MEDICAL STAFF RULES
FOR
THE PROVINCIAL HEALTH SERVICES AUTHORITY

BOARD APPROVED JUNE 24, 2021

Revisions (Board approved):
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PREAMBLE

This document comprises the Rules of the Medical Staff of the Provincial Health Services Authority.

Rules assist the Medical Staff to discharge their responsibilities to the Board of Directors by establishing standardized procedures that apply to all members of the Medical Staff.

These Rules are to be interpreted with appropriate reference to the Medical Staff Bylaws. If doubt exists, the appropriate Head of the Department will clarify their interpretation.

In the case of any inconsistency between these Rules and the Medical Staff Bylaws, the provisions of the Medical Staff Bylaws shall prevail.

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

ARTICLE 1 — DEFINITIONS

Affiliation Agreement — an agreement with the University of British Columbia or another educational facility to facilitate teaching and practicum activities within a Facility or Program.

Associate Department/Program — A second Department/Program, other than the primary Department/Program with which a member of the Medical Staff is associated.

Attending Physician or Attending Midwife or Attending Nurse Practitioner —The physician, midwife or nurse practitioner who is the primary caregiver.

Board of Directors — the governing body of the Provincial Health Services Authority.

Bylaws — The Medical Staff Bylaws.

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

Clinical Fellows/Subspecialty Residents — Physicians, dentists or nurse practitioners temporarily attached to a Facility for the educational purpose of gaining additional experience in a medical/dental or scientific discipline and who are supervised by a member of Medical Staff.

Clinical Trainees — A physician with a temporary educational license temporarily engaged by the facilities for the purpose of training in a medical discipline and who are supervised by a member of Medical Staff.

Consultant — A physician or dentist with privileges in a specialty or a physician, dentist, midwife, nurse practitioner or member of the scientific & research staff who has been asked to give an opinion.

Dean, Faculty of Dentistry — The Dean of the Faculty of Dentistry of the University of British Columbia.

Dean, Faculty of Medicine — The Dean of the Faculty of Medicine of the University of British Columbia.

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

Department — Any organizational unit of the Medical Staff to which members with a similar field of practice have been assigned, including a program.

Department Head — The member of the Medical Staff appointed by the Provincial Health Services Authority, and responsible to the Senior Medical Administrator, to be in charge of and responsible for the operation of a Department, and to review members of the Medical Staff and recommend their appointment, as appropriate for the Facility. For the purposes of these Rules, a Department Head may be responsible for a single department across health authority Facilities or Programs or could be a Provincial Lead that is in charge of and responsible for a group of departments or programs.

Department Head, Nurse Practitioners — The member of the Medical Staff appointed by the Provincial Health Services Authority, and responsible to the Senior Nursing Administrator, to be in charge of and responsible for the operation of the department.

Division — A component of a Department/Program with clearly defined sub-specialty interests and organized as such.

Division Head — The person appointed by the Department Head to be in charge of, and responsible for, the operation of a Division under the direction and supervision of the Department Head.

Facilities — The patient care facilities operated by the Provincial Health Services Authority, pursuant to the Hospital Act.

Health Authority Medical Advisory Committee (HAMAC) — The advisory committee to the Provincial Health Services Authority on medical, dental, midwifery and nurse practitioner practice matters.

House Staff — Physicians, dentists, midwives, or nurse practitioners temporarily engaged by or attached to a Facility for the purpose of post graduate training in a medical, dental or scientific discipline and who are supervised by a member of Medical Staff.

Medical Advisory Committee (MAC) — The advisory committees of the Facilities that advisethe Health Authority Medical Advisory Committee (HAMAC) on medical, dental,midwifery and nurse practitioner matters, as described in Article 8.

Medical Care — In these Rules, medical care includes the clinical services provided by Physicians, Dentists, Midwives and Nurse Practitioners.

Medical Staff — The physicians, dentists, midwives and nurse practitioners who have been appointed to the Medical Staff and have been granted Privileges by the Board of Directors to practice in the Facilities and Programs operated by the Provincial Health Services Authority.

Medical Staff Bylaws (or Bylaws) — The bylaws approved by the Board of Directors and the Ministry of Health that set out the organization and conditions governing the Medical Staff, of the Facilities and Programs.

Medical Staff Rules (or Rules) — The rules approved by the Board of Directors governing the day-to-day management of the Medical Staff in the Facilities and Programs.

Medical Students — Undergraduate medical students temporarily attached to a Facility for the educational purpose of gaining practical clinical experience during a specified rotation and who are supervised by a member of Medical Staff.

Most Responsible Provider (MRP) – the physician, oral maxillofacial surgeon, midwife or nurse practitioner who has the overall responsibility for the management and coordination of care of the patient, at any given time. Dentists cannot be MRPs. An MRP may delegate the care of a patient to an appropriately qualified member of the Medical Staff or a Resident/Fellow. **Nurse Practitioner** – A member of the Medical Staff who is duly licensed by the British Columbia College of Nurses and Midwives and who is entitled to practice nursing as a nurse practitioner in British Columbia.

Oral and Maxillofacial Surgeon – A dentist who holds a specialty certificate from the College of Dental Surgeons of B.C. authorizing practice in oral and maxillofacial surgery.

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

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

Senior Operational Administrator— The person engaged by the Provincial Health Services Authority to provide leadership to a Facility or Site in the Health Authority and to oversee the day-to-day operation and management of the Facilities and Programs.

President of Medical Staff — The representative of the Medical Staff elected to that office.

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

Privileges — A permit to practice medicine, dentistry, midwifery or nursing as a nurse practitioner in the Facilities and Programs operated by the Health Authority and granted by the Provincial Health Services Authority to a member of the Medical Staff, as set forth in the *Hospital Act* and *Regulations*. Privileges describe and define the scope and limits of each practitioner's permit to practice in the Facilities and Programs of the Provincial Health Services Authority.

Procedural Privileges — A permit to practice medicine in the Facilities granted by the Board of Directors to members of Medical Staff for specific procedures, based on need, proven competency and ongoing expertise in that procedure.

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

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

Section Head — The person appointed by the Division Head to be in charge of, and responsible for, the operation of a Section, under the direction and supervision of the Division Head.

Senior Medical Administrator — The physician, appointed by the CEO, responsible for the coordination and direction of the activities of the Medical Staff.

Senior Nursing Administrator — The nurse or nurse delegate engaged by the Provincial Health Services Authority to provide leadership for nursing practice across Facilities and Programs.

Signature — Authentic signature and/or electronic sign off.

Specialist — A Physician with Fellowship or Certificate status with the Royal College of Physicians and Surgeons of Canada or equivalent, or relevant clinical experience and licensed to practice as a specialist by the College of Physicians and Surgeons of British Columbia.

Temporary Privileges — A permit to practice in the Facilities and Programs operated by the Health Authority that is granted to a member of the Medical Staff for a specified period of time in order that he/she may provide a specific service.

University — The University of British Columbia and its affiliates.

ARTICLE 2 — MEMBERSHIP AND APPOINTMENT

2.1 Criteria for Membership

Terms of appointment, criteria for membership, procedure for initial appointment, burden of providing information, and process for application is outlined in Article 3 and Article 4 of the Medical Staff Bylaws.

2.2 Privileging Procedure

The credentialing process will be completed at or before the applicant's start date.

2.2.1 References

Minimum required references upon application for a Medical Staff appointment

Newly Qualified Family Physicians

i.) one faculty reference (under-graduate) from the Dean of the medical school, or alternate, at which the physician graduated;

ii.) one reference from the Director of the applicant's residency program;

iii.) one reference from a teaching member of the faculty at which the applicant performed the residency.

Established Family Physicians

i.) one reference from the Department Head or Senior Medical Administrator of last Hospital, at which the applicant practised;

ii.) two or more references from physicians familiar with the current practice of the applicant.

Newly Qualified Midwife:

i.) one faculty reference (undergraduate) preferably from the Dean, or Director, of the school, or alternate, at which the midwife graduated;

ii.) two or more references from teaching members of the program at which the applicant trained.

Established Midwife:

i.) one reference from the Department Head or Senior Medical Administrator of last hospital at which the applicant practiced;

ii.) two or more references from physicians or midwives familiar with the current practice of the applicant.

Newly Qualified Specialists

i.) one reference from the Department Head under which the applicant trained;

ii.) one reference from the Senior Medical Administrator of the Hospital at which the applicant trained;

iii.) two or more references from a teaching member of the faculty who was involved in teaching during the applicant's residency.

f. Established Specialists

i.) one reference from the Department Head or Senior Medical Administrator of the last Hospital at which the applicant worked;

ii.) two or more references from physicians familiar with the current practice of the applicant.

g. Newly Qualified Nurse Practitioner:

iii.) one faculty reference (undergraduate) preferably from the Dean, or Director, of the school, or alternate, at which the applicant graduated;

iv.) two or more references from teaching members of the program at which the applicant trained.

h. Established Nurse Practitioner:

iii.) one reference from the Department Head or Senior Medical Administrator or Senior Nursing Administrator of last hospital at which the applicant practiced;

iv.) two or more references from physicians, midwives or nurse practitioners familiar with the current practice of the applicant.

2.2.2 Locum Tenens

a. Appointments for locum tenens are governed by the relevant Articles of the Medical Staff Bylaws (Section 6.7 and 4.1).

b. Three (3) letters of reference are required on the initial application, with competency of the Locum Tenens reviewed on each subsequent application by the Department Head.

c. The granting of a locum tenens appointment provides no preferential access to an active, provisional or other appointment at some later time.

d. The Department Head of the Medical Staff member who will be replaced by the locum tenens is responsible for ensuring that the locum tenens is suitably qualified.

2.2.3 Procedural Privileges

a. Physicians, dentists or nurse practitioners who are appointed to the Medical Staff must also apply for procedural privileges. All procedural privileges require documentation of training and experience. This documentation may be general or specific.

b. Certain procedural privileges may be defined as “basic privileges” and may be automatically granted to all Medical Staff members.

c. For specialist physicians,dentists or nurse practitioners, the Health Authority may grant “major privileges” in a specialty to that physician, dentist or nurse practitioner. The scope and type of procedures will be limited by the Site’s role in that specialty area, and specific training, demonstrated expertise, and current practice of the applicant physician, dentist or nurse practitioner.

d. The granting of procedural privileges to a physician, dentist, or nurse practitioner is dependent on the service needs of the Site; on the qualifications of the physician, dentist or nurse practitioner requesting such privileges; and on the ability of the Site to perform such a procedure.

e. Specific procedural privileges are granted by the Health Authority upon the recommendations of the MAC and/or the Department Head.

f. Individual procedural privileges require an individual application process in the following situations:

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

ii.) the request of privileges outside a specialty area;

iii.) the request of procedural privileges in a specialty area by a non-specialist in the specialty area;

iv.) the request of privileges generally not included in a specific staff category as defined in the Medical Staff Bylaws.

g. The Department Head, in consultation with the Head of the specialty Department/Program in which the 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, dentists, or nurse practitioners for a number of cases.

h. Procedural privileges may be granted to a physician, dentist or nurse practitioner based on adequate documentation provided by another Site where that physician, dentist, or nurse practitioner has obtained such privileges.

i. Where specific procedural privileges have been granted, the Board of Directors in consultation with the Medical Staff, and/or the Department Head, may specify the frequency at which such a procedure should be performed for this privilege to be retained by the physician, dentist, or nurse practitioner.

2.2.4 Procedural Privileges in Administration of Electro Convulsive Therapy (ECT)

a. Procedural privileges in administration of ECT will be granted for a period of 2 years consistent with the applicant's date of (re-)appointment to the Medical Staff.

b. Initial granting and bi-annual renewal of privileges will be subject to a written recommendation (paper or electronic) from the Physician Leader that the applicant meets the following criteria.

c. In order to be recommended for Procedural Privileges in ECT, a physician must:

i.) be a member of the Active (or provisional) Medical Staff;

ii.) hold or be recommended for un-restricted clinical privileges in Psychiatry;

iii.) have completed a prescribed orientation in the ECT Service and received a recommendation from the ECT Service Medical Manager that the orientation was satisfactorily completed;

iv.) indicate that the required skill set, knowledge or competencies as outlined in the Provincial ECT Guidelines have been acquired through a combination of training and/or experience. Training includes a formal educational process such as:

- specific courses/lectures through the American Psychiatric Association or American Association Convulsive Therapy (ACT) course(s) on practice of ECT);
- a Fellowship in ECT;
- a training program offered by the RVH ECT Service; or
- UBC Dept of Psychiatry courses/sessions/programs.

d. Bi-annual review/renewal of procedural privileges, the psychiatrist must provide evidence of:

i.) active clinical practice in ECT in the preceding 2 years;

ii.) continuing professional development in ECT, broadly construed as taking courses, reading, publishing and/or research, but specifically to include as a minimum of:

- one update course (eg: UBC/APA/CPA/ACT);

- review all *Journal of ECT* issues; participation in the ECT Journal Club.

2.2.5 Temporary Privileges

Applications for appointment of temporary privileges are to be completed on the prescribed forms and are processed according to the Medical Staff Bylaws Article 4. Temporary privileges may be granted, without application, to physicians or nurse practitioners for situations such as education, demonstration of medical equipment, etc.

An appointment to the Temporary Staff Category cannot exceed 12 months (Bylaws 6.6.1). At the completion of 12 months, the applicant loses the appointment or must be moved to another medical staff category by the Department Head.

2.2.6 Infant and Maternal Transport Teams (the transport teams) and Organ Retrieval Teams

Members of the transport and organ retrieval teams will be granted temporary privileges, without application, for the purpose of stabilizing patients and preparing them for transport to another Site.

2.2.7 Clinical Associate Staff

a. Members of the Clinical Associate staff are appropriately qualified and registered medical staff who work in highly specialized areas under the direction of a Department/Division Head or senior member of a Department/Division who will be their sponsor and will be responsible for their work. The Department/Division Head will define their scope of practice.

b. Members of the Clinical Associate staff must satisfactorily complete the required period on the Provisional Staff (as described in Section 6.2.5 of the Medical Staff Bylaws), unless exempted from that requirement by the Board of Directors.

c. Members of the Clinical Associate staff provide clinical services and are not in an official training program.

d. Members of the Clinical Associate staff are assigned to a Primary Department and may not admit, but may attend, investigate, diagnose and treat patients within the limits of that member's privileges.

e. Members of the Clinical Associate staff are eligible to hold office and vote at Medical Staff and departmental meetings.

f. Unless specifically exempted by Children's & Women's Health Centre of British Columbia, members of the Clinical Associate staff are required to participate in fulfilling the organizational and service responsibilities, including on-call responsibilities, of the Department to which the member is assigned, as determined by Children's & Women's Health Centre of British Columbia and described in Medical Staff Rules.

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

2.3 Medical Staff Evaluation

Quality assurance ("QA"), quality improvement ("QI") and in-depth review are processes which can be utilized to ensure that professionalism; appropriate standards and patterns of medical care are created and maintained. Under the MAC and Safety and Quality of Medical Care Committee(s), each Medical Staff Department/Program, is responsible for establishing an adequate system for QA, QI and in-depth review.

2.3.1 Review at Reappointment

Members of the Medical Staff seeking re-appointment and privileges shall comply with the requirements outlined in the Medical Staff Bylaws Article 4.4 and 4.5. The review will include, but not be limited to, a review of quality of the member's contribution to the Health Authority and Site, compliance with Health Authority Bylaws and Rules, policies and procedures, medical record documentation, continuing medical education initiatives, conduct, and review and setting of annual professional goals and objectives.

2.3.2 In-Depth Review

The in-depth review is an evaluation of a Medical Staff member's practice and performance and occurs every 3 years in addition to, or in conjunction with, the member's annual review. The intent of in-depth review is quality improvement and career development. The process involves an achievement review, which provides those being reviewed with feedback about their medical practice through the eyes of those they work with and serve. The review also includes a self assessment and is designed to be educational and potentially corrective. In-depth review will be performed in accordance with disclosure safeguards found in Section 51 of *the Evidence Act*.*1*

In-Depth Review Procedure:

a. Members of the Medical Staff must submit to the in-depth review process. It must be completed prior to appointment as a member of the Active Medical Staff and *every third year* thereafter for all full time members of the Active Medical Staff.

b. It will be initiated by the Department Head, a Department subcommittee, the MAC, the Senior Medical Administrator, the Senior Nursing Administrator (if applicable), or other appropriate body of the Medical Staff.

c. The in-depth review is to be conducted by members of the Medical Staff as appointed by the Department Head, a Department/Program subcommittee, the MAC, the Senior Medical Administrator, the Senior Nursing Administrator (if applicable), or other appropriate body of the Medical Staff. The review process will be coordinated through the Department Head, and the Medical Staff Office.

d. The in-depth review will include:

   i.) Input from non-medical staff coworkers, medical colleagues, and members of clinical or academic teams, who will assess attributes of the medical staff member's performance in relation to clinical knowledge and skills; communication skills; psychosocial management; office management; and collegiality. Selection of those providing input will be made by the Department Head or designate (50 percent) and the medical staff member (50 percent).

   ii.) In addition, the in-depth review may include any or all of the following:

   - inpatient and outpatient clinical documentation with an assessment of the quality, accuracy, and timeliness of reports;

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

- input from patients to determine their view of the medical staff member's professional attitude and communication skills (for those specialties where appropriate);
- review of current Curriculum Vitae and a personal statement from the medical staff member outlining goals and objectives, including successes and challenges;
- complications and mortality review;
- review of incident reports and complaints;
- continuing medical education, including MOCOMP hours and CME for additional competence training done since last review, plus updates specific to departmental/program requirements;
- procedural privilege evaluation, including frequency of procedures done;
- direct observation of procedural and assessment skills;
- interview or communication with members of affiliated organizations and regulatory bodies;
- utilization/quality assurance information.

e. The results of the Medical Staff member's in-depth review are presented to the Department Head (or designate),Senior Medical Administrator and the Senior Nursing Administrator (if applicable), who reviews them and then discusses the results and with the medical staff member, and where necessary, will assist the member to develop an implementation plan for either a correction of deficiencies or an ongoing improvement in performance.

f. The medical staff member shall respond in writing to the completed review, within the time period designated by the Department Head, Senior Medical Administrator and Senior Nursing Administrator (if applicable).

g. Documentation of the in-depth review process will include the in-depth review report and any corrections of errors in fact, the Medical Staff member's response, recommendations, implementation plan and reports on the implementation of recommendations. Discussions between the Department Head,Senior Medical Administrator andSenior Nursing Administrator (if applicable) and the Medical Staff member will be documented.

h. Documentation of the in-depth review process becomes part of the Medical Staff member's confidential personnel file.

i. The MAC and subsequently the Board of Directors will be informed of the results of the in-depth reviews of medical staff members.

2.3.3 Comprehensive Review

In circumstances where serious concerns arise from the medical staff member's in-depth review, the Senior Medical Administrator will be informed, and a decision will be made in conjunction with the Department Head to undertake a comprehensive review by a Review Committee consisting of:

i.) Department Head or delegate of the member's Department, or if several departments are collaborating, a Department Head from another Department;

ii.) A medical staff member from the Department of the member being reviewed;

iii.) A member of the hospital team with whom the member works regularly.

a. The Comprehensive Review Committee will undertake a further in-depth review, which will include all criteria outlined in item 2.3.2 d. i) and ii)..

b. The Comprehensive Review Committee will report to the Department Head, the Senior Medical Administrator and Senior Nursing Administrator (if applicable) on the results of the In-Depth Review in accordance with the Medical Staff Bylaws Article 4.5 and 4.6, and will provide recommendations on the requirements for corrective action.

c. The MAC and subsequently the Board of Directors will be informed of the results of the comprehensive review of Medical Staff members.

ARTICLE 3 — RESPONSIBILITY FOR PATIENT CARE

3.1 Admission, Discharge, and Transfer of Patients

3.1.1 Every patient shall be admitted by a member of the Medical Staff who has admitting privileges and who has primary responsibility for the care of the patient. This practitioner shall be identified as the "Most Responsible Provider" (MRP).

3.1.2 Patients admitted to a Facility where there has been no predetermined MRP shall be assigned to a member of the Medical Staff within the medical speciality required to meet the patients' medical care needs in accordance with call rosters.

3.1.3 Admission documentation is required for all patients receiving in patient care at the time the patient is admitted. The admission documentation includes: presenting problem, allergies/sensitivities, medications, significant past history, review of systems including deviation from normal, physical examination relevant to presenting problem, results of pertinent diagnostic investigations, active problem list, provisional diagnosis and a management plan.

3.1.4 Pre-admission requirements for elective patients include the patient's medical history, physical examination, diagnosis, blood work, appropriate consultations, special tests and documentation of special precautions, and patient, procedural and transfusion consents.

3.1.5 For emergency admissions, the admitting physician,midwife or nurse practitioner will certify the severity of the patient's condition and the circumstances necessitating special consideration,

3.1.6 The admitting physician, midwife or nurse practitioner shall note special precautions regarding the care of the patient on the patient's health record. Precautionary notes are required for, but not limited to, chemical dependency, potential suicide, violence, epileptic seizures, psychiatric conditions, infections, drug reactions and allergies

3.1.7 Dental Admissions: For patients admitted for dental treatment, the physician on the Medical Staff who admitted the patient shall be the attending physician for the medical care. The attending dental surgeon shall be responsible for the patient's dental care.

3.1.8 Discharge

a. Discharge planning shall begin at the time of admission.

b. All patients shall have their discharge order written (paper or electronic) as early as possible on the day of discharge. Physicians, midwives and nurse practitioners shall, when possible, indicate the planned discharge on the day prior to discharge.

c. Patients will be discharged only on the order of the attending physician, midwife, nurse practitioner or designate.

d. The attending physician, midwife or nurse practitioner shall be responsible for ensuring that a discharge summary is completed on all patients.

3.1.9 Transfer of Responsibility

a. Members of the Medical Staff will ensure continuous coverage for their patients in the Facility.

b. Any member of the Medical Staff who is away from practice shall enter in the chart the name(s) of the Medical Staff member(s) assuming responsibility for the patient's care.

c. If a Medical Staff member wishes to withdraw from involvement in a patient's care when services are still required, the Medical Staff member shall inform the patient and arrange in writing (paper or electronic) for another Medical Staff member of appropriate qualification to assume responsibility for the care of the patient.

d. A patient has the right to request a change in Medical Staff member. The attending physician, dentist, midwife or nurse practitioner shall cooperate in transferring responsibility for care to a new Medical Staff member acceptable to the patient. If an acceptable alternative Medical Staff member cannot be found, the Department Head, Senior Medical Administrator, or Senior Nursing Administrator (if applicable) shall appoint a Medical Staff member who will continue to provide care to the patient until such responsibility is transferred.

e. When the patient is to be transferred to another Facility, the attending physician, dentist midwife or nurse practitioner shall ensure that there is an appropriately qualified Medical Staff member on staff at the receiving site who is fully informed about the patient's condition and is prepared to assume responsibility for the patient's care. The physician, dentist midwife or nurse practitioner shall identify relevant documentation from the patient's clinical record to be sent to the receiving Site, with appropriate reference to the *Freedom of Information and Protection of Privacy Act.*[2]

3.2 Medical Consultations

3.2.1 Consultation shall be initiated by the attending physician, dentist, midwife, nurse practitioner or other Medical Staff member involved in the care of the patient. The urgency of the consultation will be communicated to the consultant at the time the consultation request is made. Nursing staff shall not be expected to initiate the consultation request.

3.2.2 Consultation shall be held:

a. at the request of the attending physician, dentist midwife or nurse practitioner;

b. whenever requested to do so by the Department Head, Senior Medical Administrator, or Senior Nursing Administrator (if applicable);

c. in other situations, as determined by the Department Head, Senior Medical Administrator, or Senior Nursing Administrator (if applicable).

3.2.3 The consultant shall examine the patient and immediately record the findings, opinions, and recommendations on the consultation record. The consultant will, where patient need requires, directly communicate the results of the consultation to the requesting physician, dentist, midwife or nurse practitioner.

[2] *Freedom of Information and Protection of Privacy Act,* [RSBC 1996] Chapter 165 - https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96165_00

3.3 Health Records

The attending physician, dentist, midwife or nurse practitioner involved in the patient's care shall be held responsible for the preparation of the medical component of the health record for each patient. The record shall include the following items, where applicable:

3.3.1 Admission History

The attending physician, dentist, midwife or nurse practitioner shall ensure that every patient admitted to the Facility shall have on the chart within 24 hours after admission and, prior to every delivery or operation except in extreme emergency, the admission documentation set out in 3.1.3 above.

3.3.2 Progress Notes

The progress notes shall be sufficient to describe changes in the patient's condition, reasons for change of treatment and outcome of treatment and shall be written (paper or electronic) as frequently as the patient's condition warrants. Within 48 hours, the MRP/M is to review the admission documentation and where appropriate add additional history regarding the present illness, a revised problem list, a revised management plan and a discharge plan.

3.3.3 Operative Notes

a. In elective or urgent surgical cases, the case history with a physical examination report and the signed operation consent shall be submitted to the booking clerk prior to the booking of the operation.

b. If such history and physical examination are not recorded before the time slated for operation, the operation shall be cancelled unless the attending physician/dentist states in writing (paper or electronic) that such delay would result in mortality or significant morbidity. Such cases shall be reviewed by the Surgical Committee or other appropriate body of the Medical Staff at its next regular meeting.

c. A written (paper or electronic) note denoting the operative procedure, complications, and post-operative orders must be placed on the chart prior to the patient leaving the post anaesthetic recovery unit.

d. Prior to any anaesthetic procedure, a pre-anaesthetic assessment must be documented on the anaesthetic record by the anaesthesiologist. The anaesthetic record is considered complete when the patient is discharged from the post-anaesthetic recovery room.

e. All operations shall be described fully by the operating surgeon or delegate within 24 hours of surgery.

3.3.4 Prenatal Record

The prenatal record is considered an integral part of the health record, and the information will be submitted in accordance with the B.C. Reproductive Care Program guidelines.

3.3.5 Completion of Health Records

a. All health records must be completed according to Health Records policies. If the attending physician, dentist, midwife or nurse practitioner is no longer available to sign orders, the clinical record will be completed by the appropriate Department Head.

b. The attending physician, dentist, midwife or nurse practitioner is responsible for notifying the Facility of planned absences prior to their occurrence. Following notification by the Facility, the physician, dentist, midwife or nurse practitioner will be responsible for the completion of outstanding health records within five working days of return from such leave or absence.

c. The patient's health record should be completed at the time of discharge, or at least must be completed within 14 days of discharge from the Facility.

d. If the patient's health record is not completed at the time of discharge, the following policy will be adhered to:

i.) the physician, dentist, midwife or nurse practitioner is notified of incomplete charts every two weeks;

ii.) following notification, the physician, dentist, midwife or nurse practitioner is responsible for completion of the charts within 14 days;

iii.) failure to comply with this notification will result in a couriered letter being sent to indicate suspension of admitting privileges. The attending physician, dentist, midwife or nurse practitioner will arrange transfer of the patient's care to an appropriate member of the Medical Staff;

iv.) the suspension of privileges is removed when the health records are completed;

v.) if the health records are not completed within 28 working days following receipt of such notification, Medical Staff privileges are automatically cancelled and the physician, dentist, midwife or nurse practitioner must reapply for appointment. Such reapplications will be handled as new applications for appointment to the Medical Staff;

vi.) physicians, dentists, midwives or nurse practitioners who are suspended more than three times in a consecutive 12 month period will be interviewed by the appropriate Department Head and the repeated suspensions may be grounds for discipline including revocation of membership on the Medical Staff;

vii.) locum tenens Medical Staff members are responsible for completion of clinical records; failing the completion by the locum tenens, the physician, dentist, midwife or nurse practitioner arranging for the locum tenens is responsible for completing any outstanding records.

3.3.6 Ownership and Access

a. Ownership — Health records relating to the patients of the Health Authority, even where maintained in a medical staff member's office on Facility are the property of the Facility and are not to be removed from the Facility except as ordered by the courts.

b. Access to and copies of the health record or information contained therein can only be obtained by:

i.) physicians, dentists midwives or nurse practitioners appointed to the Medical Staff and providing care to the patient the information is about;

ii.) house staff and clinical trainees who are responsible to members of the Medical Staff and have a reasonable connection to the patient the information is about;

iii.) Medical Staff members carrying out a bona fide study of research upon application and approval by the Research Review Committee or other appropriate body;

iv.) Medical Staff members carrying out medical quality assurance, medical audits and utilization review upon application and signed approval of the Manager of Health Records, as well as subject to Section 51 of the *Evidence Act*;

v.) Medical Staff members or house staff and clinical trainees seeking information from Health Records for the purposes of medical rounds upon written (paper or electronic) authorization from the appropriate Department Head or delegate;

vi.) written (paper or electronic) request of a Department Head/Member of the Department of Quality, Safety and Risk Management for purposes of review;

vii.) written (paper or electronic) request by the patient's physician, dentist midwife or nurse practitioner for transfer of medical treatment and patient care;

viii.) Coroner's examination;

ix.) patient or authorized representative request for own record;

x.) court order or subpoena;

xi.) request of the Facility solicitor;

xii.) written (paper or electronic) request of the College of Physicians, Surgeons and College of Dental Surgeons, and College of Nurses and Midwives in accordance with applicable legislation.

3.3.7 Storage and Transfer of Records

a. Health records are to be retained in the Health Records Department/Program unless otherwise approved by the Chief Executive Officer or delegate.

b. A photocopy of the health records shall be made available when the transfer of the health record is authorized under organizational policy, consistent with *Freedom of Information and Protection of Privacy Act.*

3.4 Informed Consent

3.4.1 Examination, treatment, procedure or operation, other than in the case of an emergency, may not be carried out on any patient in the Facility unless the informed consent of the patient or authorized representative has been obtained, as per appropriate Facility policy and governing legislation.

3.4.2 The attending physician, dentist,midwife or nurse practitioner of the Medical Staff is responsible for obtaining the informed consent of the patient or authorized representative prior to carrying out a particular procedure and will not proceed until a signed and witnessed Facility consent form has been completed.

3.5 Confidentiality of Quality Management Information

Medical Staff quality assurance activities are protected under Section 51 of the *Evidence Act*. It should be noted that Section 51 of the *Evidence Act*, if properly implemented in the hospital, overrides the *Freedom of Information and Protection of Privacy Act* ("FIPPA").

3.5.1 Access to Quality Assurance/Improvement Information — professional staff who access quality assurance data for projects or preparation of papers shall comply with requirements regarding ownership and access of the information that must adhere to *FIPPA* and Section 51 of the *Evidence Act.*

3.5.2 Access by other users — access by other personnel must be authorized by the Chair of the appropriate Safety and Quality of Medical Care Committee(s) in consultation with the Senior Medical Administrator, and in accordance with *FIPPA*.

3.5.3 All written (paper or electronic) communication between the various committees shall be identified specifically as being for the purpose of the committees involved.

3.5.4 In all circumstances, the communication of Quality Assurance Committee data shall avoid identifying the person or persons whose condition or treatment has been studied or reviewed and avoid identifying the staff, Medical Staff members, and other personnel who were involved with the case.

3.6 Emergency Care

3.6.1 In an emergency, any physician, midwife, or nurse practitioner is expected to provide medical care until a patient's attending physician**,** or midwife assumes responsibility.

3.7 Orders

3.7.1 All orders for treatment shall be written (paper or electronic) and signed by a registered and licensed member of a College, as defined in the Health Professions Act (1996) in accordance with the standards and scope of practice of that College

3.7.2 In an emergency, a Medical Staff member may give verbal orders for treatment to a registered nurse, to a respiratory therapist or a perfusionist or a pharmacist, who shall transcribe the order onto the chart under the Medical Staff member's name per the writer's name. Such orders shall be countersigned by the Medical Staff member or designate as soon as possible, but no later than 24 hours after the event.

3.7.3 The admitting physician,midwife or nurse practitioner shall provide orders necessary for the patient's care at the time of admission.

3.7.4 The attending physician, midwife or nurse practitioner prescribing medication shall comply with the Facility's safe prescribing guidelines.

3.7.5 House staff and Clinical Fellows may write orders and prescribe controlled drugs according to the Facility's safe prescribing guidelines.

3.8 Pre-printed Orders

3.8.1 A Department/Program may establish pre-printed order sets for patients under the care of members of the Department/Program. The appropriate Department Head must approve pre-printed order sets, and review pre-printed order sets on an annual basis. The attending physician, dentist midwife or nurse practitioner must sign the pre-printed order set for each patient. Pre-printed order sets must comply with the Facility's safe prescribing guidelines and the standards of the College of Physicians and Surgeons of British Columbia, the College of Dental Surgeons of BC or the British Columbia College of Nurses and Midwives, as applicable.

3.9 Responsibility for Provision of Continuous Medical Care of Patient

3.9.1 On-call Rota

Each member of the Medical Staff has a duty to ensure that his or her patient(s) is (are) continuously under appropriate and available medical care. Each member of the Medical Staff has a duty to comply with the Department/Program and/or Division's on-call rules as approved by the Facility. The admitting or attending physician, dentist, midwife or nurse practitioner shall not, whatever the reason; withdraw services prior to the patient's discharge without proper transfer of the patient's medical care.

a. Each Department/Program and/or Division, if applicable, shall assure that an on-call service is available to provide service to all patients of that Department/Program and/or Division 24 hours per day, 7 days per week.

b. All members of the Medical Staff with admitting privileges shall participate in Department/Program on-call rosters, except in special circumstances as approved by the Department Head.

c. Department Head or delegate, shall assign each member to a reasonable on-call schedule.

d. On-call physicians, dentists,midwives and nurse practitioners will be expected to provide acceptable levels of availability including the ability to be on-Facility in a reasonable response time as determined by the urgency of patient need. Those

Department/Programs which deal with life-threatening emergencies shall delineate the method of obtaining assistance when the first physician, dentist,midwife or nurse practitioner on-call cannot respond within these timeframes.

3.9.2 Where two or more physicians, dentists,midwives or nurse practitioners are involved with the care of the patient, one physician, dentist,midwife or nurse practitioner must be identified as the Most Responsible Provider (MRP). Transfer of the patient's care to another Medical Staff member must be recorded on the order sheet. Unless otherwise indicated, the admitting physician, dentist midwife or nurse practitioner shall be deemed to be the attending physician, dentist midwife or nurse practitioner.

3.9.3 Post-operative Care

The operating physician, surgeon, or dentist is responsible for the post-operative care of the patient unless otherwise indicated on the order sheet or the patient's health record.

3.9.4 Delegated Functions

Members of the Medical Staff may delegate certain functions to a variety of health professionals. The relevant Facility's Administration Policies must be followed.

A delegated medical function is a medical act that, with the agreement of the relevant Department/Program, has been formally transferred to a professional in a Department/ Program, 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.

a. Delegated medical functions are decided by mutual agreement among officials of the Medical Staff, the relevant health discipline and program co-directors (medical and professional).

b. Proposed delegated medical functions shall be recommended to program co-directors (medical and professional), medical and professional discipline heads, and the appropriate Safety and Quality of Medical Care Committee(s). The delegated medical function shall be approved by the Safety and Quality of Medical Care Committee(s) and endorsed by the MAC and the PHSA Board of Directors and the College of Physicians and Surgeons of British Columbia, College of Dental Surgeons of BC, or BC College of Nurses and Midwives, as applicable.

c. The delegated medical function shall be performed by qualified members of the health discipline, who have proven and continuing competence in accordance with Facility guidelines.

d. Delegation of selected medical functions takes place by means of certification in accordance with Facility policy.

e. Education for delegated medical functions and the mechanism for 'certification of competence' are developed by the Medical Staff and the relevant health professional in conjunction with the respective educational services. Educational programs for delegated medical functions certification of competence include:

    i.) a written policy that identifies the delegated medical function and any limitations associated with it;

    ii.) pre-requisite 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;

    vi.) specified date for re-certification where applicable;

vii.) records of those qualified to perform the delegated function shall be maintained by the Department/Program or program;

viii.) the performance of delegated medical functions will be monitored in accordance with Facility policy guidelines.

3.10 Organ Donation and Retrieval

3.10.1 Membership and Appointment

Members of the organ retrieval team will be granted temporary privileges, by the Senior Medical Administrator or delegate, without application for the purpose of organ recovery.

3.10.2 Responsibility for Patient Care

a. *Transfer of Responsibility* — The attending medical staff member may transfer responsibility for the physiological maintenance of the organ donor, after the declaration of neurological death, to a member of the Organ Recovery Team.

b. *Consultation* — In the declaration of neurological death for organ donation, consultation shall be held with a neurosurgeon or neurologist, or the medical practitioner representing the highest level of neurological skills available at the health care Facility.

c. *Identification of Potential Donors* — In accordance with the *Human Tissue Gift Act,*[3] all deaths or impending deaths of infants 39 weeks gestation at birth or older, children, or adults up to and including 75 years must be reported to the BC Transplant Society (BCTS) for the determination of medical suitability for organ donation. In accordance with the Facility's Policy "Identification of Donor-Death Registration", the referring individual who contacts the BCTS' Donor Referral Line shall be the Attending Physician or informed designate. The determination of appropriateness for organ donation will be done by the BCTS in conjunction with the referring individual. All ventilated patients with an impending or determined diagnosis of brain death will be evaluated as potential solid organ donors, and those individuals who have had a cardiac death will be evaluated as potential donors of corneas and tissue.

d. *Designated Requestor* — If the BCTS determines that the patient is medically suitable for organ, cornea, or tissue donation, then approach for consent to the family will be made by a designated requestor specifically trained in accordance with the Facility's Policy. Such an individual may be a physician, nurse practitioner, nurse, social worker or other trained individual.

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

f. In the event of eye and/or tissue donation only, consent shall be obtained from the next of kin after cardiac death, by a member of the Facility staff, or an employee of the Eye Bank or the Tissue Bank of British Columbia.

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

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

h. *Pronouncement of Death, Autopsy and Pathology* — In the case of organ donation, the criteria for the diagnosis of neurological death published in the most recent iteration by the Canadian Council for Donation and Transplantation (2003), will be followed in accordance with Part 2 Section 7 of the *Human Tissue Gift Act*.

3.11 Infant and Maternal Transport Teams (the transport teams)

The attending physician may transfer responsibility to a member of the transport team for the physiological maintenance of the patient while the patient remains under the care of the Facility. As the Most Responsible Provider (MRP) caring for the patient, the transport team is authorized to give verbal orders to a registered nurse or respiratory therapist to ensure optimum physiological maintenance of the Patient during preparation for transport.

3.12 Pronouncement of Death, Autopsy and Pathology

3.12.1 A physician or nurse practitioner must pronounce death.

3.12.2 The attending physician or attending nurse practitioner shall seek autopsy permission on all deaths including stillborns.

3.12.3 A medical practitioner who attended the death of the child or attended the child during the child's last illness must report the death of a child to the chief coroner, via the pediatric coroner. If a child died in circumstances described in 3.12.4 below, the medical practitioner must immediately report to the duty coroner, in the form required by the chief coroner, the facts and circumstances relating to the child's death. Stillbirths are not to be reported to the coroner.

3.12.4 The attending physician or attending nurse practitioner must immediately refer the case to the Coroner if there is reason to believe that a death occurred within the following stipulations of the BC Coroner's Act.
https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/00_07015_01

(a) as a result of violence, misadventure, negligence, misconduct, malpractice or suicide,

(b) by unfair means,

(c) during pregnancy or following pregnancy in circumstances that might reasonably be attributable to pregnancy,

(d) suddenly and unexpectedly,

(e) from disease, sickness or unknown cause, for which the person was not treated by a medical practitioner,

(f) from any cause, other than disease, under circumstances that may require investigation, or

(g) in a correctional centre, youth custody centre or penitentiary or a police prison or lockup.

3.12.5 An autopsy or post-mortem examination of a fetus shall not be performed without order of the Coroner or written (paper or electronic) consent of the appropriate relative or legally authorized agent of the patient, or without consent received over the phone from the appropriate relative or legally authorized agent of the patient and noted in writing.

3.12.6 All tissue or material of diagnostic value shall be sent to the Department of Pathology. From time to time, the MAC may determine that some materials need not be examined by the Department of Pathology.

3.12.7 Pathology specimens including body tissues, organs, materials, and foreign bodies shall not be released without due authorization of the Department Head of Pathology or delegate, in accordance with Facility Policies.

3.12.8 The attending physician or attending nurse practitioner shall complete the medical certificate of death or the medical certificate of stillbirth.

3.12.9 Death shall be reported to the Coroner in accordance with the requirements of the *Coroner's Act*.[4]

ARTICLE 4 — EDUCATIONAL PROGRAMS

4.1 House Staff and Clinical Trainees

4.1.1 House Staff are physicians, dentists, midwives, or nurse practitioners temporarily attached to the facilities for the purpose of education.

4.1.2 Appointments of House Staff shall be made annually and must be supported by the Department Head concerned, and recommended by the MAC and approved by the Board of Directors.

4.1.3 The House Staff shall consist of those physicians, dentists, midwives, or nurse practitioners who:

a. are registered with the University, are engaged in post-graduate training, and include residents, subspecialty residents and clinical fellows;

b. have applied directly to and have been accepted by the university program affiliated to the Facility;

c. have adequate liability insurance;

d. are appointed by the University;

e. are licensed by the College of Physicians and Surgeons of B.C., College of Dental Surgeons of B.C. or B.C. College of Nurses and Midwives.

4.1.4 Clinical Trainees shall consist of those physicians, dentists, or midwives who:

a. are engaged by the Facility for the purposes of training;

b. have applied directly to and have been accepted by the Facility;

c. have adequate liability insurance;

d. are licensed by the College of Physicians and Surgeons of B.C., or the College of Dental Surgeons of B.C. or the B.C. College of Nurses and Midwifes.

4.1.5 House Staff and Clinical Trainees may attend patients under the supervision of a member of the active or provisional staff responsible to the Facility for the work performed.

4.1.6 Duties and Responsibilities

The House Staff and Clinical Trainees shall:

a. carry out such duties that are assigned to them by the Head of the Department of the Program to which they have been appointed;

b. not admit patients to the Facility under their name;

c. attend Medical Staff meetings if requested to do so;

d. serve on committees to which they have been appointed or elected;

e. attend Department/Program clinical conferences and rounds regularly.

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

4.2 Physicians, Dentists, Midwives, or Nurse Practitioners Attached to a Facility for the Purposes of Clinical Upgrading

4.2.1 This shall consist of persons who:

a. are practising physicians, dentists, midwives, or nurse practitioners who wish to upgrade in a specific clinical discipline;

b. are licensed by the College of Physicians and Surgeons of B.C., the College of Dental Surgeons of B.C. or the B.C. College of Nurses and Midwifes;

c. have qualifications commensurate with the level of training required;

d. have applied directly to and have been accepted by the Facility;

e. have adequate liability insurance.

4.2.2 Duties and Responsibilities

Physicians, dentists, midwives, or nurse practitioners attached to a Facility for the purposes of clinical upgrading shall:

a. carry out such duties that are assigned to them by the Head of the Department of the Program to which they have been appointed;

b. not admit patients to the Facility;

c. attend Department/Program clinical conferences and rounds.

4.3 Medical and Dental Students

4.3.1 Appointments

Medical or dental students are undergraduate medical or dental students who spend a portion of their clinical rotations in different Facility settings for the purpose of receiving practical clinical experience, under the direction of the University and with the agreement of the Facility.

Medical or dental students may attend patients under the supervision of a member of the active medical, provisional or house staff of the Department who is responsible to the Facility for the work performed.

4.3.2 Duties and Responsibilities

a. the medical or dental student must ensure orders are countersigned by the attending physician or house staff;

b. the medical students shall not sign certificates of birth or death;

c. the medical students may not discharge a patient.

4.4 Registration of Observers

Observers are practicing physicians, dentists, midwives, or nurse practitioners who wish to come to the Facility to observe. All observers at the Facility, prior to their start date, must be registered with British Columbia's College of Physicians and Surgeons, College of Dental Surgeons or College of Nurses and Midwifes, as appropriate, and the Medical Staff Office. The observer must be informed of this requirement when invited to the Facility. The required Facility documentation for observers is available in the Medical Staff Office.

ARTICLE 5 — ORGANIZATION OF MEDICAL STAFF

The organization of Medical Staff, Medical Staff Department/Programs and the responsibilities of the Department Head is described in the Medical Staff Bylaws Article 7.

5.1 Clinical Department/Programs, Divisions, and Sections

5.1.1 Where the Facility is of sufficient size, individual Department/Programs may be further organized into Divisions of clearly defined sub-specialty interests.

5.1.2 In large Facilities, Divisions may also be further organized into Sections, i.e., a component of a Division with clearly defined sub-specialty interests.

5.1.3 The Departments of the Facility, if applicable are outlined in Appendix D.

5.2 Department Head

The Head of each Department shall be a member of the Active or Provisional Medical Staff of the Department/Program and shall be appointed by the Board of Directors in consultation with the appropriate University Department/Program.

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

5.3 Responsibilities of Department Head

In addition to those defined in the Medical Staff Bylaws Article 7.2, the responsibilities of the Department Head are to:

5.3.1 Advise the MAC 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 by ensuring effective assessment, planning, implementation, modification, utilization and evaluation of care for patient care processes, patients, and families in selected dimensions of quality, including:

a. mortality and morbidity reviews and tracking;

b. clinical audits;

c. outcome tracking and monitoring;

d. annual quality improvement projects.

5.3.2 Advise the Board of Directors, through the MAC and the Quality and Access Committee of the Board, of the adequacy of resources as they affect the quality of medical care and academic activities.

5.3.3 Function as the channel of communication to and from the Department/Program; and keep members of the Department/Program informed regarding Facility and Department/ program objectives, policies and general activities.

5.3.4 Develop standards of clinical practice and behavior for the Department, as delineated by Facility policies, the Medical Staff Bylaws and these Rules.

5.3.5 Develop annual operating objectives and the budget for the Department.

5.3.6 Monitor and evaluate the utilization of Health Authority resources by members of the Department/Program in order to ensure effective and efficient use of these resources.

5.3.7 Be responsible for the human resource plan of the Department/Program and the recruitment of new members in accordance with the plan.

5.3.8 Evaluate and make recommendations concerning persons wishing to be appointed or reappointed to the Medical Staff, including completing an impact analysis, making

recommendations regarding privileges, where appropriate, consistent with the needs of the Department, the Facility and Health Authority.

5.3.9 Review and make recommendations to the Credentials and Human Resource Planning Committee concerning the annual review or in-depth review and assignment of privileges to all members of the Department or other members of the Medical Staff.

5.3.10 Investigate concerns where necessary, of medical staff behavior, and delivery of patient care, and where appropriate initiate disciplinary procedures in accordance with the Medical Staff Bylaws, these Rules and Health Authority policies.

5.3.11 Recommend suspension or limitation of privileges and notify the Senior Medical Administrator, and Senior Nursing Administrator (if applicable), when necessary, of any member of the Department or Program whose patient care or behavior appears to be contrary to the interests of the patients or the Facility, and appoint another member of the Staff to undertake care of the patients in the Facility who have been the responsibility of the suspended staff member until such time as a review has taken place as outlined in the Medical Staff Bylaws.

5.3.12 Consider and make recommendations regarding all applications for leave of absence.

5.3.13 Ensure that Medical Staff are assigned to provide out of hours coverage of the Facility and its patients.

5.3.14 Develop and maintain specific job descriptions for the Head of each Division.

5.3.15 Foster and mentor the professional development of the individuals of the Department/ Program, to include the pursuit of knowledge, research activities and teaching responsibilities as they pertain to the goals and objectives of the Health Authority and Facility and promote, cooperate in and support the participation of staff in research, education and other developmental activities and to be responsible for the allocation of professional academic time and priorities and to facilitate the undertaking of educational and clinical investigation activities.

5.3.16 Work with the University to ensure that education programs and research activities are being sufficiently promoted and supported.

5.3.17 Arrange and chair departmental meetings as required in these Rules.

5.3.18 Appoint a senior member of the Department/Program to fulfill the duties and responsibilities in the absence of the Department Head and Assistant Department Head.

5.4 Responsibility of the Assistant Department Head

5.4.1 The Assistant Department Head shall be appointed by the Department Head,

5.4.2 The Assistant Department Head shall fulfil the duties and responsibility of the Head in the absence of the Department Head,

5.4.3 The Assistant Department Head shall perform such duties as are delegated by the Head.

5.5 Division Heads

Division Heads shall be appointed by the Department Head, for such term as the Department Head shall decide with the advice and recommendation of the Senior Medical Administrator, and subject to the specific Affiliation Agreement, if applicable.

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

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

5.5.3 The Division Head shall be an active member of the Medical Staff, and selected based on qualifications by training, experience and demonstrated ability in clinical, teaching and administrative activities.

5.6 Section Heads

Section Heads shall be appointed by the Division Head for such term as the Division Head shall decide with the advice and recommendation of Department Head, and subject to the specific Affiliation Agreement, if applicable.

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

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

5.6.3 The Section Head shall be an active member of the Medical Staff, and selected based on qualifications by training, experience and demonstrated ability in clinical, teaching and administrative activities.

5.7 Department/Program and Divisional Meetings

5.7.1 Each Department/Program and Division if applicable shall meet at least five (5) times a year and more frequently if required to conduct its administrative affairs, clinical appraisals, teaching, and service commitments. The Department/Program and Division if applicable are responsible for studying, investigating and evaluating the care provided by its members for the purpose of improving care and shall report regularly on these activities to the Medical Advisory Committee through the Department Heads. The meetings will be used to discuss matters concerning:

a. clinical program planning;
b. budget submissions;
c. medical human resources;
d. appointments;
e. quality of medical care;
f. education and research;
g. discipline;
h. use of Facility resources;
i. cases of mortality and morbidity;
j. clinical audits;
k. quality improvement projects.

5.7.2 Records of the meetings shall be kept and attendance shall be recorded. Records relating to QA and QI activities such as the matters discussed under items e., g., i., j. and/or k. above are privileged pursuant to section 51 of the *Evidence Act* and should be segregated from other records.

5.7.3 Active and Provisional Medical Staff members shall attend at least 70% of the Department/Program/Divisional meetings in a calendar year, unless excused by the Department Head for just cause.

5.7.4 A quorum shall consist of 50% of the voting members of the Department/Program/ Division.

5.8 Selection Process for Department Head

When a vacancy exists for the position of Department Head and the Board of Directors has expressed a desire that the vacant position be filled, a search for a Department Head shall be

conducted by a Selection Committee**.**

5.8.1 Composition

The Department Head Selection Committee shall be composed of the following:

a. the Chair, who shall be recommended by the MAC;

b. the Dean of Medicine or designate;

c. one member of the Department/Program elected by that Department/Program. If there are more than ten members of that Department/Program, two representatives shall be elected representing clinical and academic staff;

d. one additional Department Head, or other senior member of the medical staff from the Facility who shall be chosen by the MAC;

e. a representative of the Board of Directors (optional at the discretion of the Board of Directors);

f. the Senior Medical Administrator and Senior Nursing Administrator (if applicable).

g. The Senior Operational Administrator or designate of the Facility with which the Department/Program is associated.

5.8.2 Duties

The Selection Committee shall:

a. develop a position description for the Head to be selected and make it available to each member of the Selection Committee with a list of qualifications to be met by the appointee;

b. advertise the position according to the requirement of the Facility;

c. review candidates and/or statements in writing in support of candidates (references) submitted by individuals or groups;

d. develop a short list of individuals to be reviewed by the Selection Committee as a whole and by selected Selection Committee members individually;

e. interview candidates;

f. ensure that the candidate has complied with the requirements of the credentialing process;

g. make a report in writing to the Senior Medical Administrator and the MAC.

5.8.3 The Medical Advisory Committee shall consider the report and make its recommendation to the Health Authority Medical Advisory Committee, Board of Directors and the Senior Operational Administrator of the Facility concerning the appointment.

5.9 Selection Process for Division Head

When a vacancy exists for the position of Division Head and the Department Head has expressed a desire that the vacant position be filled, a search for a Division Head shall be conducted by a Selection Committee composed of:

5.9.1 The Division Head Selection Committee shall be composed of:

a. the Head, or designate of the Facility Department/Program who shall be Chair;

b. the Head of the corresponding academic discipline (if not the same person referred to in a);

c. one elected member of the Division involved if the Division has between three and ten members, or two elected members if the Division has more than ten members or, if the Division has less than three members;

d. one Department/Program member in good standing chosen by the Department Head; or
one representative of the same or similar discipline from outside (decision between alternatives (a) and (b) to be reached by the Head of FacilityDepartment/Program as Chair in consultation with Division members);

e. one Division Head elected by and from the Department/Program concerned;

f. a representative of the MAC;

5.9.2 Duties

The Selection Committee shall:

a. develop a position description for the Head to be selected and make it available to each member of the Selection Committee with a list of qualifications to be met by the appointee;

b. advertise the position according to the requirement of the Facility;

c. review candidates and/or statements in writing in support of candidates submitted by individuals or groups;

d. develop a short list of individuals to be reviewed by the Selection Committee as a whole and by selected Selection Committee members individually;

e. interview candidates;

f. ensure that the candidate has complied with the requirements of the credentialing process;

g. make a report in writing to the Department Head..

5.10 Review of Departments and the Department Head

5.10.1 Department Heads are appointed for a term of five (5) years. The Senior Medical Administrator or Senior Nursing Administrator, as applicable, shall be responsible for conducting an annual performance review of each medical Department Head.

5.10.2 In the fourth year of appointment, a Facility review committee shall be convened to formally assess the performance of each Department Head, and report its recommendations to the MAC. In the case of a University Department Head, the review will use the existing mechanism prescribed by the University procedure.

The review report shall include a recommendation regarding the reappointment or non-reappointment of the Department Head for a further five (5) year term.

5.10.3 The purpose of the review is to assess the performance of the Department Head in the following areas:

a. departmental and hospital administration;

b. medical staff management;

c. quality of care;

d. resource utilization and management;

e. academic responsibilities.

Performance will be measured against the position description, strategic plans, and other relevant documentation, and in relation to the resources available to the Head/Medical

Director/Program Leader. The results of the review will be considered by the Hospital and University and if applicable, the Search Committee, in the process of appointment/ reappointment.

5.10.4 Composition of the Review Team

The committee membership shall be specific for each review process. Membership shall consist of:

a. the Chair, who shall be recommended by the MAC;

b. the Dean of Medicine or designate, as applicable;

c. one member of the Department/Program nominated by that Department/Program. If there are more than ten members of that Department/Program, two representatives shall be nominated representing clinical and academic staff;

d. one additional Department Head from the Facility who shall be chosen by the MAC;

e. at least one external reviewer, selected by the Facilitywith input from the Department Head and the members;

f. the Senior Medical Administrator and Senior Nursing Administrator, as appropriate, or delegate.

5.10.5 Review Process

A briefing package will be prepared in advance for the review team. This will include:

a. Terms of Reference developed by the Senior Medical Administrator and Senior Nursing Administrator (if applicable), or delegate and appropriate others to focus the review;

b. The position description;

c. Facility and departmental strategic plans and mission statements;

d. A departmental overview prepared by the Department, which includes a description of all patient care activities, teaching programs, research activities, funding and issues facing the department;

e. Curriculum Vitae of department members;

f. Summaries of recent reviews (UBC Faculty of Medicine, Royal College reviews and accreditation reports) and other relevant material.

The committee will meet with the Department Head, Department/Program members and other interested members of the Facilitystaff. It will weigh information as to:

a. whether the Department/Program objectives have been reached;

b. whether the Department/Program maintains equitable working relationships with other Departments and health professionals;

c. ability of the Department Head to administer the matter of the Department;

d. leadership of the incumbent and his/her programme for future development of his/her Department/Program

5.10.6 Review Report

A confidential draft report will be sent by the Committee Chair to the Senior Medical Administrator and the Senior Nursing Administrator (if applicable), who will forward it to the Department Head for review and correction of errors of fact. Correction of errors will be made in the draft report and the Senior Medical Administrator or Senior Nursing Administrator will send a final confidential report to the Department Head for Departmental/ Program response. The final report and the Departmental/program

response will be sent to the Chair of the Medical Advisory Committee for action. This action may be:

a. to recommend re-appointment;

b. to recommend re-appointment with conditions attached;

c. to recommend a transitional appointment for a finite term;

d. to recommend not to re-appoint.

5.10.6 Confidentiality

All correspondence and communications with the committee will be held in confidence. All deliberations of the Committee will be in confidence and a specific report on deliberations will not be issued except for the ultimate recommendation.

5.11 Suspension or Termination

The Board of Directors may, on the recommendation of the MAC, 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 MAC.

ARTICLE 6 — MEDICAL STAFF ASSOCIATION

6.1 Role and Structure

6.1.1 The objectives of the Medical Staff Association include the promotion and advancement of Medical Staff involvement in the provision of the Facility's medical services and to represent and advocate for the interests of the Medical Staff of the Facility.

6.1.2 The operation and structure of the Medical Staff Association shall be in accordance with the Rules as approved and adopted by its members.

6.2 Elected Officers of the Medical Staff

6.2.1 The elected officers of the Medical Staff shall be:

a. President of the Medical Staff

b. Vice-President

c. Secretary-Treasurer

6.2.2 Duties

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

a. meetings – Regular, Annual and Special;

b. appointing special subcommittees as needed.

6.3 Election Procedure

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

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

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

6.4 Duties of the President of the Medical Staff

The President of the Medical Staff shall:

6.4.1 convene and chair all meetings of the Medical Staff;

6.4.2 be a member *ex-officio*, of all Medical Staff committees;

6.4.3 be a voting member of the MAC;

6.4.4 receive information and directives from the MAC and disseminate this information to the Medical Staff as appropriate;

6.4.5 communicate matters of concern from the Medical Staff to the Senior Medical Administrator;

6.4.6 represent the collective interests of the Medical Staff.

6.5 Duties of the Vice-President

The Vice-President, in the absence of the President of the Medical Staff, shall assume all the duties and authorities of the President of the Medical Staff.

6.6 Duties of the Secretary-Treasurer

The Secretary-Treasurer shall:

6.6.1 give notice and be responsible for minutes of all meetings of the Medical Staff;

6.6.2 attend to all correspondence of the general Medical Staff;

6.6.3 prepare a financial statement of the Medical Staff funds for presentation to the annual meeting, and ensure that an audit of the Medical Staff funds is conducted annually;

6.6.4 perform such other duties pertaining to the office of the Secretary-Treasurer as may be required;

6.6.5 assume the duties and authorities of the President of the Medical Staff in the absence of the President and Vice-President.

6.7 Duties of the Past President of the Medical Staff

The Past President of the Medical Staff shall serve in an advisory capacity, along with the President of the Medical Staff, Vice President, and Secretary-Treasurer.

6.8 Recall, Removal and Filling of Vacant Offices

Officers of the Medical Staff may be recalled and removed in accordance with the following:

6.8.1 Upon receipt of a Petition seeking recall of an officer, signed by at least one third of the members eligible to vote, the President of the Medical Staff shall call a special meeting to be held within 30 days of receipt of the Petition.

6.8.2 If at this meeting, with a quorum present, two-thirds of eligible voters present vote in favour of recall, the office shall be declared vacant. An election for the vacant office may be held at the same meeting.

6.8.3 In the event of death, removal or resignation of an officer during the term of office, another Medical Staff member may be elected at a regular or special meeting to fill the balance of the expired term. Nominations will occur in accordance with section 4.2 in

Rules and Regulations. Otherwise, the duties of that office shall be assumed by the remaining officers.

6.8.4 In the event of simultaneous removal or resignation of the entire elected officers of the Medical Staff, the Past President of the Medical Staff shall assume the duties and responsibilities of the President of the Medical Staff, will handle all urgent matters, and will immediately call an election for the vacant offices.

6.8.5 Conduct of special meetings is described in the Medical Staff Rules Article 7.3.

ARTICLE 7 — MEETINGS OF THE MEDICAL STAFF ASSOCIATION

7.1 Annual Meeting

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

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

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

7.1.4 An annual report on the financial affairs of the Medical Staff in the past year and a proposed budget in writing for the ensuing year presented by the Secretary-Treasurer.

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

7.1.6 Meetings shall be conducted according to Robert's Rules of Order, newly revised.

7.1.7 Records of the meeting shall be kept.

7.2 Regular Meetings

7.2.1 Regular meetings of the Medical Staff shall be held at least three (3) times per year, or as deemed appropriate by the President of the Medical Staff or officers of the Medical Staff.

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

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

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

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

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

7.2.7 All meetings shall be conducted according to Robert's Rules of Order, newly revised.

7.2.8 The business of regular meetings shall inform the Medical Staff of actions recommended by the MAC.

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

7.3 Special Meetings

7.3.1 With the exception of special meetings to recall or remove elected officers of the Medical Staff, as described in Rule 6.8, a special meeting of the Medical Staff may be called by the Board of Directors, Chief Executive Officer, President of the Medical Staff**,** Chair of

the MAC or at the request of one-third of eligible voting members of Medical Staff and shall be held within ten days of receipt of the request.

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

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

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

7.3.5 Meetings shall be conducted according to Robert's Rules of Order, newly revised.

7.4 Attendance

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

7.5 Quorum

7.5.1 At general Medical Staff meetings, a quorum shall consist of 50 medical staff members in the Active category.

7.6 Membership Dues

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

7.6.2 Payment of membership dues is a requirement to retain membership in the Medical Staff, and shall be made payable within two (2) months following the Annual Meeting. Non-payment of dues within the time specified shall be grounds for loss of privileges and/or disciplinary action.

ARTICLE 8 — MEDICAL ADVISORY COMMITTEE

The Medical Advisory Committee is appointed by the Board of Directors, as defined in the Medical Staff Bylaws Article 8. The MAC may establish subcommittees with clearly defined functions and reporting to the MAC.

Quality Assurance reports and documents generated by these committees shall be marked for quality assurance purposes only and shall be prepared in accordance with section 51 of the *Evidence Act* as appropriate.

All written (paper or electronic) communications between the committees and other persons or committees shall be identified specifically as being for the purpose of the committees involved.

The General Principles and Relationships between MAC and other Medical Staff Committees is outlined in the Medical Staff Bylaws Article 9.

All committee meetings shall be conducted according to Robert's Rules of Order (newly revised).

The standing committees of the MAC include:

8.1 Credentials and Human Resource Planning Committee

8.2 Bylaws and Rules Committee

8.3 Nominations Committee

8.4 Safety and Quality of Medical Care Committee(s)

8.5 Health Records Committee

8.6 Infection Control Committee

8.7 Mortality Review Committee

8.8 Priorities and Evaluation Committee

8.9 Research, Professional Development and Medical Education Committee

8.0.1 Purpose

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

a. All matters of a medical nature including organizational, clinical, educational and research activities;

b. The monitoring of the quality, quantity, effectiveness, and sufficiency of medical care provided;

c. The quality of care delivered to patients;

d. The continuing education of the members of the Medical Staff, research and teaching issues at the Facility;

e. The maintenance of professional standards by members of the Medical Staff;

f. The conduct of the Medical Staff;

g. Disciplinary matters relating to Medical Staff.

8.0.2 Composition (see Appendix A for composition at the different Agencies)

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

- Chair
- Vice Chair
- Chair/Director, Safety and Quality of Medical Care Committee(s)
- Administrative and Medical Staff as designated by the Facility
- President of the Medical Staff Association
- Senior Medical Administrator

a. All voting MAC members shall attend all meetings of the MAC. Repeated failure by voting members to meet attendance requirements (less than 80% of meetings) will result in a review of membership.

b. Regular attendees shall designate delegates to attend in the event of their absence. The designate shall be announced before each meeting. The designate must come prepared for meetings and have sufficient information to be able to participate in discussions.

c. The term of appointment of each MAC member shall be a two year term, unless fixed by other role appointments.

d. It is expected that the Medical Staff President will inform the MAC regarding Medical Staff Association issues.

8.0.3 Duties

a. <u>Patient Care</u>

i.) to receive, study and act upon reports from Department Heads, departments, programs and committees concerning the review, analysis and evaluation of clinical practices of the Medical Staff to determine the quality of care delivered to patients;

ii.) to ensure medical practice standards are developed and adhered to by all medical Departments, and that the outcomes of surveillance systems regarding the quality of medical care are directed towards its continuing improvement;

iii.) to liaise with other health care providers as required in order to ensure a high quality of care is delivered to patients;

iv.) to make recommendations regarding Medical Staff resource requirements to meet the medical needs of patients in the Facility, either as a committee of the whole, or as a properly constituted human resource planning committee.

b. Administration

i.) to appoint chairs and members of standing committees, in consultation with the Medical Staff, and to ensure that these committees function effectively;

ii.) to make recommendations to the Board of Directors on the development, maintenance, and updating of these Rules;

iii.) to submit recommendations to the Board of Directors concerning appointments, reappointment, evaluations and review of Medical Staff members and delineation of specific clinical and procedural privileges;

iv.) to monitor and report to the Facility Senior Operational Administrator(s) and Board of Directors on the maintenance of the professional standards and conduct of the Medical Staff and where appropriate to take action to address deficiencies;

v.) to report to the Senior Medical Administrator, the Facility Senior Operational Administrator(s), and Board of Directors on disciplinary measures to be applied to members of the Medical Staff following violation of the provisions contained in the Medical Staff Bylaws, Medical Staff Rules, or Facility Policies/Procedures;

vi.) to monitor the professional and ethical conduct of all members of the Medical Staff and to report any concerns to the MAC and to the Board of Directors when required;

vii.) to perform regular self-evaluations to ensure the MAC is fulfilling its mandate.

c. Academic

i.) to receive, study, and act upon reports regarding education, research, and continuing education of members of the Medical Staff, and research and teaching at the Facility.

8.0.4 Chair

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

b. The Chair of the MAC shall be appointed by the Board of Directors upon recommendation of the MAC. The nominee for the Chair of MAC will be selected by the Nominations Committee as per Article 8.3 of the Rules.

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

d. The MAC Chair or their designate is responsible for attending the Board of Directors Quality and Access Committee meetings and presenting a report of the committee's activities as described in 8.0.3

8.0.5 Vice Chair

a. The Vice-Chair of the MAC shall be appointed by the Board of Directors upon recommendation of the MAC. The nominee for the Vice Chair of MAC will be selected by the Nominations Committee as per Article 8.3 of the Rules.

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

8.0.6 Operational Protocol

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

b. Meetings shall be held monthly or at the call of the Chair. A minimum of ten meetings shall be held each year.

c. An executive of the MAC will be determined by the MAC. The MAC executive will have the authority to act on urgent issues when a full MAC meeting is not feasible. The MAC executive will report back to the MAC on actions or decisions that are made.

d. The minutes, agenda and other documentation of the Committee are maintained in the Medical Staff Office.

8.0.7 Authority

a. The MAC has the authority:

   i.) to ensure compliance of Medical Staff members with the *Hospital Act* and Regulations, Medical Staff Bylaws, Medical Staff Rules and policies of the Medical Staff and the Health Authority;

   ii.) to appoint committees of the MAC;

   iii.) to exercise discipline within and up to the limitations of authority delegated by the Board of Directors on any of its members, including issuing reprimands;

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

b. To make recommendations concerning:

   i.) supervision of clinical practice;

   ii.) establishment and maintenance of professional standards and conduct in the Facility;

   iii.) continuing improvement in the quality of care delivered to patients, including resource allocation;

   iv.) the provincial mandate, and research and academic activities in the Facility;

   v.) restriction, modification, suspension, revocation, non-renewal, or maintenance of a Medical Staff member's appointment or privileges, or other disciplinary action as may be appropriate.

8.0.8 Evaluation

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

8.1 CREDENTIALS AND HUMAN RESOURCE PLANNING COMMITTEE

8.1.1 Purpose:

a. To make recommendations regarding the appointment, reappointment, review and delineation of privileges of physicians, dentists, midwives, nurse practitioners, and staff applying to or belonging to the Scientific and Research Medical Staff category;

b. To receive recommendations from Department Heads that are made following the investigation of professional qualifications, standards of care, and professional conduct of Medical Staff;

c. To receive reports from Department or Program Heads regarding medical human resource planning and requirements;

d. To make recommendations to the Bylaws and Rules Committee regarding changes to policies and procedures related to credentials and human resource planning.

8.1.2 Composition (refer to Appendix B for individual Facility composition)

a. The committee shall consist of:

- at least three (3) Medical Staff members, representing the major clinical disciplines and specialties;
- a University of British Columbia representative who may be one of the existing members;
- a Medical Administrative representative appointed by the Senior Medical Administrator.

b. The Chair shall be appointed by the MAC for a two (2) year term, with a maximum consecutive term of four (4) years total.

c. All members on the Committee shall be appointed for a two (2) year term and all members are voting members.

8.1.3 Duties

a. To review the Department/Program and or Division Head's report concerning the investigation of the character, behaviour, qualifications, standing and intentions for appointment and reappointment to the Medical Staff and make recommendations to the MAC;

b. To recommend clinical and procedural privileges for each candidate based on the Department/Program and or Division Head's report. These privileges shall be commensurate with the training, experience, competence, judgment, character and current capability of the candidate;

c. To consider and make recommendations regarding all applications for modification of privileges, including applications made in accordance with policies for obtaining additional privileges;

d. To review and monitor all Department/Program's and Division's credentialing process including Department/Program medical human resource plans and make recommendations to the MAC for changes;

e. The Committee shall be accountable to and report to the MAC.

8.1.4 Operational Protocol

a. A simple majority shall constitute a quorum.

b. The Credentials Committee will meet ten (10) times per year, or at the call of the

Chair.

c. Minutes will be taken at each meeting. The original minutes, agenda and other documentation of the Committee will be submitted to and maintained in the Medical Staff Office. The files of the Credentials Committee shall be secure in keeping with the requirements of the *Freedom of Information and Protection of Privacy Act* and section 46(6) of the *Hospital Act*.[5]

d. Recommendations, actions, and decisions are presented to the MAC in writing as necessary.

8.1.5 Authority

The Credentials Committee has the authority to seek the advice of the Department Head, if applicable, in arriving at a recommendation regarding the assessment of an applicant's qualifications and the delineation of an applicant's privileges, and the assessment of a Department/Program credentialing processes.

8.1.6 Evaluation

The Credentials Committee shall conduct an annual self-evaluation. The result of the evaluation shall be presented to the MAC annually.

8.2 BYLAWS AND RULES COMMITTEE

8.2.1 Purpose

a. To make recommendations regarding the Medical Staff Bylaws and Medical Staff Rules;

b. To review the monitoring process in departments to ensure Medical Staff compliance with the Medical Staff Bylaws and Medical Staff Rules.

8.2.2 Composition

a. The committee shall consist of: at least six (6) Medical Staff members, two of whom shall be department heads, and one of whom shall be the Medical Staff President

b. All members shall be selected by the MAC for at least a two (2) year term. Terms will be staggered in order to have less than 50% turn-over per year. There will be an attempt to select members from different disciplines and specialties.

c. The Chair shall be appointed by the MAC members for a two (2) year term with a maximum consecutive term of four (4) years total.

d. All members of the Bylaws and Rules Committee are voting members.

8.2.3 Duties

a. To review the Medical Staff Bylaws and Medical Staff Rules at least annually and recommend any necessary changes to the MAC;

55[5] *Hospital Act,* [RSBC 1996] Chapter 200, Section 46(6): All information or evidence (a) about an application for a practitioner's permit to practice in a hospital, or contained in the decision of a board of management resulting from the application, or (b) received by, or presented to, a hospital appeal board for an appeal is privileged and an action must not be brought against a person for it.

b. To report to the MAC annually or following any meeting at which changes have been recommended;

c. To review sections of the Medical Staff Bylaws or Medical Staff Rules at the request of the MAC or Medical Staff Departments;

d. To review Department/Program policies and procedures to ensure Medical Staff compliance with the Medical Staff Bylaws and Medical Staff Rules and to make recommendations for improvement.

8.2.4 Operational Protocol

a. A simple majority shall constitute a quorum.

b. The Bylaws and Rules Committee will meet as necessary at the call of the Chair, with at least four (4) meetings per year.

c. Minutes will be taken at each meeting and adopted minutes shall be submitted to the Medical Staff Office within seven (7) days of adoption.

d. Administrative support will be provided by the Medical Staff Office.

8.2.5 Documentation Protocol

a. The maintenance of the minutes, agenda and other documentation related to the Committee is the responsibility of the Committee Chair. The original minutes, agenda and other documentation of the Committee will be submitted to and maintained in the Medical Staff Office.

b. Minutes of the Committee are submitted to the MAC through the Medical Staff Office. Recommendations, actions, and decisions are presented by the Chair to the MAC in writing as necessary.

8.2.6 Authority

The Bylaws & Rules Committee has the authority to make recommendations to the MAC regarding the Medical Staff Bylaws and Medical Staff Rules.

8.2.7 Evaluation

The Bylaws & Rules Committee shall conduct an annual self-evaluation. The result of the evaluation shall be presented to the MAC annually.

8.3 NOMINATIONS COMMITTEE

8.3.1 Purpose

a. To make recommendations to the MAC regarding the appointment of the MAC Chair and Vice Chair.

b. To make recommendations regarding the appointment of other MAC committee members when requested to do so by the MAC.

8.3.2 Composition

a. Membership includes:

- the President of the Medical Staff Association;
- six current MAC members;
- two Medical Staff members;
- the Senior Operational Administrator or Senior Medical Administrator or designate.

b. The MAC members on the Committee will be selected by the MAC. Every effort will be made to ensure Facility-wide representation.

c. The Medical Staff members on the Committee will be appointed by the Medical Staff President. Every effort will be made to ensure Facility-wide representation.

d. The Chair of the Nomination Committee shall be appointed by the current MAC. The Chair shall serve for two (2) years.

e. All members of the Nomination Committee shall serve for two (2) years and all members are voting members.

8.3.3 Duties

To recommend and present to the MAC its recommendations for the MAC Chair and Vice-Chair positions. If these recommendations are approved by a majority vote of the MAC, they shall be then presented to the Board of Directors for final approval.

8.3.4 Operational Protocol

a. A simple majority shall constitute a quorum.

b. The Nomination Committee will meet as necessary at the call of the Chair. Minutes will be taken at each meeting and adopted minutes shall be submitted to the Medical Staff Office within seven (7) days of adoption.

c. Administrative support for the committee will be provided by the Medical Staff Office.

8.3.5 Documentation Protocol

a. The maintenance of the minutes, agenda and other documentation related to the Committee is the responsibility of the Committee Chair. The original minutes, agenda and other documentation of the Committee will be submitted to and maintained in the Medical Staff Office.

b. Minutes of the Committee are submitted to the MAC through the Medical Staff Office. Recommendations, actions, and decisions are presented by the Chair to the MAC as necessary.

8.3.6 Authority

The Nominations Committee has the authority to seek the advice of any Medical Staff member in arriving at a recommendation regarding the MAC officers' positions.

8.3.7 Evaluation

The Nomination Committee shall conduct an annual self-evaluation. The results of the evaluation shall be presented to the MAC annually.

8.4 SAFETY AND QUALITY OF MEDICAL CARE COMMITTEE(S)

8.4.1 Purpose

a. The Safety and Quality of Medical Care Committee(s) is responsible to monitor and report upon the quality of medical care provided by the Facility to specified patient populations. The Committee will also raise awareness of quality of care issues within the organization.

b. The Safety and Quality of Medical Care Committee(s) provides support and participates in the creation of a safety culture by raising awareness of patient safety issues.

c. The Safety and Quality of Medical Care Committee(s) initiates continuous quality improvement projects in areas identified as having the need, using established tools and models for improvement.

d. The Safety and Quality of Medical Care Committee(s) may have sub-committees, and will coordinate and provide overall direction for the sub-committees.

8.4.2 Composition

a. Members shall be appointed by the Board of Directors on the recommendation of the MAC.

b. The Chair shall be appointed from among the Medical Staff members of the Safety and Quality of Medical Care Committee(s) for a two (2) year term. The Chair shall normally have a maximum consecutive term of four (4) years.

c. A Vice-Chair shall be appointed for a two (2) year term, to serve in the absence of the Chair. In the selection of the Vice-Chair, consideration should be given to the multidisciplinary nature of the programs within the Facility.

d. Representative members on the committee shall be appointed for a two (2) year term. All other members are appointed to the committee by virtue of their position.

e. The appointed Chair shall report to the MAC.

f. A member of the Department of Quality, Safety, and Risk Management.

8.4.3 Duties

a. To study, investigate, evaluate and report on the quality of patient care provided by the Facility to their mandated patient population(s);

b. To ensure the existence of the quality, utilization, and risk system in the programs, Department, and integrated services;

c. To ensure the existence of committees or structures that formally review quality of care issues within Departments serving their mandated patient population;

d. To identify priorities related to quality, utilization and risk related initiatives;

e. To regularly receive, monitor and review information, including corporate quality and utilization reports, regarding performance, based upon established indicators of performance;

f. To review on a regular basis statistics concerning issues of mortality and morbidity, and make special inquiries or investigations into trends of specific deaths as warranted;

g. To sponsor ongoing projects dedicated to improving identified processes and outcomes;

h. To report regularly and make recommendations to the MAC regarding quality, utilization, risk system and the activities of the Committee(s);

i. To establish effective reporting relationships between the Quality of Care and Safety Committee(s) and its sub-committees, the programs, Departments and integrated services;

j. To receive reports from and support the sub-committees' activities, and to ensure that quality of care issues at the program level are reviewed, acted upon, resolved and continuously monitored;

k. The Chair of the Safety and Quality of Medical Care Committee(s) will regularly liaise with the Senior Medical Administrator;

l. Ensure that recommendations approved by MAC are acted upon in a timely and ongoing fashion, with regular reports to the MAC.

8.4.4 Operational Protocol

a. A simple majority shall constitute a quorum.

b. The Committee(s) shall meet at least ten (10) times a year and at the call of the Chair.

c. The Department of Quality, Safety and Risk Management provides secretarial support to the committee. Minutes will be taken at each meeting.

d. All action items will be brought forward at subsequent meetings. It is the responsibility of the secretary of the Committee(s) to keep a bring forward list. It is the responsibility of the Chair to ensure that follow-up takes place for all action items.

e. Minutes of the meeting are circulated with the agenda for the next meeting.

8.4.5 Documentation Protocol

a. Documents prepared for the Committee(s) and at the request of the Committee(s) are protected under Section 51 of the *Evidence Act*.

b. The maintenance of the minutes, agenda and other documentation related to the Committee(s) is the responsibility of the Committee Chair(s) with support provided by the Department of Quality, Safety, and Risk Management. The original minutes, agenda and other documentation of the Committee are maintained in the Department of Quality, Safety and Risk Management.

c. Minutes of the Committee(s) will be made available to the MAC, and the Senior Medical Administrator.

8.4.6 Accountability

a. The Committee(s) shall be accountable and provides standardized reports to the MAC, and the Quality and Access Committee of the PHSA Board of Directors.

b. The Committee(s) will be responsive to specific requests from the MAC for information related to the quality of patient care.

8.4.7 Authority

The Safety and Quality of Medical Care Committee(s) has the authority to:

a. Monitor and report on the quality of care, safety and risk management of Departments;

b. Study and act upon reports from other committees including the Infection Control Committee, Mortality Committee, the Health Record Committee and the Priorities and Evaluation Committee;

c. Seek the advice of any Medical Staff member, healthcare practitioner, or others, if applicable, in arriving at a recommendation regarding the assessment of the quality of care, safety and risk management activities;

d. Recommend changes to the terms of reference of the Committee(s) and Subcommittees, with review and approval by the Committee(s) as a whole, and when appropriate, by the MAC.

8.4.8 Evaluation

The Safety and Quality of Medical Care Committee(s) shall conduct self-evaluations and submit the results to the MAC. The type and frequency of the evaluation will be determined by the Committee(s) with consultation from the MAC.

8.5 HEALTH RECORDS COMMITTEE

8.5.1 Purpose

To ensure the overall quality of and appropriate access to the health record for the provision of excellent patient care. To make specific recommendations on maintenance and improvement of the quality of and access to the health record.

8.5.2 Composition (refer to Appendix B for individual Facility membership)

a. Minimum membership will include:

- medical Staff members to represent all clinical components of the Facility
- nursing representative
- non-medical and non-nursing profession representative
- administration representative from risk management
- manager of Health Records or designate

b. Representative members of the Health Records Committee shall be appointed by the MAC with input from the applicable Department Head, Division Head, or Vice President. Effort will be made to select members from all Facilities and from different specialties.

c. The Chair shall be appointed by the MAC for a two (2) year term.

d. All members of the Health Records Committee shall be appointed for a two (2) year term and all members are voting members.

e. Regular attendees can designate delegates to attend in the event of their absence. The designate must come prepared for meetings and have information to participate in discussions, provided by the regular attendee. Delegates may attend at the discretion of the Chair.

8.5.3 Duties

a. To make recommendations to the MAC regarding

i.) policies governing access to the health record to ensure that access to, and storage of, the patient record complies with confidentiality and privacy legislation, and is consistent with excellent patient care;

ii.) policies for completion of health records;

iii.) planning, decision-making, and formulation of those medical standards and policies that affect the Health Record;

iv.) develop, test, implement, and set minimum documentation standards for the patient record consistent with excellent patient care;

v.) approval of forms for inclusion in the health record;

vi.) standards for electronic forms of the health record;

vii.) approval of quality assurance assessment of records process.

b. To assist in facilitating the enforcement of policies regarding completion of delinquent charts.

c. To monitor and evaluate compliance with the set standards and to assist in the conduct of clinical audits for quality of care purposes.

d. To solicit feedback from user areas and respond by setting priorities to the needs identified in reaching the overall goal of an electronic patient record.

e. To develop a future vision of the patient record and create a framework to ensure the

migration from a paper to an electronic patient health record.

f. To act as a resource regarding the Health Record.

8.5.4 Operational Protocol

a. A simple majority shall constitute a quorum.

b. The Health Records Committee shall meet monthly or at the call of the Chair. The Committee will meet at least nine (9) times per year.

c. Minutes and an agenda will be circulated to each member of the Committee at least five (5) working days (1 week) before each meeting. Minutes will be taken at each meeting and adopted minutes and attachments shall be submitted to the Quality, Safety and Risk Management Department, in both the electronic and in paper formats, within 7 days of adoption.

d. All action items are to be brought forward at subsequent meetings. It is the responsibility of the secretary of the Committee to keep a bring forward list. It is the responsibility of the Chair to ensure follow-up takes place for all action items.

8.5.5 Documentation Protocol

a. Documents prepared for the Committee and at the request of the Committee are protected under Section 51 of the *Evidence Act*.

b. The maintenance of the minutes, agenda and other documentation related to the Committee is the responsibility of the Committee Chair. The original minutes, agenda and other documentation of the Committee will be submitted to and maintained in the Department of Quality, Safety and Risk Management.

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

8.5.6 Accountability And Reporting Relationships

a. The Committee shall be accountable to the MAC. The Committee will report to the MAC at least three times a year.

b. The Committee will be responsive to specific requests from the MAC for information related to the quality of patient care.

8.5.7 Authority

a. The Committee has the authority to evaluate the overall quality of record keeping, and to make specific recommendations to individual groups or services on the maintenance and improvement of the quality of health records.

b. Changes to the terms of reference of the committee must be reviewed and approved by the MAC and, when appropriate, by the Board of Directors.

8.5.8 Evaluation

The Committee will ensure a self-evaluation consistent with the standards and requirements of the MAC. The results of the evaluation shall be presented to the MAC annually.

8.6 INFECTION CONTROL COMMITTEE

8.6.1 Purpose

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

8.6.2 Composition (refer to Appendix B for individual Facility membership)

a. The Infection Control Committee shall consist of at least five (5) members, including but not restricted to:

- representation from the main medical discipline from the Medical Staff including a member of the Division of Infectious Diseases or equivalent;
- the Senior Infection Control Nurse;
- the Infection Control Officer;
- representation from Microbiology;
- representation from Nursing;
- representation from Occupational Health and Safety;
- representation from Administration;
- representation from Pharmacy;
- representation from Quality, Safety and Risk Management;
- Representation from Obstetrics; and
- Representation from Adult infectious disease / medicine.

b. The Chair shall be appointed by the MAC for a two (2) year renewable term. The Chair will report to the MAC.

c. All members of the Infection Control Committee shall be appointed for a two (2) year term and all members are voting members.

d. Regular attendees can designate delegates to attend in the event of their absence. Delegates may attend at the discretion of the Chair.

e. A Vice-Chair shall be appointed for a two (2) year term, to serve in the absence of the Chair. In the selection of the Vice-Chair, consideration should be given to the multidisciplinary nature of the programs within the Facility.

8.6.3 Duties

a. To formulate policies for the maintenance of the safest environment that is practical for the patients, family, visitors and staff of the hospital in all situations involving the possible transfer of infectious agents;

b. To review and approve systems for reporting, evaluating and recording infection statistics developed by the infection control service;

c. To conduct any business delegated by the MAC.

8.6.4 Operational Protocol

a. A simple majority shall constitute a quorum.

b. The Infection Control Committee shall usually meet on a monthly basis, but a minimum of eight (8) times per year, at the call of the Chair.

c. Minutes and an agenda will be circulated to each member of the Committee at least five (5) working days (1 week) before each meeting. Adjusted minutes will be taken at

each meeting. An adjustor will be elected from the attendees at each meeting to ensure accuracy of minutes before they are distributed to the group

d. All action items are to be brought forward at subsequent meetings. It is the responsibility of the secretary of the Committee to keep a bring forward list. It is the responsibility of the Chair to ensure follow-up takes place for all action items.

e. Administrative support will be provided by Quality, Safety & Risk Management.

8.6.5 Documentation Protocol

a. Documents prepared for the Committee and at the request of the Committee are protected under Section 51 of the *Evidence Act.*

b. The maintenance of minutes, agenda and other documentation related to the Committee is the responsibility of the Committee Chair. The original minutes, agenda and other documentation of the Committee are maintained in the Department of Quality, Safety and Risk Management.

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

8.6.6 Accountability

a. The Infection Control Committee shall be accountable to and report to the MAC or BCCH and BCWH. The Infection Control Committee shall advise the Senior Medical Administrator of these Facilities of critical concerns.

b. The Committee will be responsive to specific requests from the MAC for information related to the quality of patient care.

8.6.7 Authority

The Infection Control Committee has the authority to:

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

b. Formulate policies for the maintenance of the safest environment that is practical for the patients, family, visitors and staff of the hospital in all situations involving the possible transfer of infectious agents and shall review regularly the effectiveness of these policies.

c. Make changes to the terms of reference of the committee, which must be reviewed and approved by the MAC, and when appropriate by the Board of Directors.

8.6.8 Evaluation

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

8.7 MORTALITY REVIEW COMMITTEE (see Appendix C for Children's & Women's Mortality Review Committee)

8.7.1 Purpose

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

Code Blue Team related to cardiac resuscitation to identify issues and concerns.

8.7.2 Composition

a. Membership will include:

- Chairs of Safety and Quality of Medical Care Committee(s)
- Four (4) Medical Staff representatives.
- Nursing Administration representative
- Risk Management representative
- Decision Support Services representative (non-voting member)
- Representative from the Code Blue Committee (ad hoc member)

b. All members are voting members.

c. Ad hoc members will attend the Mortality Review Committee meetings if cases relevant to their population mandate areas are being reviewed, or at the request of the Chair.

d. Representative members are appointed for two-year terms by their Department Head or Senior Medical administrator.

e. The Chair shall be appointed for a two-year term by the Chair of the MAC.

f. Regular attendees can designate delegates to attend in the event of their absence. Delegates may attend at the discretion of the Chair.

8.7.3 Duties

a. To ensure that the mortality review process is functioning thoroughly and in a timely manner.

b. To review the minutes of the committees reviewing all deaths occurring in the facility, out-patient clinics and emergency department.

c. To review all cardiac arrests occurring in the Facility through report by the Code Blue Committee.

d. To survey all deaths for similarities in cause, pathogenesis and/or therapy that may require evaluation.

e. To provide a full review of any death when requested by an individual mortality review committee, the MAC, or Safety and Quality of Medical Care Committee(s).

f. To follow-up and report on the enactment of its recommendations for all cases investigated, including Coroner's cases.

g. To bring forward to the Safety and Quality of Medical Care Committee(s), MAC, Facility Executive and Board of Directors confirmation that complete mortality reviews are occurring in a timely manner and that actions are taken appropriately.

h. To liaise with the public relations department on matters of a general concern to the community.

8.7.4 Operational Protocol

a. A simple majority shall constitute a quorum.

b. The Mortality Review Committee shall meet ten (10) times per year or at the call of the Chair.

c. All action items are to be brought forward at subsequent meetings. It is the responsibility of the secretary of the Committee to keep a bring forward list. It is the responsibility of the Chair to ensure follow-up takes place for all action items

d. Minutes and an agenda will be circulated to each member of the Committee at least five (5) working days (1 week) before each meeting. Minutes will be taken at each meeting.

e. The Mortality Review Committee shall receive and review reports from departmental/ program mortality committees. The Chair or alternate of the Mortality Review Committee may attend any departmental/program mortality committees or other quality assurance committees where a mortality is being reviewed, as deemed necessary.

8.7.5 Documentation Protocol

a. Documents prepared for the Committee and at the request of the Committee are for quality assurance purposes and are protected under Section 51 of the *Evidence Act*.

b. The maintenance of minutes, agenda and other documentation related to the Committee is the responsibility of the Committee Chair. The original minutes, agenda and other documentation of the Committee are maintained in the Department of Quality, Safety and Risk Management.

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

8.7.6 Accountability And Reporting Relationships

a. The Mortality Review Committee shall be accountable to the MAC. The Committee will report to the Safety and Quality of Medical Care Committee(s) at least three (3) times a year.

b. The Committee will be responsive to specific requests from the MAC for information related to the quality of patient care.

8.7.7 Authority

a. The Mortality Review Committee has the authority to review the minutes of the Departments or the Department committees reviewing all deaths occurring in the hospital, out-patient clinics and emergency department.

b. The Committee has the authority to follow-up and report on the enactment of its recommendations for all cases investigated, including Coroner's cases.

c. Changes to the terms of reference of the Committee must be reviewed and approved by the MAC and when appropriate, by the Board of Directors.

8.7.8 Evaluation

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

8.8 PRIORITIES AND EVALUATION COMMITTEE

8.8.1 Purpose

a. The Priorities and Evaluation Committee shall provide a mechanism by which medical interventions are developed, evaluated, funded, introduced and reviewed. The committee's mandate includes new and current interventions, technologies, pharmaceuticals, protocols and innovative treatments. The committee will advise

regarding the use of treatment interventions, protocols, pharmacologically active agents and new technologies. The committee will develop policies regarding the evaluation, selection and control of the use of these agents or treatments in the Facility. For the purposes of the committee, pharmacologically active agents include pharmaceuticals, biologicals, blood and blood products, non-blood colloids, intravenous therapy, enteral and parenteral nutrition and investigational agents.

b. To recommend policies and procedures regarding the distribution, evaluation, selection, safe practice, control, and other matters pertaining to the use of protocols, technologies and agents at the Facility. Efficacy, safety and economics of utilization will also be evaluated.

c. To promote safe, rational and economic use of nutritional products in the hospital.

8.8.2 Composition

a. Membership of the Priorities and Evaluation Committee will include but not be restricted to:

- at least three (3) Medical Staff members, representing the major clinical disciplines, specialties and departmentss.
- representation from Pharmacy
- representation from Pathology/Clinical Laboratory
- representation from Nursing.

b. The Chair shall be appointed for a two (2) year renewable term. The Chair may be required to sit on the MAC.

c. All members of the Priorities and Evaluation Committee will be appointed for a two (2) year term.

d. Regular attendees can designate delegates to attend in the event of their absence. The designate must come prepared for meetings and have information to participate in discussions, provided by the regular attendee. Delegates may attend at the discretion of the Chair.

8.8.3 Duties

To serve in an advisory capacity:

a. To provide a mechanism by which medical interventions are developed, evaluated, funded, introduced and reviewed. The committee's mandate includes new and current interventions, technologies, pharmaceuticals, protocols and innovative treatments.

b. To assist or plan suitable education programs for the professional staff in matters relating to drug use and nutritional products, protocols, new technologies and innovative treatments**,** and to provide appropriate staff access to resource materials regarding policies, procedures and formulary revisions.

c. To establish policies for safe medication ordering and administration.

d. For established medical interventions, protocols, pharmaceuticals:

i.) to organize and supervise audits of ordering and prescribing practices, drug administration and adverse drug/medication events.

ii.) to review quality assurance activities related to the distribution, ordering, administration and use of medications with emphasis on appropriateness, safety and effectiveness.

iii.) to review adverse drug or transfusion reactions.

iv.) to review and approve drug use review programs and studies and to review the results of such activities.

e. For patients:

To maintain allergy identification protocols.

f. For Medical Staff:

i.) to review and monitor the patterns of prescribing.

ii.) to develop and maintain a current formulary of accepted drugs.

iii.) to review and recommend written policies, procedures, rules and regulations reflecting the legal and ethical requirements of the medical and pharmacy professions, including:

- selection and procurement of drugs;
- ordering and prescribing drugs;
- distribution of drugs to clinical areas and their preparation for use;
- dispensing and administering drugs;
- investigational new drugs (IND), and to supervise the use of investigational drugs;
- safe use of drugs and drug interactions;
- intravenous and blood products therapy;
- nutritional products and services.

g. For Pharmacy:

i.) to review the storage and control of drugs, including hazardous and investigational drugs, to ensure adequate and safe standards are developed and maintained;

ii.) to present recommendations to the MAC for approval;

iii.) to conduct any business delegated by the MAC.

8.8.4 Operational Protocol

a. A simple majority shall constitute a quorum.

b. The Priorities and Evaluation Committee shall meet at least ten (10) times per year, or at the call of the Chair.

c. Minutes and an agenda will be circulated to each member of the Committee at least five (5) working days (1 week) before each meeting. Minutes will be taken at each meeting.

d. All action items are to be brought forward at subsequent meetings. It is the responsibility of the secretary of the Committee to keep a bring forward list. It is the responsibility of the Chair to ensure follow-up takes place for all action items.

e. The Chair of the Priorities and Evaluation Committee may act on behalf of the committee between meetings, on matters of urgent business regarding drug therapy. The Chair should consult with appropriate individuals when making decisions; this may include the Senior Medical Administrator, Chair of the MAC, and any individuals with expertise on, or substantially impacted by, the topic.

8.8.5 Documentation Protocol

a. Documents prepared for the Committee and at the request of the Committee are protected under Section 51 of the *Evidence Act*.

b. The Committee Chair is responsible to maintain minutes, the agenda and other documentation related to the Committee. The original minutes, agenda and other documentation of the Committee are maintained in the Department of Quality, Safety and Risk Management.

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

8.8.6 Accountability

a. The Priorities and Evaluation Committee shall be accountable and report to the MAC.

b. The Committee will be responsive to specific requests from the MAC for information related to the quality of patient care.

8.8.7 Authority

The Priorities and Evaluation Committee has the authority to:

a. Make recommendations to the MAC as described in the purpose. The committee will also make recommendations to Nutrition Services, the Pharmacy, or other services as necessary;

b. Establish subcommittees, task forces, or working groups as necessary;

c. Make changes to the terms of reference of this Committee, which must be reviewed and approved by the MAC.

8.8.8 Evaluation

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

8.9 RESEARCH, PROFESSIONAL DEVELOPMENT AND MEDICAL EDUCATION COMMITTEE

8.9.1 Purpose

The Research, Professional Development and Medical Education Committee shall advise the MAC on education and research matters in the Facility relating to Medical Staff, house staff, clinical fellows, medical students, and patients.

8.9.2 Composition

a. Members of the Research, Professional Development and Medical Education Committee shall be appointed by the MAC.

b. The membership shall include, but not be restricted to:

- representation from at least three (3) members of the Medical Staff;
- representation from Learning and Development;
- representation from house staff and clinical trainees;
- ad hoc members from clinical departments.

c. The Chair of the Research, Professional Development and Medical Education Committee shall be appointed by the MAC in conjunction with the Vice President of Research and Education for a maximum consecutive term of three (3) years.

8.9.3 Duties

a. To advise on the role and responsibility of the Facility and its Medical Staff concerning education for the Medical Staff and the profession at large;

b. To assist the clinical departments and divisions in the planning and coordination of all educational activities of the Medical Staff within the Facility;

c. To participate in the arrangement of rounds, clinical conferences and symposia;

d. To advise on the need for and methods of providing patient education for all patients at the Facility;

8.9.4 Operational Protocol

a. A simple majority shall constitute a quorum.

b. The Committee will meet as necessary at the call of the Chair.

ARTICLE 9 — DISCIPLINE AND APPEAL

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

9.1 General Considerations

9.1.1 The Medical Staff member should be informed in writing of any complaints or concerns involving his or her care or professionalism in a timely fashion.

9.1.2 Where the Board of Directors refuses, restricts, modifies, suspends or revokes the privileges of a member of the Medical Staff, the Medical Staff member has the right to appeal to the Hospital Appeal Board as per the *Hospital Act* and *Regulations*.[6]

9.2 Complaints or Concerns About the Conduct of a Member of the Medical Staff

9.2.1 Complaints or Concerns Other Than Those Relating to Professional Conduct, Ethical Conduct, or Medical Competence

a. Complaints or concerns relating to issues aside from professional conduct or medical competence, such as interpersonal conduct, will be dealt with by the Human Resources Department, which has an established process for handling these events. In accordance with this policy, the complainant may pursue either an informal or formal investigation as described in the PHSA Human Rights Policy.

b. When a request for formal investigation is made in writing, the Human Rights Advisor will investigate, in accordance with the PHSA Human Rights Policy, and prepare a report which shall be submitted, to the Department Head, the Senior Medical Administrator, the complainant, and the Medical Staff member. The Senior Medical Administrator shall meet with the Medical Staff member involved and the appropriate Department Head. The Department Head and Senior Medical Administrator shall discuss with the Medical Staff member their recommendations as to the appropriate

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

action to be taken. If the Medical Staff member concurs, the action will be confirmed in writing to the Medical Staff member, with a copy to his/her personnel file.

c. If the Medical Staff member objects to the proposed action, the Senior Medical Administrator shall forward the complaint to the Chair of the MAC to be dealt with under Rule 9.2.2.

9.2.2 Complaints or Concerns about Professional or Interpersonal Conduct, Ethical Conduct, or Medical Competence

a. Complaints or concerns about professional conduct, interpersonal conduct (where the member objects under 9.2.1(c)), ethical conduct, or medical competence, which are not deemed to require a change in privileges at that time, may be managed by the Department Head. The Department Head shall investigate the circumstances giving rise to the complaints or concerns and shall ensure that all findings, actions, and outcomes are documented.

b. If, in the opinion of the Department Head, the complaints or concerns are significant, but do not require immediate action to protect patients or staff, then these are to be reported to the Senior Medical Administrator within 72 hours of the Department Head becoming aware of the problem.

c. Critical incidents, that is, those related to a life-threatening event, are to be reported to the Senior Medical Administrator within 24 hours. The established processes concerning critical incidents will then be followed.

d. In accordance with Medical Staff Bylaws Article 11.2.1, where the CEO or Senior Medical Administrator becomes aware of a serious problem or a potential problem with a specific member of the Medical Staff which adversely affects or may adversely affect the care of patients or the safety and security of patients or staff, and action is required to protect the safety and best interests of patients and staff, the CEO or Senior Medical Administrator may summarily restrict or suspend privileges of a member of the Medical Staff.

e. For those complaints which are being managed initially at the Department/Program level, as per Rule 9.2.2.a or 9.2.2.b, the member involved will be provided with details of the complaint in writing and will have the opportunity to submit to the Department Head, in writing, a response within ten (10) days of receipt of notice of the complaint.

f. During the course of investigation of the complaint, and within thirty (30) days of receipt of the complaint, the Department Head shall interview the member. The Department Head may obtain an internal or external review of the incident or practice of the member and/or advice of legal counsel where appropriate, upon consultation with the Chair of the Facility's Medical Advisory Committee and the Senior Medical Administrator.

g. If the matter is not resolved by the Department Head within 30 days of the interview with the Medical Staff member, the Department Head will draw up a report for the Facility Senior Operational Administrator, Senior Medical Administrator and the Chair of the MAC. This report may provide a recommendation on the remedial measures or further investigation that should be considered.

h. If the complaint is directed against a Department Head, the Senior Medical Administrator will appoint another Department Head to investigate the complaint.

i. A copy of the Department Head's report will be provided to the member under investigation. If the matters raised in the report are of sufficient gravity and potentially warrant disciplinary measures, then the report must be accompanied by a letter from the Facility through the Senior Medical Administrator, which explains the seriousness of the matter and potential consequences, including modification of

privileges, unless it can be shown that the concerns are either mistaken or misplaced.

j. If the Senior Medical Administrator determines that complaints or concerns about the Medical Staff member warrant a change in status or privileges, then the Senior Medical Administrator shall request a review by the MAC in accordance with Article 11.2 of the Medical Staff Bylaws.

k. When a complaint is referred to the MAC, the Chair will strike a Medical Staff Member Review Subcommittee. This subcommittee will consist of the chair of the MAC (who will chair the meeting), the chair of the Credentials Committee, the president of the Medical Staff Association, a Department Head, and an additional member of the Medical Staff Association. The membership of the subcommittee will be chosen to avoid conflict of interest and to ensure the necessary expertise of the committee, and when necessary, alternatives will be selected from the permanent MAC membership, the Department Head, or from the elected officers of the Medical Staff Association.

l. The Medical Staff Member Review Subcommittee will examine the documentation, will receive input from the Department Head, who will present the report, and will also receive input from others, including external reviewers where appropriate, who can speak directly to concerns raised in the report.

m. The member of the Medical Staff and his/her counsel shall be permitted to make a presentation of their own, including references to any supporting materials they may wish to submit together with comments from others who can speak directly to the concerns raised in the report.

n. Following the investigation by the subcommittee, the Department Head will make a recommendation to the subcommittee on the action s/he feels to be appropriate. Similarly, the Facility, through the Senior Medical Administrator, will also make a recommendation.

o. The subcommittee will deliberate and reach a conclusion and formulate a recommendation to submit for consideration by the MAC.

p. A special meeting of the full MAC will be called within one (1) month of the subcommittee hearing and the report of the subcommittee and its recommendation will be presented for discussion. Only permanent members of the HAMAC will attend this special meeting. A quorum must be present to proceed with this meeting. If a quorum is not present, a second meeting must be called within one (1) month. Those MAC members who have a conflict of interest may attend the meeting and may be asked to contribute but will not vote.

q. The Department Head to which the member under investigation belongs will present his/her report, along with other supporting documents, and comments from other persons who can speak directly to the concerns raised in the report. The member of the Medical Staff and his/her counsel shall be permitted to make a full presentation of their own, including references to any supporting materials they wish to submit together with comments from others who can speak directly to the concerns raised in the Department Head's report and the subcommittee's report and recommendation.

r. The HAMAC will develop recommendations for the Board of Directors. Those with a conflict will withdraw and a vote will be taken by secret ballot. A majority vote is sufficient to pass the recommendation. The recommendations of the HAMAC are communicated by the Chair of the MAC to the Board of Directors and to the Senior Medical Administrator in writing.

s. The Chair will make the CEO and Senior Medical Administrator aware of the HAMAC's recommendation, and the Senior Medical Administrator will immediately inform the member and his/her counsel. In accordance with Bylaw 11.2.2.b, the

member must be given seven (7) days' notice in writing of any recommendation of the HAMAC to the Board of Directors and of the date and time at which the recommendation will be considered in-camera by the Board of Directors.

t. In accordance with Bylaw 11.2.2.a, if the privileges of the individual under investigation have been recommended for revocation, refusal, suspension, restriction, or non-renewal, the Board of Directors must consider the recommendations of the HAMAC and the CEO or Senior Medical Administrator within 60 days.

u. The Facility Senior Operational Administrator will present the case to the Board of Directors and the Chair of the MAC will report its recommendations. In accordance with Bylaw 11.2.2.c, the member of the Medical Staff has the right to be heard at this meeting and to bring legal representation.

v. The Board of Directors will determine the action to be taken. In accordance with Bylaw 11.2.2.e, the Board of Directors must convey its decision in writing, within seven (7) days of its decision, to the member of the Medical Staff.

9.2.3 The Medical Staff member and his/her counsel will determine if they will appeal the decision and whether this appeal will be to the Board of Directors or directly to the Hospital Appeal Board. The member of the Medical Staff has the right to appeal to the Hospital Appeal Board as per the *Hospital Act* and *Regulations*.

ARTICLE 10 — AMENDMENTS

Amendments to the Medical Staff Rules shall be made by the Board of Directors after consultation with the Facility MACs and the HAMAC.

Requests for amendment may be initiated by any member of the Medical Staff, by the Bylaws Committee, by the Facility MACs, by the HAMAC, or by the Board of Directors.

The Medical Staff Rules are reviewed at least every three (3) years by the Bylaws Committee, revised as necessary, and dated accordingly.

ARTICLE 11 — APPROVAL OF RULES

These Rules become effective only when first adopted by the Board of Directors.

THIS IS TO CERTIFY:

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

Signed by:

_____
Chair, Board of Directors

_____
CEO

_____
Vice President, Legal, Privacy, Risk Management and Medical Affairs

APPENDIX A

COMPOSITION OF FACILITY MEDICAL ADVISORY COMMITTEES

BC Cancer

Voting Members

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

Non Voting Members

1. Chief Medical Officer
2. Chief Operating Officer
3. Senior Executive Director of Operations
4. Senior Executive Director of Clinical Programs
5. Senior Executive Director, Medical Affairs and Quality
6. Director of Risk Management (as required)

Children's and Women's Health Centre

Voting Members

1. Chair, Medical Advisory Committee
2. Vice-Chair, Medical Advisory Committee
3. President, Medical Staff Association
4. Head, Department of Pediatric Anesthesia
5. Head, Department of Obstetric Anesthesia
6. Head, Department of Family Practice
7. Head, Department of Medical Genetics
8. Head, Department of Medicine
9. Head, Department of Midwifery
10. Head, Department of Obstetrics & Gynecology
11. Head, Department of Pediatrics
12. Representative, Dept of Pediatrics (appointed by Dept Head)
13. Head, Department of Pathology

14. Head, Department of Psychiatry
15. Head, Department of Radiology
16. Chief, Department of Pediatric Surgery (to include Dentistry, Ophthalmology and Orthopaedics)
17. Representative, Department of Pediatric Surgery (appointed by Chief of Surgery)
18. Head, Department of Pediatric Dentistry
19. Head, Department of Nurse Practitioners

Non-Voting Members

20. Senior Operational Administrator, BC Children's Hospital and Sunny Hill Health Centre
21. Senior Operational Administrator, BC Women's Hospital & Health Centre
22. Vice-President, Medical Affairs, BC Children's Hospital and Sunny Hill Health Centre,
23. Vice-President, Medical Affairs, BC Women's Hospital
24. Vice-President, BC Mental Health and Addiction Services
25. Executive Director, Child & Family Research Institute
26. Executive Director, Women's Health Research Institute
27. Sr. Nursing Administrator (or delegate)

APPENDIX B

COMPOSITION OF COMMITTEES – CHILDREN'S & WOMEN'S HEALTH CENTRE

COMPOSITION OF HEALTH RECORDS COMMITTEE

The Health Records Committee shall consist of:

- Women's Programs (3 representatives – physicians and nurse leaders)
- Children's Programs (3 representatives – physicians and nurse leaders)
- Pathology (1 representative)
- Radiology (1 representative)
- Professional Services (2 representatives)
- Nursing Administration (1 representative)
- Pharmacy (1 representative)
- Safe Medication Committee (1 representative)
- Decision Support Services (1 representative)
- Health Information Services (3 representatives)
- Quality/Risk Management Representative (1 representative)
- Ad hoc representatives as required.

COMPOSITION OF INFECTION CONTROL COMMITTEE

The Infection Control Committee shall consist of:

- at least five (5) medical staff members
- representation of the main medical disciplines from the Medical Staff, including Pediatrics, Emergency, Surgery, Obstetrics, Oncology and Neonatology;
- representation from Infectious Disease, Microbiology and an Infection Control Officer (may be the same individual);
- the Senior Infection Control Nurse;
- representation from Nursing;
- representation from Occupational Health and Safety;
- representation from Pharmacy;
- representation from Quality, Safety and Risk Management (QSRM);
- representation from public health;

- representation from Sterile Processing;
- representation from Sunny Hill Health Centre for Children;
- representation from Housekeeping;

COMPOSITION OF CREDENTIALS AND HUMAN RESOURCE PLANNING COMMITTEE

a. The committee shall consist of:

- at least six (6) Medical Staff members, representing the major clinical disciplines and specialties;
- a University of British Columbia representative who may be one of the existing members;
- a Medical Administrative representative appointed by the Senior Medical Administrator.

b. The Chair shall be appointed by the Facility MAC for a two (2) year term, renewable for three (3) terms.

c. Members on the Committee shall be nominated by the Head of the respective Department, and approved by the Facility MAC.

d. Members on the Credentials and Human Resource Planning Committee shall be appointed for a two (2) year term, renewable at the discretion of the respective Department Head and in consultation with the committee member. The Department Head shall notify the Committee in writing of any desired change in representation. All members are voting members.

COMPOSITION OF SAFETY AND QUALITY OF MEDICAL CARE COMMITTEES (Article 8.4)

- Child Health Safety and Quality of Care Committee
- BCWH Ambulatory Service Quality Committee
- BCWH Acute Perinatal Quality Committee
- Tissue Advisory Committee

APPENDIX C

8.7 MORTALITY REVIEW COMMITTEE – Children's & Women's Health Centre Only

8.7.1 Purpose

To ensure that the mortality review process is functioning thoroughly and in a timely manner. To review the mortality reports of Departments to identify similarities in cause, pathogenesis and/or therapy that may require evaluation.

8.7.2 Composition

a. Membership will include:

- Medical Staff from Pathology
- Chairs of Children's Safety and Quality of Medical Care and Women's Quality Committees
- Four (4) Medical Staff representatives from C&W, including obstetrics/MFM, surgery, pediatrics, and PICU/NICU.
- Nursing Administration representative
- Risk Management representative
- Clinical ethics service representative

- Advanced Symptom and Palliative Care Service representative
- Bereavement services representative

b. All members are voting members.

c. Ad hoc members will attend the Mortality Review Committee meetings if cases relevant to their population mandate areas are being reviewed, or at the request of the Chair (but remain non-voting members).

d. Representative members are appointed for two-year terms by their Department Head or Senior Medical Administrator.

e. The Chair shall be appointed for a three-year term by the MAC, renewable for one term.

f. Regular attendees can designate delegates to attend in the event of their absence. Delegates may attend at the discretion of the Chair.

8.7.3 Duties

a. To ensure that the Children's (BCCH), Women's (BCW) and Sunny Hill (SHHCC) Hospitals' mortality review process is functioning thoroughly and in a timely manner.

b. To review the minutes of the Departmental /Program committees reviewing all deaths occurring in BCCH, SHHCC and BCW.

c. To review mortality statistics and autopsy rate for BCCH and WH on a quarterly basis; supported by Decision Support Services

d. To receive annual mortality rate reports from NICU, PICU, Cardiovascular surgery, Oncology, Perinatal mortality review committee, and Midwifery from Decision Support Services, with further discussion and presentation as requested by the committee.

e. To survey all deaths for similarities in cause, pathogenesis and/or therapy that may require evaluation.

f. To provide a full review of any death when requested by ~~an individual~~ a Departmental /Program) mortality review committee, the MAC, or Safety and Quality of Care Committee(s).

g. To provide direction to the MAC, Facility Executive and Board of Directors, including regarding resources, to enact recommendations from reporting committees

h. To follow-up and report on the enactment of its recommendations for all cases investigated, including Coroner's cases.

i. To bring forward to the MAC, Facility Executive and Board of Directors confirmation that complete mortality reviews are occurring in a timely manner and that actions are taken appropriately.

8.7.4 Operational Protocol

a. A simple majority shall constitute a quorum.

b. The Mortality Review Committee shall meet ten (10) times per year or at the call of the Chair.

c. All action items are to be brought forward at subsequent meetings. It is the responsibility of the secretary of the Committee to keep a bring forward list. It is the responsibility of the Chair to ensure follow-up takes place for all action items

d. Minutes and an agenda will be circulated to each member of the Committee at least five (5) working days (1 week) before each meeting. Minutes will be taken at each meeting.

e. The Mortality Review Committee shall receive and review reports from Departmental/Program mortality committees. The Chair or alternate of the Mortality Review Committee may attend Departmental/Program mortality committees or other quality assurance committees where mortality is being reviewed, as deemed necessary.

8.7.5 Documentation Protocol

a. Documents prepared for the Committee and at the request of the Committee are for quality assurance purposes and are protected under Section 51 of the *Evidence Act*.

b. The maintenance of minutes, agenda and other documentation related to the Committee is the responsibility of the Committee Chair. The original minutes, agenda and other documentation of the Committee are maintained in the Department of Quality, Safety and Risk Management.

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

8.7.6 Accountability And Reporting Relationships

a. The Mortality Review Committee shall be accountable to the MAC. The Committee will report to MAC annually.

b. The Committee will be responsive to specific requests from the MAC for information related to the quality of patient care.

8.7.7 Authority

a. The Mortality Review Committee has the authority to review the minutes of the Departments or the Department committees reviewing all deaths occurring in the Agencies (cf above, 8.7.3.a)

b. The Committee has the authority to follow-up and report on the enactment of its recommendations for all cases investigated, including Coroner's cases.

c. Changes to the terms of reference of the Committee must be reviewed and approved by the MAC and when appropriate, by the Board of Directors.

8.7.8 Evaluation

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

APPENDIX D

DEPARTMENTS OF BC CHILDREN'S HOSPITAL AND BC WOMEN'S HOSPITAL AND HEALTHCARE CENTRE

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

- Paediatric Anesthesia
- Adult Anesthesia
- Paediatric Dentistry
- Paediatric Diagnostic Imaging
- Women's Diagnostic Imaging

- Family Practice
- Medical Genetics
- Medicine
- Midwifery
- Nurse Practitioners (primary department)
- Obstetrics and Gynaecology
- Paediatric Ophthalmology
- Paediatric Orthopaedics
- Paediatric Pathology
- Paediatrics
- Psychiatry
- Paediatric Surgery

DEPARTMENTS OF BC CANCER

The Departments of the BC Cancer are:

- Bone Marrow Transplant and Hematology
- Colon Check Program
- Diagnostic Imaging
- Functional Cancer Imaging
- Hereditary Cancer Program
- Medical Assistance in Dying
- Oral Oncology
- Pain and Symptom Management
- Pathology
- Psychosocial Oncology
- Radiation Oncology
- Surgical Oncology
- Systemic Therapy