2 – DEFINITIONS

***Affiliation Agreement* —** An agreement between the IHA and a University, College or other educational entity to facilitate teaching and clinical-training activities within an IHA Facility or Program.

***Appointment* —** The process by which a Physician, Dentist, Midwife or Nurse Practitioner becomes a member of the Medical Staff. Appointment does not constitute employment by the IHA.

***Board of Directors (the Board)* —** The governing body of the Interior Health Authority appointed by the Minister of Health for the Province of British Columbia (BC).

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

***Computerized Provider Order Entry (CPOE)* —** The process of order placement into the electronic health record by a healthcare provider or designated Medical Staff member, employing either single electronic orders or groups of orders (electronic clinical order sets).

***Credentialing* —** The process of evaluating Medical Staff qualifications, including appropriate training, licensure, experience, references, professional college requirements and malpractice insurance necessary for appointment to the Medical Staff. The Credentialing process requires, in part, Medical Staff compliance with competency expectations outlined in the BC Provincial Privileging Dictionaries.

***Delegation of a Restricted Act* —** The process of delegating to another (regulated or unregulated) healthcare professional a restricted activity.

***Cultural Safety* -** Indigenous Cultural Safety is a health care approach that considers how social and historical contexts, as well as structural and interpersonal power imbalances, shape health and health-care experiences. In a culturally safe organization, staff are self-reflective and self-aware and understand their role in creating Culturally Safe spaces for colleagues and clients. This self-reflection process is Cultural Humility.

***Department* —** An organizational unit of the Medical Staff to which members with a similar practice or specialty have been assigned. ***Department Head* —** A member of the Active Medical Staff appointed by the IHA and responsible to the Senior Facility Medical Administrator or Senior Nursing Administrator (in the case of Nurse Practitioners) to lead the clinical, academic, quality improvement and governance activities of a Department.

***Dentist* —** A member of the Medical Staff who is duly licensed and registered with the College of Dental Surgeons of B.C. and who is entitled to practice dentistry in British Columbia.

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

***Division Head* —** A member of the Active Medical Staff appointed by and responsible to a Department Head to lead the clinical, academic, quality- improvement and governance activities of a Division.

Electronic Health Record (EHR) — A secure, integrated, digital collection of a patient's medical information and encounters with the healthcare system, comprising a comprehensive digital record of that individual's health history.

Executive Medical Director (EMD) — A physician appointed by the Senior Executive Medical Administrator, responsible for the coordination and direction of the activities of the Medical Staff within a Region or Program.

Facility — A healthcare site operated by the IHA.

Health Authority (HA) — One of five geographical entities and one strategic entity, led by a government-appointed Board, to oversee the provision and management of healthcare services and delivery in BC. Geographical HAs are established under the *BC Health Authorities Act* or the regulations thereto, while the Provincial Health Services Authority (PHSA) is established under the *BC Society Act.*

Health Authority Medical Advisory Committee (HAMAC) — The senior medical committee, advisory to the IHA Board and CEO, on medical, dental, midwifery and nurse practitioner governance and practice matters, including quality-of-care issues, as described in Article 8 of the Bylaws.

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

Hospital — A health care facility defined in the *Hospital Act* and owned or operated by the IHA.

Interim Appointment - is a term used by Interior Health to describe a procedure whereby Privileges are granted on an interim basis to an applicant whose clinical services are required by Interior Health, but the application is pending the approval process, as defined by Article 4 of the Bylaws.

Just Culture - Interior Health promotes a 'just culture' in which transparency, fairness, accountability and a focus on learning and improvement from Adverse Events (AEs) are key elements. We support all people with empathy and support following an AE. We avoid speculation or making assumptions that a poor clinical outcome is the result of error or poor judgment – a review needs to take place before any assignment of accountability might occur.

Local Medical Advisory Committee (LMAC) — The medical advisory committee of a Facility or part of a regional service delivery area that reports to the HAMAC via RMAC on local medical, dental, midwifery and nurse practitioner matters, as described in Article 8 of the Bylaws.

Medical Advisory Committee (MAC) — A general term describing any LMAC, RMAC and the HAMAC operating within the IHA (see specific definitions elsewhere in this section).

Medicine Portfolio — An administrative branch of the IHA, the portfolio of the **Senior Executive Medical Administrator (Vice President Medicine)**. Part of the responsibility of **the Medicine Portfolio** is to assist the HAMAC, RMACs, LMACs, Departments and Programs to fulfill their obligations regarding Medical Staff organization, credentialing and privileging, hiring and workforce planning, and governance.

Medical Care — The clinical services provided by Physicians, Dentists, Midwives and Nurse Practitioners to IHA patients and clients.

Medical Director — A member of the Medical Staff who holds an administrative role in the HA responsible for the coordination and direction of the activities of the Medical Staff within a Region, Program, Network or Portfolio. Includes **Senior Medical Director (SMD)**.

Medical Leader – member of the Medical Staff who holds an administrative role in the HA, including, but not limited to, Department or Division Heads, Medical Directors, and Senior Facility Medical Administrators.

Medical Staff — The Physicians, Dentists, Midwives and Nurse Practitioners who have been granted privileges to practice by the Board in the Facilities and Programs operated by the IHA.

Medical Staff Association — The component of the Medical Staff Organization, established by Article 10 of the Bylaws, to represent the Medical Staff and to ensure effective communications between the Medical Staff, administration, and the Board of Directors for the IHA. All members of the Medical Staff belong to and fulfill the responsibilities of the Medical Staff Association.

Medical Staff Bylaws (the Bylaws) — The Bylaws, approved by the BC Minister of Health, which set out the organization, structure, function, governance and accountability of the Medical Staff.

Medical Staff Organization —The membership of the Medical Staff including every practitioner providing care in the Facilities and Programs of the IHA, organized in accordance with the *Hospital Act and its Regulation.*

Medical Staff Policy — Administrative guidelines or policies establishing standards for the delivery of medical care to patients within the Facilities and Programs operated by the IHA.

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

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

Most Responsible Practitioner (MRP) –– the member of the Medical Staff who has the overall responsibility for the management and coordination of care for a patient admitted to, or being treated in, a Facility or Program operated by the IHA.

Network — An IHA organizational structure that focuses on a patient population with similar conditions, such as mental health and substance use, or a specific type of clinical practice, such as trauma or emergency-department care.

Nurse Practitioner — A nurse who is duly registered with the B.C. College of Nurses and Midwives as a Nurse Practitioner and who is entitled to practice as a Nurse Practitioner in British Columbia.

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

Practitioner — A Physician, Dentist, Midwife or Nurse Practitioner who is a member of the IHA Medical Staff.

Primary Department — The Department to which a member of the Medical Staff is assigned, based on training and the specialty in which the member delivers the majority of care to patients.

Privileges — A permit to practice medicine, dentistry, midwifery or nursing as a Nurse Practitioner in the Facilities and Programs operated by the IHA and granted by the Board to a member of the Medical Staff, as set forth in the *Hospital Act and its Regulation*. Privileges describe and define the scope and limits of each practitioner's permit to practice in the Facilities and Programs of the IHA. Privileges are site-specific.

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

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

Regional Medical Advisory Committee (RMAC) — A medical advisory committee reporting to the HAMAC, established in each of the IHA's Health Service Delivery Areas, having delegated responsibilities and Terms of Reference approved by the HAMAC.

Regulatory Body — The discipline-specific BC provincial regulatory college for each category of the Medical Staff.

Resident — Resident Staff are qualified physicians, dentists, midwives or nurse practitioners who are undergoing training, and who are temporarily attached for educational purposes to a Facility or Program operated by the IHA. Resident Staff are not members of the Medical Staff as defined in the Bylaws and therefore are not governed by these Rules.

Senior Executive Team (SET) — The primary planning, strategic- management and decision-making team supporting the CEO of the IHA, comprised of the HA Vice Presidents, including the Senior Executive Medical Administrator.

Senior Executive Medical Administrator (VP Medicine)— The senior administrative physician of the IHA, usually titled the **Vice President Medicine**, appointed by the CEO, responsible for the oversight, coordination and direction of the activities of the Medical Staff.

Senior Executive Nursing Administrator — A registered nurse, appointed by the CEO of the IHA, usually titled **Chief Nursing Officer** (CNO) who has Health Authority wide responsibility and accountability for providing senior leadership and strategic direction for the professional practice of Nursing and Allied Health.

Senior Facility Medical Administrator — The senior administrative physician of an IHA Facility, often referred to as the **Chief of Staff**, reporting to the Senior Executive Medical Administrator through the Senior and Executive Medical Directors.

ARTICLE 3 — CATEGORIES OF MEDICAL STAFF

Medical Staff categories are identified and defined in Article 6 of the Bylaws, which should be referenced for detailed information. These Rules provide further details about some of these categories. The Medical Staff categories are as follows:

3.1 **Provisional Staff**:

The initial appointment for all applicants seeking active staff privileges, unless specifically exempted from this requirement by the Board. This category may also apply to members of the Medical Staff who are under review or have been disciplined.

3.2 **Active Staff:**

The preferred category for appointment to the IHA Medical Staff, with specific rights and obligations that correspond with this appointment.

3.2.1 Members of the Provisional Staff may, on recommendation of their Department Head, apply to the HAMAC and Board of Directors for appointment to the Active taff after completion of 6 months of

Provisional Staff membership. The application will include, at a minimum, a comprehensive review as outlined in Article 5 of the Rules.

3.3 **Associate Staff:**

A restricted appointment to the Medical Staff for members who may utilize diagnostic facilities, assist in the operating room or undertake other duties specifically assigned to them, but who shall not perform surgical or investigational procedures for which additional privileges are required.

For clarity, those individuals eligible for educational, Associate Physician or Physician Assistant classes of registration are not eligible for appointment to the Medical Staff.

3.3.1 Members of the Associate Staff are appropriately qualified, credentialed and privileged Medical Staff who work in highly-specialized areas under the direction of a Department or Division Head, or a senior member of a Department or Division, who acts as their sponsor and is responsible for their work. The Department or Division Head shall define their scope of practice.

3.3.2 Members of the Associate Staff must satisfactorily complete the required period on the Provisional Staff as described in Section 6.1 of the Bylaws, unless exempted from that requirement by the Board.

Members of the Associate Staff provide clinical services and are not part of a clinical training program.

3.3.3 Members of the Associate Staff are assigned to a Primary Department and may not admit patients to the Programs and Facilities operated by the IHA, but may attend, investigate, diagnose and treat patients within the scope of their privileges.

3.3.4 Members of the Associate Staff are not eligible to hold office and vote at Medical Staff and departmental meetings.

3.3.5 Unless specifically exempted by the HAMAC, members of the Associate Staff are required to participate in fulfilling organizational and service responsibilities, including on-call responsibilities as described in these Rules.

3.3.6 Members of the Associate Staff are required to participate in administrative and educational activities of the Medical Staff and are required to attend at least 70 percent of Primary Departmental or Divisional meetings.

3.3.7 Appointment to the Associate Staff conveys no preferential status or privilege in seeking a future appointment to any category of the Medical Staff.

3.3.8 **Clinical Fellows**

3.3.8.1 Clinical Fellows are a specific sub-category of the Associate Staff.

3.3.8.2 Clinical Fellows are physicians who have applied to and been

accepted by the IHA for further training, upon recommendation from the IHA Department Head.

3.3.8.3 Along with standard privileging process and documentation as outlined in the *Bylaws*, Clinical Fellows must be registered with the Faculty of Medicine, University of British Columbia.

3.4 **Consulting Staff:**

Physicians, Dentists, Midwives and Nurse Practitioners with special training or other qualifications in a particular discipline, who have been recommended by the HAMAC to be of special advantage to the Facilities and Programs operated by the Interior Health Authority.

3.5 **Temporary Staff:**

3.5.1 The purpose of an appointment to the Temporary Staff is to fill a time-limited-service need, as outlined in Article 6.5 of the *Bylaws*.

3.5.2 Appointment to the Temporary Staff conveys no preferential status or privilege in seeking a future appointment to any category of the IHA Medical Staff.

3.5.3 Under normal circumstances, a Temporary Staff appointment must follow the policies and procedures employed for any other IHA Medical Staff appointment.

3.5.4 In special or urgent circumstances, the Senior Executive Medical Administrator, acting on the authority of the CEO, may grant Temporary Privileges. Examples of special or urgent circumstances include, but are not limited to:

i. Demonstrating equipment or new procedures;

ii. Providing care during mass casualties; or

iii. Meeting a time-limited clinical need that temporarily overwhelms a Department’s capacity to provide adequate coverage.

3.5.5 The Senior Executive Medical Administrator may grant Temporary Privileges for a fixed period, with specific conditions or for a designated purpose.

3.5.6 The process for appointing Temporary Privileges under special or urgent circumstances is:

3.5.6.1 Prior to the Senior Executive Medical Administrator granting Temporary Privileges, the Medicine Portfolio must review the application to ensure completeness, and the Senior Facility Medical Administrator (or designate) must have obtained favourable reports, including verbal reports, from the referees identified in Article 4.1.3 of the Bylaws.

3.5.6.2 The Senior Executive Medical Administrator must perform due diligence prior to granting Temporary Privileges.

3.5.6.3 Decisions to grant Temporary Privileges must be documented in a manner that reflects the special or urgent circumstances, the Medicine Portfolio's review, the Senior Executive Medical Administrator's due diligence and the rationale for the length of the fixed term and any specific conditions.

3.5.7 Temporary Privileges must be ratified or terminated by the Board at its next meeting. Temporary Privileges will remain in effect no longer than a period of twelve (12) months.

3.5.8 Temporary Privileges may be renewed one (1) time if the Senior Executive Medical Administrator is satisfied that special or urgent circumstances justify the renewal.

3.5.9 In the event that Temporary Privileges are not ratified by the Board or the fixed period of the Temporary Privileges ends, the Practitioner will cease all clinical activity in the Facilities and Programs operated by IHA and immediately transfer the ongoing care of any admitted patients to an appropriate member of IHA Medical Staff.

3.5.10 Individuals recognized by BC Transplant are deemed as having time-limited Temporary Privileges without application for the purpose of organ retrieval and transplant only.

3.6 Locum Tenens Staff:

Article 6.6 of the Bylaws defines the Locum Tenens Staff category and scope of practice. For better clarity, these Rules define activation and de-activation of Privileges, maintenance of Privileges, responsibilities for Locum Tenens Staff, as well as the role of Provisional, Active or Consulting Staff members seeking a Locum Tenens.

3.6.1 Members of the Locum Tenens Staff are appointed for a specified period of time, not to exceed twelve months, for the purpose of replacing a member of the Provisional, Active, or Consulting Staff during a period of absence.

3.6.2 A Provisional, Active or Consulting Staff member must advise the Medicine Portfolio of the specific dates of any upcoming Locum Tenens requirement. The request must be approved by the Department or Division Head in advance.

3.6.3 Members of the Locum Tenens Staff may only replace an absent member of the Provisional, Active or Consulting Staff. In this context, "absent" means being away from a Facility or Program- based practice for vacation, parental, educational, illness or Board-approved leave of absence.

3.6.4 Members of the Locum Tenens Staff may cover on-call shifts only when they are providing locum coverage for an absent member for the specific period of the absence.

3.6.5 A request for Locum Tenens Staff for a period of less than 48 hours shall only be approved in urgent circumstances, as determined by the Senior Executive Medical Administrator, or delegate.

3.6.6 While Locum Tenens Staff Privileges may be granted for up to twelve months, each new period of locum coverage must be approved in advance. When the approved period of coverage concludes, Locum Tenens Staff cannot continue to exercise their Privileges. For each subsequent Locum Tenens coverage period, a Provisional, Active or

Consulting Staff Member must submit a completed locum scheduling form to the Credentialing and Privileging Office of the Medicine Portfolio, confirming coverage dates. This must be approved by the Department or Division Head prior to Locum Tenens Staff exercising their Privileges.

3.6.7 Minimum lead times for Locum Tenens category Privileges are:

3.6.7.1 New Applicants: six weeks

3.6.7.2 Current Locum Tenens Staff requesting additional site Privileges: two weeks

3.6.8 In situations requiring urgent Locum Tenens appointment, the Senior Executive Medical Administrator, or delegate, may grant an Interim Appointment for Temporary Privileges while the application is being processed.

3.6.9 Upon approval by the Division or Department Head, for applicants who have not previously held Medical Staff Privileges, the Medicine Portfolio shall provide an application package for new Locum Tenens Privileges. The completed application package must be approved by the Department or Division Head, following which it shall be forwarded to the HAMAC by the Medicine Portfolio for a recommendation to the Board for approval.

3.6.10 <u>Responsibilities of the Medical Staff Member Requesting a Locum</u>

i. The Medical Staff member shall notify the Medicine Portfolio of an upcoming Locum Tenens arrangement by forwarding the completed locum scheduling form, indicating start and end dates, within the required minimum lead time.

ii. The Medical Staff member must be absent from the hospital or Facility for the full period of locum coverage, except to facilitate orientation and patient handover.

iii. The Medical Staff member is responsible to arrange the orientation of the Locum Tenens to the Facility or Program, including orientation to program policies and procedures required to support provision of care to patients. If the Medical Staff member is unavailable to fulfil these responsibilities, the Department or Division Head shall assign the responsibility to another member of the Medical Staff.

iv. In facilities where the EHR has been implemented, the Medicine Portfolio shall facilitate timely IHA-approved EHR competency training and advise the Locum Tenens of this requirement. This training must be completed before Privileges shall be activated.

v. The Medical Staff member requesting the Locum Tenens shall complete a performance appraisal as soon as possible after the locum has finished. This shall be forwarded to the Medicine Portfolio for

future reference and follow-up, if necessary.

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

3.6.11 Responsibilities of the Locum Tenens

i. Locum Tenens Privileges are granted to an individual practitioner for a defined period of time.

ii. Where the EHR has been deployed, the IHA shall ensure that the prospective Locum Tenens has access to adequate EHR training and, in turn, the new Locum Tenens must ensure EHR education training has been completed and competency has been achieved. Failure to do so may result in not receiving Privileges in time to cover the requested locum.

iii. Locum Tenens Staff members are responsible for the completion of all Health Records of patients for whom they have been caring. Failure to complete Health Records shall result in a review of Privileges by the Department or Division Head, which may impact the locum's ability to obtain future Locum Tenens Privileges.

iv. Locum Tenens Staff may not assign their locum coverage to another practitioner with Locum Tenens Privileges, unless that assignment is part of a regularly-scheduled on-call.

v. The term of the Locum Tenens Staff ends automatically when the regular Medical Staff member returns to practice. Any requests to provide future Locum Tenens coverage must be submitted to the Credentialing & Privileging Office of the Medicine Portfolio for approval.

3.7 **Scientific and Research Staff:** qualified researchers or educators who, in recognition of their training, experience and ability, have been granted this appointment to carry out duties related to teaching and research assigned to them by the Head of the Department to which they have been appointed. Members of the scientific staff must not admit patients, write orders, vote, or be officers of the Medical Staff Associations.

3.8 **Honorary Staff:** Medical Staff members not active in the Facilities and Programs operated by the IHA, but whom the Board of Directors wishes to honour. This category may include individuals with outstanding reputations or prominent physicians, dentists, midwives or nurse practitioners who have retired. Honorary Staff are not privileged to practice in the Facilities and Programs operated by IHA, and they have none of the Departmental responsibilities or rights that apply to other categories of the Medical Staff. As Honorary Staff do not actively provide services in IHA Facilities and Programs, the requirements for licensure and liability coverage may be waived.

ARTICLE 4 — MEMBERSHIP AND APPOINTMENT

4.1 Membership

4.1.1 Terms and criteria for appointment to the Medical Staff, as well as procedures for application and review, are detailed in Articles 3 and 4 of the *Bylaws*. The IHA supports and strives for consistency and transparency in all these processes.

4.1.2 Appointments to the Medical Staff are Health Authority wide. Each appointment shall describe the scope and limits of the Medical Staff Member's permit to practice in a Facility or Program operated by the IHA.

4.1.3 Privileges are Facility or Program specific.

4.1.4 An application for the appointment to the Medical Staff to perform services within the Facilities or Programs operated by the IHA requires the completion of an impact analysis, based on Article 3.1.5 of the *Bylaws*, together with approval from the SET, or delegate, that the impact can be addressed within the availability of current resources.

4.2 Application Procedure

The procedures for application and appointment to the Medical Staff are set out in Articles 4.1, 4.2 and 4.3 of the Bylaws. The credentialing and privileging process must be completed on or before the applicant's start date.

4.3 Terms of Appointment

4.3.1 Appointments to the IHA Medical Staff are Health-Authority wide.

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

4.3.3 Facility-specific Privileges convey no preferential status for Privileges in any other Facility or Program operated by the IHA.

4.3.4 A member of the Temporary, Provisional, Active or Consulting Staff may apply for Privileges in another Facility or Program operated by the IHA.

4.3.5 Additional Privileges may be granted by the Board after considering the recommendation of the HAMAC.

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

4.4 Interim Appointment

4.4.1 Interim Appointment is the term used by the Interior Health Authority to describe Privileges granted to an applicant whose clinical services are

required while an application is still proceeding through the application process outlined in article 4 of the Bylaws.

4.4.2 When circumstances require Privileges to practice in a Facility or Program operated by the IHA before a final application can be reviewed by HAMAC and approved by the Board, the Senior Executive Medical Administrator may grant an interim Appointment to the Medical Staff. The Medicine Portfolio must have already reviewed the application to ensure completeness and the Senior Facility Medical Administrator or delegate must have obtained favourable reports, including verbal reports, from the referees identified in Article 4.1.3 of the Bylaws.

4.4.3 The Interim Appointment will remain in effect until the Board has an opportunity to review HAMAC's recommendation and reach a decision, or for up to three (3) months, whichever period is shorter.

4.4.4 An Interim Appointment may be renewed once if the Senior Executive Medical Administrator is satisfied that extenuating circumstances justify the renewal.

4.4.5 An Interim Appointment conveys no preferential status or privilege in seeking a future Appointment to any category of the Medical Staff.

4.4.6 The application of a Practitioner granted an Interim Appointment must be reviewed at the next possible HAMAC meeting and forwarded to the Board for decision at the Board's next possible scheduled meeting.

4.4.7 In the event that the Board does not approve the Appointment of an applicant with an Interim Appointment, the applicant will cease all clinical activity in the Facilities and Programs operated by Interior Health and immediately transfer the ongoing care of any admitted patients to an appropriate member of Medical Staff.

4.5 **References**

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

4.5.1 **Newly Qualified Medical Staff:**

i. One reference from the Dean or the Dean's representative of the medical school / professional program from which the applicant graduated;

ii. One reference from the applicant's residency, post-graduate or clinical Program Director;

iii. At least one reference from a teaching member of the facility where the applicant completed the majority of residency, post-graduate or clinical training.

4.5.2 **Established Medical Staff:**

i. One reference from the Senior Facility Medical Administrator of the last Facility where the applicant practised

ii. At least two references from clinicians familiar with the current practice of the applicant. For physicians, references

should be obtained from other physicians, where possible.

4.6 Procedural Privileges

Procedural Privileges are a permit to perform specific operations or procedures in designated Facilities and Programs operated by the IHA. Procedural Privileges are assessed using criteria from specialty-specific British Columbia Provincial Privileging Dictionaries and are granted by the Board on the recommendation of the HAMAC after a satisfactory review of the training, experience and competence of the Practitioner, the service needs of the IHA, and the requisite available resources in a specific Facility or Program operated by the IHA.

4.6.1 Physicians, dentists, midwives or nurse practitioners appointed to the Medical Staff may apply for procedural privileges. All procedural privileges require documentation of training and experience.

4.6.2 Certain procedural privileges may be defined by the HAMAC as "core privileges" and may be granted automatically to all Medical Staff members, or specifically to members of certain specialties or sub-specialties.

4.6.3 The Department Head, or delegate, shall re-evaluate procedural Privileges during the reappointment process to confirm the Practitioner's maintenance of competence, the ongoing service needs of the IHA, and the requisite available resources in a specific Facility or Program operated by the IHA.

4.6.4 Procedural privileges may be granted to a physician, dentist, midwife or nurse practitioner based on adequate documentation provided by another Facility where that physician, dentist, midwife or nurse practitioner has held such privileges.

4.6.5 Where specific procedural privileges have been granted, the Board, on the recommendation of HAMAC, on the advice of the appropriate Department Head, may specify the frequency at which such a procedure must be performed in order for the physician, dentist, midwife or nurse practitioner to maintain these Privileges.

4.6.6 Procedural privileges require a special application to the Board of Directors on advice of the HAMAC in the following circumstances:

i. The introduction of new technology for which training has not previously been available to the specialty;

ii. A request for privileges outside the practitioner's specialty area;

iii. A request for specialty-specific privileges by a non-specialist practitioner.

4.7 Postgraduate Training Programs

4.7.1 Resident Staff

i. All appointments to Resident Staff shall be made through the office of Postgraduate Medical Education in conjunction

with the Faculty of Medicine at the University of British Columbia (UBC) and licensed by the College of Physicians & Surgeons of British Columbia.

ii. Resident Staff may attend patients under the supervision of a member of the Active or Provisional Medical Staff of the department responsible for supervision of their work in the hospital. They may carry out such duties as are assigned to them by the Medical Staff member to whom they have been assigned. (Further details of Resident Staff roles and responsibilities are available through the office of Medical Postgraduate Education at the University of British Columbia (UBC)).

4.7.2 Clinical Fellows

i. Clinical Fellows are physicians who have applied to and been accepted by the Interior Health Authority for further training in a clinical discipline. They must have adequate medical liability insurance, be licensed by the College of Physicians & Surgeons of British Columbia and be registered with the Faculty of Medicine at the University of British Columbia. Clinical Fellows shall be accepted only if supported by the Department Head concerned and recommended by the Medical Staff Resource Planning and Credentials Committee, the HAMAC and approved by the Board of Directors.

ii. Clinical Fellows may attend patients under the supervision of a member of the Active or Provisional Medical Staff of the department responsible for supervision of their work in the hospital. They may carry out such duties as are assigned to them by the Head of the Department or delegate to whom they have been assigned. They may not admit patients. They may not vote at Medical Staff or Department meetings.

4.8 **Students**

4.8.1 Medical Students

All Medical Students working within a hospital, program or department must either be registered through the Faculty of Medicine at the University of British Columbia or be attending a WHO/FAIMER-recognized medical school and have a valid educational license from the College of Physician and Surgeons of British Columbia. Medical students may attend patients under the direct supervision of a member of the Active or Provisional Medical Staff, Resident staff or a Clinical Fellow in the department responsible for their training program. Orders written by medical students must have been discussed with the supervisor prior to being written and must be countersigned at the earliest opportunity, within 24 hours. Medical students shall not sign certificates of death. Medical Students shall not discharge patients without appropriate review by a qualified physician. Although not members of the Medical Staff, Medical students must abide by the policies and guidelines of Interior Health.

4.8.2 Midwifery, Nurse Practitioner and Dental Students

All Midwifery, Nurse Practitioner and Dental Students working within a hospital, program or department must either be registered through the University of British Columbia or be attending a school with which the Interior Health Authority has an affiliation agreement. The student must have a valid educational license from his/her professional College in British Columbia. Students may attend patients under the direct supervision of a member of the Active or Provisional Medical Staff, Resident staff or a Clinical Fellow in the department responsible for their training program. Orders written by students must have been discussed with the supervisor prior to being written and must be countersigned at the earliest opportunity, within 24 hours. Students shall not sign certificates of death. Students shall not discharge patients without appropriate review by a qualified member of the Medical Staff. Although not members of the Medical Staff, Students must abide by the policies and guidelines of Interior Health.

4.8.3 Elective Clinical Rotations

Medical Students, Residents and Clinical Fellows from the University of British Columbia (UBC) and from medical schools outside of British Columbia may be authorized by the Executive Medical Director to do elective clinical rotations at facilities and programs of the Interior Health Authority. All electives must be approved and registered through the Faculty of Medicine at the University of British Columbia and be licensed by the College of Physicians and Surgeons of British Columbia. The scope of practice and requirements for supervision shall be the same as the respective articles in this Section.

4.9 **Enhanced Clinical Training:**

Physicians, Dentists, Midwives or Nurse Practitioners, not otherwise privileged with IHA, who apply to the IHA for the purposes of Enhanced Clinical Training (upgrading, remediation or mandated extra training) are not considered a member of the Medical Staff and are under the direct supervision of the Department Head or delegate.

They shall be:

4.9.1 Licensed by the College of Physicians and Surgeons of BC, College of Oral Health Professionals of BC or College of Nurses and Midwives of BC;

4.9.2 Approved by the Department Head of the Department where upgrading will take place;

4.9.3 Approved and registered with the IHA Medicine Portfolio;

4.9.4 Have qualifications commensurate with the level of training required (as determined by the Department Head or delegate);

4.9.5 Have adequate approved professional liability insurance;

4.9.6 Carry out such duties that are assigned to them by the Department Head in which Department they have been approved for Enhanced Clinical

Training. This does not include admission or discharge of patients;

4.9.7 Have a documented term for this Training.

4.10 **Observers**

4.10.1 Observers are practicing physicians, dentists, midwives, or nurse practitioners who wish to come to an IHA Facility to observe the provision of care or procedures related thereto. All observers, prior to their start date, shall be registered, as appropriate, with the College of Physicians and Surgeons of BC, College of Oral Health Professionals of BC or College of Nurses and Midwives of BC, as well as with the IHA Medicine Portfolio.

4.10.2 Observers other than those enrolled as students of health professions regulated by the *Health Professions and Occupations Act* or *Emergency Services Act of BC* are not supported by the College of Physicians and Surgeons of BC (CPSBC).

4.11 **Procedure to Address Letters of Intent Where No Medical Staff Vacancy Exists**

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

4.11.1 An unsolicited letter of intent for membership on the Medical Staff where a vacancy does not exist does not constitute an application in accordance with Article 4.1.3 of the Bylaws.

4.11.2 Unsolicited letters of intent to apply for Medical Staff membership where a vacancy does not exist must be forwarded immediately to the Medicine Portfolio for appropriate review and management.

ARTICLE 5 — REVIEW PROCEDURES

Members of the Medical Staff must undergo routine reviews, during Reappointment and at regular intervals. This has the purpose to ensure quality of care, support professional development and assist in the development of individual improvement plans for Medical Staff.

5.1 Review at Reappointment

Members of the Medical Staff seeking re-appointment shall comply with the requirements outlined in Articles 4.4 and 4.5 of the Medical Staff Bylaws. Further, the review shall include, at a minimum:

5.1.1 A review of the quality of the member's contribution to the IHA and Facility or Program;

5.1.2 Compliance with the IHA Bylaws, Rules, policies and procedures;

5.1.3 Quality and consistency of Health-Record documentation;

5.1.4 Completion of continuing-professional-development objectives generally defined by the relevant College of the Medical staff and including anti-racism education and training;

5.1.5 Professional conduct; and

5.1.6 The establishment and review of annual personal goals and objectives.

5.2 Comprehensive Review: Definition

A comprehensive review is intended for professional development and quality of care improvement (also called "in-depth performance evaluation" in the Bylaws). Reviews are meant to be a collaborative and positive approach to professional growth and development, Using the principles and practices of Just Culture, reviews are designed to be both educational and for improvement. The comprehensive review shall be performed in compliance with *Section 51 of the Evidence Act*, RSBC 1996 c 124 ("Evidence3 Act")

5.3 Comprehensive Review: Procedure

5.3.1 All members of the Medical Staff shall participate in a comprehensive review process prior to promotion from Provisional Staff to Active Staff and on a regular basis (i.e. approximately every four years or more regularly if concerns are identified).

5.3.2 The review shall be initiated by the Department Head or delegate, or requested by the Medical Staff member.

5.3.3 The comprehensive review may include input from non-Medical Staff colleagues, Medical Staff colleagues, and members of clinical teams, who shall assess the Medical Staff member's performance in relation to clinical knowledge and skills, communication skills, and practice management. This may be performed with a standardized tool, such as the Medical Council of Canada (MCC) 360 tool.

5.3.4 50% of those providing input shall be selected by the Department Head or delegate - the other 50% by the Medical Staff member.

5.4 Comprehensive Review: Contents

The Comprehensive Review may include the following:

5.4.1 Inpatient and outpatient clinical documentation including an assessment of the quality, accuracy, and timeliness of reports;

5.4.2 Current Curriculum Vitae;

5.4.3 Statement from the Medical Staff member outlining goals and objectives, including successes and challenges;

5.4.4 Patient incident reports, clinical complications and mortality events;

5.4.5 Staff and Medical Staff incident reports and concerns;

5.4.6 Continuing professional development, including the completion of Maintenance of Certification required by the College of Family Physicians of Canada or the Royal College of Physicians and Surgeons of Canada, additional specific competence training completed since the last review, as well as any updates specific to departmental or program requirements;

5.4.7 Indigenous anti-racism education or training or indigenous cultural safety and humility education or training;

5.4.8 Procedural-privileges evaluation, including frequency of performance of specified procedures;

5.4.9 Direct observation of procedural and clinical assessment skills;

5.4.10 Interviews or communication with members of affiliated organizations and regulatory bodies;

5.4.11 Resource-utilization; and

5.4.12 Teaching evaluations from students and residents;

5.4.13 Patient or client feedback.

5.5 Comprehensive Review: Review and Actions

5.5.1 The results of the Medical Staff Member's Comprehensive Review shall be presented to the Department Head (or delegate), Senior Executive Medical Administrator (or delegate) or the Senior Executive Nursing Administrator (in the case of a Nurse Practitioner). The Senior Facility Medical Administrator, or delegate, shall review the results with the Medical Staff member and, where necessary, assist to develop a plan for ongoing performance and/or personal improvement.

5.5.2 The Medical Staff member shall acknowledge, in writing, receipt of the completed review, including planned follow-up discussion with the Department Head, or delegate, and shall confirm agreement with any plan to address areas for improvement. The Medical Staff member shall complete and deliver this document to the Department Head, Senior Executive Medical Administrator or Senior Nursing Administrator (in the case of a Nurse Practitioner) within four (4) weeks of completion of the comprehensive review.

If the Medical Staff member will not acknowledge the results of the review in writing or refuses to agree to the requirements outlined in the Comprehensive Review, a list of resources will be provided and the

Department Head shall refer to the LMAC, RMAC or HAMAC for follow-up. The member has the right to appear before the MAC during the review process.

5.5.3 Final documentation of the Comprehensive Review shall include the report, any corrections of errors of fact, the Medical Staff Member's response, recommendations, implementation plan and reports on the implementation of recommendations. Discussions among the Department Head, Senior Executive Medical Administrator and Senior Executive Nursing Administrator (in the case of a nurse practitioner's) and the Medical Staff Member shall be summarized in writing and appended to the review.

5.5.4 Documentation of the Comprehensive Review process becomes and remains part of the Medical Staff Member's confidential personnel file.

5.5.5 The HAMAC and the Board shall be notified in writing of Comprehensive Review recommendations that require remedial action.

ARTICLE 6 – RESPONSIBILITY FOR PATIENT CARE

6.1 Admission, Discharge, and Transfer of Patients

6.1.1 Most Responsible Practitioner (MRP)

Every patient shall be admitted by a member of the Medical Staff who has admitting privileges and who has primary responsibility for the management and coordination of care for the patient. This Practitioner shall be identified as the Most Responsible Practitioner (MRP). The MRP is established on the basis of whose scope of practice is best suited to treat the most responsible diagnosis at the time of admission.

6.1.1.1 The MRP is determined either prior to the admission for planned surgical admissions or subspecialty interventions and treatment, or at the time a decision to admit is made in the Emergency Department (ED).

6.1.1.2 The MRP works collaboratively with a team to deliver care and treatment to the patient.

6.1.1.3 If the patient's medical condition warrants consultation with other members of the Medical Staff, the MRP coordinates and facilitates these consultations.

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

6.1.1.5 Further, the MRP shall:

i. Accept patients for admission from the Emergency Department (ED) or following acceptance of a transfer-of- care from another Practitioner;

ii. Admission order must be complete as soon as possible to enable timely transfer of the patient to most appropriate location in the hospital

iii. At the request of the MRP, "holding" admission orders may be completed by the emergency physician, these orders, including the Best Possible Medication History must be reviewed by the MRP within 24 hrs.

iv. Complete and document a full assessment for admission, including a full history, physical examination and orders for ongoing care;

v. Work collaboratively with healthcare team members, including in the development of a Best Possible Medication History, complete medication

reconciliation and order appropriate medications;

vi. Oversee the patient's care, either directly or through an on-call group;

vii. Provide daily ongoing direct care documented daily, or more frequently as the clinical condition dictates, progress notes for all acute-care patients, or provide direct care documented in weekly, or more frequent as the clinical condition dictates, progress notes for alternate- level of-care patients;

viii. Communicate with the patient, the patient's family and the patient's care-team members, including the patient's primary-care provider, regarding medical conditions, tests and planned consultations. This information shall be shared with other parties at the patient's written request and consent, or as required by law;

ix. When necessary, clarify and resolve apparent treatment or management conflicts among care providers;

x. Facilitate and coordinate discharge to the community and communication with the primary-care provider, where possible, as well as with community support teams; and

xi. Ensure medication reconciliation is completed and prescriptions are available upon discharge for the time period until the patient can be followed in the community.

6.1.2 Pre-Admission Requirements

The admitting member of the Medical Staff (MRP) is responsible for pre-admission requirements for elective patients and residents, which include the patient's medical history, physical examination, diagnosis, laboratory investigations, appropriate consultations, special tests and documentation of special precautions, patient consents and directives.

6.1.3 Admission

6.1.3.1 Patients and residents shall only be admitted to the facility for investigation or treatment upon the order of a member of the Medical Staff from an "Admitting Department". The Admitting Department is the area where patients are formally registered and prepared for admission to the Facility as inpatients, outpatients, or for procedures, such as the Emergency Department, ambulatory/outpatient service, clinics, or other Facility.

6.1.3.2 Where two (2) or more Medical Staff are involved with the care of the patient, one (1) Medical Staff must be identified as the MRP.

6.1.3.3 Unless properly indicated on the orders, the admitting

member of the Medical Staff shall be deemed to be the MRP.

6.1.3.4 The MRP, or delegate, or Resident / Fellow acting on the advice of the MRP or delegate shall request admission of the patient from the Admitting Department and provide the admitting diagnosis, and an outline of the investigations/treatment for which hospitalization is required.

6.1.3.5 The Admitting Department shall inform the admitting member of the Medical Staff for elective admissions.

6.1.3.6 All patients for surgery must have a current history and physical examination recorded on the patient/resident health record prior to surgery.

6.1.3.7 When an emergency admission is required and where a member of the Medical Staff other than the MRP has provided "holding orders", with consent of the MRP, the MRP must provide complete admission orders within 24 hours of admission.

6.1.3.8 All patients and residents must have a record of history and physical examination within twenty-four (24) hours of admission.

6.1.3.9 All patients and residents must have a goals of care discussion (or discussed with a representative decision maker) and a documented Medical Orders for Scope of Treatment (MOST) completed by the MRP or delegate within twenty-four (24) hours of admission.

6.1.3.10 If, at the time prior to accepting MRP but, where possible, after assessing the patient in person, the Medical Staff member does not believe he/she is the most appropriate Practitioner for the role of MRP, the Medical Staff member shall liaise directly with an alternate service and with the Admitting Department regarding the most appropriate Medical Staff member or service to assume the MRP role.

6.1.3.11 Where a disagreement exists with respect to the admission of a patient, including the assignment of an MRP, an Admitting Department shall contact the Head(s) of the Division(s) or Department(s) to which the Medical Staff members in dispute are assigned. If this is not possible or unsuccessful, the Admitting Department shall contact the Senior Facility Medical Administrator (or delegate), who shall make an immediate service assignment. At the earliest opportunity during regular working hours the incident shall be reviewed by the appropriate Department or Division Head(s).

6.1.4 Admissions for Treatments by Other Regulated Health Professionals

For patients admitted for treatment by other regulated health professionals, an eligible member of the Medical Staff shall be the MRP.

6.1.5 Discharge

6.1.5.1 Discharge of patients from the Hospital, Program or Facility may be authorized only by the MRP or delegate, or by a Resident / Fellow acting on the advice of the MRP or delegate.

6.1.5.2 Discharge planning should begin at the time of admission. The MRP or delegate is responsible for identifying the expected date of discharge (EDD) within twenty-four (24) hours of admission on the patient’s chart and updating the EDD regularly throughout the stay.

6.1.5.3 The MRP or delegate shall, when possible, indicate the planned discharge on the day prior to discharge.

6.1.5.4 Any alterations to the discharge plan following the discharge order must be documented, including new discharge orders.

6.1.5.5 Should a patient, or an incapacitated patient's substitute decision maker, or legal guardian or committee demand that the patient be allowed to leave the Hospital against the MRP or delegate’s advice, the patient or his substitute decision maker, legal guardian or committee shall be asked to sign a release on the prescribed form. Refusal to sign this release should be noted in the medical record.

6.1.5.6 Patients who have been absent without a pass for greater than six (6) hours of the end of an official pass period are deemed discharged Against Medical Advice. Psychiatric patients are excluded from this rule.

6.1.5.7 A discharge summary shall be dictated on discharge or within one working day of a patient’s discharge as outlined in 6.10.5.

6.1.6 Readmission

All readmissions require a full history and physical. For unplanned readmissions, special attention should be paid to any contributing factors.

6.2 **Medical Consultations**

6.2.1 In-Patient Consultation Process

6.2.1.1 Consultation shall be initiated by the MRP or delegate or other member of the Medical Staff or delegate with appropriate supervision, involved in the care of the patient. Direct communication between referring and consulting providers is the responsibility of members of the Medical Staff. Nursing staff are not expected to be involved in the consultation request. The urgency in response for consultation should be conveyed at initiation.

6.2.1.2 In the case of an urgent or emergent situation, if the MRP is engaged in ongoing care, another healthcare professional may request the consultation.

6.2.1.3 Consultation shall be held:

6.2.1.3.1 At the request of the MRP or delegate.

6.2.1.3.2 At the request of the Department Head, Associate Department Head, Division Head, Local Medical Director or the Senior Medical Director.

6.2.1.3.3 In other situations as determined from time to time by the Department Head, Division Head, Local Medical Director or the Senior Medical Director.

6.2.1.3.4 The MRP shall obtain consultation when required by Law, or as directed in the IHA's Organizational Policy or Procedure.

6.2.1.4 The consultant will make every effort to respond in a timely fashion, in accordance with the clinical condition of the patient, and within 48 hours in all cases. If the consultation cannot be completed within 48 hours, the consultant must notify the referring practitioner.

6.2.2 Consultation Record

The consultant member of Medical Staff shall examine the patient and document the findings, opinions, and recommendations on the clinical record. When a Resident / Fellow performs the consultation, the findings, opinion and recommendations may be recorded on the consultation record or dictated. The consultant physician must confirm agreement by signing the plan outlined in the consultation record or notes completed by the Resident / Fellow or confirming in the notes that they agree with the Resident / Fellow dictated consult record or dictation of a formal consult. In cases where telephone advice was received, this will be documented as such, and the consultant will maintain an appropriate medical record, preferably in the EHR.

6.3 **Emergency Care**

In an emergency, any member of the Medical Staff is expected to provide and document medical care until a patient's MRP or delegate can assume responsibility.

6.4 **Post-Operative Care**

6.4.1 The MRP or delegate is responsible for the post-operative care and completion of the health record of the patient unless otherwise indicated on the orders of the patient's health record and confirmed, in writing, by the member of the Medical Staff assuming this responsibility.

6.4.2 Where a post-operative patient has medical co-morbidities requiring management by another Medical Staff member, the parameters of that care shall be clearly described in the Health Record.

6.4.3 For patients admitted for dental surgery, the Dental or Oral Maxillofacial Surgeon shall be responsible for the patient's dental surgery and dental care only. An alternate Medical Staff member must be identified and recorded in the medical record, who shall attend the patient for any required medical care.

6.5 **Ambulatory Care and Outpatient Facilities or Programs**

6.5.1 Only Medical Staff members with appropriate Privileges shall act as MRP

for patients who require medical or mental health treatment in Ambulatory Care and Outpatient Facilities and Programs operated by the IHA.

6.5.2 A Medical Staff member wishing to treat a patient in an Ambulatory and Outpatient Facility or Program shall be designated as the MRP, or by prior agreement with the facility a member of a group providing coverage, and shall remain the MRP for all subsequent care ordered and carried out in the Facility or Program, whether or not the Practitioner is physically present at the site. This excludes routine out-patient laboratory testing and medical imaging appointments.

6.5.3 In exceptional circumstances, the Senior Executive Medical Administrator or delegate may authorize a non-privileged Practitioner to order or provide care in an out-patient Facility or Program, as determined on a case-by-case basis.

6.6 **Interfacility Transfer of Care**

6.6.1 When a patient is to be transferred to another facility, the MRP shall ensure that there is an appropriately qualified Practitioner available at the receiving site who is fully informed about the patient's condition and has agreed to assume responsibility for the patient's care. Acknowledgment of this conversation and acceptance of the transfer of care shall be documented in the Health Record before the transfer shall occur. The MRP shall identify to the staff member arranging the transfer all relevant documentation from the patient Health Record to be sent to the receiving Facility. The transfer of care must be documented in the Health Record.

6.6.2 Where a patient is transferred to another Facility or Program for administrative rather than medical reasons (for example, lack of available beds at the sending facility or program), the MRP, if not assuming the MRP role at the new Facility or Program, shall speak to the receiving Practitioner directly to provide information regarding the plan of care. Acknowledgment of this conversation and acceptance of the transfer of care shall be documented in the Health Record by the sending and receiving practitioners before the transfer shall occur. The Administrator-on-Call at the receiving site shall coordinate this conversation to ensure safe and timely access to necessary services. The transfer of care must be documented in the Health Record.

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

6.6.4 A medication reconciliation should be performed by the sending and receiving MRP.

6.6.5 Transfer to a Higher-Level-of-Care Facility or Program

6.6.5.1 When, in the opinion of the MRP, clinical resources are not available for the appropriate and safe care of the patient, the practitioner shall initiate a process to transfer the patient to a more suitable Facility or Program.

6.6.5.2 The practitioner shall be responsible to identify the level of

resources needed to provide safe care and provide relevant medical information in keeping with clinical policies and procedures where they apply.

6.6.5.3 The logistics of the transfer of the patient to a Facility or Program with adequate resources shall not be the responsibility of the MRP.

6.6.5.4 No tertiary or regional service area hospital within IHA may refuse transfer of a Life Limb Threatened Organ (LLTO) and psychiatric behavioural emergency patient where the standard of care or treatment required is available at the hospital, regardless of in-patient bed capacity. This in compliance with IHA Policy (AH0300).

6.6.6 Repatriation from a Higher-Level-of-Care Facility or Program Back to a Referring Facility or Program

6.6.6.1 Repatriation back to the original referring Facility or Program shall comply with IHA Policy (AH3600)

6.6.6.2 The logistics of the transfer of the patient to a Facility or Program with adequate resources shall not be the responsibility of the MRP.

6.6.7 Transfer due to a Health Facility Evacuation Order

6.6.7.1 In the situation of a Health Facility Evacuation Order, the MRP will undertake all reasonable efforts to identify an appropriate receiving MRP and fulfill all requirements of 6.6.1, with the support of IHA operations and the Medicine Portfolio.

6.6.7.2 The logistics of the transfer of the patient to a Facility or Program with adequate resources shall not be the responsibility of the MRP.

6.7 Responsibility for Provision of Medical Care

6.7.1 Continuous Care

6.7.1.1 Each member of the Medical Staff has a duty to comply with the Bylaws and these Rules including the responsibility to ensure that every patient is continuously under the care of the appropriate and available member of the Medical Staff. The MRP or delegate shall not withdraw services, whatever the reason, prior to the patient's discharge without proper transfer of the patient's medical care.

6.7.1.2 Any member of the Medical Staff who is away from practice or who has transferred responsibility of care to another member of the Medical Staff shall order change of MRP in the patient's health record (electronically or on the order sheet). The receiving member of the Medical Staff shall acknowledge transfer in writing in the documentation section of the patient's health record.

6.7.1.2.1 This requirement does not include group coverage where there is a service labelled

as MRP* in the patient’s health record or when there is a policy, guideline, and/or formal, documented agreement outlining transfer of care or episodic coverage for evenings or weekends.

6.7.1.3 If the member of the Medical Staff wishes to withdraw from involvement in a patient's care when services are still required, they shall inform the patient and arrange for another member of the Medical Staff of appropriate qualification to assume responsibility for the care of the patient and document that on the order sheet of the patient’s health record.

6.7.1.4 In the event of a risk of personal safety of the MRP, they shall notify the Department Head or Senior Facility Medical Administrator and work collaboratively with the Interior Health operations administration to safely administer care.

6.7.1.5 In the event that an MRP or delegate fails to attend upon a patient for whom he/she is responsible, the Department Head concerned shall delegate an appropriate member of the Medical Staff to be responsible for the patient (MRP) and shall report the matter in writing to the Senior Facility Medical Administrator and LMAC.

6.7.1.6 A patient, deemed to have capacity, has the right to request a change in any member of the Medical Staff involved in their care. The MRP or other member of the Medical Staff shall cooperate in transferring responsibility for care to an appropriate new member of the Medical Staff with appropriate Privileges who is acceptable to the patient. If an acceptable alternative cannot be found, the Department Head will assist the patient in finding another member of the Medical Staff to provide care to the patient. If a willing alternate member of the Medical Staff cannot be found, the appropriate Department Head will discuss options with the patient. Until an alternate member of the Medical Staff has accepted responsibility for the patient, the Medical Staff providing current care must continue to do so for the patient. Any transfer of care must be documented on the order sheet of the patient’s health record or in the appropriate place in the Electronic Health Record.

6.7.2 Daily Care

6.7.2.1 A patient in acute care must be seen or reviewed on the ward by the MRP or delegate, at least daily, or more frequently as required, unless they are designated as an alternate level of care patient, in which case they must be seen at least weekly or more frequently as required.

6.7.2.2 Whenever the MRP or delegate sees a patient, a progress note shall be written. 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 MRP or delegate in the patient's care.

6.7.3 On-Call Coverage

On-call coverage is meant to meet the needs of the population of the Interior Health Authority and other regions that may be served from time to time by the Medical Staff of the Interior Health. The goals of Interior Health are to cultivate a healthy Medical Staff workforce and there is recognition of the burden of call, and the need to balance immediate needs with sustainability and the health of the Medical Staff. These rules outline obligations to engage constructively in meeting the needs of the population through collaboration with appropriate members of the Medical Staff throughout the Health Authority and in conjunction with the LMAC, HAMAC, and SET or their delegates.

6.7.3.1 All members of the Provisional, Active, Consulting, Temporary and Locum Tenens Medical Staff shall participate in departmental on-call rosters as outlined in the bylaws in article 6, except in special circumstances, approved by the Department Head and Senior Executive Medical Administrator on advice of the HAMAC.

6.7.3.2 Each Department and/or Division shall ensure a rotation of members to provide emergency coverage and shall routinely provide a list of such rotation to the Emergency Departments and medical administration. The list must be updated as changes occur. Unless specifically excluded by the HAMAC and subsequently approved by the Board, all Departments and Divisions are required to provide continuous on-call coverage to manage:

6.7.3.2.1 Emergency-Department (ED) patients who require urgent consultation or in-patient admission; and

6.7.3.2.2 Patients already admitted to a Facility whose condition necessitates urgent intervention or consultation by a Medical Staff member other than the MRP.

6.7.3.3 The Department Head or delegate, if applicable, shall assign each member to an on-call schedule. Unless specifically excluded by the Board, on advice from the HAMAC and the applicable Department Head, all Department members are required to contribute equitably in fulfilling the on-call responsibilities of the Department.

6.7.3.4 Where a member of the Medical Staff is unable to contribute to the on-call responsibilities of the Department the Health Authority is committed to working collaboratively with the specific Member to understand

their circumstances, and with other members of the Medical Staff to come to an equitable solution that meets patients' needs. Such a solution should be presented to the HAMAC for a recommendation that can be considered and approved by the Board.

6.7.3.5 The Interior Health Authority recognizes there may be periods where a Department is unable to meet on-call responsibilities due to the number of practitioners, or vacancies within the Department or Division. The Interior Health Authority recognizes the importance of creating long-term sustainable programs in the health authority through the collaboration of Medical Staff throughout the Health Authority with the Health Authority. In these settings the members of the Medical Staff will work collaboratively with the Senior Executive Medical Administrator or delegate to:

6.7.3.5.1 Identify needed changes to the Medical Staff Resource Plan to support development of a sustainable continuous on-call and make recommendations to the HAMAC for consideration and approval by the BOD.

6.7.3.5.2 Engage other members of the Medical Staff and other partners as appropriate (for example external Health Authority call groups) to create a mutually agreeable alternate plan for on-call coverage, during the period of shortage, which will be presented to the HAMAC for a recommendation that can be considered and approved by the BOD. This plan should support the physical and psychological health and well being of the Medical Staff and balance the immediate and long term needs of the population.

6.7.3.6 Where a site is unable to provide continuous on-call coverage, and the medical leaders at the Facility will work collaboratively to develop a plan as outlined in 6.7.3.5

6.7.3.7 On-call members of the Medical Staff will be expected to maintain acceptable levels of availability. Those Departments and Divisions, which deal with life-threatening emergencies, shall maintain timely Medical Staff availability and response to calls.

6.7.3.8 Groups of practitioners with a similar scope of practice may organize in call-groups to share the requirements of their patients' care. These practitioners shall create an on-call rota to ensure 24-hour coverage for the group's in-patients in a manner acceptable to their Department or Division Head and the Senior Executive Medical

Administrator.

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

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

6.7.3.11 Where call-group members practice in different communities, the members may establish a cross-community on-call rota, provided a clinical service-delivery model is established to ensure patients have local access to an on-call member as required. A cross-community on-call rota requires HAMAC and the Senior Executive Medical Administrator, or delegate, approval.

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

6.7.3.13 On-call requirements, terms and conditions may be governed through contractual arrangements between the IHA and individual members of the Medical Staff. The availability, or lack thereof, of a Medical On-Call Availability Program (MOCAP) contract has no bearing on the individual or collective requirement to ensure continuous on-call coverage for admitted patients.

6.7.4 On-call Scheduling

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

6.7.4.1 Provide a Medical Staff member available to assess and treat a patient(s) at all times;

6.7.4.2 Be kept current at all times;

6.7.4.3 Identify the Medical Staff member by name, including up-to-date expedited contact information;

6.7.4.4 Identify the practitioner responsible for maintaining the on-call list, including contact information;

6.7.4.5 Be made available in a manner, time and format acceptable to the IHA in order to distribute it to necessary recipients;

6.7.4.6 Be submitted by the Department Head, Division Head or

delegate as soon as possible, but at least 30 days prior to the date on-call is to be provided. Changes to the call schedule shall be clearly distributed in advance to all necessary recipients;

6.7.4.7 In the event of an unresolved dispute concerning on-call frequency, the matter shall be reviewed and resolved by an IHA LMAC, RMAC or, ultimately, the HAMAC.

6.7.5 On-Call Exemptions

6.7.5.1 A member of the Medical Staff may be exempted from providing on-call coverage only when continuous coverage can still be assured by the Department.

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

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

6.7.5.4 The Department Head shall provide the HAMAC with reasons for a proposed exemption, any changes to an already-existing exemption and the potential consequences of an exemption, which shall assist the HAMAC to provide an appropriate recommendation to the Board.

6.8 Scheduled Treatments and Procedures

This article applies to all medical and surgical procedures or treatments requiring pre-booking according to IHA policy and procedure.

6.8.1 Booking

6.8.1.1 Medical Staff who book patients for surgical procedures shall comply fully and fairly with operating room and ambulatory care booking codes.

6.8.1.2 If a scheduled treatment or procedure is cancelled for administrative reasons, administrative staff shall be responsible for rebooking the procedures in consultation with the Medical Staff member and for notification of the patient and the primary care provider.

6.8.2 Requirements in Operating Rooms

6.8.2.1 The Medical Staff performing the procedure (the "surgeon") shall be the MRP during the operative and peri-operative periods, and for subsequent post-operative management of the patient.

6.8.2.2 All surgery for which providing assistance would detract from the scrub nurse performing his / her duties will be performed with the assistance of a second physician or a trained assistant.

6.8.2.3 Prior to the patient entering the operating room for any surgical procedure, the surgeon or delegate must personally discuss with the patient the procedure, obtain or confirm informed consent, and confirm the site to be operated upon and mark the site in an approved manner as per IHA's Policy.

6.8.2.4 For all operative procedures a surgical safety checklist shall be performed in compliance with Interior Health policies. Before leaving the operating room, the surgeon shall ensure that a pathology requisition for examination of all tissues or other removed material that is to be sent to pathology has been completed. All tissues or materials which are not specified as being exempt by Interior Health policy must be sent to the Pathology Department.

6.8.3 Requirements for Treatments and Procedures Performed Outside Operating Rooms

6.8.3.1 The Medical Staff performing the procedure (the "surgeon") shall be the MRP during the operative and peri-operative periods, and for subsequent post-operative management of the patient.

6.8.3.2 Prior to the patient entering the procedure room for any surgical procedure, the surgeon or delegate shall personally discuss with the patient the procedure, obtain or confirm informed consent, and confirm the site to be operated upon and mark the site in an approved manner as per IHA's Policy.

6.8.3.3 Before leaving the procedure room, the surgeon shall ensure that a pathology requisition for examination of all tissues or other removed material has been completed. All tissues or materials must be sent to the Pathology Department.

6.9 Medical Staff Orders

6.9.1 Documentation

6.9.1.1 All orders and documentation by a Medical Staff member must be entered into the EHR by CPOE, dictation or electronic entry in all IHA Facilities where the EHR is in use.

6.9.1.2 Where CPOE is not deployed, orders written on an IHA-approved order form may be faxed and implemented, provided they are signed by a member of the Medical Staff.

6.9.2 Orders for Treatment

All orders for treatment shall have the name printed and be legibly written, dated, timed, numbered (with the professional body's license number), and signed by a practicing (and privileged) registrant of a Professional College as defined in the *Health Professions and Occupations Act*, in accordance with the standards and scope-of-practice for members of that Regulatory Body. Medication orders will follow acceptable standard with respect to legibility, use of abbreviations (avoidance of 'Do Not Use Abbreviations'), and adherence to formulary policies.

Failure to comply with 6.9.2 will initiate the following:

6.9.2.1 In the first instance, a letter to the member of the Medical Staff detailing the non-compliance. A copy of this letter will be forwarded to the appropriate Department / Division Head.

6.9.2.2 Medical Staff receiving a second letter will receive a warning from the Department Head.

6.9.2.3 Medical Staff receiving a third letter for failure to comply with 6.9.2 will need to complete the online Safe Prescribing module and meet with the Department Head and the Senior Medical Director. The meeting will be documented and a summary will be added to his/her personnel file.

6.9.2.4 Medical Staff receiving a fourth letter may be automatically suspended from the Medical Staff. This notice will be forwarded to the College of Physicians and Surgeons as required by the Health Professions and Occupations Act.

6.9.3 Medication Orders

6.9.3.1 Medical Staff members prescribing medication shall comply with the *Narcotic Control Act* and other legislation pertaining to the prescription and use of drugs.

6.9.3.2 Where the HAMAC has approved standards, policies or guidelines for the use of certain drugs, these drugs shall be distributed by the Director of Pharmacy in accordance with the HAMAC's directions.

6.9.3.3 Medical Staff members who knowingly order medication in contradistinction to established IHA standards, policies or guidelines shall accept full accountability for those orders.

6.9.3.4 In accordance with IHA policy, all medications ordered by a Medical Staff member that are not listed in the IHA Drug Formulary shall be reviewed by pharmacy staff, who shall make a recommendation for appropriate substitutions to the ordering Medical Staff.

6.9.3.5 Investigational drugs and therapies that are requested in an urgent situation may be used only with the written approval of an Executive Medical Director, the Senior Facility Medical Administrator or the Pharmacy Director. These drugs must be ordered by the MRP or a by another member of the Medical Staff who has been consulted by the MRP.

6.9.4 Orders Sets

6.9.4.1 A Regional Department, Program or Network may sponsor and establish order sets for patients under the care of members of that Department, Program or Network. The appropriate subcommittee of the HAMAC approves order sets and shall arrange for order set review at least bi-annually.

6.9.4.2 Order sets will be developed to be applicable for use at all IHA Facilities.

6.9.4.3 Order sets shall comply with the IHA's safe-prescribing guidelines and the standards set by the Medical Staff member's Regulatory Body.

6.9.4.4 The Medical Staff member shall sign patient specific order sets for each patient.

6.9.5 Verbal Orders

6.9.5.1 Under normal circumstances, the Medical Staff Member will enter orders in the patient's chart, or EMR. If necessary, a Medical Staff Member may give verbal or telephone orders for treatment to a registered nurse, a registered psychiatric nurse, a licensed practical nurse, a respiratory therapist or a perfusionist, or a pharmacist, who shall transcribe the order onto the chart under the Medical Staff Member's name per the writer's name.

6.9.5.2 The registered nurse, registered psychiatric nurse licensed practical nurse, respiratory therapist, perfusionist, or pharmacist will read the order back to the member of the Medical Staff who will confirm that it is correct prior to it being carried out. Such orders shall be countersigned by the Medical Staff member or delegate at the earliest opportunity, but no later than 24 hours.

6.9.5.3 At non-CPOE sites, orders provided by telephone shall be written over the name of the ordering Medical Staff

member and signed by the person to whom they are dictated. At CPOE sites, upon order entry, orders shall be notated as "verbal orders" on behalf of the ordering Medical Staff member and shall be assigned to that member for electronic co-signature. These orders shall be counter-signed by the ordering Medical Staff member as soon as possible, and as directed by IHA policy.

6.9.6 Resident / Fellow Orders

Resident / Fellow may write orders and prescribe controlled drugs according to IHA guidelines and any Affiliation Agreement.

6.9.7 Student Orders

When a student in the course of studying medicine, midwifery, dentistry or to qualify as a nurse practitioner and working under appropriate licenses from their respective professional college has been assigned to a patient's care for teaching, the student may write orders as per an Affiliation Agreement. In the
cases of orders for therapeutic drugs or invasive procedures or investigations, the MRP or delegate shall, except in an emergency, discuss such orders with the student and approve them. The MRP or delegate must countersign the order at the earliest opportunity, but no later than 24 hours.

6.10 **Health Records**

Health Records are those electronic or paper documents compiled by the Medical Staff and other clinical staff of the IHA to document care provided to patients, residents and clients. Health Records may be Facility-based or community-based. The term Health Records, as described in the Bylaws, Rules and Policies, shall mean Facility-based records. A timely, comprehensive and complete Health Record is essential to ensure that patients, clients and residents receive the best care possible in Facilities operated by the IHA, as well as in the community after they are discharged from IHA Facilities.

All IHA Medical Staff members shall obtain and maintain access to the IHA EHR.

The MRP or delegate 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:

6.10.1 Admission History

6.10.1.1 Except in extreme emergency, the MRP or delegate shall ensure that every patient admitted to a IHA facility has an adequate clinical history, physical examination and provisional diagnosis recorded in the health record within twenty-four (24) hours after admission and prior to every delivery or operation.

6.10.1.2 The admission documentation shall include:
a) presenting complaint

b) history of presenting complaint
c) allergies and sensitivities
d) medications
e) significant past medical, social and family history
f) review of systems including any deviations from normal
g) physical examination
h) results of pertinent diagnostic investigations
i) active problem list
j) management plan with an estimated length of stay
k) admitting diagnosis, or differential diagnosis if the diagnosis is unclear at the time of admission
l) admission orders including, at a minimum, diet, activity level, frequency of vital-signs measurement, required investigations and diagnostic tests, and any treatment to be initiated.

6.10.2 Progress Notes

The progress notes shall:

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

6.10.2.2 Be documented as frequently as the patient's condition warrants.

6.10.2.3 For written progress notes, be legible, dated, timed, and signed.

6.10.3 Operative Records

6.10.3.1 In elective or urgent surgical cases a documented surgical consultation, including history and physical examination, and the signed operation consent shall be submitted to the booking clerk prior to the booking of the operation.

6.10.3.2 If such history and physical examination are not recorded before the time slated for operation the operation shall be canceled unless the MRP or delegate states in writing that such delay would result in mortality or significant morbidity. The appropriate surgical management committee shall review all such cases.

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

6.10.3.4 The operative report shall contain, at a minimum:

a) the patient's name and Health Record number;
b) the name of the primary surgeon and assistant(s);
c) the names of practitioners who should receive a copy of the report;
d) date and time of admission;
e) date of procedure;
f) pre-operative and post-operative diagnosis;
g) proposed procedure(s) and indications;
h) operative procedure(s) performed;
i) operative complications, if any;
j) the patient's condition before, during and immediately after the operation;
k) estimated blood loss;

l) specimens removed and their disposition (for example, "sent to pathology").

6.10.3.5 For medical imaging and laboratory medicine procedures, or where the HAMAC has deemed an operative report is not required, a procedure note is required in lieu of an operative report.

6.10.3.6 In the exception of a patient requiring immediate surgical intervention, prior to any anaesthetic procedure, the anaesthesiologist must record a pre-anaesthetic assessment on an appropriate record. The anaesthetic record must be completed before the patient leaves the recovery room.

6.10.4 Antenatal Record

The British Columbia Antenatal Record Parts 1 and 2 is considered to be an integral part of the health record and will constitute a history and physical, and the information will be submitted in accordance with the Perinatal Services B.C. guidelines.

6.10.5 Discharge Record

A discharge record is a critical record of information to ensure quality of patient care. Incomplete or inaccurate discharge summaries may potentially compromise ongoing patient care and impair the ability of the Health Records Department to extract vital data.

6.10.5.1 The MRP or Medical Staff member on-call shall provide a discharge order and complete a discharge summary using a HAMAC-approved discharge template. The discharge summary shall be completed electronically in Facilities where the EHR is in use. Discharge summaries shall be completed through the IHA transcription service or on an approved written template for those Facilities employing a paper Health Record.

6.10.5.2 All patients shall have their discharge order written on paper, or electronically if the Facility uses CPOE, as early as possible on the day of discharge. For expedited planning purposes, the MRP shall note the estimated date of discharge (EDD) daily in the patient's Health Record except for non-alternate level of care patients.

6.10.5.3 A discharge summary is required for all in-patient discharges, all deaths and all obstetrics and newborns cases, except for those patients with:
a) an uncomplicated daycare or short-stay surgery or procedure;
b) an uncomplicated obstetrical delivery;
c) an uncomplicated neonatal admission; or

d) a short admission where the HAMAC has approved an abbreviated discharge documentation process.

6.10.5.4 For uncomplicated obstetrical admissions, the British Columbia Antenatal Record Parts 1 and 2, or electronic equivalent for Facilities using an EHR, shall become an integral part of the patient record. The BC Labour and Birth Summary Record or electronic equivalent, together with the BC Newborn Record Part 1 and 2 shall be completed and placed in the Health Record by the MRP and shall form the discharge summary in uncomplicated deliveries.

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

6.10.5.6 To ensure continuity of care and patient safety, the discharge summary should be dictated, or electronically transcribed in those Facilities using the EHR, at the time of discharge but must be completed within seven (7) days of the discharge date.

6.10.5.7 A discharge summary shall include:

a) a single most responsible discharge diagnosis
b) other relevant diagnoses and co-morbidities
c) past medical history
d) surgical or interventional procedures performed
e) unexpected occurrences, including new post-admission diagnoses, that impacted the patient's length of stay, complexity, clinical care or treatment
f) a summary of the patient's course in hospital
g) the patient's condition at discharge
h) the disposition of the patient, whether to another hospital, home or to a community facility
i) a list of medications prescribed or continued at discharge, including dosage and frequency
j) discharge instructions, including follow-up instructions and a specific post-discharge plan provided to the patient, the patient's regular medical Practitioner, and any caregivers reasonably expected to require this information for ongoing care-delivery. These instructions should include a list of all appointments made with consultants, any pending outpatient investigations, outstanding tests, and any home and community-care support arranged or needing to be arranged.

6.10.6 Completion of Health Records

6.10.6.1 All Health Records shall be completed and validated by all Medical Staff members involved in the patient's care, in compliance with the IHA Health Information Management (HIM) policies. All Medical Staff members must comply with IHA HIM clinical documentation requirements.

6.10.6.2 The MRP or delegate is responsible for notifying Health Records and the respective Division or Department Head of planned absences prior to their occurrence. Following notification, the MRP or delegate will be responsible for the completion of outstanding health records within twelve (12) days of return from such leave or absence.

6.10.6.3 If the MRP is no longer available to sign orders, the Health Record shall be completed by the appropriate Department or Division Head.

6.10.6.4 Where the EHR has been implemented in an IHA Facility or Program, Medical Staff members shall enter all required documentation and orders into the IHA EHR. Written orders or paper documentation are not accepted for Health-Record completion in these Facilities or Programs.

6.10.6.5 Draft electronic and transcribed reports shall be corrected and finalized within 72 hours of report generation.

6.10.6.6 Reports will not be distributed until they are corrected and finalized.

6.10.6.7 Each Medical Staff member shall have at least one report-distribution method identified and activated in the EHR.

6.10.6.8 The patient's Health Record should be completed at the time of discharge but must be completed within seven (7) days of discharge from the Facility.

6.10.6.9 If the patient's Health Record is not completed at the time of discharge, the following policy shall apply:

6.10.6.9.1 The Medical Staff member shall be notified of incomplete charts within fourteen (14) days and every seven (7) days thereafter.

6.10.6.9.2 Following the first notification, the Medical Staff member shall complete the charts within fourteen (14) days.

6.10.6.9.3 Failure to comply with 6.10.6.9.2 will result in the IHA Health Records Department sending two further notifications, each seven (7) days apart with notification to the Senior Facility Medical Administrator.

6.10.6.9.4 Failure to comply with 6.10.6.9.3 will initiate a letter to the member of the Medical Staff automatically suspending hospital privileges, sent from the Senior Executive Medical Administrator (VP Medicine). A copy of this letter will be forwarded to the appropriate Department Head. The MRP or delegate

must arrange transfer of care of patients to an appropriate member of the Medical Staff.

6.10.6.9.5 The suspension of privileges is automatically cancelled once the outstanding Health Records are complete.

6.10.6.9.6 Medical Staff members suspended three or more times in a consecutive 12-month period shall attend an interview with the appropriate Department Head or delegate to plan remedial action. If administrative suspensions continue following this meeting, the member shall be required to appear before an LMAC, RMAC or ultimately the HAMAC, which shall recommend to the Board an immediate 30-day suspension of privileges and may recommend disciplinary action up to and including permanent revocation of Medical Staff Privileges.

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

6.10.6.9.8 Medical Staff leaving practice, including for retirement, relocation or removal from the Medical Staff, must complete all Health Records available on or before the effective date of the termination of IHA Medical Staff privileges.

6.10.7 Ownership and Access

6.10.7.1 Health records are the property of IHA and are not to be removed from IHA except as ordered by the courts or with consent of IHA.

6.10.7.2 Access to and copies of the health record or information contained therein is governed by policies of IHA. Breach of these policies would be managed as per policy.

6.10.7.3 Medical Staff who have private offices within IHA retain ownership of their office records as described by the B.C. College of Physicians and Surgeons.

6.10.8 Storage of Records

Health Records shall be maintained and stored by the IHA Health Information Management (HIM) services, unless otherwise approved by

the CEO or delegate.

6.11 Informed Consent

6.11.1 Informed Valid Consent

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

6.11.2 Medical Staff Responsibility for Obtaining Consent

The member of the Medical Staff 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 IHA consent form has been placed on the patient health record.

6.12 Organ Donation and Retrieval

Interior Health and its Medical Staff will cooperate with the British Columbia Transplant Society in supporting the provincial program for organ donation and retrieval.

6.12.1 Membership and Appointment

6.12.1.1 In cases where, under special or urgent circumstances, such as organ retrieval, Temporary Medical Staff Privileges are required, those physicians recognized by the BC Transplant Society will be deemed as having an interim appointment and temporary privileges with IHA without application for the purpose of organ retrieval and transplant only.

6.12.2 Responsibility for Patient Care

6.12.2.1 In the event of organ donation, responsibility for the maintenance of the physiological status of the organ donor may be transferred, at the discretion of the MRP, to a Physician member of the Organ Retrieval Team

6.12.2.2 Consent for organ and tissue donation will be validated through the British Columbia Transplant Society Registry or obtained through the patient's next of kin in accordance with the Human Tissue Gift Act and Regulations.

6.12.2.3 Organ donation, after the declaration of neurological or cardiac death, permits the MRP to transfer to or share responsibility with the Organ Retrieval Team. Standard protocols available from the Organ Retrieval Team may be followed and orders may be given to a registered nurse or a respiratory therapist for the maintenance of the physiological status of the donor.

6.13 Pronouncement of Death, Autopsy and Pathology

6.13.1 Pronouncement of Death

In expected death in hospital, the decision as to who is the appropriate person to pronounce death is made collaboratively by the healthcare team.

6.13.2 Medical Certificate of Death

The MRP or delegate shall complete the medical certificate of death and stillbirth as soon as possible and not more than 2 (two) working days after death or stillbirth.

6.13.3 Report to the Coroner

As stated by the *Coroner's Act*, anyone who believes the circumstances of death meet the criteria for reporting outlined in the Coroner's Act must notify the Coroner or a peace officer.

6.13.4 Autopsy

No autopsy shall be performed without order of the Coroner or written consent of the appropriate relative or legally authorized agent of the patient.

6.13.5 Permission for Autopsy

In appropriate cases, the MRP or delegate shall make all reasonable efforts to obtain permission for the performance of an autopsy.

6.13.6 Diagnostic Material

All tissue or material of diagnostic value shall be sent to the Department of Pathology.

6.13.7 Pathology Specimens

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

6.14 Medical Care in Long-Term Care Facilities Operating under the Hospital Act

The IHA operates a number of long-term care facilities under Part 2 of the *Hospital Act*. The IHA Medical Staff Rules apply to Practitioners providing care in IHA-operated care facilities.

This section highlights unique rules that guide the medical care of residents in long-term care facilities.

6.14.1 Most Responsible Practitioner (MRP)

6.14.1.1 The medical care of every resident shall be directed and authorized by an appropriately-privileged Medical Staff member who shall have primary responsibility for the care of the resident. This Practitioner shall be identified as the MRP.

6.14.1.2 MRP's are those Practitioners who agree to accept residents within a long-term-care Facility under their medical direction. The MRP shall be determined either prior to, or at the time of admission.

6.14.1.3 In urgent situations where the MRP is not available, other duly-qualified practitioners may provide immediate care. The MRP shall be informed subsequently that such care was provided.

6.14.2 Admission to a Long-Term Care Facility

6.14.2.1 Every resident shall be admitted and attended by a member of the Medical Staff who has appropriate privileges and has agreed to take primary responsibility for the care of the resident and who has primary responsibility for the care of the resident.

6.14.2.2 When a resident is admitted to a long-term care facility, the MRP or delegate shall submit a complete and updated medical record as outlined in Article 6.10.1.2.

6.14.3 Care and Treatment

6.14.3.1 The MRP or delegate shall note special precautions regarding the care of the resident on the order sheet in the resident's record at the time of admission (e.g. infectious disease, emotional disturbance, etc.).

6.14.3.2 Directives for care (MOST) shall be completed in a timely manner, preferably before admission, and updated as clinically indicated and at least annually.

6.14.3.3 The MRP or delegate shall visit or virtually assess the newly admitted resident within seven (7) days and thereafter at least every ninety (90) days, or more frequently if clinically indicated.

6.14.3.4 All orders for medical treatment shall be legibly written, faxed, or entered electronically in Facilities where CPOE is deployed, and signed by the MRP or delegate. An order for medical care or treatment may be dictated over the telephone to a registered nurse or licensed practical nurse. Telephone orders at CPOE sites, upon order entry, orders shall be notated as "telephone orders" on behalf of the ordering Medical Staff member, and shall be assigned to

that member for electronic co-signature. Such orders shall be countersigned by the ordering practitioner as soon as possible, but no longer than seven (7) days following dictation.

6.14.3.5 Orders pertaining to other professional disciplines, (e.g. occupational therapist, physical therapist, dietitian, pharmacist) may be dictated by the medical practitioner to a member of that discipline who will read the order back to the practitioner for confirmation prior to its being carried out.

6.14.3.6 Dentists treating residents shall enter in the resident's health record a description of every dental treatment or procedure performed immediately following the provision of care.

6.14.3.7 Only members of the Medical Staff holding appropriate privileges at IHA may provide on call coverage for Medical Staff in IHA facilities.

6.14.3.8 The MRP or delegate shall carry out a Medication Review every ninety (90) days or more frequently in collaboration with the Medical Director or Medical Leader, pharmacist or nurse (licensed practical nurse, registered nurse or registered psychiatric nurse, within defined scope of practice), as appropriate. Medications shall be re-authorized every ninety (90) days by updating and signing the drug profile or rewriting drug orders on the order sheet.

6.14.3.9 All orders for controlled drugs and antibiotics shall have a stated limit as to the number of doses, or the hours or days of administration. The ordering practitioner or MRP shall countersign telephone orders for controlled drugs within seven (7) days. For drug orders given without such dosage or time limit, an automatic stop order shall be in effect, with the exception of palliative patients.

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

6.14.3.11 The MRP or delegate shall request a consultation when appropriate.

6.14.3.12 Practitioners requested to see a resident in consultation shall be members of the Medical Staff and shall provide a written report for the resident's chart.

6.14.3.13 The MRP or delegate shall be asked to attend interdisciplinary conferences to discuss and plan resident care. In the absence of the MRP or delegate, the Medical Director or Medical Leader shall make recommendations

regarding care to the multidisciplinary team and the MRP or delegate.

6.14.3.14 If, in the opinion of the Medical Director or Medical Leader, 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 or delegate, such consultation, referral or transfer may be arranged by the Medical Director or Medical Leader.

6.14.3.15 The MRP or delegate shall visit or review the residents discharge summary and medications within a week of the resident returning from acute care and provide an update in the resident's chart.

6.14.3.16 The MRP or delegate shall visit to pronounce death within a reasonable time after notification. In the event of an expected death, the MRP or delegate may transfer the responsibility for "pronouncement of death" to a registered nurse in charge of the resident's care, provided the MRP or delegate has visited the resident within the previous thirty (30) days and documented on the resident's chart that death may be expected shortly. In the event of an unexpected death, death due to unnatural cause, or death with unusual circumstances, the MRP or delegate is required to attend for the purpose of "pronouncement of death" and to review the circumstances surrounding the death. Completion of a "Certificate of Death" remains the responsibility of the MRP or delegate in all circumstances. Members of the Medical Staff pronouncing death shall record the time, date and cause of death (if known) on progress notes.

6.14.3.17 The MRP or delegate shall notify the Coroner of deaths that require notification under the *Coroner's Act.*

6.14.4 Long-term Care Medical Director

In any IHA Facility with a contracted site medical director, the medical director may provide direct care to residents without prior consultation with the MRP. When care has been provided based on any provisions in this article, the MRP shall be informed as soon as possible. Such direct care is limited to:

6.14.4.1 Treatment changes, following a multidisciplinary care-conference review, where the MRP has been invited and has not attended, or where there is a team consensus that the change is in the best interest of the resident. In such cases the resident or their substitute decision maker must have been included in reaching consensus;

6.14.4.2 Referral for a psychiatric consultation where nursing staff and the medical director deem it necessary for the ongoing care of the resident or the safety and protection of other residents or staff;

6.14.4.3 Medical orders to comply with infection prevention and control requirements or recommendations of the Medical Health Officer;

6.14.4.4 Routine medical orders where the MRP has failed to respond to requests for care in a timely manner;

6.14.4.5 Urgent medical care where the MRP is not available or has failed to respond to requests for care.

6.14.5 Health Records

6.14.5.1 Admission Record

When a resident is admitted, a record of a complete medical history and physical examination will be provided by the MRP or delegate as soon as possible within 7 (seven) days.

6.14.5.2 Progress Notes

Progress notes shall be documented at each visit and at least every ninety (90) days thereafter. Progress notes shall be sufficient to describe changes in the resident's condition, reasons for change of treatment and outcome of treatment.

6.14.5.3 Discharge Record

Within seven (7) days following the death or discharge of a resident, the MRP or delegate shall complete (dictated or electronically-entered) the resident's discharge summary using a HAMAC-approved discharge template. The discharge summary shall conform to the IHA EHR documentation policy. It shall be completed electronically in Facilities where the EHR has been deployed.

6.15 **Delegation of a Restricted Activity**

6.15.1 Delegation of a restricted activity or aspect of practice must be in compliance with:

i. Relevant regulatory college bylaws;

ii. Relevant IHA policies and procedures;

iii. Endorsed by both the Senior Executive Nursing Administrator and the HAMAC; and

iv. Approved by the Board of Directors.

Article 7 – Quality and Safety of Care

As stated in the Bylaws, Medical Staff are accountable for the quality of medical care provided in the Programs and Facilities of the IHA. To achieve this purpose, Medical Staff are critical as leaders, active contributors, and participants.

IHA Medical Staff shall participate, as required and requested by IHA Medical Leaders, in Quality and Safety activities. IHA Medical Staff are expected to collaborate with IHA Medical Leaders and contribute to the following specific activities: Culture and People: Ensuring dignity and respect for all individuals, with open communication and information sharing, collaboration, psychological safety, a respectful workplace free of discrimination and racism and interdisciplinary teamwork. Fostering trust.

Quality Learning Systems: Continuous improvement in care design and delivery and improvement capacity.

Quality and Patient Safety Management: Prioritization of improvements and response to harms based on review of performance / population needs and response to adverse events and care concerns.

Patient, Family and Community Engagement: Foster involvement and inclusivity of patients, family members, and communities in health service design and delivery. The IHA Framework for Person- and Family-Centred Care provides guidance for this Focus area.

All members of the Medical Staff will participate as required and requested by their Department or Division Head, or other delegated Medical Leader, in Quality and Safety activities. Medical Staff are expected to collaborate with IHA administration and contribute to the following specific activities in collaboration with and supported by Interior Health administration:

7.1 **Quality Reviews**

Quality Review activities are an integral component of the medical staff function and responsibility, focused on continual improvement.

7.1.1 These include, but not limited to:

7.1.1.1 Facility, Program, Network, Department or Division Quality Committees

7.1.1.2 Facility, Program, Network, Department or Division Clinical Audits

7.1.1.3 Facility, Program, Network, Department or Division Patient Safety and Quality Rounds

7.2 **Responding to Adverse Events**

Medical staff have a critical role in recognizing and responding to hazards, near misses, and adverse events. This is guided by IHA Policy AK0400. Specifically, Medical Staff have responsibility to:

7.2.1 Report and notify others of hazards, near misses, and adverse events

7.2.2 Respond to adverse events, which includes:

7.2.2.1 Providing physical / psychological support for the patient and family, employees and Medical Staff

7.2.2.2 Participating in adverse event reviews

7.2.2.3 Leading or participating in disclosure, including Restorative Approaches

7.2.2.4 Leading or participating in Quality reviews, as it pertains to adverse events

7.2.2.5 Documentation in the health record

7.2.2.6 Sharing learning, as appropriate, and leading changes to improve safety

7.3 **Accreditation**

Accreditation is an ongoing process of evaluation with a focus on quality and safety. This process can be supported by Accreditation Canada or through the Diagnostic and Accreditation Program, of the College of Physicians and Surgeons of B.C.

7.3.1 Medical Staff will actively participate in Accreditation processes

7.4 **Responding to Care Concerns**

Patients and families may raise concerns about the care they receive. This may be through the Patient Care Quality Office (PCQO), or through other channels.

7.4.1 Medical Staff will actively participate in a response to any care concerns. This will include interactions with patients and families, responding to PCQO requests, assisting in investigations, communicating a response, and providing an apology, where applicable.

7.5 **Compliance with Quality and Safety Activities**

7.5.1 All members of the Medical Staff are required to comply with IHA's Quality Improvement and Safety Policies, and activities in 7.1, 7.2, 7.3, and 7.4, above, where requested by their Medical Leader or delegate.

7.5.2 Failure to comply with 7.5.1 will initiate a letter to the member of the Medical Staff detailing the specific non-compliance. A copy of this letter will be forwarded to the appropriate Department / Division Head and Senior Facility Medical Administrator.

7.5.3 Should the member of the Medical Staff fail to respond to the measures as outlined in 7.5.1 and 7.5.2 the matter will be considered under article 9 of the Medical Staff Rules.

7.6 **Assurances**

7.6.1 Quality and Safety Activities are protected under Section 51 of the Evidence Act and, by IHA policy regarding Freedom of Information and Protection of Privacy Act (FOIPPA). Section 51 (7) of the Evidence Act expressly states that its protection supercedes FOIPPA.

7.6.2 Medical Staff will not be held accountable for system and / or organizational factors that impact quality and safety over which they have no control.

7.6.3 Medical Staff will be treated with care, compassion, support, respect and dignity in IHA's response to adverse events and care concerns.

7.6.4 Medical Staff involved in adverse events may experience psychological harm; appropriate supports and referrals will be provided.

7.6.5 Medical Staff have the option for consultation and advice from independent legal counsel, including from their respective associations.

Article 8 - Organization of the Medical Staff

8.1 General Organization

8.1.1 Departments and Divisions

Departments and Divisions may be organized at the level of the Health Authority or at the level of individual sites as deemed appropriate by the Board.

After considering the recommendations of the HAMAC, the CEO and the Board, shall from time to time:

8.1.1.1 organize the Medical Staff or any part thereof into such Departments and Divisions as it may see fit and shall as provided herein

8.1.1.2 appoint the Heads thereof

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

8.2 Medical Staff Departments

8.2.1 Article 7 of the Medical Staff Bylaws describes, in general terms, the organization of the Medical Staff, Medical Staff Departments, and the responsibilities of the Department Head.

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

8.2.3 Departments are generally facility based and support the work of Networks, Programs and the SET in achieving the goals of the Health Authority. The scope of academic and clinical activity is specific to each Facility.

8.2.4 Departments shall be comprised of Medical Staff members who belong to the same medical or clinical discipline.

8.2.5 Department members shall assist the Department Head in monitoring the quality of patient care and the services provided by their members. All Department members shall participate in Quality Review activities, as outlined in Article 7 of the Medical Staff Rules – Quality Reviews.

8.2.6 All members of the Medical Staff shall belong to at least one Department and maintain Privileges in at least one site within the IHA.

8.2.7 The IHA Medical Staff Departments are:

- Anaesthesia
- Dentistry
- Diagnostic Imaging
- Emergency Medicine
- Family Practice
- Hospitalist Medicine
- Laboratory Medicine
- Medicine
- Midwifery
- Nurse Practitioners
- Obstetrics and Gynecology
- Pediatrics
- Psychiatry
- Public Health
- Surgery

8.3 **Medical Staff Divisions**

Individual Departments and Programs may be further organized into Divisions of Medical Staff members with clearly defined sub-specialty interests.

8.4 **Department / Division Meetings**

8.4.1 Departments and Divisions shall meet regularly to conduct administrative affairs, clinical appraisals, teaching, research and service commitments. Each is responsible for studying, investigating and evaluating the care provided by its members for the purpose of improving care, and Department Heads shall report regularly on these activities to the appropriate LMAC, RMAC or the HAMAC.

8.4.2 Each Department shall meet at least five (5) times per annum and at the call of the Department Head to discuss matters or importance to the IHA and to the Department.

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

8.4.4 Each Division shall meet at least four (4) times per annum and at the call of the Division Head to discuss matters or importance to the IHA and to the Division.

8.4.5 Records of all duly-called meetings shall be kept and attendance shall be recorded.

8.4.6 Provisional and Active Medical Staff members are required to attend 70% of their primary Departmental and Divisional meetings unless excused in advance by the Department or Division Head.

8.4.7 Quality Review activities during Department meetings shall be privileged pursuant to Section 51 of the *Evidence Act*, shall be separated from

other records and shall be compiled under the heading: "THIS REVIEW IS PROTECTED UNDER SECTION 51 OF THE BRITISH COLUMBIA EVIDENCE ACT."

8.4.8 A quorum shall consist of 50% of the voting members of each of the Department or Division.

8.4.9 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 Department Head shall cast the deciding vote.

8.5 Medical Staff Wellness

Medical Staff Departments shall support the health and well-being of its members. Department Heads, in collaboration with Senior Facility Medical Administrators and Executive Medical Directors, shall work with the Senior Executive Medical Administrator and the IHA to:

8.5.1 promote health and wellness amongst Medical Staff;

8.5.2 encourage and prioritize a healthy and respectful workplace;

8.5.3 establish mechanisms to identify Medical Staff at risk or who need assistance;

8.5.4 develop strategies and supports for timely, respectful intervention for Medical Staff;

8.5.5 establish mechanisms to withdraw from practice impaired Medical Staff, report impaired Medical Staff, support recovery and transitions to resuming practice;

8.5.6 assist in the development and implementation of Medical Staff Wellness programs, including through collaboration with regional Medical Staff Associations and the LMAC.

8.6 Appointment of Department and Division Heads

8.6.1 Department Heads shall be appointed by the Board of Directors on the recommendation of the Senior Executive Medical Administrator, whose recommendation shall be given after receiving advice from the HAMAC and LMAC.

8.6.2 All active Medical Staff members within a Department may be eligible to hold the position of Department Head.

8.6.3 The term of appointment for each Department Head shall not exceed three (3) years. The Board of Directors may reappoint a Department Head for a subsequent term of up to three (3) years after receiving advice from the Senior Executive Medical Administrator, based on the progress of the Department under the Department Head's leadership, and a review of the Department Head's performance during the appointment term. The Senior Executive Medical Administrator shall also consider the advice of the LMAC and HAMAC in making their

recommendation.

8.6.4 The Department Head shall be selected on the basis of qualifications, training, leadership experience and satisfactory references; as well as demonstrated clinical, academic and administrative ability.

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

8.6.6 The Department Head shall report through the Senior Facility Medical Administrator to the IHA Senior Executive Medical Administrator.

8.6.7 A Department Head, or formal delegate, shall attend all meetings of the LMAC as a voting member and participate on LMAC sub-committees at the request of the LMAC Chair.

8.6.8 Department Heads shall name an Assistant Department Head who assumes all the responsibilities in the absence of the Department Head as described in Article 7.1.2 of the Bylaws.

8.6.9 An Interim Department Head or Interim Division Head may be appointed by the Board on the recommendation of the CEO and HAMAC and the Department Head concerned for a period of six (6) months.

8.7 **Responsibilities of Department Heads**

Department Heads support the organization of the medical staff to meet the medical needs of the population of the Interior Health Authority in conjunction with the Health Authority administration, and support the health and well-being of their Department Members. They provide assurance of public safety by ensuring each practitioner is duly qualified and privileged to provide care and that the quality of care meets an acceptable standard. In order to achieve these goals Department Heads work with resources throughout the Health Authority to receive reports and inform policies that support their work, including Digital Health, Operations, Quality and others. Department Heads will also be supported by members of their Department, depending on the size of the Department and qualifications of members, as well as with administrative supports through the Medicine Portfolio in achieving outlined responsibilities.

The specific responsibilities of the Department Head are outlined within the Medical Staff Bylaws, Article 7.2 and the Department Head contract, as provided by IHA. These shall include:

8.7.1 Organize, direct and govern the Medical Staff members within the Department;

8.7.2 Collaborate with the administration of a Facility or Program to inform the operational objectives;

8.7.3 Organize, plan and chair Department meetings as required by these Rules;

8.7.4 In conjunction with the Medicine Portfolio administration develop and maintain specific job descriptions for the Head of each Division;

8.7.5 Appoint Division Heads within the Department, ensuring that the LMAC and HAMAC is notified of these appointments;

8.7.6 Lead and support standards and processes for the provision of high-quality, evidence-informed care to patients and their families;

8.7.7 Works collaboratively with the Senior Facility Medical Administrator in modeling and implementing acceptable standards of behaviour for members of the Department, as prescribed by the members' provincial regulatory body, the Bylaws, these Rules and the health-human-resource policies of the IHA;

8.7.8 Advise appropriate LMACs, RMACs or HAMAC regarding the quality of medical care the Department provides, as well as Department members' compliance with professional standards;

8.7.9 Lead, participate and delegate Department members and resources for Quality Review activities;

8.7.10 Advise the Board of Directors, through the LMAC, RMAC and HAMAC, and other facility operational committees as appropriate on the adequacy of resources affecting the quality of medical care and academic activities within the IHA;

8.7.11 Function as the direct communication link between the Department and the MAC structure;

8.7.12 Support the communication of the IHA's leadership strategies, objectives, policies and ongoing activities to the Department;

8.7.13 Support implementation of and compliance with processes and policies to ensure all new department members are appropriately oriented to IHA Facilities, Programs and services, including completion of IHA EHR competency training, prior to commencement of their Privileges;

8.7.14 Collaborate with site operational leadership on informing budgetary matters;

8.7.15 Collaborate with site operational leadership in monitoring and evaluating the utilization of IHA resources by Department members to ensure effective and efficient use of these resources;

8.7.16 Develop and maintain a health-human-resources plan for the Department in the IHA Medical Staff Resource Plan and in collaboration with the LMAC and HAMAC, and recruit new members in accordance with the plan, consistent with the established care Facilities, requirements and resources of the IHA;

8.7.17 Evaluate and make recommendations about persons wishing to be appointed or reappointed to the Medical Staff, including fully-completed impact-analysis reviews; and make recommendations regarding Privileges, including Procedural Privileges where appropriate, consistent with the requirements of the Department, the Facility or Program, and the IHA;

8.7.18 Review and make recommendations to the HAMAC concerning the annual review or in-depth (comprehensive) review, and Privileges for all members of the Department; or members of other Departments,

when called upon by the HAMAC to do so;

8.7.19 Identify Department members with potential or established impairment and assist with Executive Medical Directors to refer these members to programs that support practitioner health and well-being, with the aim of promoting recovery and re-entry into professional practice (and referral to regulatory colleges where required);

8.7.20 Where required by the Bylaws, these Rules and IHA policies, recommend to the Senior Executive Medical Administrator the restriction or suspension of Privileges of any Department member whose clinical care or behaviour could reasonably be deemed to be detrimental to the well- being of patients and staff members in particular, or the effective functioning of any IHA Facility in general; and, if necessary, appoint another member of the Medical Staff to care for patients who have been the responsibility of that Medical Staff member until such time as a formal review can occur;

8.7.21 Consider and make recommendations regarding all applications for Department member leaves of absence;

8.7.22 Ensure that all Department members contribute to on-call coverage to Facilities and unattached patients and works collaboratively with the Senior Facility Medical Administrator and Senior Executive Medical Adminstrator to develop appropriate on-call arrangements when vacancies or staff number do not allow the safe implementation of continuous on-call coverage;

8.7.23 Foster and mentor the continuing professional development of Department members, including clinical, teaching and research objectives of the Department and the IHA;

8.7.24 Work with the UBC to ensure education and research objectives are being adequately promoted and supported.

8.8 Responsibilities of Division Heads

8.8.1 Department Heads shall appoint Division Heads for a term not to exceed three (3) years, renewable once upon successful review.

8.8.2 Division Heads shall be, or be eligible to immediately become, members of the Active Medical Staff, selected on the basis of qualifications, training, experience and demonstrated leadership ability in clinical, teaching and administrative activities.

8.8.3 The responsibilities of the Division Head shall be similar, but subordinate, to those of the Department Head and shall be focused on the specific activities of the Division.

8.8.4 The Division Head shall report to the Department Head on all clinical, educational, research and administrative matters within the Division.

8.9 Selection Process

8.9.1 Selection process for Department Head

Where a vacancy exists for the position of Department Head Executive Medical Director, or Senior Facility Medical Administrator shall strike a

selection committee including the advice of the Department members, advisory to the LMAC and Senior Facility Medical Administrator, to recommend a candidate to fill the vacancy.

8.9.2 Selection process for Division Head

When a vacancy exists for the position of Division Head and the Department Head has expressed a desire that the vacant position be filled, the Department Head shall strike a selection committee**,** advisory to the Head**,** to recommend a candidate to fill the vacancy.

8.9.3 Decision for Department / Division Head

The LMAC and HAMAC shall consider the selection committee recommendation and make its recommendation to the IHA Senior Executive Medical Administrator, who shall consider the HAMAC's recommendation in making the final candidate selection.

8.10 Review / Reappointment of Department / Division Head

8.10.1 The Senior Facility Medical Administrator shall conduct an annual performance review of each Department Head. This shall be documented and provided to the Department Head.

8.10.2 Within the final year of the term, the review should include recommendations regarding reappointment or non-reappointment of the Department Head for another term.

8.10.3 Department Heads are responsible to perform similar annual and end-of-term performance reviews for their Division Heads.

8.10.4 The Board shall make the final decision on reappointment after receiving advice from the Senior Executive Medical Administrator (VP Medicine), and HAMAC.

8.11 Program / Network Medical Directors

8.11.1 Program / Network Medical Directors, together with their respective Administrative Program / Network Directors, lead and facilitate a collaborative inter-professional structure to enhance patient-and-client-focused care delivery.

8.11.2 The Program / Network Medical Director reports to the appropriate Vice President or delegate for functional aspects of the Program or Network; and to the Senior Executive Medical Administrator or delegate for medical quality-of-care and professional-standards matters.

8.11.3 As part of their overall duties, Program / Network Medical Directors shall:

8.11.3.1 work in collaboration with other Medical Directors, Operational Directors and Department Heads to ensure that all programs support the IHA strategic plan;

8.11.3.2 support the development of management strategies that focus on interdisciplinary collaboration and decision-making;

8.11.3.3 ensure that policies and procedures are established for the

delivery and evaluation of services offered within the program's core services;

8.11.3.4 work in collaboration with Department Heads on the development and promotion of clinical standards, education and research;

8.11.3.5 provide leadership and direction for quality improvement, utilization management and risk management within the program or network;

8.11.3.6 Informs the HAMAC on development of a Medical Staff Resource Plan for the Program or Network's clinical area to meet the strategic priorities of the Health Authority;

8.11.3.7 perform other related duties as may be required from time to time.

8.12 **Direction of Board**

8.12.1 Nothing set forth in this Article 8 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 a manner and to such extent as the Board may deem necessary or appropriate.

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

8.12.1.1 Withdraw such an appointment

8.12.1.2 Appoint an interim Department Head

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

8.13 **Suspension or Termination of Department or Division Head**

Notwithstanding anything to the contrary in this Article 8, the Board may, either on the recommendation of the Senior Executive Medical Administrator or, in its sole discretion, at any time, suspend or terminate the appointment of any Department Head or Division Head. In the event the Board intends to consider the suspension or termination of a Department Head or Division Head, the person involved shall be given reasonable notice of such intended consideration and shall have the right to appear before the Board and make representation. At any time, the CEO or Senior Executive Medical Administrator may place a Department Head or Division head on a suspension or leave pending investigation. The CEO must notify the Board and the Department Head or Division Head has the right to appear at the next Board meeting to make a presentation.

Article 9 – Discipline and Appeal

Discipline and appeal are enabled by Article 11 of the Bylaws. The Rules outline the disciplinary and appeal processes and procedures for Medical Staff practicing within the Facilities and Programs operated by the IHA.

The goal of the Interior Health Authority, and its obligation in both legislation and policy, is to foster, with the Medical Staff, a safe and respectful environment exemplary of the principles outlined in Article 1 of the Rules while enabling the delivery of care to the population of the Interior Health Authority. The Interior Health Authority affirms a commitment to procedural fairness, and the use of principles of restorative justice when possible and encourage informal resolution of concerns wherever possible. The process is grounded in providing opportunities for awareness, growth and improvement, and to restore or enhance relationships fostering a culture of respect and a psychologically safe workspace.

The processes outlined below provides fairness to all parties by describing the pathway of escalating dispute resolution and encouraging early use of informal resolution processes.

The IHA Policy 3.15: *Safe Reporting* provides that a review of the conduct of any person associated with the IHA, including a member of the Medical Staff, may be initiated through the Director, Internal Audit. The policy is intended to supplement and does not replace the established processes for the reporting, investigation, and resolution of concerns against a member of the Medical Staff as described in Article 9.

The scope of quality assurance protection afforded by section 51 of the Evidence Act extends to disciplinary proceedings under Article 9 and records generated in this process are not producible in legal proceedings, except in accordance with the Evidence Act.

9.1 **Procedural Fairness**

A Concern raised with respect to a member of the Medical Staff [the "Subject Member"], including allegations of a breach of IHA Bylaws, Rules and Policies *may* result in a disciplinary process and, if deemed founded, in disciplinary action. The Subject Member is entitled to procedural fairness during all proceedings under Article 9, including:

9.1.1 The right to a copy of the Concern and a right to respond to the Concern.

9.1.2 The right to initiate and/or participate in consensual resolution at any time during the proceedings.

9.1.3 The right to legal counsel or an advisor.

9.1.4 The provision of a copy of any documentation sent by IHA to the relevant College as required under the *Health Professions and Occupations Act*, to the extent permitted by law.

9.1.5 The right to review documentation maintained on their personnel file.

9.1.6 The right to a confidential process consistent with the nature of the proceeding, and to the extent permitted by law, provided that the Subject Member does not present a risk to patients or the public; and

9.1.7 The right to a process that is free of bias or conflicts of interest.

9.1.8 The right to a decision and the rationale for that decision.

Without limiting the foregoing, the following general principles of procedural fairness shall also apply:

Efficiency - A disciplinary process should facilitate the resolution of the matter under investigation as expeditiously as possible.

Clarity - Article 9 shall be reviewed by Medical Staff at the time of their initial appointment to IHA. The requirement for Medical Staff to confirm in writing they have read and agree to abide by the IHA Bylaws and Rules at the time of appointment and re-appointment shall be deemed sufficient for this purpose.

Timeliness - A disciplinary process shall be conducted in a timely fashion to ensure patient and staff safety, and to ensure the Medical Staff member is not unfairly disadvantaged or prejudiced. Expediency in resolving Concerns shall be balanced with ensuring appropriate time for thorough investigation, a fair process, and best decisions.

Conformity with Standards of Practice - A fair and reasonable evaluation of Medical Staff shall be informed by standards of practice and professional behaviour established by the provincial regulatory body, relevant IHA clinical policies and/or through expert evidence.

Concerns that are behavioural in nature shall be guided by language in the AU1000 and the BC Human Rights Code, including but not limited to the following issues, Respectful versus Disrespectful Behaviour, Discrimination, Discriminatory Harassment, Sexual Harassment and Personal Harassment and guide investigation and resolution of concerns.

Respectful communication and advocacy for patients or improvements of the system by Medical Staff are encouraged and protected by IHA, including through access to anonymous reporting systems, that promote respectful and professional dialogue.

9.2 **A Concern**

9.2.1 A Concern with respect to a Subject Member shall be:

9.2.1.1 in writing;

9.2.1.2 Signed by either the Complainant or by the individual conveying the Concern involving the Subject Member; and

9.2.1.3 Supported by a reasonable degree of relevant detail forming the basis of the Concern.

9.2.2 A Concern may be received from a Complainant or, if deemed warranted, may be initiated by IHA or brought by IHA on behalf of a Complainant.

9.2.3 The basis of a Concern may include, but are not limited to:

9.2.3.1 quality and safety of patient care;

9.2.3.2 clinical performance;

9.2.3.3 participation in continuing professional development and maintenance of competence activities relevant to the Medical Staff;

9.2.3.4 ethical conduct;

9.2.3.5 professional behaviour and conduct, including interactions with patients, families, visitors, professional colleagues, and IHA clinical and non-clinical staff;

9.2.3.6 breach of the responsibilities and expectations pursuant to the Bylaws, the Rules, IHA policies, the Professional Code of Conduct of the relevant College and/or the respective code of ethics of the relevant profession;

9.2.3.7 breach of any formal agreement with IHA;

9.2.3.8 Any health problem that significantly affects the ability of the Medical Staff to carry out their IHA professional responsibilities; and,

9.2.3.9 Any retaliatory actions against a Complainant.

9.2.4 The Complainant shall be notified that the Concern has been received and has been forwarded to an appointed IHA medical leader for consideration and, if appropriate, for an investigation.

9.3 Procedures for Investigation and Management of a Concern

9.3.1 The IHA Medical Leader that is appointed to manage the Concern [the "Appointed Medical Leader"] shall initially assess the Concern to determine its seriousness and if it is deemed founded, including whether further action under the Rules is warranted. If further action is deemed warranted, the Appointed Medical Leader shall consider the appropriate stage of intervention, as provided in 9.3.4.

If the Appointed Medical Leader determines, after the initial investigation is complete, that the Concern is frivolous or unsubstantiated, then no documentation will be made in the Subject Members personnel folder.

9.3.2 At any time during the process under 9.3 the Appointed Medical Leader can recommend, or the Subject Member can request, that the process be addressed through consensual resolution. Consensual resolution discussions shall be confidential and without prejudice to the parties and the process under 9.3. If there is an opportunity to resolve the Concern by consensual resolution, the Appointed Medical Leader shall prepare a report to the Senior Facility Medical Administrator and the Senior Executive Medical Administrator, or delegate, who shall decide, within fourteen (14) days, whether consensual resolution of the Concern is appropriate.

9.3.3 A Subject Member may request the presence of another member of the Medical Staff or an advisor at any meetings required under Article 9.3. The request must be made to the Appointed Medical Leaders at least one day in advance of the scheduled meeting.

9.3.4 The Appointed Medical Leader shall consult with the Senior Facility Medical Administrator and the Senior Executive Medical Administrator prior to initiating a Stage 1, Stage 2, or Stage 3 intervention, unless Crisis Intervention is deemed warranted by the Appointed Medical

Leader.

9.3.5 Interventions by IHA shall follow a staged approach, as described below:

9.3.5.1 **Stage 1**: is warranted for behaviour that meets criteria for unprofessional conduct that cannot be resolved informally, or where unprofessional behaviour appears to be part of a recurring pattern.

9.3.5.2 **Stage 2**: is warranted where a Stage 1 intervention has been ineffective.

9.3.5.3 **Stage 3**: is warranted for significant unprofessional conduct or for serious clinical concerns that persist despite a Stage 2 intervention.

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

9.3.6 **Staged Intervention Process**

9.3.6.1 **Stage 1 Intervention**

The Appointed Medical Leader, in consultation with Senior Facility Medical Administrator, shall:

i. Meet with the Subject Member to discuss the Concern and review any relevant documents.

ii. Provide the Subject Member with an opportunity to respond to the Concern;

iii. Discuss with the Subject Member how others have interpreted or received the conduct giving rise to the Concern; and

iv. Explore with the Subject Member mitigating factors that may be present including environmental or personal factors that may inform a resolution plan:

v. Offer advice, guidance, and information on how to access support resources, if required;

Following discussion with the Subject Member, the Appointed Medical Leader shall make a determination that the Concern is deemed founded and decide the format and substance of a resolution to the Concern if appropriate, including a response to the Complainant; and document the Stage 1 Intervention process to be kept on the personnel file of the Subject Member. Should the Subject Member and Appointed Medical Leader not come to agreement with the format and substance of a resolution they will consult with the Senior Facility Medical Administrator and follow the process as outlined in Stage 2 Intervention.

Stage 1 intervention should be completed within four (4) weeks of

receiving the Concern.

9.3.6.2 **Stage 2 Intervention**

The Appointed Medical Leader, in consultation with the Senior Facility Medical Administrator, shall conduct an initial investigatory meeting, as described in the Stage 1 Intervention and perform further investigation as required. Should the Concern be found to be valid at conclusion of the investigation the Appointed Medical Leader and Senior Facility Medical Administrator shall then work with the Subject Member to develop a remediation plan, which may include the following:

i. A method for redress, which may include but is not limited to, education, coaching, counselling, practice supervision or supervision of practice in another program, with regular reports to be received by the Appointed Medical Leader;

ii. A requirement to participate in psychological or other medical testing; substance use therapy; leadership training; written project or tutorial sessions including referral of the Subject Member to an external resource such as a Practitioner Health Program;

iii. Quality metrics sufficient to determine whether the remediation plan was successful;

iv. A time frame within which progress must be demonstrated by the Subject Member; and

v. The failure to complete the remediation plan shall result in a new Concern.

If the Subject Member agrees with the remedial plan, the Appointed Medical Leader shall notify the Medical Staff member in writing that another substantiated incident shall result in a review by the HAMAC in accordance with the Bylaws, and that Medical Staff Privileges may be modified or terminated at that time.

If an agreement on the remediation plan is not reached within thirty (30) days from the time the Subject Member receives the proposed remediation plan the remediation plan shall be finalized by the Appointed Medical Leader, taking into account any feedback received from the Subject Member, and:

i. If the proposed remediation plan does not impact the medical appointment of privileges of the Subject Member, it shall be forwarded to the HAMAC with a recommendation from the Appointed Medial Leader that the remediation plan be unilaterally imposed on the Subject Member; or

ii. If the proposed remediation plan impacts the medical appointment of privileges of the Subject Member, it shall be forwarded to the RMAC for the following review process:

a) The Subject Member shall have the opportunity to provide written submissions to the RMAC detailing any objections to the proposed remediation plan;

b) The RMAC may initiate an external review and incorporate any findings into the remediation plan; and,

c) If the Subject Member still does not agree with the proposed remediation plan, the RMAC shall forward it to the HAMAC recommending that it be unilaterally imposed on the Subject Member.

9.3.6.3 **Stage 3 Intervention**

The Appointed Medical Leader and the Senior Facility Medical Administrator shall immediately involve the Senior Executive Medical Administrator and the HAMAC Chair.

A review of the Concern by the HAMAC shall be scheduled as soon as possible. The Senior Executive Medical Administrator, or delegate, is responsible to oversee and manage the Stage 3 intervention. The HAMAC shall:

i. Review the Concern, the behavioural or clinical history of the Subject Member and any relevant evidence;

ii. Hear and consider any evidence or submissions made on behalf of the Subject Member; and

iii. Make a recommendation to the IHA Board of Directors with respect to disciplinary action, including, but not limited to:

1. Modification, suspension, revocation, or refusal to renew the privileges and appointment of the Subject Member; and,

2. Any other conditions the HAMAC deems appropriate.

9.3.6.4 **Crisis Intervention**

Where the Concern constitutes a serious problem or potential problem which adversely affects or may adversely affect the care of patients or the safety and security of patients or staff, and is not appropriate for a staged intervention, the Appointed Medical Leader and the Senior Facility Medical Administrator shall make the CEO and/or the Senior Executive Medical Administrator aware and recommend a summary suspension of privileges pursuant to Article 11.2.1 of the Bylaws.

9.4 Automatic Temporary Suspension

Further to Article 11.3.1 of the Bylaws, a member of the Medical Staff shall receive

an automatic temporary suspension of privileges in circumstances including, but not limited to, where the member of the Medical Staff has:

9.4.1 Abandoned a patient admitted to an IHA Facility;

9.4.2 Charged with committing a criminal offence while exercising clinical privileges;

9.4.3 Had their license to practice revoked by the provincial regulating body;

9.4.4 Provided clinical care, the exercising of clinical privileges, or the fulfillment of contractual arrangements for the provision of patient care, while impaired by drugs or alcohol; or

9.4.5 Failed to comply with the completion of Health Records as described in Section 6.10 of these Rules.

Article 10 – Health Authority Medical Advisory Committee

10.1 **Purpose**

As listed in 8.1 of the Bylaws, the purpose of the HAMAC shall be:

10.1.1 To function as the senior medical leadership committee within the IHA.

10.1.2 To provide advice and recommendations to the IHA Board and CEO on the provision of medical care, the monitoring of the quality and effectiveness of medical care, the adequacy of Medical Staff resources, the continuing education of the Medical Staff and the planning goals for meeting the medical care needs of the population served by the IHA.

10.1.3 To provide advice and recommendations to the IHA Board and CEO on any matters pertaining to the appropriate organization governance, management and discipline of the Medical Staff.

10.2 **Authority**

HAMAC has the authority:

10.2.1 to ensure compliance by the Medical Staff with the Hospital Act and Hospital Act Regulations, the Health Authorities' Act and relevant regulations, the Bylaws, these Rules, and the policies of IHA;

10.2.2 to appoint sub-committees of the HAMAC;

10.2.3 to exercise discipline within and up to the limitations of authority delegated by the Board of Directors on any Medical Staff, including the issuing of reprimands or a request to participate in educational or remedial programs; and

10.2.4 to require any member of the Medical Staff to appear before it whenever necessary to carry out its responsibilities.

10.3 **Duties and Responsibilities of the HAMAC**

10.3.1 Medical Administration

The HAMAC has the authority to, and shall:

10.3.1.1 Appoint chairs and members of standing committees and ensure these committees function effectively, including recording minutes of the meetings;

10.3.1.2 Make recommendations to the Board of Directors on the development, maintenance, review and revision of these Rules and policies pertaining to medical care provided within the Facilities and Programs operated by the Authority;

10.3.1.3 Advise and make recommendations to the Board on matters pertaining to medical technology, the clinical organization of the Medical Staff and any other administrative matters affecting the Medical Staff;

10.3.1.4 Make recommendations to the Board regarding general disciplinary measures for violation of the Bylaws, Rules or policies governing the conduct of the Medical Staff;

10.3.1.5 Review and report any concerns related to the professional and ethical conduct of members of the Medical Staff to the Board and, where required by provincial legislation, report those concerns to the appropriate provincial regulatory body;

10.3.1.6 After reviewing reports from the Credentialing and Privileging Committee, make recommendations to the Board on the appointment, reappointment, privileging and review of Medical Staff members;

10.3.1.7 Establish professional standards of practice and conduct for Medical Staff members in Facilities and Programs operated by the IHA, in compliance with all relevant provincial legislation and the IHA Bylaws, Rules and policies;

10.3.1.8 Make recommendations for the continuing professional development of members of the Medical Staff;

10.3.1.9 Make recommendations to the Board for the renewal, restriction, suspension, cancellation or non-renewal of Medical Staff appointments and privileges;

10.3.1.10 Report to the Board on the Medical Staff resources required to meet the healthcare needs of the population served by the IHA, including the availability and adequacy of existing resources to provide appropriate patient care.

10.3.2 Quality of Care

The HAMAC has the authority to, and shall:

10.3.2.1 Review and make recommendations on matters related to the quality and safety of the medical care provided within the Facilities and Programs operated by the IHA;

10.3.2.2 Receive, review and make recommendations on reports from Quality Review activities concerning evaluation of the clinical practice of members of the Medical Staff;

10.3.2.3 Ensure Medical Staff members comply with the *Hospital Act* and its Regulation, and with the Bylaws, Rules and policies;

10.3.2.4 Establish ad hoc sub-committees to recommend Medical Staff disciplinary action, including reprimands, within and up to the limitations of authority delegated by the Board;

10.3.2.5 Make recommendations on the supervision of clinical practice.

10.3.3 Medical Staff Resource Planning

The HAMAC has the authority to, and shall:

10.3.3.1 Review information regarding the Medical Staff human resources required to meet the medical, dental, midwifery and nurse practitioner needs of the population served by

the IHA and, following the review, provide advice to the Board and CEO;

10.3.3.2 Submit an annual Medical Staff Human Resource Plan to the Board.

10.3.4 Continuing Medical Education / Teaching and Research

The HAMAC has the authority to, and shall:

10.3.4.1 Advise on and assist with the development of formally-structured ongoing programs for Medical Staff continuing professional development;

10.3.4.2 Advise on, and assist where possible, with programs for continuing education for other healthcare providers in the facilities and programs operated by the IHA;

10.3.4.3 Advise on and make recommendations regarding teaching and research within IHA.

10.4 **Membership**

10.4.1 Voting members:

- the IHA Senior Medical Health Officer (1)
- the IHA Senior Executive Medical Administrator (1)
- the Chairs of the Regional Medical Advisory Committees (4)
- an elected Medical Staff Association member from each of the four health service delivery areas (4)
- the IHA Department Head of Laboratory Medicine (1)
- the IHA Cardiology Medical Program Director (1)
- the IHA Renal Medical Program Director (1)
- the Senior Facility Medical Administrators of the Royal Inland Hospital and the Kelowna General Hospital (2)
- a Regional Senior Facility Medical Administrator (1)
- a Long Term Care / Seniors' Health Physician Leader (1)
- a Representative from the Interdivisional Strategic Council who is appointed to the Medical Staff (1)
- the IHA Department Head of Nurse Practitioners (1)

10.4.2 Non-voting members:

- the IHA Board Chair
- the IHA CEO
- the IHA Vice Presidents accountable for Clinical Operations
- the IHA Vice President Quality, Research and Academic Affairs
- the IHA Chief Nursing Officer
- the IHA Executive Medical Directors
- the IHA Medical Director of Patient Transportation Services

10.4.3 Ad-hoc members:

- the remaining IHA Vice Presidents
- Other professional, clinical or administrative members appointed from time to time to fulfill specific roles as required by the HAMAC
- Medicine Portfolio support staff

10.5 **Officers and Terms**

10.5.1 There shall be a Chair and Vice-Chair of the HAMAC.

10.5.2 The Chair shall normally be selected from among the voting members of the HAMAC. Where the Chair is a Medical Staff member not selected from the HAMAC voting membership outlined in 10.4.1 above, the total committee membership shall increase by one member for the duration of that Chair's appointment.

10.5.3 The Chair shall be appointed for a term of not more than three (3) years, and may be re-appointed for one additional term for a maximum of two consecutive terms.

10.5.4 The Vice-Chair shall be selected from among the voting members of the HAMAC.

10.5.5 The Vice-Chair shall be appointed for a term of not more than three (3) years, and may be re-appointed for an additional term for a maximum of two consecutive terms.

10.5.6 The Office of the Senior Executive Medical Administrator shall provide secretariat services to the HAMAC.

10.6 **Chair**

10.6.1 Six months prior to the end of a HAMAC Chair's term of office, the HAMAC shall strike an ad hoc Nominations Sub-Committee. After a search and review process for a new Chair, the sub-committee shall recommend a nominee to be ratified by the HAMAC and referred to the Board for approval. The Chair shall be appointed by the Board after reviewing the recommendation of the HAMAC. The Board is under no obligation to appoint the individual so recommended.

10.6.2 The Chair shall have authority to invite any Medical Staff member, staff member, or other party relevant to the business of the HAMAC to attend a HAMAC meeting to address specific agenda items. Invitees shall attend in a non-voting capacity and respect HAMAC confidentiality.

10.6.3 Duties:

10.6.3.1 Chair all meetings of the HAMAC or, if unavailable, delegate this role to the Vice Chair or another suitable candidate in the Vice-Chair's simultaneous absence;

10.6.3.2 Chair the HAMAC Executive Committee;

10.6.3.3 With a facilitator, chair the annual HAMAC retreat;

10.6.3.4 Oversee the preparation of written agendas for each meeting after seeking input from the Senior Executive Medical Administrator and Chief Executive Officer;

10.6.3.5 In conjunction with the Medicine Portfolio, manage the affairs of the HAMAC between meetings, and ensure committee and sub-committee responsibilities are discharged in a timely manner;

10.6.3.6 Oversee the HAMAC secretariat in coordinating and ensuring timely reporting by the HAMAC's subcommittees;

10.6.3.7 Represent the HAMAC at meetings of the Senior Executive Team and other relevant administrative meetings;

10.6.3.8 Attend meetings of the Board of Directors in accordance with Article 8.2.5 of the Bylaws**,** ensuring timely reporting of HAMAC issues and concerns and related recommendations;

10.6.3.9 Act as the principal spokesperson for HAMAC in liaising with the CEO and Board Chair;

10.6.3.10 Serve as an ex-officio member of all HAMAC subcommittees;

10.6.3.11 Oversee annual confirmation of the HAMAC membership and appointment of sub-committee Chairs;

10.6.3.12 Ensure the HAMAC secretariat communicates broadly to the Medical Staff on the committee's business, decisions, approved motions and advice provided to the Board, CEO and Senior Executive Team (SET);

10.6.3.13 At the request of the Senior Executive Medical Administrator, CEO or Board, perform other duties relevant to the HAMAC's role and responsibilities.

10.7 **Vice-Chair**

10.7.1 An appropriate search committee of HAMAC shall recommend a nominee for Vice-Chair to be endorsed by HAMAC and referred to the Board for approval. The Vice-Chair shall be appointed by the Board after reviewing the recommendation of the HAMAC. The Board is under no obligation to appoint the individual so recommended.

10.7.2 The Vice-Chair shall serve as a member of the HAMAC Executive Committee.

10.7.3 The Vice-Chair shall act in the capacity of, and exercise the duties and responsibilities of the Chair in the Chair's absence.

10.8 **Procedures**

10.8.1 A simple majority of voting members present at all regular meetings and duly-called extraordinary meetings of the HAMAC shall constitute quorum for the meeting.

10.8.2 The success or failure of a motion before the HAMAC shall be decided by a simple majority vote (50% plus one) of those voting members present at all regular meetings and duly-called extraordinary meetings.

10.8.3 The HAMAC Chair shall not vote on any motion except where the

vote is tied.

10.9 Meetings

10.9.1 The HAMAC shall schedule regular meetings and shall meet at least ten (10) times per year.

10.9.2 The HAMAC shall also meet at the call of the Chair to deal with special or urgent issues. In this case a formal agenda need not be issued in advance, but must be presented in writing or in electronic format at the meeting itself. All members shall be advised of the purpose of the meeting, and given as much notice as the urgency of the situation permits.

10.9.3 The IHA Medicine Portfolio shall maintain the agendas, meeting packages, minutes and any other documentation relevant to or required by the HAMAC.

10.9.4 Except under emergency circumstances, the agenda and all related material for a regular meeting shall be distributed to the members at least seven (7) days before the meeting.

10.9.5 Minutes shall be prepared on a timely basis after each meeting and made available to all voting and non-voting members within two (2) weeks following the meeting.

10.9.6 All members may suggest additions to the agenda. If a suggested addition is subsequently placed on the agenda, the Chair and the Senior Executive Medical Administrator shall be given at least a one-month's written notice to ensure sufficient time for the development and provision of a briefing document to expedite discussion.

10.9.7 All members should submit brief reports to be included in the agenda

10.9.8 HAMAC members should participate in meetings in person, but may attend by telephone or virtually. A member participating in a meeting by any of these means shall be duly recorded as present at the meeting.

10.9.9 Members attending HAMAC meetings by telephone or virtually must assure the Chair at the start of the meeting there are and shall be no uninvited or unidentified individuals observing, listening to or recording the meeting from the remote site.

10.10 Annual Review and Planning Meeting

10.10.1 The HAMAC shall conduct an annual face-to-face meeting, open to all HAMAC members, Chairs of HAMAC sub-committees and others at the invitation of the HAMAC Chair.

10.10.2 The purpose of the meeting shall be:

a) To receive and review annual reports from the Chairs of the HAMAC sub-committees;

b) To review and confirm the membership of HAMAC and its sub- committees for the coming year;

c) To review HAMAC progress during the past year;

d) To create a HAMAC workplan for the coming year;

e) To develop new strategies or initiatives to improve the operational effectiveness of the HAMAC to deliver its mandate.

f) To conduct a formal self-evaluation to determine whether HAMAC is fulfilling its mandate.

10.11 **Executive Committee**

10.11.1 The HAMAC Executive Committee shall plan, develop, prioritize and finalize the agenda for each regular meeting, as well as address any business arising between regular meetings of the HAMAC at the request of the Chair or Senior Executive Medical Administrator.

10.11.2 The Executive Committee shall meet at least two weeks prior to each scheduled HAMAC meeting, and at the request of the Chair or Senior Executive Medical Administrator.

10.11.3 The Executive Committee shall be comprised of:

- The HAMAC Chair;
- The HAMAC Vice-Chair;
- The Senior Executive Medical Administrator;
- One Executive Medical Director, on a one-year rotational basis;
- One Chair from the four RMACs, on a one-year rotational basis;
- One Senior Facility Medical Administrator, on a one-year rotational basis;
- One LMAC Chair, on a one-year rotational basis;
- One Medical Staff President, on a one-year rotational basis;
- One IH-wide Department Head or Medical Program Director;
- Medicine Portfolio support staff.

10.11.4 In situations where a full HAMAC meeting is not feasible or quorum cannot be established, the HAMAC Executive Committee shall have the authority to undertake preliminary action on urgent issues. The HAMAC Executive shall report to the HAMAC at its next regularly-scheduled meeting on decisions made or actions undertaken. At this meeting, the HAMAC shall ratify, modify or rescind the actions taken by the Executive Committee.

10.12 **Reporting and Accountability**

10.12.1 The HAMAC shall make recommendations to the Board at each scheduled meeting regarding Medical Staff appointments and privileges. This report shall be provided in advance to the Board in written or electronic format compliant with the Board's established meeting protocols.

10.12.2 The Chair or Vice-Chair of the HAMAC will attend meetings of the Board and the appropriate committees of the Board.

10.12.3 Advice to the IHA on other matters within the scope of the HAMAC's duties and responsibilities shall be addressed to both the Chair of the Board and the CEO.

10.13 **Subcommittees**

10.13.1 Article 9.1.2 of the *Medical Staff Bylaws* provides that the Board of Directors, on the advice of the HAMAC, may establish other Standing Committees, reporting to the HAMAC, to undertake specific responsibilities that fall within the responsibility of the Medical Staff organization.

10.13.2 Detailed Terms of Reference for each of these Committees will be established separately and approved by HAMAC.

10.13.3 Committees may be added or deleted as the HAMAC considers which of its responsibilities may best be fulfilled through more detailed review by a Committee.

10.13.4 The Chair, in consultation with the Senior Executive Medical Administrator will annually propose the leadership and membership for each of the Standing Committees for election by the HAMAC.

10.13.5 The HAMAC may also from time to time appoint ad hoc Committees and or Task Forces to address specific issues. In all cases there will be clear Terms of Reference which include the time limits or events that will bring the assigned mandate to a close.

10.13.6 Each Standing Committee, ad hoc Committee and Task Force will report in a timely manner to the HAMAC on the results of its meetings.

10.13.7 A committee member may be removed or replaced at any time by the HAMAC Chair and will cease to be a member.

10.14 **Regional Medical Advisory Committees (RMACs)**

10.14.1 RMAC Committees

The Board shall approve the establishment of four RMACs:

10.14.1.1 East Kootenay
10.14.1.2 Kootenay Boundary
10.14.1.3 Okanagan
10.14.1.4 Thompson-Cariboo-Shuswap

10.14.2 Purpose

10.14.2.1 Each RMAC shall have written Terms of Reference that reflect the Region's Medical Staff structure and needs.

10.14.2.2 Each RMAC makes recommendations through the HAMAC to the Board regarding appointments and privileges for new members of the Medical Staff; the maintenance of privileges resulting from the annual review process; and with respect to the cancellation, suspension, restriction, non-renewal

or denial of privileges for all members of the Medical Staff within the Facilities and Programs operated by the IHA within that RMAC's Region. These recommendations require approval by the HAMAC before being forwarded to the Board.

10.14.2.3 Each RMAC also provides advice to the HAMAC on Medical Staff governance within the Facilities and Programs operated by the IHA within the Region, as outlined in the Bylaws 8.1.3 and within these Rules, 10.1.2.

10.14.3 Duties and Responsibilities

10.14.3.1 The RMAC shall have the same authority as the HAMAC for the governance of the Medical Staff practicing within the Region.

10.14.3.2 The RMAC shall share the same responsibilities and fulfill the same duties as the HAMAC, but limited to the Medical Staff practicing within the Region.

10.14.4 Membership

10.14.4.1 The voting members of each RMAC shall include:

- IHA Medical Staff Department Heads and Medical Program Directors whose departments or Programs operate within the Region;
- one elected representative from each Medical Staff Association within the Region;
- the LMAC Chairs within the Region;
- following approval by the HAMAC, other members of the Medical Staff, determined by the RMAC

10.14.4.2 The non-voting members of each RMAC shall include:

- the SET Vice President with accountability for the Region, or delegate;
- at least one IHA Executive Medical Director appointed by the Senior Executive Medical Administrator;
- Medicine Portfolio support staff.

10.14.5 Officers and Terms

10.14.5.1 The Chair and Vice-Chair of the RMAC shall be appointed by the HAMAC and selected from a list of nominees submitted by the RMAC.

10.14.5.2 The Chair and Vice-Chair shall be selected from

among the members of the RMAC or from the LMACs within the Region.

10.14.5.3 The Chair and Vice-Chair shall be appointed for a term of three (3) years, renewable for one additional term upon satisfactory review, for a maximum of two (2) consecutive terms.

10.14.5.4 The Office of the Senior Executive Medical Administrator shall provide secretariat services to the RMAC.

10.14.6 Chair

10.14.6.1 The RMAC Chair shall have the same responsibilities as the HAMAC Chair, but with governance limited to the Medical Staff practicing within the Region.

10.14.6.2 The RMAC Chair shall act as the principal spokesperson for the RMAC in liaising with the Senior Executive Medical Administrator and the SET through the Medicine Portfolio Leadership Structure.

10.14.6.3 The RMAC Chair shall be a voting member of the HAMAC.

10.14.6.4 The RMAC Chair shall ensure the timely communication of relevant information, concerns and recommendations from the RMAC to the HAMAC, and from the HAMAC to the RMAC.

10.14.7 Meetings

10.14.7.1 The RMAC shall schedule regular meetings and shall meet not less than six (6) times per year.

10.14.7.2 RMAC meetings, agendas and voting procedures shall be the same as those for the HAMAC, as outlined in these Rules, 10.9, above.

10.14.8 Reporting and Accountability

10.14.8.1 The RMAC shall report directly to the HAMAC.

10.14.8.2 Recommendations for Medical Staff appointments and privileges shall be made to the HAMAC in a written report. The RMAC Chair or delegate shall present this report to the HAMAC and shall speak to the recommendations.

10.14.8.3 The Chair of the HAMAC shall respond to the RMAC reports, advising the Board Chair and CEO of any issues requiring the Board’s attention.

10.14.8.4 The RMAC shall only report to the Board through the HAMAC, or at the request of the Board Chair.

10.15 **Local Medical Advisory Committees (LMACs)**

10.15.1 LMAC Committees

After considering the advice of the RMAC, the HAMAC has the authority to establish LMACs at individual Facilities within a Region covered by a RMAC.

10.15.1.1 Each LMAC shall function under the mandate of a RMAC.

10.15.1.2 Each LMAC reports directly to its RMAC.

10.15.2 Purpose

10.15.2.1 Each LMAC shall have written Terms of Reference that reflect the Facility Medical Staff structure and needs.

10.15.2.2 Each LMAC makes recommendations through its RMAC to the HAMAC to the Board regarding appointments and privileges for new members of the Medical Staff; the maintenance of privileges resulting from the annual review process; and with respect to the cancellation, suspension, restriction, non-renewal or denial of privileges for all members of the Medical Staff within the Facility. These recommendations require approval by the RMAC and HAMAC before being forwarded to the Board.

10.15.2.3 Each LMAC also provides advice through the RMAC to the HAMAC on Medical Staff governance within the Facilities and Programs operated by the IHA within the Region, as outlined in the Bylaws 8.1.3 and within these Rules, 10.1.2.

10.15.3 Duties and Responsibilities

10.15.3.1 The LMAC shall have the same authority as the HAMAC for the governance of the Medical Staff practicing within the Facility.

10.15.3.2 The LMAC shall share the same responsibilities and fulfill the same duties as the HAMAC but limited to the Medical Staff within the Facility.

10.15.4 Membership

10.15.4.1 The voting members of each LMAC shall include:

- The Senior Site Medical Administrator;
- All Facility Medical Staff Department

  Heads; The Facility Medical Staff

  Association President;
- following approval by the RMAC, other members of the Medical Staff, determined by the LMAC.

10.15.4.2 The non-voting members of each RMAC shall include:

- the SET Vice President with accountability for the Facility, or delegate;
- one IHA Executive Medical Director appointed by the Senior Executive Medical Administrator;
- The Senior Site Facility Administrator and other Site Administrators

Medicine Portfolio support staff.

10.15.5 Officers and Terms

10.15.5.1 The Chair and Vice-Chair of the LMAC shall be appointed by the RMAC and selected from a list of nominees submitted by the LMAC.

10.15.5.2 The Chair and Vice-Chair shall be selected from among the members of the LMAC.

10.15.5.3 The Chair and Vice-Chair shall be appointed for a term of three (3) years, renewable for one additional term upon satisfactory review, for a maximum of two (2) consecutive terms.

10.15.5.4 The Office of the Senior Executive Medical Administrator shall provide secretariat services to the LMAC.

10.15.6 Chair

10.15.6.1 The LMAC Chair shall have the same responsibilities as the HAMAC Chair, but with governance limited to the Medical Staff practicing within a Facility.

10.15.6.2 The LMAC Chair shall act as the principal spokesperson for the LMAC in liaising with the Senior Executive Medical Administrator and the SET through the Medicine Portfolio Leadership Structure.

10.15.6.3 The LMAC Chair shall be a voting member of the RMAC.

10.15.6.4 The LMAC Chair shall ensure the timely communication of relevant information, concerns and recommendations from the LMAC to the RMAC, and from the RMAC to the LMAC.

10.15.7 Meetings

10.15.7.1 The LMAC shall schedule regular meetings and shall meet not less than ten (10) times per year.

10.15.7.2 LMAC meetings, agendas and voting procedures shall be the same as those for the HAMAC, as outlined in these Rules, 10.9, above.

10.15.8 Reporting and Accountability

10.15.8.1 The LMAC shall report directly to the RMAC.

10.15.8.2 Recommendations for Medical Staff appointments and privileges shall be made to the RMAC in a written report. The LMAC Chair or delegate shall present this report to the RMAC and shall speak to the recommendations.

10.15.8.3 The Chair of the RMAC shall respond to the LMAC reports, advising the HAMAC of any issues requiring the attention of the HAMAC or the Board Chair and CEO.

10.15.8.4 The LMAC shall only report to the Board through the RMAC and HAMAC, or at the request of the Board Chair.

Article 11 – Medical Staff Association

11.1 **Role and Structure**

11.1.1 The objectives of the Medical Staff Associations (MSA's) include promoting and engaging Medical Staff involvement in the provision of the IHA's medical and clinical services, as well as representing and advocating for the interests of the Medical Staff.

11.1.2 Medical Staff Associations are currently Facility specific, but the IHA MSAs may elect to establish a Regional MSA.

11.1.3 The structure and operation of the MSAs shall comply with these Rules.

11.2 **Elected Officers of the Medical Staff Association**

11.2.1 The elected officers of the Medical Staff Association shall be:

11.2.1.1 President of the Medical Staff Association

11.2.1.2 Other officers deemed necessary by the respective Medical Staff Association

11.2.2 Duties

The elected officers of the Medical Staff Association shall be responsible for:

11.2.2.1 Meetings – Regular, Annual and Special;

11.2.2.2 Appointing special subcommittees as needed.

11.3 **Election Procedure**

11.3.1 A slate of nominated officer(s) will be proposed by a committee constituted for this purpose; consisting of the a Past President of the Medical Staff (Chair) and two (2) other members to be appointed by the elected officers of the Medical Staff.

11.3.2 The nominated officers of the Medical Staff shall be elected at an annual general meeting of the Medical Staff and shall hold office for a period of not more than three (3) years, assuming continuous membership to the active staff.

11.3.3 All members of the Active staff are eligible to vote, stand for election, and hold office. Elections will be by acclamation or by a simple majority vote by all active members present and eligible to vote.

11.4 **President of the Medical Staff Association**

The President of the Medical Staff shall:

11.4.1 Convene and chair all meetings of the Medical Staff;

11.4.2 Be a member ex-officio, of all Medical Staff committees;

11.4.3 Be a voting member of the LMAC;

11.4.4 Receive information and directives from the LMAC and disseminate this information to the Medical Staff as appropriate;

11.4.5 Communicate matters of concern from the Medical Staff to the Senior Facility Medical Administrator;

11.4.6 Represent the collective interests of the Medical Staff.

11.5 Past President of the Medical Staff Association

The Past President of the Medical Staff shall serve in an advisory capacity, along with the President of the Medical Staff and its elected officers.

11.6 Meetings

11.6.1 Annual Meeting

11.6.1.1 The annual meeting shall be the last meeting of each year at which time officers shall be elected for the ensuring year.

11.6.1.2 The President of the Medical Staff shall post a notice for members of the Medical Staff at least ten (10) days prior to the annual meeting announcing the time and place of the meeting.

11.6.1.3 An annual report from the officers and committees shall be presented in writing.

11.6.1.4 An annual report on the financial affairs of the Medical Staff in the past year and a proposed budget in writing for the ensuing year presented.

11.6.1.5 Representatives of the Board of Directors shall be invited to attend.

11.6.1.6 Records of the meeting shall be kept.

11.6.2 Regular Meetings

11.6.2.1 Regular meetings of the Medical Staff shall be held at least four (4) times per year, or as deemed appropriate by the President of the Medical Staff or officers of the Medical Staff.

11.6.2.2 The President of the Medical Staff shall post a notice for members of the Medical Staff at least ten (10) days prior to a regular meeting announcing the time and place of the meeting.

11.6.2.3 The Chief Executive Officer shall be given notice of, and may attend appropriate portions of all meetings of the Medical Staff.

11.6.2.4 President(s) shall be given notice of, and may attend appropriate portions of all department meetings of the Medical Staff.

11.6.2.5 The Senior Facility Medical Administrator may attend appropriate portions of all meetings of the Medical Staff.

11.6.2.6 The Chair of the LMAC will attend all meetings of the Medical Staff, and report on LMAC issues.

11.6.2.7 The business of regular meeting shall inform the Medical Staff of actions recommended by the LMAC.

11.6.2.8 Department/Program and committee reports may be presented at these meetings.

11.6.3 Special Meetings

11.6.3.1 A special meeting of the Medical Staff may be called by the Board of Directors, CEO, President of the Medical Staff, Chair of the HAMAC or at the request of one-third of eligible voting members of Medical Staff and shall be held within ten (10) days of receipt of the request.

11.6.3.2 At a special meeting, no business shall be transacted except as stated in the notice calling the meeting.

11.6.3.3 Notice shall be posted by the President of the Medical Staff at least two (2) days before the special meeting and shall contain the purpose of the meeting.

11.6.3.4 No regular business shall be transacted at a special meeting.

11.6.4 Attendance

11.6.4.1 Active and provisional Medical Staff members shall attend at least 50% of the general Medical Staff meetings in a calendar year.

11.6.5 Quorum

11.6.5.1 At general Medical Staff meetings, a quorum shall consist of 20% of the members of the Medical Staff eligible to vote.

11.6.6 Membership Dues

11.6.6.1 Members of the Medical Staff shall pay annual membership dues at their primary site as applicable for their category. Membership dues shall be determined by a vote at the annual meeting on the recommendation of the elected officers of the Medical Staff.

11.6.6.2 Payment of membership dues is a requirement to retain membership in the Medical Staff, and shall be made

payable within two (2) months following the Annual meeting. Non-payment of dues within the time specified shall be grounds for loss of privileges and/or disciplinary action.

Article 12 – Amendments

Amendments to the IHA Medical Staff Rules shall be made by the HAMAC and approved by the Board of Directors.

12.1 Review of Medical Staff Rules

The Rules are 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.

12.3 Authority

12.3.1 A copy of these Rules shall be forwarded electronically to all members of the Medical Staff, following which the Medical Staff shall be deemed to be informed of them and expected to be compliant with them.

12.3.2 A copy of these Rules signed by the Chair of the IHA Board and the Chair of the HAMAC may be given in evidence in any proceeding within the IHA without any further proof of authenticity.

Article 13 – Approval of the IHA Medical Staff Rules

This is to certify that these Medical Staff Rules were approved by the Board of Directors of the Interior Health Authority at a meeting held on April 14, 2026.

Chair, IHA Board of Directors | Date of Signature

CEO, IHA | Date of Signature

Senior Executive Medical Administrator, IHA | Date of Signature

HAMAC Chair, IHA | Date of Signature