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**MEDICAL STAFF RULES**  
**FOR THE**  
**VANCOUVER ISLAND HEALTH AUTHORITY**

March, 2017

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## PREAMBLE

This Document presents Rules for the medical staff of facilities operated by the Vancouver Island Health Authority.

These Rules are promulgated by the Board of Directors of the Vancouver Island Health Authority pursuant to the authority and requirements of the *Hospital Act* and its *Regulations*, and the *Health Authorities Act*. Medical Staff Rules outline the details of the Organization of the medical staff and the day-to-day processes by which the medical staff provides patient care. The Board's obligation to patient care includes supporting the medical staff through the provision of adequate and appropriate resources.

The medical staff must be organized in conformity with the Medical Staff Bylaws, these Medical Staff Rules and Medical Staff Policies and Procedures.

The Board of Directors is ultimately responsible for the quality of medical care and provision of appropriate resources, in the facilities and programs operated by the Vancouver Island Health Authority. This responsibility extends to the Chief Executive Officer (CEO) who is the Board of Directors' representative as outlined in the *Hospital Act Regulation* section 3(1).

The members of the medical staff are accountable to the Head of the Department and/or Chief of medical staff of the facility to which they are assigned for the quality of medical care in the facilities operated by the Vancouver Island Health Authority.

Members of the medical staff are required to adhere to, and are offered the protections of, the *Freedom of Information and Protection of Privacy Act* and other applicable legislation respecting personal privacy.

## DEFINITIONS

Readers are referred to the Bylaws for Definitions not listed here.

**Chief of Medical Staff** - A member of the Active medical staff responsible for the assurance of the quality of medical care provided by members of the medical staff within a non-departmentalized facility or a community hospital and for providing local medical input into operational decisions. The Senior Medical Administrator in consultation with the local medical staff will appoint these individuals.

**Clinical Fellows** - Physicians who have already completed a residency and are currently recognized by a university program who applied to and have been accepted by the Vancouver Island Health Authority for further training in a clinical discipline.

**Clinical Trainees** - Those physicians, dentists or midwives who applied to and have been accepted by VIHA for further clinical training.

**Consultation** - The medical opinion of another member of the medical staff. Consultation does not mean transfer of care.

**Delegated Medical Function** - A delegated medical function is a medical act that, with the agreement of the relevant Department (i.e. the Department responsible for permitting health care professionals to perform the delegated medical function), has been formally transferred to a professional in that Department, in the interest of good patient care and efficient use of health care resources. A delegated medical function is part of the specialized skills inventory of the affected health professional.

**Disruptive Behavior** - Behaviors that are unprofessional, uncooperative and/or contentious that create a hostile work environment and/or could reasonably be expected to interfere with the delivery of safe patient care.

**Executive Medical Director** – A physician member of the Medical Administration directly reporting to the Senior Medical Administrator.

**Medical Staff Association** - The body of all members of the medical staff whose professional interests are represented by their elected officials as per article 10 of the Bylaws.

**Most Responsible Practitioner** - The practitioner who has accepted the overall responsibility for the management and coordination of care of the patient.

**Senior Medical Administrator** – Chief Medical Officer or delegate.

**Site Chief** - The member of the medical staff appointed by the Department Head in consultation with local medical staff to be in charge of and responsible for the relevant medical operation of a single site or a group of amalgamated sites.

## **SECTION 1 - AUTHORITY TO MAKE RULES**

1.1 The authority and process to make and amend Medical Staff Rules is set out in Article 12 of the Medical Staff Bylaws.

1.2 Amendments to the Rules require approval by both the Health Authority Medical Advisory Committee (HAMAC) and the Board.

1.3 Any recommendations from the HAMAC to change the Rules require a motion at a duly constituted and advertised meeting that is passed by at least half of the delegates attending the meeting.

## **SECTION 2 - RESPONSIBILITY FOR THE PROVISION OF MEDICAL CARE**

2.1 Each member of the medical staff has the duty to comply with Article 5 of the Medical Staff Bylaws including the responsibility to ensure the patient is continuously under appropriate and available medical staff care. Details of coverage will be determined by departments, divisions and sections including availability to be on site in a reasonable response time as determined by the urgency of patient need.

2.2 When, in the opinion of the Most Responsible Practitioner (MRP), clinical resources are not available for the appropriate and safe care of the patient:

- (a) The practitioner shall be responsible to identify the patient who requires transfer, the resources needed, provide relevant medical information and ensure appropriate communication with the accepting physician. This must be in keeping with clinical policies and procedures where they apply (e.g. No Refusal Policy, BC Bedline).
- (b) The transfer of the patient to a facility with adequate resources shall be the responsibility of local administration as per established policies.

2.3 The practitioner shall report apparent inappropriate delays and/or concerns to the Department Head and/or to the Senior Medical Administrator on call.

2.4 The Department, Division or Section Head, with the agreement of their members, shall ensure that there is a reasonable on-call schedule. The provision of emergency call must be considered in context of the volume, complexity and location of the call.

- (a) When a Department includes Members whose practices are sufficiently distinct from those of other Members, either by reason of specialty of practice or by geographic distinction, as to preclude participation by all Members in a common on-call rota covering the practices of all Members, the Department shall designate separate on-call rotas to assure the continuous availability of on-call services for the appropriate groupings of practices within the same maximum on call frequency.
- (b) Where Members are a common clinical specialty practice in different communities, a common on-call rota may be established by the Department,

provided a clinical service delivery model is established to ensure that patients have access to the on-call Member as necessary.

- (c) All Members shall participate in departmental, divisional or sectional on-call rosters at the facility(s) in which they conduct active medical practice, except in special circumstances as set out below and only with the agreement of the Senior Medical Administrator.
- (d) Department Heads, with the agreement of Department Members, shall have the right to excuse an individual Member of the Department from on-call responsibilities in special circumstances according to criteria determined by the Department which may include, but not be limited to:
  - (i) Age of the Department Member;
  - (ii) Seniority of the Department Member;
  - (iii) Health concerns;
  - (iv) Extraordinary personal circumstances; and/or
  - (v) Other contributions made to the Department by the Department Member.
- (e) When a Member(s) is excused from on-call responsibilities, the Department Members shall be responsible for ensuring that on-call coverage is maintained. If the remaining Department Members cannot maintain on-call coverage, the Department Head shall be responsible for the development of alternative arrangements for maintaining on-call coverage.
- (f) All Departments shall develop a governance document with respect to call rota expectations within their Department, Division, Section or Site. The Department Head, or Chief of Staff of a Facility with call schedules specific to the Facility, shall assign each Member to a reasonable on-call schedule. No Member shall be required to be on-call more frequently than one-in-five unless the Member specifically agrees otherwise.
- (g) When on-call, Members will be expected to maintain acceptable levels of availability. Departments that deal with life/limb/organ threatening emergencies shall delineate the method of obtaining assistance when the first Member on-call cannot respond within these timeframes.
- (h) When circumstances do not allow on-call coverage that is consistent with safe patient care, the Senior Medical Administrator, or Chief of Medical Staff together with the relevant Department, Division or Section Head shall assist in making alternative arrangements.
- (i) Temporary changes in the availability of regional/facility resources may alter the requirement to provide emergency on-call coverage at a department, division or section level. In planning for such changes, the relevant Department, Division or Section Head, the affected members and the relevant Program Directors shall meet to determine an appropriate level of on-call emergency coverage reflecting the altered level of resources provided.

2.5 Medical staff members may enter into contractual arrangements with VIHA for the provision of availability to respond to the emergent care needs of new and unassigned patients

within contractually defined anticipated response times. Such contracts do not supersede the responsibilities of members as described above in Section 2.4 and its subsidiary sections. Medical staff members may, for the sake of expediency, fulfill their Departmental on-call responsibilities concurrently with their contracted availability.

2.6 Remuneration for on-call availability shall be based on a contract with VIHA and shall be in accordance with contractual rates for on-call availability as may be established from time to time through the negotiation of a provincial medical on-call availability program.

2.7 Members of the medical staff when not available to provide care to their patients shall indicate the name(s) of the practitioner(s) assuming responsibility for each patient's care in accordance with the Most Responsible Practitioner Policy.

## 2.8 Delegated Functions

- (a) The Board must approve all delegated medical acts before they can be performed within the Facilities and Programs of VIHA as in keeping with Section 11 of this document.
- (b) Delegated medical functions are decided by mutual agreement between the relevant Department and VIHA administration and, where applicable through legislation, the appropriate regulatory bodies.
- (c) Delegated medical functions are recommended by the Chief of the relevant Department and HAMAC and approved by the Board.
- (d) Health care professionals of the relevant Department, with proven and continuing competence in accordance with VIHA guidelines, perform delegated medical functions.
- (e) Education for delegated medical functions "certification of competence" is developed by the relevant Department and medical education services in conjunction with the relevant medical and health care professionals. Education Programs for delegated medical functions certification of competence include:
  - (i) A written policy that identifies the delegated medical function and any limitation associated with it;
  - (ii) Prerequisite skills required to meet objectives;
  - (iii) Objectives that are achievable, measurable and time limited;
  - (iv) The knowledge, theory and competence required for safe practice;
  - (v) A plan for evaluation that demonstrates theoretical knowledge of the procedure and competence in performance; and
  - (vi) A specified date for re-certification, where applicable.
- (f) Delegation of selected medical functions takes place by means of certification by Members.

- (g) Administrators within the relevant Department ensure that records are maintained of the relevant health care professionals qualified to perform delegated medical functions.
- (h) The relevant Department monitors performance of delegated medical functions through a quality assurance/risk management program and reports regularly to the appropriate Department Chief, HAMAC and the Board, subject to Section 51 of the *Evidence Act*.

2.9 Disciplinary procedures for dealing with inadequacy of medical care quality and non-compliance with Medical Staff Bylaws, Rules and policies shall be established by the HAMAC through the Discipline Committee as outlined in section 15.9.

### **SECTION 3 - ADMISSION, TRANSFER AND DISCHARGE OF PATIENTS**

#### **3.1 Admission of Patients**

- (a) Every patient shall be attended by an appropriately privileged physician or midwife member who has primary responsibility for the care of the patient. This practitioner shall be identified as the "Most Responsible Practitioner".
- (b) Patients admitted as an inpatient for Dental Surgery being provided by a dentist shall be admitted under a physician member of the medical staff with admitting privileges who shall be the Most Responsible Practitioner (MRP). For those dental procedures done as a day surgery encounter an accompanying recent History and Physical by a duly licensed practitioner is acceptable.
- (c) Patients admitted to a facility when there has been no predetermined MRP, shall be assigned to a consenting available member of the medical staff with the appropriate skills, training and privileges to meet the patient's health care needs in accordance with local MRP policy.
- (d) A medical history and complete physical examination is required for all patients receiving inpatient care at the time the patient is admitted and in an approved modality for the Electronic Health Record. The documentation should include:
  - (i) Identifying provider and patient information;
  - (ii) Distribution of copies to the referring physician and/or family physician or others;
  - (iii) Date of admission;
  - (iv) Date and time of service;
  - (v) Introduction/chief complaint;
  - (vi) History of present illness;
  - (vii) Past health history;
  - (viii) Family history;
  - (ix) Social history;

- (x) Allergies;
  - (xi) Medications;
  - (xii) Review of systems;
  - (xiii) Physical examination;
  - (xiv) Mental status examination, *if appropriate*;
  - (xv) Diagnostic findings on admission;
  - (xvi) Diagnoses;
  - (xvii) Advance directives, *if appropriate*;
  - (xviii) Treatment plan; and
  - (xix) Estimated length of stay.
- (e) When a patient requires admission in emergency circumstances, the practitioner who initially assesses and determines that the patient requires admission is responsible for legibly documenting a pertinent physical examination, diagnostic and treatment plans. The Most Responsible Practitioner must provide full documentation for each emergency patient within 24 hours of admission.
  - (f) The admitting practitioner shall provide a history and indicate in both the history and order sheet (or equivalent) a note of special precautions regarding the care of the patient (e.g. infectious disease, emotional disturbance, elder alert, chemical dependency, potential suicide, history of violence, history of seizures, etc.) at the time of admission or booking.
  - (g) When a patient is readmitted to an acute care facility within 2 weeks for the same reason, a History and Physical must be completed to include pertinent new findings and at a minimum to include a review of medications, review of symptoms, physical examination and mental status.

### 3.2 Admission from an emergency department

- (a) The practitioner who initially assesses and determines that the patient requires admission is responsible for documenting clinical findings, the diagnosis and treatment plan.
- (b) The Most Responsible Practitioner must provide full documentation for each emergency patient within 24 hours of admission.
- (c) The Most Responsible Practitioner must provide admission orders including medication reconciliation at the time of admission. In circumstances where a different physician than the MRP has provided holding orders the MRP must provide orders within 8 hours of admission. Where appropriate additional history regarding the present illness, a revised problem list, a revised management plan, and initiation of a discharge plan should occur at the same time.

### 3.3 Transfer of Responsibility

- (a) It is the duty of the Most Responsible Practitioner to contact the practitioner to whom he/she wishes to transfer care. The transfer of MRP status (other than “on-call”) from one practitioner to another shall be duly recorded on the health record.
- (b) If a member of the medical staff wishes to withdraw from involvement in a patient’s care when services are still required, the member shall arrange for another practitioner with appropriate qualifications to assume responsibility for the care of the patient and then inform the patient. If the practitioner cannot find another practitioner who is willing to assume care, the original medical staff member will continue to provide care to the patient. The practitioner who is seeking to withdraw service may discuss options with the appropriate medical administrator to determine what other options may be available.
- (c) A competent patient has the right to request a change of practitioner. That practitioner shall cooperate in transferring responsibility for care of that patient to another practitioner with appropriate privileges who is acceptable to the patient. If an acceptable practitioner cannot be found, the appropriate medical administrator shall assist the patient in finding another practitioner who will agree to continue to provide care to the patient. If a willing practitioner cannot be found, the appropriate medical administrator will discuss options with the patient.
- (d) When a patient is to be transferred to another hospital or facility for medical reasons, the Most Responsible Practitioner shall ensure that there is an appropriately qualified practitioner on staff at the receiving site who is fully informed about the patient’s condition and who is prepared to assume responsibility for the patient’s care.
- (e) A transfer summary is required in all cases where a patient is being transferred to another facility. The transfer summary should be dictated immediately prior to or upon patient transfer.
- (f) At the time of transfer, the Most Responsible Practitioner or delegate shall sign the transfer order and should complete the transfer summary in an approved modality for the Electronic Health Record. The transfer summary should include the following:
  - (i) Identifying information;
  - (ii) Distribution of copies to the referring physician and/or family physician or others;
  - (iii) Date of admission;
  - (iv) Date of discharge;
  - (v) Admission diagnoses;
  - (vi) Discharge diagnoses, including major complications;
  - (vii) Details of discharge medications, including reasons for giving or altering medications, frequency, dosage and proposed length of treatment;
  - (viii) Allergies;

- (ix) Brief summary of the management of each of the active medical problems during the admission; including major investigations, treatments and outcomes;
  - (x) Reason for transfer, patient disposition and advanced directives.
- (g) In those instances where a patient is transferred to another facility for administrative rather than medical reasons, e.g. lack of beds, the Most Responsible Practitioner may choose to be relieved of the responsibility for ongoing care of that patient and hospital employees shall ensure the move is completed in accordance with established policy and procedure. It will be up to the Executive Medical Director to ensure an MRP is available at the receiving facility.

### 3.4 Discharge of Patients

- (a) At the time of discharge, the Most Responsible Practitioner or delegate shall provide a discharge order and should complete the discharge summary in an approved modality for the Electronic Health Record. The discharge summary should include the following:
- (i) Identifying patient and provider information;
  - (ii) Distribution of copies to the referring physician and/or family physician or others;
  - (iii) Date of admission;
  - (iv) Date of discharge;
  - (v) Admission diagnoses;
  - (vi) Discharge diagnoses;
  - (vii) Complications;
  - (viii) Allergies;
  - (ix) Details of discharge medications, including reasons for giving or altering medications, frequency, dosage and proposed length of treatment;
  - (x) Brief summary of the management of each of the active medical problems during the admission; including major investigations, treatments and outcomes; and
  - (xi) Follow-up instructions and specific plans after discharge, including a list of follow-up appointments with consultants, further outpatient investigations, and outstanding tests, patient disposition and advanced directives if applicable;
- (b) A Discharge Summary is required for:
- (i) All in-patient discharges regardless of length of stay except for uncomplicated obstetrics and newborns. The prenatal record is considered to be an integral part of the patient record. The BCRPC Labor, Birth Summary and Newborn Record must be completed by the

physician/midwife and will form the discharge summary in uncomplicated deliveries.

- (ii) All deaths; and
- (iii) All complicated Obstetrics and Newborns.
- (c) The Discharge Summary must be completed within 5 days of patient discharge.
- (d) An operative report is required for all invasive procedures except those documented as part of a medical imaging procedure.
- (e) The Operative Report/Procedural Report must be documented in an approved modality suitable for the Electronic Health Record upon completion of the procedure. The operative report should include:
  - (i) Identifying patient and provider information;
  - (ii) Distribution of copies to the referring physician and/or family physician or others;
  - (iii) Date of admission;
  - (iv) Date of procedure;
  - (v) Preoperative diagnosis/indications;
  - (vi) Proposed procedure;
  - (vii) Post operative diagnosis;
  - (viii) Operative procedure performed; and
  - (ix) Description of procedure performed including condition of patient during and at conclusion of operative procedure, estimated blood loss and specimens removed.
- (f) A combined OR/Discharge summary including follow-up plans is required for Day Care Surgery.

#### **SECTION 4 - CONSULTATIONS**

4.1 Consultation shall be initiated by the Most Responsible Practitioner or another practitioner involved in the care of the patient. Communication shall always be from practitioner to practitioner.

4.2 The Consultant shall examine the patient and the health record as appropriate. The findings, opinions and recommendations must be communicated to the practitioner who requested the consultation. The consultation shall be documented in an approved modality suitable for the Electronic Health Record. The consultation report must include the following:

- (a) Identifying provider and patient information;
- (b) Distribution of copies to the referring physician and/or family physician or others;
- (c) Date of admission or outpatient encounter;
- (d) Date of consultation;

- (e) Introduction/chief complaint;
- (f) History of present illness;
- (g) Allergies;
- (h) Medications;
- (i) Diagnoses;
- (j) Recommendations.

4.3 The consultation report may also include as appropriate the following:

- (a) Past health history;
- (b) Family history;
- (c) Social history;
- (d) Review of systems;
- (e) Physical examination;
- (f) Mental status examination;
- (g) Diagnostic findings; and
- (h) Advanced directives.

4.4 A Department or Division Head or a Site Chief may request or require a practitioner with privileges in his/her department or division to obtain a consult when, in the opinion of the Department or Division Head:

- (a) Diagnosis of the patient is in doubt after reasonable investigation; or
- (b) Patient does not appear to be responding to the prescribed treatment; or
- (c) Patient's condition is serious enough to be considered life threatening; or
- (d) There are other circumstances, which in the opinion of the Department or Division Head require consultation.

4.5 The Senior Medical Administrator or Chief of Medical Staff may direct a Department or Division Head to obtain a consultation as outlined in 4.4 (a), (b) or (c).

4.6 Consultation shall be obtained by the most responsible practitioner when required by government policy or law, Medical Staff Bylaws or Rules, or Department policy as approved by the HAMAC.

## **SECTION 5 – SCHEDULED TREATMENTS AND PROCEDURES**

This section refers to all scheduled medical, surgical and interventional treatments or procedures (hereinafter called "procedure(s)") that require booking through VIHA booking services.

### **5.1 Booking Requirements**

- (a) Booking requests shall be requested by, or on behalf of, the practitioner who has the authority to perform or request the procedure(s).
- (b) Booking requests shall be submitted in accordance with approved VIHA booking request forms, processes and timelines.
- (c) Required documentation, in accordance with established VIHA standards, shall be submitted at the time of the booking request.
- (d) If scheduled treatments or procedures are cancelled for administrative reasons, hospital staff shall be responsible for rebooking the procedure(s) in consultation with the practitioner and for notification of the patient and the practitioner.

## 5.2 Consent Requirements

Subject to applicable legislation, the VIHA Health Care Consent policies and procedures as well as applicable legislation will be followed at all times when obtaining and documenting consent for all electively scheduled procedure(s).

5.3 For any individual not involved with care of the patient, patient consent is always required before observation of any procedure(s) is allowed.

## 5.4 Requirements for Surgical Procedures

- (a) A surgeon shall be the Most Responsible Practitioner for peri-operative management of the patient and for the performance of any surgical procedure.
- (b) When surgery is performed by a dentist (DDS), it is the responsibility of the dentist to arrange coverage by an MRP with admitting privileges to manage and coordinate the care of any inpatients. For outpatient or day surgery patients the dentist may provide a history and physical from a medical practitioner and the dentist will act as MRP in these situations.
- (c) Surgery will be performed with the assistance of a second health professional when so required by VIHA policy.
- (d) The manager or supervisor of the operating room has the authority to cancel any procedure(s) if there are insufficient operational resources. The operation will be rescheduled in consultation with the Most Responsible Practitioner with the main considerations being the patient's interests and the optimum use of the operating room suite.
- (e) Prior to the commencement of emergency procedure(s) in the operating room, a physician must ensure documentation including a brief history, clinical status, and indication(s) for the procedure(s) has been performed.
- (f) An anesthetic record must be completed prior to the patient leaving the operating room/post anesthetic recovery area.

- (g) A post procedure note detailing any unusual circumstances related to the anesthetic shall be documented by the anesthesiologist (or delegate). This note must identify the specific practitioners who require copies of the report.
- (h) Before leaving the operating room, the surgeon shall ensure that the appropriate pathology requisition(s) for examination of tissues or other material has been completed.
- (i) The surgical record of operation must be completed within 24 hours of the procedure.
- (j) Any patient deaths that occur in the operating room/post anesthetic recovery area must be reported to the Coroner at the time of death in accordance with the *Coroners Act*. All such cases shall be referred for review by the relevant quality and patient safety committee(s).

#### 5.5 Requirements for Non-Surgical Treatments/Procedures

- (a) On completion of non-surgical treatment(s) or procedure(s), the practitioner shall document a progress note on the patient record, describing the treatment(s) or procedure(s), the outcome and any unusual circumstances.
- (b) A post procedure note detailing any unusual circumstances related to incidents of clinical significance shall be documented by the practitioner. This note must identify the specific practitioners who require copies of the report.

### **SECTION 6 - HEALTH RECORDS**

6.1 Health Records are those documents compiled by the medical and professional staff of VIHA to document care provided to patients/residents. Members of the medical staff involved in patient care shall be responsible for the preparation and legibility of their component of the health record.

#### 6.2 Orders

- (a) All orders for medical treatment shall be documented and signed by a practitioner with appropriate medical staff privileges.
- (b) An order for medical care may be dictated over the telephone to a registered nurse, licensed practical nurse or registered psychiatric nurse. An order dictated over the telephone shall be written over the name of the ordering practitioner and be signed by the person to whom they are dictated. The ordering practitioner shall authenticate such orders as soon as possible.
- (c) Orders may be faxed if signed by a medical practitioner.
- (d) Telephone orders pertaining to other professional disciplines, e.g. medical imaging, laboratory medicine, occupational therapy, physical therapy, respiratory therapy, dietary, pharmacy, etc., may be given by the medical practitioner to a member of that discipline who shall document the orders on the Physicians Order

Sheet over the name of the ordering practitioner. The ordering practitioner shall authenticate such orders as soon as possible.

- (e) In an emergency a practitioner may give verbal orders for treatment to other members of the care team who shall transcribe the order onto the chart over the practitioner's name per the writer's name. Such orders shall be authenticated by the ordering practitioner as soon as possible.
- (f) 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 staff member of a professional practice group as defined in the *Health Professions Act* and in accordance with the standards of the member's College. Medication orders will follow the acceptable standard according to the policies of the HAMAC with respect to legibility, use of abbreviations, and adherence to formulary policies of the hospital.
- (g) Practitioners prescribing medication shall comply with section 19 of the *Controlled Drugs and Substances Act, 1996* and other legislation pertaining to the use of drugs. All Medication Policies and Procedures will be followed as approved by HAMAC through the Pharmacy and Therapeutics subcommittee.
- (h) No drug, whether supplied by the hospital or not, may be administered to a patient without an order from a health professional authorized to administer medications. This may include practitioners outside the scope of this document including nurse practitioners and pharmacists as per local policy.
- (i) Only those drugs approved by the HAMAC and listed in the hospital formulary shall be available for prescribing by practitioners. All other medications, including investigational drugs, may be used as per existing policies.
- (j) Clinical Order Sets, including preprinted orders, may be used by a medical department or division following approval by the Medical Quality Committee of HAMAC. The practitioner is responsible for signing preprinted orders.

### 6.3 Progress Notes

- (a) Progress notes for acute care patients should be documented at least daily and more often if the patient condition warrants. Progress notes should describe;
  - (i) Date and time of service;
  - (ii) Any change in the patient's condition;
  - (iii) Active monitoring and measuring including the management of a problem list; and
  - (iv) Anticipated discharge, discharge plan or prognosis.
- (b) Progress notes for ALC patients must be documented as often as the patient's condition warrants.

#### 6.4 Completion of Health Records

- (a) Health records containing all relevant documents should be completed and validated by all involved practitioners as soon as they become available. All health records must be completed according to policies that have been formally accepted by HAMAC and by the Board.
- (b) The Health Record will be accepted for filing as incomplete only under extenuating circumstances (extended Leave of Absence, Resignation, Retirement, Death) and only if the Physician is unable to complete the records assigned. If the physician responsible is no longer available to complete the chart(s), the appropriate Department Chief or Chief of Staff will be responsible for reviewing the record and providing written authorization for filing the health record as incomplete.
- (c) If the practitioner is unable to complete and validate the health record because all relevant documents and reports are not available or completed, the Health Records Department is to be notified.
- (d) Prior to planned absences, the practitioner shall complete all outstanding patient records (as per Section 3.4(a)). Practitioners who have notified Medical Administration in advance of their absence shall not lose privileges for incomplete records identified during their absence. Outstanding records shall be completed within 14 days after the practitioner's return (as per Section 3.4(a)).
- (e) Locum tenens practitioners are responsible for the completion of the health records of patients they have been caring for. When possible, records left incomplete shall be completed by the medical staff member replaced by the locum tenens.
- (f) Written notification of failure to complete records shall be provided to the responsible practitioner by the Health Records Department. Within 14 days of issuance of this notice, the practitioner shall complete the identified records. A 7-day pre-notice of automatic suspension will be issued should the records remain incomplete. Failure to do so may result in the suspension of all hospital privileges except for the ongoing care of patients already in hospital and on-call obligations until the records are completed.
- (g) Repeated failure to comply with the above regulations incurring an automatic suspension on 3 occasions during any 12-month period may result in a suspension of up to 30 days of all privileges following a review by the HAMAC.
- (h) Physicians whose privileges remain suspended more than 30 days will be reported to the BC College of Physicians & Surgeons.

#### 6.5 Release of Health Records

- (a) Health records are owned by VIHA and are not to be removed from a facility without the permission of the Director, Health Records Services (or designate), or as ordered by the courts.

- (b) Community based health records may travel with the patient, family or caregiver during the provision of care.
- (c) All available VIHA records of any patient shall be available to a practitioner currently involved in the care of that patient.
- (d) Confidentiality of patient medical information is paramount. Practitioners must respect and adhere to relevant organizational policies governing privacy and access to health records.

## **SECTION 7 – QUALITY ASSURANCE, QUALITY IMPROVEMENT AND PEER REVIEW**

7.1 Quality assurance, quality improvement and peer reviews are processes that ensure appropriate standards and patterns of medical care are created and maintained throughout VIHA. Medical staff are required to participate on quality committees relevant to their area of expertise as requested.

7.2 Departments shall be responsible for monitoring the quality of patient care and services provided by its Members. Department members shall participate in a program of structured quality assurance regarding the care provided to patients by its Members, which shall at minimum include:

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

7.3 Quality assurance activities of Departments shall be performed in accordance with Section 51 of the *Evidence Act*.

7.4 The recommendations of Departmental quality assurance activities shall be reported to the Quality Committee of the HAMAC. Local medical advisory committees shall be involved in this process.

7.5 The specific quality assurance activities of the Department shall be described in the Department policies and procedures.

7.6 Quality improvement activities are the shared responsibility of the Quality and Patient Safety portfolio. Departments and their members are expected to participate in these multi-disciplinary processes.

## **SECTION 8 – MEDICAL STAFF MEMBERSHIP AND PRIVILEGES**

8.1 Appointment to the Medical Staff

- (a) 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 Medical Staff Bylaws.

- (b) Members of the medical staff are appointed to the clinical Department(s) of medical staff of VIHA.
- (c) The local medical advisory committee (LMAC), as the governing committee for local medical staff, will recommend to the HAMAC the scope of privileges being requested in specific facilities based on the local need for the Member to complement local medical services.
- (d) Active Staff privileges may be limited in scope as defined by a Department, through its Department Head, subject to review and approval by the Medical Planning and Credentials Committee.

## 8.2 Procedural Privileges

- (a) Physicians, Dentists and Midwives who are being or have been appointed to the medical staff must apply to the Board for procedural privileges. The HAMAC will make recommendations to the Board based on input of the LMAC in which the privileges are being requested and input of the relevant Department Chief.
- (b) All procedural privileges require documentation of training and experience. The granting of Procedural Privileges to a Member is dependent on the training, experience and qualifications of the Member requesting such Procedural Privileges as well as the service needs of the local medical staff and the ability of VIHA to provide adequate resources and staff to perform such a procedure.
- (c) Procedural privileges may be granted to a Member on the basis of adequate documentation provided by another British Columbia Health Authority or Facility where that Physician has obtained such procedural privileges.
- (d) As part of the annual review (or otherwise as per Article 4.4.4 of the Bylaws) of all privileges, maintenance of procedural privileges will be determined by the Department Head's evaluation of proven competence and ongoing expertise as well as program requirements.

## 8.3 Basic Procedural Privileges

- (a) Certain procedural privileges will be defined by the Medical Planning and Credentials Committee as Basic Procedural Privileges and will be automatically granted to all Members within defined Departmental, Division or Section categories.
- (b) Basic Procedural privileges will be reviewed and amended as directed by the Medical Planning and Credentials Committee based on input of the relevant Chief of the Department/Site/Division.

## 8.4 Advanced Procedural Privileges

- (a) The Medical Planning and Credentials Committee will define certain procedural privileges that require additional training, e.g. Anesthesia conducted by general practitioners.

- (b) These procedures may also include a group of related procedures (e.g. advanced laparoscopic general surgery) and will relate to the specific training, demonstrated expertise and current practice of the applicant member of the medical staff.
- (c) Advanced Procedural privileges will be reviewed and amended as directed by the Medical Planning and Credentials Committee based on input from the relevant Chief of the Department/Site/Division.

#### 8.5 Specific Procedural Privileges

- (a) Specific Procedural Privileges require an individual application process in the following situations:
  - (i) The introduction of a new technology for which training has not previously been available to the specialty;
  - (ii) A request for privileges outside the applicant's specialty area;
  - (iii) A request by a non-Specialist for procedural privileges in a specialist area;
  - (iv) A request for privileges generally not included in a specific staff category as defined in the Bylaws; and/or
  - (v) Procedural privileges not included as basic or advanced privileges.
- (b) The Department Chief, in consultation with the Chief of the specialty Division and/or Site (if applicable) in which the procedural privilege is requested, will determine and evaluate the training and experience required or gained by an applicant to support his or her request for Specific Procedural Privileges. This may include supervision of the procedure by qualified physicians for a number of cases.
- (c) The training and experience requirements will be determined as a standard for all new applicants.
- (d) In exceptional circumstances the Department Head may determine and evaluate the training and experience on an individual basis if the applicant does not meet the standard for new applicants but can demonstrate training and experience of a similar validity.
- (e) Where Specific Procedural Privileges have been granted, the Board in consultation with the HAMAC and Department Head may specify the frequency at which such a procedure should be performed for this specific procedural privilege to be retained by the Member.

#### 8.6 Locum Tenens Staff

- (a) Appointments for locum tenens are governed by Article 6.6 in the Medical Staff Bylaws and are subject to approval of the Department Head.

- (b) The granting of a locum tenens appointment provides no preferential access to appointment to any other category of the medical staff at some later time.
- (c) The Physician who will be replaced by the Locum Tenens has the responsibility to determine what aspects of his/her practice the Locum Tenens is prepared and qualified to cover and for making arrangements with other qualified Practitioners to attend to those aspects of the practice that the Locum Tenens will not be covering.
- (d) The medical staff member who will be replaced by a locum tenens and the relevant Department Head, Site Chief or Chief of Staff as required shall familiarize the locum tenens with facility and program policies and procedures necessary for the medical care of patients.

#### 8.7 Temporary Appointments to Medical Staff

- (a) Appointments for temporary medical staff are governed by Article 6.5 in the Medical Staff Bylaws. The purpose of these appointments is to fill a temporary service need.
- (b) The granting of a temporary medical staff appointment provides no preferential access to appointment to any other category of the medical staff at some later time.
- (c) Documentation
  - (i) Applications for temporary staff privileges are to be completed on the prescribed forms before being processed according to the Bylaws.
  - (ii) Temporary privileges may be granted without application to Physicians for limited situations such as organ retrieval, education, demonstration of medical equipment, etc.
  - (iii) Temporary privileges granted without application shall be granted by the Senior Medical Administrator based on his/her assessment of the emergent need to grant such privileges and of the appropriate training and experience of the individual.

#### 8.8 Urgent Appointment to Temporary Medical Staff

- (a) Pursuant to Article 4.1.4 of the Bylaws, Temporary Procedural Privileges, including Basic, Advanced and Specific Procedural Privileges, may be granted to an applicant for membership on the medical staff or to a physician duly qualified and licensed in British Columbia under special or urgent circumstances such as a medical emergency or where there is a demonstrated need for the applicant to begin to provide clinical services in advance of a Board meeting to consider the application.
- (b) The temporary appointment must be ratified or terminated by the Board at its next meeting.

- (c) If the next Board meeting falls in advance of the Medical Planning and Credentials Committee meeting to consider the temporary member's application for Appointment, the Board may, on the advice of the Senior Medical Administrator, extend the Temporary Appointment until the next scheduled Board meeting.
- (d) In the event that the Board terminates the appointment to temporary medical staff, the applicant or temporary member shall cease all clinical activity in VIHA Facilities and immediately transfer the ongoing care of any patient under his/her care to another medical staff member.

## 8.9 In-depth Performance Evaluations

- (a) In-depth review is the periodic, or ongoing, evaluation of a medical staff member's practice and performance and occurs in addition to, or in conjunction with, the member's annual review (or otherwise as per Article 4.4.4 of the Bylaws). Each member must undergo this review at the following times:
  - (i) Application for change in category of medical staff appointment including change from Provisional to Active status;
  - (ii) At the first anniversary of the Members' appointment to the Active medical staff;
  - (iii) At an interval to be determined by the Department Head of the primary Department to which the Member has been appointed, in consultation with the Heads of other Departments to which the Member may also be appointed, but no less frequently than every 3 years at the time of re-application for Appointment to the medical staff.
- (b) The intent of in-depth review is quality improvement and the process is designed to be educational and potentially corrective. In-depth reviews should be performed in accordance with disclosure safeguards found in Section 51 of the *Evidence Act*.
- (c) Any recommendations involving a change of privileges resulting from the in-depth review will be sent to the HAMAC via its credentialing process.
- (d) In depth reviews will be held where concerns are identified with quality of care, interpersonal communications, documentation standards, or at the discretion of the Department Head and Site Chief where an opportunity for improvement is identified. They may be regularly scheduled as part of a continuing professional development plan.
- (e) The process for a performance review will be coordinated through the member's Department Head and Site Chief with input from the Division Chief as required. The review will include review of any or all of the following:
  - (i) Inpatient and outpatient clinical documentation for quality, accuracy and timeliness;
  - (ii) Complications, morbidity and mortality review;

- (iii) Incident reports and complaints;
  - (iv) Continuing medical education including updates specific to departmental and/or program requirements;
  - (v) Patient satisfaction data;
  - (vi) Procedural privilege evaluation including frequency of procedures done;
  - (vii) Direct observation of procedural and assessment skills;
  - (viii) Compliance with bylaws, rules and departmental policies and procedures;
  - (ix) Communication with medical colleagues and other members of the health care team and health authority staff with whom the member works; and
  - (x) Utilization/quality management data.
- (f) The performance review will be coordinated by the Department Head in discussion with the Executive Medical Director and may be completed by:
- (i) Department Head;
  - (ii) Division Chief;
  - (iii) Site Chief;
  - (iv) Chief of Staff;
  - (v) Departmental subcommittee;
  - (vi) Delegated representative of the Department Head;
  - (vii) Another appropriate body of the medical staff; or
  - (viii) External reviewers appointed by the Department as approved by the HAMAC on the recommendation of the Department Head, Executive Medical Director or Senior Medical Administrator.
- (g) The Department Head or delegate will discuss the results and recommendations of the in-depth review with the medical staff member before any report is sent to the Medical Planning and Credentials Committee for further action. A copy of the final report will be provided to the member.
- (h) Should the member of the medical staff have concerns with the report, the concerns should be addressed through the Medical Staff Association and/or the HAMAC Executive Committee as necessary.
- (i) The process of performance review shall be monitored and audited by the Medical Planning and Credentials Committee for consistency, validity and the process and results of such audit shall be reported to the HAMAC.

#### 8.10 Leave of Absence

- (a) Any absence from practice for a period exceeding 6 weeks shall be considered a leave of absence and requires approval of the Board as per Article 4.7.2 of the Medical Staff Bylaws. The Board may delegate authority to grant this to the Senior Medical Administrator.

- (b) In considering granting a leave of absence the Board shall consider Department Rules, the advice of the Chief of the Department and the impact the leave of absence will have on the ongoing ability of the Department members to provide ongoing care to the population their Department is serving.

## **SECTION 9 – ORGAN DONATION AND RETRIEVAL**

9.1 VIHA and its medical staff will cooperate with the British Columbia Transplant Society in supporting the provincial program for organ donation and retrieval.

### **9.2 Membership and Appointment**

The Board of Directors through the Chief Executive Officer or delegate may grant temporary privileges to physicians for situations such as organ retrieval.

### **9.3 Responsibility for Patient Care**

- (a) 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 Most Responsible Practitioner, to a physician member of the Organ Retrieval Team.
- (b) Consent for organ and tissue donation shall 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*.
- (c) Organ donation, after the declaration of neurological death, permits the Most Responsible Practitioner to transfer to and/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.

## **SECTION 10 – PRONOUNCEMENT OF DEATH, AUTOPSY AND PATHOLOGY**

10.1 Only a physician member of the medical staff may pronounce a neurological or unexpected death. Either a physician member of the medical staff or qualified practitioner may pronounce death in other circumstances.

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

10.3 In appropriate cases, the Most Responsible Practitioner shall make all reasonable efforts to obtain permission for the performance of an autopsy.

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

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

10.6 A physician member of the medical staff shall complete the medical certificate of death or stillbirth.

10.7 Deaths shall be reported to the Coroner in accordance with the requirements of the *Coroner's Act*.

## **SECTION 11 – DELEGATION OF A MEDICAL ACT**

11.1 The delegation of a medical act to a health professional other than another physician may be appropriate in certain restricted circumstances in the interest of good patient care. Such delegation does not absolve the physician of responsibility for the care of the patient but rather widens the circle of responsibility for the safe performance of the procedure. Responsibility is shared between the delegating physician and the professional who performs the delegated act.

11.2 The medical act must be clearly defined and circumscribed with the degree of medical supervision indicated. The professional who will perform the delegated act must be in agreement. Competency requirements of individuals and the scope of practice of a professional group must be determined to decide what additional training is needed. A physician with relevant expertise must ensure the required knowledge and skill are appropriately taught. A non-physician may carry out the teaching, but not the examination for competence. Re-evaluation and, if necessary, re-training of all professionals who perform delegated medical acts should be carried out on a regular basis as required to maintain professional competency and an appropriate standard of care.

11.3 The Board of Directors must approve all delegated medical acts before they can be performed within the facilities and programs of VIHA.

## **SECTION 12 – POSTGRADUATE TRAINING PROGRAMS**

### **12.1 Resident Staff**

#### **(a) Appointments**

All appointments to Resident Staff shall be made through the office of Medical Postgraduate Education in conjunction with the Faculty of Medicine at the University of British Columbia and the College of Physicians & Surgeons of BC.

#### **(b) Resident Staff**

Resident Staff may attend patients under the supervision of a member of the Active, Temporary, Locum 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 contained in the Residents Manual available through the office of Medical Postgraduate Education.)

## 12.2 Clinical Fellows

### (a) Appointments

Clinical Fellows must have adequate medical liability insurance, be licensed by the College of Physicians & Surgeons of BC 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 Chief concerned and recommended by the Medical Planning and Credentials Committee, the HAMAC and approved by the Board of Directors.

### (b) Clinical Fellows

Clinical Fellows may attend patients under the supervision of a member of the Active, Locum, Temporary, Provisional or Consultant 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 under their name. They may not vote at medical staff or Department meetings.

## 12.3 Clinical Trainees

### (a) Appointments

Clinical Trainees must have adequate liability insurance and be licensed by the College of Physicians and Surgeons of BC, the College of Dentistry of BC or the College of Midwives of BC. Clinical Trainees shall be accepted only if supported by the Department Head concerned and recommended by the Medical Planning and Credentials Committee, the HAMAC and approved by the Board of Directors.

### (b) Clinical Traineeships

The purpose of Clinical Traineeship is to provide a licensed physician, dentist or midwife an opportunity to maintain or enhance their clinical skills. Clinical Trainees 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 Department Head or delegate to whom they have been assigned. They may not admit patients. They may not vote at medical staff or Department meetings.

## 12.4 Medical Students

(a) All medical students working within a Facility, Program or Department must be registered with the Faculty of Medicine at the University of British Columbia and the College of Physicians & Surgeons of BC.

(b) Medical students may attend patients under the direct supervision of a member of the Active, Locum, Temporary or Provisional medical staff, Resident staff or a Clinical Fellow in the department responsible for their training program.

(c) Medical students must ensure that orders are discussed in advance with and countersigned by the supervising physician, resident or fellow.

(d) Medical students shall not sign certificates of death and shall not discharge patients without appropriate review by a qualified physician.

- (e) Medical students are not permitted to dictate final versions of discharge summaries or consultation letters. Learning how to prepare discharge summaries or consultation letters under supervision has potential educational value and should be encouraged.

## **SECTION 13 –MEDICAL STAFF ASSOCIATION**

### 13.1 Purpose

The Medical Staff Association as constituted in Article 10 of the Medical Staff Bylaws is the association of all members of the medical staff responsible for representing the interests of medical staff and to assure effective communications between the medical staff, administration and the Board of Directors of the Health Authority.

### 13.2 Meetings of the Medical Staff Association

- (a) Annual General Meeting
  - (i) An Annual General Meeting shall be held every 12 months at which time officers shall be declared for the ensuing year.
  - (ii) The President shall ensure a notice is sent to all members of the medical staff at least 28 days prior to the annual meeting announcing the time and place of the meeting.
  - (iii) An annual report from the officers and committees shall be presented in writing.
  - (iv) Representatives of the Board shall be invited to attend.
- (b) Special Meetings
  - (i) A special meeting shall be called by the President of the medical staff or at the request of 25% of the members of the medical staff eligible to vote and shall be held within 14 days of receipt of the request.
  - (ii) At a special meeting, no business shall be transacted except as explicitly stated in the notice calling the meeting.
  - (iii) The President shall ensure a notice is sent to all members of the medical staff at least 7 business days before the special meeting and shall contain the purpose of the meeting.
- (c) The Chief Executive Officer shall be given notice of each Medical Staff Meeting and the Chief Executive Officer or an appropriate delegate shall attend all meetings of the medical staff.

### 13.3 Organization

- (a) Officers

The elected officers of the Medical Staff Association shall consist of:

- (i) President
  - (ii) Vice-President
  - (iii) Secretary
  - (iv) Treasurer
- (b) Officers of the Medical Staff Association shall be voting members of the HAMAC and shall constitute the officers of the Medical Staff Association Executive Committee.
- (c) The Medical Staff Association will endeavor to ensure there is representation from across the entirety of VIHA in the slate of Officers.

#### 13.4 Medical Staff Association Executive Committee

- (a) Purpose
- (i) To represent the interests of medical staff members as elected representatives.
  - (ii) To provide day-to-day support to Local Medical Staff Associations regarding issues of medical professional management.
- (b) Responsible to
- This Committee is responsible to the medical staff.
- (c) Composition
- (i) President (chair)
  - (ii) Vice-President
  - (iii) Secretary
  - (iv) Treasurer
  - (v) Other members of the medical staff as decided by the elected officers, including Presidents of the Local Medical Staff Associations.
- (d) Term
- The term shall be 3 years.
- (e) Quorum
- A simple majority will constitute a quorum.
- (f) Meetings
- Meetings will be held at least quarterly or at the call of the chair. The Chief Executive Officer of VIHA and the Senior Medical Administrator or delegate(s) will attend these meetings.
- (g) Duties

- (i) Advise the HAMAC and VIHA of the concerns and opinions of the medical staff members;
- (ii) Arrange for collection of annual fees and administer medical staff funds, where deemed appropriate;
- (iii) Create and administer programs of interest to the medical staff members, which are applicable to the entire Medical Staff Association;
- (iv) Meet at the call of the Chair to nominate a candidate to fill any position vacated during the term of office in accordance with Article 10 of the Medical Staff Bylaws;
- (v) Prepare a list of candidates for the elected positions of officers of the medical staff for the Annual Meeting of the medical staff. At least 1 person shall be proposed for each position;
- (vi) Invite nominations from the members of the medical staff through a notice provided to each member at least 1 month prior to voting. Any nominations must be received 7 days prior to the meeting; and
- (vii) Ensure a fair and equitable system of voting for officers by all members of the medical staff through a mail-in ballot or similar process.

#### 13.5 Local Medical Staff Associations

- (a) The Medical Staff Association will be composed of distinct local medical staff associations. Determination of the number and location of the Local Medical Staff Associations will be determined at the annual general meeting.
- (b) Each of the Local Medical Staff Associations shall elect a President. Where applicable the President will be a member of the Local Medical Advisory Committee. Additional officers will be at the discretion of the Local Association.
- (c) Duties
  - (i) Advise the Medical Staff Association through its Executive Committee of the concerns and opinions of the local medical staff members;
  - (ii) Arrange for collection of annual fees and administer medical staff funds at the local site; and
  - (iii) Create and administer programs of interest to the medical staff members at the local site.
- (d) Regular Meetings
  - (i) Regular meetings of the local medical staff shall be held at the call of the Local President or at the request of 25% of the members of the medical staff eligible to vote at the local site and shall be held within 14 days of receipt of such a request.

- (ii) The President shall post a notice for members of the medical staff at least 3 days prior to a meeting announcing the time and place of the meeting.
- (iii) Regular meetings shall inform the medical staff of actions recommended by the HAMAC and the Local Medical Advisory Committee. Department and committee reports may be presented at these meetings.
- (e) Attendance
 

Active and provisional medical staff members should attend at least 50% of the local medical staff meetings in a calendar year.
- (f) Quorum
 

A quorum shall be determined by local policy.
- (g) Membership Dues
 

Membership dues at each local site shall be recommended by the elected officers of the medical staff and determined by a vote at the Annual General Meeting. Members of the medical staff shall pay annual membership dues as applicable for their local site. Payment of membership dues is a requirement to retain membership on the medical staff. Payment shall be made within 2 months following the Annual General Meeting. Late fees may be applied at the discretion of the Medical Staff Association Executive Committee.

## **SECTION 14 – ORGANIZATION OF MEDICAL STAFF**

### 14.1 Purpose

- (a) In accordance with Article 7 of the Bylaws, the Board of Directors, upon the advice of the HAMAC, shall organize the medical staff into departments, divisions and sections as warranted by the professional resources of the medical staff and resource availability.
- (b) All members of the medical staff will belong to at least one Department and one local Site. Members may belong to more than one Department and have privileges at more than one local site depending upon local need, resources and interest. Privileges will be site specific.
- (c) In instances where individuals are recruited to serve in a leadership position, the Board pursuant to article 6.1 of the Bylaws, will be requested to make an exemption from requirement of initial appointment to provisional staff. This exemption of article 6.1.5 of the Bylaws allows the leader to hold office and vote at medical staff and departmental meetings.
- (d) The purpose of organizing the medical staff into clinical departments, divisions and sections includes the following:
  - (i) Undertake quality improvement, quality assurance and peer review;

- (ii) Promote professional development and continuous medical education;
  - (iii) Participate in strategic resource planning; and
  - (iv) Support the medical staff through specific activities and plans to promote the wellbeing of Members.
- (e) Physician wellbeing will be a focus of all medical leaders working together to:
- (i) Promote health and wellness among Members;
  - (ii) Encourage a healthy, respectful workplace; and
  - (iii) Develop strategies and supports for timely respectful intervention for medical professionals with compromised health and wellbeing including, but not limited to mental illness, substance dependency or severe professional fatigue.

## 14.2 Meetings

- (a) Each Department, Division and Section shall meet at least 4 times per year to conduct its administrative affairs.
- (b) Although meetings may be in person or by video- or teleconferencing, Departments are encouraged to hold at least 1 in-person meeting per year.
- (c) Minutes shall be kept of each meeting and shall include a record of attendance. Minutes shall be available to the Senior Medical Administrator and to the HAMAC on request.
- (d) Voting on all motions shall be by a show of hands or by secret ballot if ordered by the meeting chair. Motions will be decided by a simple majority of those present. In case of a tie, the meeting chair shall have the deciding vote.
- (e) A quorum shall be defined in the terms of reference of the Department, Division or Section. The default is 50% of voting members.

## 14.3 Departments

- (a) Effective September 1, 2016 Medical staff Departments in VIHA shall be:
  - (i) Anesthesiology, Pain and Perioperative Medicine
  - (ii) Emergency & Critical Care Medicine
  - (iii) Laboratory & Imaging Medicine
  - (iv) Maternity Care & Pediatrics
  - (v) Medicine
  - (vi) Primary Care
  - (vii) Psychiatry
  - (viii) Surgery
- (b) All departments will not necessarily be constituted at every site reflecting both local need and resource availability. At sites of sufficient size and with adequate resources, individual Departments may be further organized into Divisions of clearly defined specialty interests.

- (c) All leaders that have VIHA-wide responsibilities will be recognized as “Heads” or “Directors”.

#### 14.4 Department Head Appointment and Selection

- (a) Each Department Head shall be a member of the Active staff of that department and shall be appointed by the Board of Directors. Department Heads shall be selected on the basis of qualifications of training, experience and demonstrated ability in clinical skills, teaching and administrative activities.
- (b) The term of appointment for a Department Head shall not be less than 1 year and shall not exceed 5 years. The Board may reappoint a Department Head for 1 consecutive additional term on the recommendation of the HAMAC.
- (c) The Senior Medical Administrator and/or the Executive Medical Director shall be responsible for conducting an annual performance review of each Department Head. In the third year of appointment, a review committee shall be convened in accordance with Section 15.7 of these Rules. The report from this committee shall include a recommendation regarding the re-appointment or non re-appointment of the Department Head for a further 3-year term.
- (d) When a vacancy exists in a position of Department Head and that vacancy is to be filled by a regular appointment by the Board, a Search Committee shall be convened in accordance with section 15.7 of these Rules. The HAMAC shall recommend to the Board the appointment of a new Department Head following consideration of the Search Committee’s recommendations.
- (e) The Board may, on the recommendation of the HAMAC, or in its sole discretion, suspend or terminate the appointment of any Department Head. Prior to such suspension or termination, reasonable notice shall be given to such Department Head and to the HAMAC.
- (f) In the absence of a Department Head, the Executive Medical Director will assume the responsibilities of the Department Head. The Executive Medical Director may designate a member of the Department as Acting Department Head awaiting the results of the Search and Selection Committee.
- (g) In the event of failure of the Department Head selection process to identify and recommend a candidate for Department Head suitable to the Board for Appointment, the Board shall delegate the responsibilities of the Department Head to the Senior Medical Administrator, or another Member recommended by the Senior Medical Administrator, on an interim basis.

#### 14.5 Responsibilities of Department Heads

- (a) Administration
  - (i) Work in collaboration with the administrative lead to develop annual operating objectives for the Department;
  - (ii) Arrange and chair Departmental meetings as required in these Rules;

- (iii) Participate in regional committees as agreed to in discussion with the Executive Medical Director;
  - (iv) Direct the organization of the medical staff assigned to their department to assure the quality of medical care. This includes agreement on recommendations made to the Medical Planning and Credentials Committee on leaves of absence, transition to retirement and cooperatively arranging vacation and educational leaves;
  - (v) Identify one of the Site Chiefs or Division Heads as the Vice Department Head to serve in his/her absence;
  - (vi) Convey the advice, relevant information, opinions and duly passed motions in two directions – both from Department members to the Health Authority and HAMAC and vice versa from the Health Authority and HAMAC to members of the department.
- (b) Credentialing
- (i) Review and make recommendations to the Medical Planning and Credentials Committee concerning the annual review and assignment of procedural privileges to all members of the department. This includes recommending the appointment of clinical fellows, temporary staff privileges and locum tenens privileges;
  - (ii) Review with the department and the relevant Executive Medical Director, personnel requirements of the department and recommend to the Medical Planning and Credentials Committee a plan for the department;
  - (iii) Advise the HAMAC regarding the appointment of Site Chiefs, Division and Section Heads. Development and maintenance of specific job descriptions will be developed in collaboration with the Executive Medical Director;
  - (iv) Develop, review and recommend Regulations and Policies concerning the delineation of clinical privileges for department members to the Health Authority and Local Medical Advisory Committees.
- (c) Quality
- (i) Develop with the members of the department, standards of clinical practice for the department and ensure that the department members work within established standards;
  - (ii) Establish a quality assurance/quality improvement structure and program within the department, which carries out the functions of review, evaluation and analysis of the quality of medical care and utilization of facility resources. This includes monitoring and evaluation of the utilization of VIHA resources by Members of the Department in order to ensure effective and efficient use of these resources;

- (iii) Advise the Health Authority and Local Medical Advisory Committees with respect to the quality of medical care provided to patients and the level of compliance with professional standards of medical care by all members of the department. This includes coordinating performance reviews as outlined in Section 8.9 of these Rules.
- (d) Education and Development
  - (i) Ensure that programs for the Continuing Medical Education of department members are established;
  - (ii) Ensure that all new department members are appropriately oriented to facilities, programs and services prior to commencement of duties;
  - (iii) Ensure that all members of the department are aware of the professional standards for medical care as set out in the Medical Staff Bylaws, Rules and Policies;
  - (iv) If applicable, working with the University of British Columbia and Island Medical Program to ensure that education programs and research activities are being sufficiently promoted and supported.

#### 14.6 Divisions

- (a) Divisions are clinically defined sub-specialty professional groups of practitioners within given Departments.
- (b) All Divisions will not necessarily be constituted at every site and will reflect both local need and resource availability.

#### 14.7 Division Head Appointment and Selection

- (a) Division Heads shall be appointed by the Department Head after consultation with Division members.
- (b) Each Division Head shall be a member of the Active or Provisional Staff and selected on the basis of qualifications of training, experience and demonstrated ability in clinical, teaching and administrative abilities.
- (c) The term of appointment for a Division Head shall not be less than 1 year and shall not exceed 5 years. The Department Head may reappoint a Division Head for 1 consecutive additional term on the recommendation of the Division members. This may be extended in exceptional circumstances as determined by the Executive Medical Director.

#### 14.8 Responsibilities of Division Heads

- (a) The Division Head shall report to the Department Head on all clinical, educational, research and administrative matters within the Division;

- (b) The responsibilities of the Division Head shall be focused on the specific clinical activities of the Division;
- (c) The Division Head shall chair Divisional meetings.

#### 14.9 Medical Director

Medical Directors have multi-site responsibilities. The Medical Director shall be appointed by the Senior Medical Administrator in consultation with the Executive Medical Director and administrative lead for the portfolio.

#### 14.10 Geographic Sections

This section suspended effective September 30, 2016

### **SECTION 15 – MEDICAL STAFF COMMITTEES**

#### **15.1 The Health Authority Medical Advisory Committee**

- (a) Purpose and Responsibility
  - (i) The terms of reference of the Health Authority Medical Advisory Committee (HAMAC) and the ability to create other committees reporting to the HAMAC are outlined in Articles 8 and 9 of the Medical Staff Bylaws.
  - (ii) The HAMAC makes recommendations to the Board of Directors with respect to cancellation, suspension, restriction, non-renewal, or maintenance of the privileges of all members of the medical staff to practice within the facilities and programs operated by the Vancouver Island Health Authority.
  - (iii) The HAMAC provides advice to the Board of Directors and to the CEO on:
    - A. Provision of medical care within the facilities and programs operated by the Vancouver Island Health Authority;
    - B. Monitoring of the quality and effectiveness of medical care provided within the facilities and programs operated by the Vancouver Island Health Authority;
    - C. Adequacy of medical staff resources;
    - D. Continuing education of the members of the medical staff; and
    - E. Planning goals for meeting the medical care needs of the population served by the Vancouver Island Health Authority.
  - (iv) Duties, as outlined in Section 8.3 of the Medical Staff Bylaws, are to be performed directly or through subcommittees enacted by the HAMAC.

- (b) Composition – Voting Members
  - (i) All medical staff Department Heads as per Article 8.2.1.1 of the Medical Staff Bylaws;
  - (ii) One LMAC Chair/Chief of Staff representative from each geography as per Article 8.2.1.1 of the Medical Staff Bylaws;
  - (iii) One Medical Staff Associations representative from each geography as per Article 8.2.1.2 of the Medical Staff Bylaws;
  - (iv) The Chief Medical Health Officer as per Article 8.2.1.3 of the Medical Staff Bylaws;
  - (v) Senior Medical Administrator as per Article 8.2.1.4 of the Medical Staff Bylaws;
  - (vi) The Chief Medical Information Officer; and
  - (vii) The HAMAC Chair who is appointed by the Board of Directors after considering the recommendation of the HAMAC, as per Article 8.2.2 of the Medical Staff Bylaws
- (c) Composition – Non-voting Members
  - (i) The CEO as per Article 8.2.1.5 of the Medical Staff Bylaws;
  - (ii) All Executive Medical Directors of Island Health;
  - (iii) The General Legal Counsel and Chief Risk Officer;
  - (iv) The Executive Vice President, Quality, Safety and Experience; and
  - (v) Other members of the senior administrative or medical staff of Island Health as appropriate and as agreed by the HAMAC Chair and Senior Medical Administrator.
- (d) Meetings
  - (i) Under normal circumstances, the agenda and related material will be distributed to the members not less than 1 week before the meeting.
  - (ii) All voting members are free to suggest additions to the agenda. Whenever possible, adequate notice should be given to the Chair or the Senior Medical Administrator so there will be an opportunity to develop background information needed to support the discussion.
  - (iii) Meetings of the HAMAC shall be held a minimum of 6 times per year at the call of the Chair. One of these meetings will be designated as the organizational meeting as per (e) below.

- (iv) The HAMAC may meet at the call of the Chair to deal with special or urgent issues. In such event, a formal agenda need not be issued. All members will be advised of the purpose of the meeting.
  - (v) Attendance at meetings of the HAMAC will be limited to the members as set out above. Alternates and other persons will attend only at the invitation of the Chair.
  - (vi) All standing subcommittees will meet a minimum of 5 times per year at the call of their chair and as outlined in the committee's terms of reference unless there are special circumstances as agreed by the HAMAC Chair.
- (e) Organizational Meeting
- (i) Annually, one of the meetings of the HAMAC shall be a face-to-face meeting open to attendance from all committee and subcommittee members.
  - (ii) The agenda for the meeting will include reports from all HAMAC standing committee chairs that will include, but not be limited to, work over the previous year, goals and challenges for the coming year.
  - (iii) Representation on the HAMAC and its subcommittees for appointed medical leaders for the following year will be determined by a vote of all medical leaders at the meeting for the 4 major committees - the HAMAC, Medical Planning and Credentials subcommittee, Medical Quality subcommittee and Pharmacy and Therapeutics subcommittee. Determining factors for committee assignment will include personal interest, maintenance of continuity and regional/portfolio representation on all committees. Each of the following groups would be expected to have approximately one-quarter of their leaders on each of the 4 committees:
    - A. Executive Medical Directors
    - B. Department Heads/Medical Directors
    - C. Nanaimo and South Island MAC Chairs and Vice-Chairs
    - D. Chiefs of Staff for Community Sites
    - E. Chiefs of Staff for Rural Sites
- (f) Role and Responsibilities of the HAMAC Chair
- (i) Acts as the principle spokesperson for the HAMAC in liaisons with the CEO and Board;
  - (ii) Presides at all meetings of the HAMAC and its Executive Subcommittee, unless absent, at which time the Vice-Chair presides;
  - (iii) Manages the affairs of the HAMAC between meetings, ensuring the Committee responsibilities are discharged in a timely manner;

- (iv) Coordinates and ensures timely reporting to HAMAC of the other standing committees of the Medical Staff (Quality, Medical Planning & Credentials and Pharmacy & Therapeutics) in order to provide direct communication to the Board on matters concerning each committee.
  - (v) Serves as an ex-officio non-voting member of all HAMAC subcommittees of which he/she is not a member;
  - (vi) In consultation with the Senior Medical Administrator appoints a Vice-Chair from voting members of the HAMAC;
  - (vii) Communicates to the HAMAC and its supporting Committee structure any and all concerns and issues identified by the Authority; and
  - (viii) Attends meetings of the Board of Directors.
- (g) Executive Committee
- (i) An executive committee shall be formed to deal with urgent issues and issues arising between meetings. The executive committee shall be comprised of:
    - A. Chair of HAMAC
    - B. Vice-Chair of HAMAC who is appointed by the Board of Directors after considering the recommendation of the HAMAC, as per Article 8.2.2 of the Medical Staff Bylaws
    - C. Senior Medical Administrator
    - D. One Medical Staff Association of the four geographies
    - E. Two medical staff Department Heads
  - (ii) The Executive Committee will be appointed by the Chair of HAMAC with consultation and input from the HAMAC and serve a 1-year term. Any disputes with the proposed membership will be dealt with by a vote of the HAMAC.
  - (iii) The Executive Committee will prepare agendas for each meeting with input from the Senior Medical Administrator and the Chief Executive Officer.
- (h) Standing Subcommittees of the HAMAC shall be:
- (i) Medical Quality Committee (MQC);
  - (ii) Medical Planning and Credentials Committee (MPC);
  - (iii) Legislative Committee (Legislative Committee);
  - (iv) Local Medical Advisory Committees; and
  - (v) Continuing Professional Development Committee.

(i) Quorum

A simple majority of voting members shall constitute a quorum for the HAMAC and all its subcommittees.

(j) Voting

Motions will be decided by a simple majority of those present. In case of a tie, the meeting chair shall have the deciding vote.

(k) Rules of Order

All meetings of the HAMAC and its subcommittees shall be conducted utilizing the most current version of Roberts Rules of Order.

## 15.2 Health Authority Medical Quality Committee

Quality assurance, quality improvement, implementation and review of clinical practice guidelines and peer performance reviews are processes which ensure that appropriate standards of care and patterns of medical practice are created and sustained throughout VIHA. It is recognized that the provision of safe care and high quality care to patients is a multidisciplinary task requiring an integrated set of solutions in which the medical staff must be highly engaged.

Each Medical Department, Division and Section is expected to assist in the development and operation of adequate systems of quality assurance, quality improvement and peer review and to participate in the resulting processes. Where necessary, discussion and reports leading to quality findings and recommendations are protected under **Section 51** of the *Evidence Act*.

(a) Purpose and Duties

(i) Quality Assurance & Improvement

- A. Receive, review, and evaluate all reports, findings and recommendations provided by LMACs or VIHA-wide medical quality committees (e.g. Laboratory Medicine Quality Committee) and make recommendations to HAMAC and the VIHA Combined Quality Council (CQC) for solutions.
- B. Four members of this committee will be selected from within the committee membership to sit on the VIHA Combined Quality Council (CQC) Executive. All members will sit on the VIHA CQC Advisory Group.
- C. While the VIHA CQC will provide overall direction of quality programs, this committee will provide expert opinions and recommendations regarding medical practice as it relates to the provision of safe and appropriate medical care. This includes participation in the development of medical standards within VIHA, practice guidelines, and policy implementation strategies.

- D. Will maintain an environmental scan of issues relating to quality emanating from medical journals and medical governance bodies, such as the CMPA and physician Colleges.

(ii) Clinical Practice Guidelines

- A. Will assist in the development and fostering of a mechanism to provide timely access to published clinical practice guidelines, protocols and Standards of Care for medical practice within VIHA.
- B. Will foster, where established medical guidelines and Standards of Care exist in other recognized jurisdictions, processes to provide the medical staff with access to these information sources.
- C. Will authorize, monitor and review medical practice guidelines and regulations developed within VIHA and released through the VIHA CQC, ensuring compliance with policies/legislation of appropriate regulatory bodies.

(iii) Peer Review

- A. Receive, review and evaluate all reports, findings and recommendations provided directly from physician review panels established at the Department level.
- B. Adjudicate in matters of substantive physician practice concerns regarding adherence to established policies, guidelines, protocols and Standards of Care. Matters of physician behaviour, interpersonal relationships and discipline are managed by the Discipline Committee.
- C. Should the committee require a member of the medical staff to provide a formal written response as part of the process of peer review the following procedure shall be followed:
  - a) The Chair of the committee shall detail the concerns in writing to the member(s).
  - (b) The member(s) after the relevant portions of the health record are available, shall respond in writing to the issues presented within a reasonable time period designated by the Chair of the committee.
  - (c) After review of the written response, the member(s) may be required to attend a committee meeting to address issues to the committee's satisfaction.
  - (d) Failure of a member to provide a written response or to appear at a committee meeting when requested shall be reported to the Senior Medical Administrator for consideration of disciplinary action.
- D. If the committee determines a member would benefit from educational or other remedial action, the committee recommendation(s) will be directed to relevant Department Head to ensure compliance and follow-up, arranging for a subsequent report to the committee regarding the results of such subsequent assessment.

- (b) Composition
  - (i) Executive Medical Director, Quality Research and Safety;
  - (ii) Representative Chairs of VIHA LMACs, one from each of North, Central and South Island, or delegate;
  - (iii) Up to three (3) appointed medical leaders as determined yearly at the organizational meeting of the HAMAC as outlined in Section 15.1(e);
  - (iv) Up to three (3) other interested medical staff members, selected annually;
  - (v) HAMAC, MPC, and P&T committee medical members may attend as non-voting members providing one week's advance notice of intention to attend.

- (c) Voting

Although consensus is the expected method for determining processes, official motions where necessary will be decided by a simple majority of those present and eligible to vote. In the case of a tie, the Chair shall cast the deciding vote. When votes are taken, the voting results will be appended to the motion.

- (d) Reporting

- (i) Received reports may contain materials meeting Section 51 of the Evidence Act definitions. These reports will be secured by the Secretariat of the VIHA CQC for retention.
- (ii) Findings and recommendations of the MQC will be sent to the Chair of HAMAC and the Chair of VIHA CQC for insertion into their respective agenda.
- (iii) Directives and policy decisions will be enacted under the auspices of the VIHA CQC through its Secretariat.

- (e) Meetings

Bi-monthly meetings will be held and additionally at the call of the Chair.

### **15.3 Medical Planning and Credentials Committee**

- (a) Purpose

- (i) Ensure that the process for credentialing members of the medical staff is consistent with the requirements identified in the Medical Staff Bylaws;
- (ii) Identify new and emergent opportunities; and

- (iii) Ensure that medical staff planning is congruent with the population health care needs within VIHA and is consistent with the VIHA strategic plan and operational priorities.
  - (iv) Ensure that medical staff planning and recruitment is consistent, where appropriate, with VIHA's academic mandate to support educational and research endeavours of undergraduate and post-graduate students.
- (b) Composition - Voting
- (i) The Chair, selected by HAMAC
  - (ii) An Island Health Executive Medical Director Representative
  - (iii) The Medical Director, Credentialing & Privileging and Medical Staff Recruitment & Retention
  - (iv) All medical staff Department Heads or delegate
- (c) Composition – Non-voting
- (i) An Island Health Executive Director Representative
  - (ii) The Medical Affairs, Corporate Director
  - (iii) The Medical Affairs, Manager, Credentialing & Privileging
  - (iv) The Medical Affairs, Manager, Medical Staff Recruitment & Retention
  - (v) Up to four Members at Large
- (d) Voting
- Motions will be decided by a simple majority of those present. In case of a tie, the meeting chair shall have the deciding vote.
- (e) Duties
- (i) Ensure fair processes and policies are in place for recruitment of new members of medical staff at all sites and ensure these policies are followed in recruitment efforts;
  - (ii) Review and make recommendations regarding personnel resource plans for all Departments and Divisions of the medical staff and ensure that such plans are updated on an annual basis. This plan will be recognized as the Physician Resource Plan;
  - (iii) Review submissions from each LMAC in regards to credentialing at their site in order to formally recommend to the HAMAC individual clinical privileges for each applicant. These privileges are to be commensurate with the education, experience, competence, judgment and character of the applicant;

- (iv) Recommend the assignment of an applicant to a primary Department and to a Division(s) and Section(s) and/or other clinical Departments (if applicable);
- (v) In conjunction with the relevant Department Head(s) recommend the Basic, Advanced and Specific Procedural Privileges for which the applicant has demonstrated competency and which the applicant may exercise in VIHA facilities with the endorsement of one or more LMACs;
- (vi) Review and make recommendations regarding criteria for the introduction of new individual clinical privileges or the extension of existing privileges, ensuring that patient care programs are involved in the process when appropriate and the new programs are congruent with existing policies and procedures;
- (vii) Ensure that the annual review of privileges for all medical staff is completed and forwarded to the HAMAC in a timely manner;
- (viii) Ensure that in-depth reviews are completed by Department Heads and their recommendations made available to the member reviewed and to the HAMAC;
- (ix) Review and make recommendations regarding all applications for leaves of absence; and
- (x) Ensure that appropriate representation is present for discussions relating to medical staff resources planning and credentialing issues as they relate to departments, divisions, sections, programs and facilities.

#### **15.4 Pharmacy and Therapeutics Committee**

Pharmacy and Therapeutics Committee dissolved effective June 28, 2016

#### **15.5 Local Medical Advisory Committee**

- (a) Purpose
  - (i) Monitor the quality of medical care within a geographic area or designated facility or facilities;
  - (ii) Make recommendations to the HAMAC on the availability of resources;
  - (iii) Make recommendations to the HAMAC, institute and monitor development of programs and services at local sites and facilities;
  - (iv) Enforce the Medical Staff Bylaws, Rules and policies; and
  - (v) Liaise with other local medical advisory committees and community health care providers to assist the HAMAC in meeting goals outlined by VIHA.

(b) Composition

Members are appointed by the HAMAC for a 3-year term in consultation with the Local Medical Advisory Committee and should include:

- (i) Representative members of the local medical staff;
- (ii) Site Chiefs;
- (iii) Elected representation of the local medical staff; and
- (iv) Administrative and professional staff as appropriate.

(c) Chair

(i) The Chair for community sites will be appointed for a defined term by the HAMAC from a list of nominees submitted by their Local Medical Advisory Committee. This individual will be recognized as the Chief of Staff at their respective site. Sites include:

- Cowichan & District General Hospital
- Campbell River General Hospital
- St. Joseph's General Hospital
- Saanich Peninsula Hospital
- West Coast General Hospital

(ii) The Chair for rural sites will be appointed for a defined term by the HAMAC from a list of nominees submitted by the Local Medical Advisory Committee. This individual will be recognized as the Chief of Staff at their respective site. Sites include:

- Lady Minto Hospital
- Tofino General Hospital
- Mount Waddington area
- Sooke
- Mount Arrowsmith
- Chemainus Health Care Centre
- Ladysmith Community Health Centre

(iii) The Chair for Nanaimo Regional Hospital and the South Island will be appointed by the HAMAC for a defined term from a list of nominees submitted by their Local Medical Advisory committee. These individuals will be recognized as Chief of Staff for their facility.

(iv) The Chairs shall be delegated in consultation with the CEO or Senior Medical Administrator to approve temporary privileges at their sites as an extension of Bylaw 4.1.4 until the Board considers the matter.

(d) Voting

Motions will be decided by a simple majority of those present. In case of a tie, the meeting chair shall have the deciding vote.

- (e) Duties
- (i) Ensure the quality assurance and quality improvement programs are in place in cooperation with regional efforts;
  - (ii) Facilitate the dissemination of information to medical staff at the local site;
  - (iii) Assess the medical staff resources for the geographic area or designated facility or facilities and to make recommendations to the HAMAC Medical Planning and Credentials Committee (MPC);
  - (iv) Collaborate with the HAMAC and its subcommittees to deal with site issues pertaining to:
    - Pharmacy and Therapeutics
    - Health Records
    - Infection Control
    - Quality of Medical Care
    - Utilization Management
    - Patient Care Programs
    - Physician Resource Planning
    - Emergent Services
  - (v) Work in collaboration with the HAMAC MPC to review applications for Membership on the medical staff for the right to exercise some or all of the clinical privileges recommended by HAMAC MPC to the Board for approval in the site as well as applications by current Members of the medical staff to exercise some or all of their currently approved clinical privileges in that site.

## **15.6 Continuing Professional Development Committee**

- (a) Purpose
- (i) Advise the Medical Director of Continuing Professional Development on the organization, provision and evaluation of Continuing Professional Development programming for VIHA medical staff.
  - (ii) Committee members will be expected to provide some or all of the following: expertise in medical education, ability to identify communities' learning needs, ability to represent a constituency, historical perspective and an ability to facilitate funding, organization and marketing.
  - (iii) Advise the HAMAC on the appointment and review of the Medical Director of Continuing Professional Development.
- (b) Composition
- (i) Medical Director of Continuing Professional Development (Chair);
  - (ii) VIHA South Island Family Medicine Coordinator;

- (iii) One representative of the Quality and Patient Safety program;
  - (iv) At least 4 Physicians (one each from South, Central and North Island and at least one consulting specialist);
  - (v) Head of VIHA Library Services;
  - (vi) The Director of Education, Professional Practice (or delegate); and
  - (vii) Others as determined by the committee.
- (c) Chair
- The Chair shall be appointed by the HAMAC for a term of 3 years and may be re-appointed.
- (d) Meetings
- Meetings shall be held quarterly and at the call of the Chair.
- (e) Voting
- Motions will be decided by a simple majority of those present. In case of a tie, the meeting chair shall have the deciding vote.
- (f) Duties
- (i) Assist the Medical Director of Continuing Professional Development in communication with medical programs and individual members of the medical staff;
  - (ii) Support the Medical Director of Continuing Professional Development in the organization, provision and evaluation of Continuing Professional Development programming for VIHA medical staff;
  - (iii) Identify through medical staff quality assurance activities the educational opportunities for quality improvement; and
  - (iv) Liaise with individuals, groups and institutions outside the VIHA to identify educational needs and opportunities.

### **15.7 Search Committee for Medical Department Heads**

- (a) Purpose

Coordinate the search and review process for each Medical Department Head.

- (b) Composition

The committee membership shall be specific for each search or review process. Individual membership for each Search Committee will be established by medical

administration in consultation with the clinical department and be approved by the HAMAC. Membership shall consist of:

- (i) Chair of HAMAC or delegate;
  - (ii) One elected officer of the Medical Staff Association who is a HAMAC member;
  - (iii) Three members of the Medical Department for which a Head is being sought selected by the Department;
  - (iv) Senior Medical Administrator or delegate;
  - (v) Executive Medical Director to whom the Department Head reports; and
  - (vi) Senior non-medical administrator relevant to the department for which a Head is being sought or reviewed.
  - (vii) Other professional staff as appropriate to the position.
- (c) Chair
- The Senior Medical Administrator or his/her delegate shall chair each Search or Review Committee.
- (d) Meetings
- The committee shall meet as required and at the call of the Chair.
- (e) Voting
- Motions will be decided by a simple majority of those present. In case of a tie, the meeting chair shall have the deciding vote.
- (f) Duties of each Search Committee:
- (i) Develop a position description for the Department Head with a list of the qualifications to be met;
  - (ii) Arrange to advertise the position in accordance with established VIHA protocols;
  - (iii) Review documents received from all candidates;
  - (iv) Develop a short list of candidates to be interviewed;
  - (v) Organize and conduct a process for each candidate on the shortlist to be interviewed by the committee and other members of the Medical, Hospital and Administrative staff; and
  - (vi) Report its recommendations to the HAMAC.

## **15.8 Legislative Committee**

### **(a) Purpose**

Review and recommend revisions to Medical Staff Bylaws, Rules and Policies.

### **(b) Composition**

The committee membership shall be established by the HAMAC as required for each review process. Membership shall include:

- (i) At least 3 physician members of the HAMAC;
- (ii) At least 1 elected officer of the medical staff;
- (iii) Senior Medical Administrator or delegate;
- (iv) Other members of the Medical and/or hospital staff as deemed appropriate.

### **(c) Chair**

The Chair shall be appointed by the HAMAC for each review process.

### **(d) Meetings**

The committee shall meet as required and at the call of the Chair.

### **(e) Voting**

Motions will be decided by a simple majority of those present. In case of a tie, the meeting chair shall have the deciding vote.

### **(f) Duties**

- (i) Review Medical Staff Bylaws, Rules, and Policies as requested by the HAMAC;
- (ii) Review the effects of legislation on the quality of medical care and/or the performance of medical staff as requested by the HAMAC;
- (iii) Seek the advice of experts as deemed necessary by the committee; and
- (iv) Report its findings and recommendations to the HAMAC.

## **15.9 Discipline Committee**

### **(a) Purpose**

Act as the investigative arm of HAMAC when issues of potential disciplinary action are forwarded to HAMAC as part of the process envisioned in Article 11.2.2 of the Bylaws. This includes but is not limited to issues relating to disruptive behavior and credentialing. The exception is this committee does not address summary restriction/suspension as outlined in Article 11.2.1 of the

Bylaws where in keeping with Article 11.2.1.5 the entire HAMAC will review these matters.

(b) General Considerations

In consideration of the need for the Board of Directors to be able to take remedial action certain principles will be applied by the medical staff and administration in developing advice on such matters for transmission to the Board. The remedial actions that may be considered include:

- (i) Reprimand;
- (ii) Restriction, modification, suspension or revocation of privileges; or
- (iii) Non-renewal of privileges.

(c) The principles include:

- (i) Lawfulness – A disciplinary procedure must meet the criteria of procedural fairness as determined by the jurisprudence of the Court, and the provisions of relevant legislation and bylaws.
- (ii) Efficiency – A procedure should allow the resolution of an issue in a timely fashion, without undue expense and administrative dislocation. The procedure should operate in a smooth and predictable way, while at the same time respecting the duty of fairness to the practitioner who is subject to the procedure.
- (iii) Clarity – The process should be understandable and made known to all of the parties from the time when practitioners are initially given privileges.
- (iv) Legitimacy – All participants should perceive the process as legitimate. In particular, the process should be seen as legitimate by the medical staff.
- (v) Timeliness – Proceedings should be concluded in a timely fashion in order to ensure protection of patients, and to ensure the member of the medical staff is not unfairly prejudiced by any long-term uncertainty that could have adverse affects on the reputation and income of the member of the medical staff. Matters should be concluded in the shortest possible time compatible with the full and careful consideration of the issue. The time constraints dictated by legislation shall be respected.

(d) Composition

Members are appointed as required by the HAMAC executive committee from the entire physician membership of the HAMAC and its subcommittees. Membership will include:

- (i) One member of the HAMAC executive committee shall serve as chair;
- (ii) Two other members of the HAMAC or its subcommittees who would be expected to be independent and neutral of the issue being considered; and

- (iii) Additional member(s) may be appointed as alternates should there be a matter that would be predicted to take a fairly long process to ensure that the committee that makes a recommendation has at least 3 voting members present.

(e) Meetings

- (i) The committee shall meet as required and at the call of the Chair.
- (ii) The Senior Medical Administrator shall provide administrative support.
- (iii) Time spent serving at the committee meetings, including time spent preparing and compiling reports, will be recompensed at sessional rates.
- (iv) As per Article 8.3.2.4 of the Bylaws the committee has the authority to require a medical staff member to appear before the committee whenever necessary to carry out its duties.
- (v) The member of the medical staff being investigated can choose to have legal counsel and/or an elected member of the Medical Staff Association present at any stage of the proceeding.
- (vi) Meetings will be conducted in-camera. All committee members, including any alternate who serves in a voting capacity, must be present for all meetings.

(f) Voting

Motions will be decided by a simple majority of those present. In case of a tie, the meeting chair shall have the deciding vote.

(g) Duties

- (i) Investigate issues of potential discipline in a timely manner. The timeframe for reporting back will be determined at the time of constitution of the committee and will reflect on the urgency of the matter;
- (ii) A report summarizing the allegations, findings and recommendations will be presented to the Chair of HAMAC. The Chair of HAMAC will determine if the matter needs to be dealt with at a special meeting of the HAMAC or at the next regularly scheduled meeting;
- (iii) At the HAMAC meeting at which the matter will be discussed, the Chair of the Discipline Committee will present the findings of the Committee and its recommendation. The member under investigation will have the opportunity to respond to the findings and recommendation. The member will not introduce new evidence at this time.
- (iv) Upon completion of presentation of the findings and recommendations, the member under investigation, the members of the Discipline Committee and any others who would self-declare themselves to be in

conflict will be excused from the deliberations. The Chair or Vice-Chair of the HAMAC will be the sole arbiter of issues of conflict of interest.

- (v) For matters of clarification only the Chair of the Discipline Committee may be asked back to the meeting during the deliberations. The member under investigation will be afforded the opportunity to be present and respond during the clarification.
  - (vi) HAMAC will choose to either accept (in whole or with modifications) or reject the recommendation of the discipline committee.
  - (vii) Where HAMAC accepts the recommendation in whole or with modifications, the decision of the HAMAC will be communicated in writing to the member of the medical staff being investigated. The medical staff member will have 7 days to notify the HAMAC chair of an appeal of the decision. If there is no notification of an appeal within this 7 days, the determination of HAMAC will be considered binding and this decision communicated to the Board of Directors as a recommendation;
  - (viii) Should the HAMAC reject the recommendation of the Discipline Committee the matter will be taken directly to appeal.
- (h) Appeal
- (i) An appeal will occur whenever either
    - A. The HAMAC rejects the recommendation of the discipline committee;
    - B. The medical staff member appeals the decision of the HAMAC.
  - (ii) Upon determination of an appeal, a special meeting of the HAMAC will be organized within 14 days of the initiation of the appeal process.
  - (iii) At least 7 days notification of the date of the appeal will be given to the medical staff member under investigation. The report of the Discipline Committee and all evidence collected during the process will be given to the medical staff member under investigation and the entire HAMAC membership.
  - (iv) The Chair of the Discipline Committee will have up to 1 hour to make a presentation to the HAMAC.
  - (v) The medical staff member under investigation will have up to 1 hour to make a presentation to the HAMAC.
  - (vi) Both presentations may include other individuals felt to be of relevance for HAMAC to make its determination as long as these presentations reasonably stay within the allotted timeframe.
  - (vii) HAMAC will make a determination as to the recommendation being forwarded to the Board of Directors as per Article 11.2.2 of the Bylaws. This determination will be done with the exclusion of members of the

Discipline Committee and any other HAMAC members who self-declare themselves to be in conflict. The Chair or Vice-chair of the HAMAC will be the sole arbiter of issues of conflict of interest.

## **SECTION 16– RESIDENTIAL CARE**

16.1 This section applies to VIHA residential facilities operating under the *Hospital Act*.

16.2 Medical care of residents in VIHA Long Term Care facilities differs in many aspects from medical care provided to patients in an acute care setting. Those differences are recognized in this section.

16.3 Admission, Transfer and Discharge of Residents

- (a) Every resident shall be attended by a member of the medical staff who has admitting privileges to residential care and who has primary responsibility for the care of the resident.
- (b) Prior to admission of a resident, the resident's physician shall submit a legible, complete and updated medical record as required by the Health Authority.
- (c) The resident's physician shall note special precautions regarding the care of the patient on the order sheet in the patient's record at the time of admission (e.g. infectious disease, emotional disturbance, etc.).
- (d) Prior to admission, the resident's physician shall assess the resident with regard to the risk of tuberculosis or other communicable disease which may pose a risk to staff or other patients and act in accordance with Provincial guidelines.

16.4 Resident Care

- (a) The MRP shall visit the newly admitted resident within 7 days and thereafter at least every 90 days, or more frequently if clinically indicated.
- (b) If, in the opinion of the nurse in charge, the condition of the resident changes significantly, the MRP or delegate shall be informed and shall act according to the urgency of the situation.
- (c) Progress notes shall be recorded in the health record by the practitioner at each visit. Written progress notes shall be made in the health record at least every 90 days. If the resident is seen in the practitioner's private office, then the practitioner shall forward to the facility all relevant investigation results and any new treatment orders arising from the visit.
- (d) All orders for medical treatment shall be legibly written and signed by a practitioner with medical staff privileges. An order for medical care may be dictated over the telephone to a nurse. An order dictated over the telephone shall be written over the name of the ordering practitioner and be signed by the person to whom they are dictated. Such orders shall be signed by the ordering practitioner as soon as possible. Orders may be faxed if signed by a medical practitioner.

- (e) Orders pertaining to other professional disciplines, e.g. occupational therapist, physical therapist, dietician, pharmacist, etc., may be given by the medical practitioner to a member of that discipline who shall write the orders on the Physicians Order Sheet. Such orders shall be signed by the ordering practitioner as soon as possible.
- (f) The MRP shall carry out a Drug Review every 90 days or more frequently if necessary, in collaboration with the medical coordinator, pharmacist and nurse, as appropriate. Medications shall be re-authorized as required by the Pharmacy and Therapeutics Committee by updating and signing the drug profile or rewriting drug orders on the order sheet.
- (g) All orders for controlled drugs and antibiotics shall be written with a stated limit as to the number of doses, or the hours or days of administration. Telephone orders for controlled drugs shall be countersigned by the ordering practitioner within 7 days. For drug orders written without such dosage or time limit, an automatic stop order shall be in effect.
- (h) The MRP shall be invited to attend interdisciplinary conferences to discuss and plan resident care. In the absence of the MRP, the Medical Coordinator shall make recommendations regarding care to the multidisciplinary team and submit the recommendations to the MRP for approval.
- (i) Advance care planning should be discussed with each resident or responsible family member, either prior to or shortly after admission. Choices for care, when stated, should be documented in an Advance Directive and can also include an order regarding cardiopulmonary resuscitation. Documentation of advance care planning discussions should be written in the resident's chart.
- (j) The MRP or delegate shall visit to pronounce death within a reasonable time after notification. In the event of an expected death, the MRP may transfer the responsibility for "pronouncement of death" to a registered nurse in charge of the resident's care, provided the MRP has visited the resident within the previous 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 in all circumstances. Physicians pronouncing death shall record the time, date and cause of death (if known) on progress notes.
- (k) The MRP or delegate shall notify the Coroner of deaths that require notification under the *Coroner's Act*.
- (l) The MRP or delegate shall obtain a consultation when appropriate in all cases in which the diagnosis is obscure or when there is doubt regarding investigation or therapy. Where a consultation is required urgently and the MRP or delegate is not available, the Medical Coordinator, the Medical Director or a Senior Administrator may authorize a consultation.

- (m) Practitioners requested to see patients in consultation shall be members of the VIHA medical staff or VIHA Allied Health Staff and shall provide a written report for the resident's chart.
- (n) The MRP shall visit the resident within a week of the resident returning from acute care and provide an update in the resident's chart, recording relevant events that occurred during admission to acute care, changes in the resident's physical findings and health status and to the plan or care for the resident.
- (o) 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.

#### 16.5 Health Records

- (a) A complete medical history and physical examination shall be provided by the MRP for each resident prior to admission. No resident shall be admitted without this information.
- (b) The admission history shall include where available:
  - (i) List of current diagnoses/problems;
  - (ii) Past medical problems, illnesses, surgery;
  - (iii) Allergies and drug sensitivities;
  - (iv) Record of a recent physical examination (performed within the previous 3 months);
  - (v) Mental status assessment;
  - (vi) Results of appropriate laboratory tests;
  - (vii) Management plan including drug orders;
  - (viii) Summary or copies of consultant reports; and
  - (ix) Drug profiles.
- (c) Progress notes shall be documented at each visit and at least every 90 days thereafter. For Long Term Care patients, orders for drugs shall be reviewed and renewed as required by the Pharmacy and Therapeutics Committee by the ordering practitioner and/or the MRP.
- (d) Progress notes shall be sufficient to describe changes in the resident's condition, reasons for change of treatment and outcome of treatment.
- (e) A practitioner shall participate in a multidisciplinary assessment of the resident, which shall be documented annually.
- (f) Within 30 days following the death or discharge of a resident, the MRP shall complete and sign the resident's discharge summary stating the final diagnosis therein.

## SECTION 17 – PROFESSIONAL CONDUCT AND DISRUPTIVE BEHAVIOUR

### 17.1 Authority

- (a) The authority to manage disruptive physician behaviour lies in the *Hospital Act*, under the *Hospital Act Regulations*, Sections 4, 5 and 6 and the delegation of that authority to VIHA through the Medical Staff Bylaws to its Board of Directors and the HAMAC.
- (b) Every practitioner with privileges in the Health Authority will be required to read and acknowledge the Principles of Partnership Governing Professionalism (Appendix A) annually.

### 17.2 Purpose

- (a) Acknowledge the right to work in a safe, cooperative and respectful health care environment, by ensuring that members of the medical staff conduct themselves in accordance with the Principles of Partnership Governing Professionalism (Appendix A).
- (b) Encourage the prompt identification of behaviour that is contrary to the Principles of Partnership Governing Professionalism or which is disruptive or potentially disruptive to the delivery of safe patient care.
- (c) Provide a formal procedure for dealing with disruptive behaviour by members of the medical staff.

### 17.3 Effects of Disruptive Behaviour

Disruptive, intimidating or abusive behaviour may affect the quality of care by:

- (a) Deflecting the physician's attention from the patient, therefore impairing clinical judgment and performance;
- (b) Increasing the likelihood of errors by leading others to avoid the disruptive physician, to hesitate to ask for help or clarification of orders or to make suggestions about patient care;
- (c) Undermining patient's confidence in the physician or hospital;
- (d) Creating a working environment that undermines recruitment and retention efforts for physicians and other staff; and/or
- (e) Affecting the reputation of individual physicians, the caring professions and the stature of the Health Authority.

### 17.4 Documentation of Disruptive Behaviour

- (a) It is the policy of the medical staff that all persons within the facilities and programs operated by VIHA be treated with courtesy, respect and dignity. To this

end, medical staff members are required to conduct themselves in accordance with this policy.

- (b) Where this policy is not observed, the matter will be addressed as outlined below in a consistent, equitable and timely manner. Confidentiality will be maintained to the degree permitted by law.
- (c) All reported disruptive behaviours will be considered carefully and reviewed whether received orally or in writing. The individual receiving the complaint or the complainant will transcribe any oral complaint to a written format. Both parties should agree upon the document.
- (d) When perceived disruptive behaviour is observed or experienced it should be reported as a matter of priority to the Department Head, Chief of Staff, Division/ Site Chief or Medical Director.
- (e) Reports of disruptive behaviour will be examined for their validity as soon as possible so that an appropriate judgment about the timing of intervention can be made. This shall be done in a reasonable time, usually within 2 weeks. It is important to note that although a complaint may be valid it does not mean that it merits further action; it simply means that it was at least worthy of investigation. It is entirely possible that upon investigation a valid complaint may have no merit because the evidence that was gathered in the investigation did not support the complaint.
- (f) Reporters of disruptive behaviour and subjects of complaints will be informed that reprisals will not be tolerated. In the event of a legal process, their names and statements may be disclosed.

## 17.5 Process to Manage Disruptive Behaviour

### (a) General Principles

Interventions will follow a staged approach with the intention of remediation:

- (i) Stage One interventions are warranted for first time behaviours that are perceived as being of low severity.
- (ii) Stage Two interventions are warranted for behaviour that is of moderate severity or where stage one intervention has been ineffective.
- (iii) Stage Three interventions are required for behaviour that has continued despite previous interventions or where there is concern about self-injury or harm to others.
- (iv) Crisis Intervention is required in the event of the sudden appearance of behaviour that is too egregious for a staged response.

### (b) Documentation Requirements

- (i) Having met with the subject of the complaint, for those concerns warranting further action, the Department Head, Chief of Staff or Medical Director will document:
  - A. A description of the behaviour;
  - B. A description of the discussion with the Staff Member;
  - C. An indication that the Member has been informed that the behaviour is perceived as being disruptive;
  - D. Evidence that mitigating factors have been considered;
  - E. Specific documentation of resources offered or mandated to assist changing behaviours;
  - F. Reports from other professionals (therapists, coaches, etc.) who have been engaged as part of any remediation; and
  - G. Documentation that the consequences of continued disruptive behaviour have been openly and clearly outlined to the Member.
- (ii) This documentation will be forwarded to the subject of the complaint and through the Department Head to the Chief Medical Officer for inclusion in the practitioner's file. A copy of the original complaint will also be forwarded to the Senior Medical Administrator for inclusion in the practitioner's file.

#### 17.6 Stage One Intervention

- (a) The Department Head, Chief of Staff or Medical Director will accomplish the following:
  - (i) Describe the incident to the Member and explain explicitly why the observed behaviour is considered disruptive;
  - (ii) Provide the Member with an opportunity to respond;
  - (iii) Assist the Member to understand how others have interpreted the behaviour;
  - (iv) Provide supportive counselling either personally or through a third party;
  - (v) In collaboration with the Member decide the format and substance of a response to the reporter in order to bring the complaint to resolution;
  - (vi) Document the discussion and intended follow up;
  - (vii) Submit feedback to the Member;
  - (viii) Submit a summary of the situation and actions taken to the Senior Medical Administrator.
- (b) This process should be completed within 4 weeks of receiving the complaint.

#### 17.7 Stage Two Intervention

- (a) The Department Head, Chief of Staff or Medical Director will immediately inform the appropriate Executive Medical Director.

- (b) The Executive Medical Director in collaboration with the Department Head, Chief of Staff, and Division/ Site Chiefs where appropriate will:
  - (i) Describe the incident to the Member and explain explicitly why the observed behaviour is considered disruptive;
  - (ii) Provide the practitioner with an opportunity to respond;
  - (iii) Assist the practitioner to understand how others have interpreted the behaviour;
  - (iv) Provide supportive counselling either personally or through a third party;
  - (v) In collaboration with the practitioner, decide the format and substance of a response to the reporter.
- (c) Develop a contract between the Member and VIHA which will include the following elements:
  - (i) Method of redress (counselling, psychological testing, leadership training, substance abuse therapy, written project, tutorial sessions, etc);
  - (ii) Method of monitoring for change/progress;
  - (iii) Description of behaviour benchmarks;
  - (iv) Timeframe within which progress must be demonstrable;
  - (v) Consequences for lack of progress or non compliance;
  - (vi) Document the above in the practitioner's file.
- (d) Notify the Member in writing that another incident may result in review of behaviour by the Discipline Subcommittee of the HAMAC and that continuation of privileges will be discussed at that time.
- (e) Consider referring the physician to an external resource such as the Physician Health Program with regular reports to be received by the Executive Medical Director.

#### 17.8 Stage Three Intervention

- (a) The Department Head, Chief of Staff or Medical Director shall immediately inform the Senior Medical Administrator and Chair of HAMAC who will schedule a review by the Discipline Subcommittee of the HAMAC.
- (b) The Discipline Subcommittee will be expected to:
  - (i) Review the behavioural history of the Member; and
  - (ii) Recommend other rehabilitation strategies or recommend disciplinary action as appropriate.
- (c) Disciplinary action that may be recommended include:
  - (i) Restriction of privileges/practice within VIHA;
  - (ii) Direct supervision of practice;

- (iii) Suspension of privileges on a time limited basis;
- (iv) Revocation of privileges;
- (d) Action on these recommendations will follow the process outlined in Section 15.9 of these Rules.

#### 17.9 Crisis Intervention

- (a) Where behavior is warranted to require a crisis intervention, the Department Head, Chief of Staff or Division/Site Chief shall request the Senior Medical Administrator to consider immediately suspending the Member's privileges as per Article 11.2.1 of the Bylaws.
- (b) Circumstances may include but are not limited to:
  - (i) Abandonment of a patient admitted to a VIHA facility under the care of the member;
  - (ii) The alleged commission by the member of a criminal offence related to the exercising of the Member's privileges, as evidenced by the laying of criminal charges;
  - (iii) The provision of clinical care, the exercising of clinical privileges, or the fulfillment of contractual arrangements for the provision of patient care by the Member while impaired, including but not limited to impairment by drugs or alcohol.
- (c) In such circumstances, the Department Head, Chief of Staff or Division/Site Chief shall:
  - (i) Arrange for an alternative practitioner to provide care for the suspended Member's patients as necessary; and
  - (ii) Arrange security as required.

## **APPENDIX A - PRINCIPLES OF PARTNERSHIP GOVERNING PROFESSIONALISM**

### **Introduction**

VIHA and \_\_\_\_\_ [insert name of medical staff member] recognize their considerable interdependence in the rapidly changing healthcare environment. The provision of high quality, cost-effective healthcare depends in large part upon the ability of all members of the Health Care Team to develop trust, communicate well, collaborate effectively, be mutually supportive, and work effectively as part of a team.

### **Principles**

In order to accomplish these goals, I agree to the following principles and guidelines. I also agree to work collaboratively to promote them in the organization and in the community.

#### **1) Respectful Treatment**

I agree to treat all members of the healthcare provider team and all direct and indirect recipients of healthcare (patients, their families, visitors) in a respectful, dignified manner at all times.

#### **2) Language**

I agree to use respectful language at all times.

#### **3) Behavior**

I agree to behave respectfully toward others at all times, and to refrain from any behavior that is disrespectful, profane, vulgar, intimidating, demeaning, harassing, humiliating, or sexually inappropriate. This includes but is not limited to: obscene gestures, violation of reasonable personal space, yelling, throwing of objects, menacing gestures, unwanted or sexual touching, degrading or sexually-oriented jokes or comments, or requests for personal or sexual favors. It also includes making inappropriate comments regarding other physicians, hospital employees, other providers, or patients.

#### **4) Confidentiality and Privacy**

I agree to maintain complete confidentiality of patient care information at all times, in a manner consistent with generally accepted principles of medical confidentiality. I recognize that practitioners and hospital staff have the right to have personal or performance problems and concerns about competence discussed in a confidential manner in a private setting. I agree to maintain this confidentiality and to seek proper, professional, objective arenas in which to deal with these issues.

#### **5) Responsible Work Practice**

As part of responsible work practice, I agree to be available to respond to calls as deemed appropriate to maintaining good quality of patient care. I agree to notify appropriate personnel if unable to attend work. I also agree to attend meetings as required by my department(s).

#### **6) Respectful Communication and Feedback**

Verbal and written communication, including chart notes and other documents, will be respectful and professional in language and tone. I recognize the need for an organizational chain of command, in order for VIHA facilities to run smoothly and efficiently. I recognize the need for each input from others regarding quality and performance. However, significant concerns about performance need to be made through appropriate channels, i.e. to supervisors, and not directly to

employees. I agree to take these concerns about employee performance or hospital issues through the appropriate chain of command. I agree to engage other parties in constructive and timely dialogue and to work collaboratively to address these issues.

**7) Supporting Rules and Regulations**

I recognize the need for certain rules and regulations for all to follow, in order to assure the smooth, harmonious, and safe functioning of VIHA facilities, both clinically and otherwise. I agree to abide by these regulations, including those that relate to safety, scheduling, confidentiality, documentation, and the like.

**8) No Retribution**

I agree not to engage in any behavior that could reasonably be considered retributive, such as: making implied or direct threats, physically-intimidating behavior, withholding information, refusing to speak to coworkers, or attempting to find out who might have registered a complaint.

The foregoing Principles of Partnership are acknowledged and agreed to this \_\_\_\_ day of \_\_\_\_\_, 20\_\_ by:

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Name: [Insert name of medical staff member]