

Summary of Material and Important Changes
IHA Medical Staff Rules

Article 1 - Purpose	
Content	<p>General overview of the regulatory compliance aspect of the MS Rules, rationale for the MS Rules, promotion of DEI, Aboriginal cultural safety and humility, treatment of staff/patients, and quality improvement.</p> <p>Makes reference to the following IHA Policies: AU2100 – DIVERSITY AU0100 - STANDARDS OF CONDUCT FOR INTERIOR HEALTH EMPLOYEES AD0200 – ABORIGINAL CULTURAL SAFETY & HUMILITY</p>
Concerns	<p>We recommend that the Purpose section should include elements of the Charter Agreement (Appendix A) that describes the accountability of the Health Authority to provide support for medical staff to conduct themselves under their professions Code of Ethics.</p>

Article 2 - Definitions	
New Section	Standard list of Definitions
Concerns	<ul style="list-style-type: none"> Concerns with the lack of definition of disruptive physician or disciplinary action and what constitutes “unprofessional behavior or unprofessional conduct. We suggest these terms should be well defined, including what does not constitute as “unprofessional behavior or unprofessional conduct”, such as advocating for patients or questioning the HA’s actions within a professional context. The term “Primary Care Practitioner” could be more specific. Instead, the term should be expanded to “Family Medicine Practitioner for CCFP or equivalent

	<p>physicians” and “Specialty Medicine Practitioner for FRCPC or FRCSC or equivalent physicians”. The term "Primary Care Practitioner" should not be the term they use to define CCFP-licensed (or non-Canadian equivalent) physicians in IHA. Family Medicine-trained physicians can, and do in many cases, provide much more than Primary Care. The percentage of family medicine-trained physicians in our country that choose to practice more "focused" areas of medicine, or simply medicine other than primary care, is large. The term "specialist" is historic and can be interpreted as insulting for Family Medicine-trained physicians, who these days are deemed "Family Medicine Specialists". This would better align with terminology both the CFPC and the BCCFP now in use.</p>
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Article 3 - Categories of Medical Staff	
Content	<p>Previous MS Rules defined medical staff as: Resident Staff, Clinical Fellows, Clinical Trainees, Students, Elective Clinical Rotations, Locums, Dentists, midwives or nurse practitioners.</p> <p>New MS Rules define medical staff as: Provisional, Active, Associate, Clinical Associate, Clinical Fellows, Consulting Staff, Temporary Staff, Locum Tenens Staff, Scientific and Research Staff, Dentists, midwives and nurse practitioners</p>
Concerns	<p>Generally good in regard to increasing what is categorized as MS, as there has been an increase in the breadth of staff and the new MS Rules reflects the changing nature of the profession. We do suggest Associate Physicians be considered medical staff.</p> <p>3.3.1.5 – Removal of the statement “ ...and may not admit patients to the Programs and Facilities...”. There are situations whereby ER Resident staff Clinical Associates</p>

are welcome to admit patients to the Hospitalist Service with support and supervision from Active Staff.

3.3.1.8: We request clarification on the requirement for CA staff to attend 70% of departmental or divisional meetings. Oftentimes OR assist or CA staff do not have the capacity to attend this percentage. We recommend lowering or removing the requirement. An alternative could be to require these staff to read and approve minutes.

3.6 Locum Tenens Staff

Locum staff cannot be used for positions that are unable to be filled or hard to recruit positions. Only can be used for replacement of a provisional staff. The locum is being used to replace gaps and absences in many sites across the Health Authority, in both rural and urban facilities. In order to assist physicians, the locum program is used as part of the job recruitment process. The current wording assumes all departments are fully staffed at all times. There are some locums who work for years with a service and provide meaningful coverage during staff shortages and unfilled shifts in surge situations. We do not believe every vacancy is due to vacation, parental, educational, illness or leave of absence. In some cases, vacant shifts are due to lack of staff.

Smaller sites should be less formal to bring in individual quickly. Many situations (3.6.5) individuals are pulled in quickly for smaller call groups without the SMD requirements.

We suggest this section should be amended such that Locum Tenens can also fill vacant FTE positions that are not currently filled by a member of the provisional, active or consulting staff. Minimum lead times are unfillable for smaller sites within the HA.

3.6.6: The requirements to complete a locum scheduling form is extra administrative

	<p>burden for active medical staff and falls within the scope of annual privilege renewals. We recommend removing this requirement to decrease administrative burden on active medical staff.</p> <p>3.6.7 – Lead times seem unreasonably long – there should be a possibility for a range that would be more in line with actual needs.</p> <p>3.6.10ii – The medical staff member may choose to have locum coverage but have other responsibilities at the hospital or facility, such as UBC teaching, OR assist, research, leadership training, and CME. A medical staff member must be absent from the hospital or facility for the full period of locum coverage. This clause should be removed. Enforcement of this rule will likely dissuade seeking locum coverage.</p> <p>3.6.10iii - The requirement for orientation and onboarding is an unpaid requirement, in particular for fee for service (FFS) physicians. It is concerning that the locum tenen must be oriented by active medical staff who are required to be absent during the locum tenen. We recommend a supported orientation structure and funding from IHA such that each department can adequately orient locums without loss of income for medical staff.</p> <p>3.6.10 v. - Performance appraisals have never been done and will be administrate onerous if necessary. It should not be completed by the party that was away and performance appraisals should be collaborative whenever possible and involve staff and allied health that have worked closely with locums.</p> <p>3.6.10 vi. - There is concern about this rule and we recommend removal. It is unethical to ask a medical staff member to complete documentation on a patient they did not provide care for, in particular admission history and physicals, operative notes and progress notes. This raises a patient safety, legal and ethical concern.</p>
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Article 4 – Membership and Appointment	
New Section	<p>Changes to the proof of licensure with a professional College removed and now requires references from medical school.</p> <p>Removed proof of registration.</p>
Concerns	<p>4.3. We recommend a nimble transfer of privileges between sites for cross coverage. This should be optional and not mandatory.</p> <p>4.4.1i – We recommend removing this rule as it is not always feasible to obtain a letter from the Dean or the Dean's representative. In an inclusive environment, where IMGs are invited to apply and work at IHA, it may not be possible to contact the Dean from their medical school/training program.</p> <p>4.4.2. We recommend requirement have more than one option for where the references can come from.</p> <p>4.5.4 There's an inconsistency in the numbering system. For example, it jumps from 4.5.4 to 4.5.6, skipping 4.5.5.</p> <p>4.7 – There are times when high school students tour facilities to encourage students to take a career path in healthcare. Is there a way to include such groups?</p> <p>We recommend that Membership and Appointment also include practice ready procedures such as fit testing, EHR training, and safety training. In addition perhaps there could be a requirement for WorkSafe coverage.</p>

Article 5 – Review Process	
New Section	Review at Reappointment that includes anti – racism education and training including review procedures.
Concerns	<p>5.1.6 - Suggested wording: <i>“The establishment and review of annual personal goals and objectives and how IHA can help fulfill them”</i>.</p> <p>5.3.1 - A comprehensive review every 3 to 5 years seems an unreasonable expectation in large departments such as medicine, hospitalists and surgery. This process is more intensive than what is currently being done. Department heads could not be expected to be complete this work in large departments.</p> <p>5.3.3 - If Comprehensive review goes to HAMAC, we suggest that there be Doctors of BC or other representation available to the physician.</p> <p>5.3.4 - A section should be included, whereby those providing input shall be given the opportunity to discuss concern for the medical staffs well being</p> <p>5.4.3 - This statement should include a section on the medical staff's perception of their wellbeing and their awareness of resources to address their wellbeing concerns.</p> <p>5.4.12 - Adjust the statement to add italicized wording: <i>“Randomized”</i> Patient or client feedback “If it is deemed to be consistent with existing performance concerns”</p> <p>5.4.13 - Add a statement about observation or staff and medical staff concern about wellness as it pertains to the individual. Training modules should be provided for review (racism, wellness, safety, civility and others)</p>

	<p>5.5.1 – Change sentence too: “The department head, or designate, shall review the results with the Medical Staff member, and when necessary, assist to develop a plan for ongoing performance <i>and personal</i> improvement.</p> <p>5.5.3 – Change sentence to: If the medical staff member will not acknowledge the results of the review. <i>“A list of resources will be provided and reviewed.”</i></p> <p>Overall, they are not currently being done and would be onerous for physician administrative leads and physicians themselves to complete. Smaller departments will be unable to fulfill this requirement.</p>
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Article 6 – Responsibility for Patient Care	
New Section	<p>Now includes all aspects of patient care (emergency, inpatient, LTC, Admission, consultation, discharge)</p> <p>Digital health – EHR</p> <p>On-call and exemptions</p> <p>Orders – Covering</p> <p>Health Records – Standardized, timelines, EHR</p> <p>Long Term Care</p> <p>Delegation of a medical act.</p>
Concerns	<p>6.1.1. – Add MRP: Every patient should be admitted by a member of the medical staff <i>“or an Associate Physician”</i>.</p> <p>6.1.1.5 iii - Seek clarification on the MRPs role in completing the BPMH? Previously this was done by the ERP.</p> <p>6.1.1.5 vii - When necessary, clarify and resolve apparent treatment or management conflicts among care providers with the support from the Medical Director if needed.</p>

6.1.3.5 - Seek clarity on this rule.

6.1.3.9 – Add to term: All patients and residents must have a history and physical exam within 24 hours of admission, *workload permitting*.

6.1.3.12 - Seek to clarify the scope within which an admission disagreement would involve the involvement of the senior facility medical administrator.

6.1.5.1 – There should be discharge provisions for situations where the actions of a patient are harming others (ie. Drug use)

6.1.5.2 - Discharge planning must begin at time of admission. The MRP or designate is responsible for identifying expected date of discharge based on documentation of discharge criteria being met. Our group would request EDD not be mandatory at time of admission or in acutely deteriorating patients or in patients with active medical investigations underway, rather a discharge criteria be outlined. Physicians are unable to determine discharge time upon admission.

6.1.5.5 - Asked to sign a release on the prescribed form, which is not the responsibility of the MRP and can be completed by nursing staff. It is unreasonable and should be a facility staff decision with physician signoff.

6.1.5.6 - We hesitate to discharge anyone who has been absent for greater than 6 hours due to patient safety concerns. What would be considered to be a “psychiatric patient”.

6.1.5.7 - A discharge summary shall be dictated on discharge or within 7 days. (As per 6.10.5.6)

6.2.1.1 - Insert ...”*direct communication (such as microblog, or phone call)*...”

6.2.1.3.4 - The MRP shall “*request*” (insert instead of obtain) consultation when required by Law. Seek clarity on what situations should enact this.

6.2.1.4 - The consultant will make every effort to respond in a timely fashion... and within 48 (insert) *working hours* in all cases.

6.2.2 - In cases where phone advice was received, this will be documented as such.

6.6.4. – Should be the facility responsibility as the facility will know what medications the patient is taking.

6.6.5.4. – There should be an allowance for situations where there is staffing shortages. Similarly, there should be allowance for psychiatric patients to be transferred to another site that has beds.

6.6.7 - In the situation of a Health Facility Evacuation Order, the MRP will undertake all efforts to identify an appropriate receiving MRP with the help of IHA operations, and department heads.

6.6.7.1 – The facility should make an effort and not the MRP. The SMD should work out the issues at receiving sites. Cross reference with Williams Lake fire to evacuated site.

6.7 - Responsibility for Provision of Medical Care

The impact to personal safety was addressed further. We believe the MRP is not required to provide medical care if personal safety is at risk. In these situations, we recommend the MPRs department head, chief of staff and medical director should be notified.

6.7.1.5 - This is unreasonable and cannot be fulfilled. This rule addresses a situation whereby the patient requests to change the medical staff involved in their care based on discrimination or racism.

6.7.2.1- should add “as required my medical condition”

6.7.3 – On-Call Coverage

Call is variable could be less frequent due to service volumes to protect physician well-being. Unless individual department groups determine the need, level is greater and can be handled within the department members.

6.7.3.1 - Seek clarity on the reasoning behind all members of the medical staff being required to participate in on-call rosters.

6.7.3.2 - ...”All departments and divisions are required to provide continuous on call coverage” Concerned about the wording in this rule, whereby in some instances there are not enough medical staff available to provide continuous on-call coverage. In these situations, limitation in service is required.

6.7.3.7 – Impossible to fulfill as certain individuals cannot be on call all the time.

6.7.4.1 - Provide a Medical Staff member available to assess and treat a patient at all times, this assessment may be completed via phone call in appropriate situations.

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

6.7.5.1 A Practitioner may be exempted from providing on call coverage only when continuous coverage can still be assured by the Department, or in emergency health situations. Perhaps language such as *“It is recognized that some services have never had continuous coverage due to group size.”*

6.9.5.2 – *“Such orders shall be countersigned by the Medical Staff Member or designate at the earliest opportunity, but no later than 24 hours”*. Suggestion that countersigning orders be a requirement in sites where electronic order entry is an option, such that medical staff members are not required to physically attend a chart to co-sign an order.

6.10.1.2.j – Physicians will not know the estimated length of stay.

6.10.3 – Operative Records

The MSA requests that this rule be adjusted as per site specific guidelines and preferences.

6.10.3.1 – “In elective or urgent surgical cases..... (remove “physician signed operation consent”)

6.10.3.3. - Dictation within 24 hours ignores busy call, fatigue and other variables impacting ability to complete timely records.

6.10.3.4 - The date and time of admission needed for OR report is not needed as it is not relevant.

6.10.5.7i - Request to remove the medications administered in hospital from the discharge summary requirement. Rather, we prefer only relevant medications be included.

6.10.6.2 - Request clarity on the requirement for the MRP to notify Health Records of planned absences prior to their occurrence. What duration of planned absence requires reporting?

6.10.6.5 – 72 hours is a very short timeframe for review and not necessary.

	<p>6.10.6.6 - Does it not apply in all circumstances such as the OR. It is assumed that they are sent automatically.</p> <p>6.10.6.9.2 - Request to change the language: <i>“Following the first notification and acknowledged receipt, the Medical Staff member shall complete the charts within 14 days.”</i></p> <p>6.10.6.9.3 - Failure to comply.... we suggest the two further notifications be shared with the chief of staff and the department head and medical director.</p> <p>6.10.6.9.7 - The MSA is concerned about the language whereby the Medical Staff member, whom the locum replaced, shall be responsible to complete any Health Records left incomplete by the Locum Tenens. We request to remove this part of the rule.</p> <p>6.11.2 - The MSA encourages the HAMAC to consider adding Associate Physicians to the Medical Staff category, such that they are able to obtain valid informed consent for blood transfusions.</p> <p>6.14.3.11 - The MRP or delegate shall request a consultation when appropriate.</p>
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Article 7 – Quality and Safety of Care	
New Section	Quality Reviews Responding of Adverse Events

	<p>Accreditation Care Concerns Compliance and Assurances.</p>
Concerns	<p>Overall, Article 7 allows physicians to do their work, but also work to improve the system in which they function including compliance with quality improvement and safety activities. However, there is some heavy handedness in the language being used. It is likely that the majority of physicians believe that this is important, but both the physicians and the facilities capacity need to be considered.</p> <p>Another distinction to be made when asking for physicians' involvement, and whether it is for quality assurance, required for accreditation, versus quality improvement, which is about activities to ensure a learning system. All are necessary to provide high quality care.</p> <p>7.6.3 – This article suggested supports for a support system of referrals could be made for physicians in the HA. There is no support structure within IH, outside the Physician Health Program offered by Doctors of BC.</p>

Article 8 – Organization of Medical Staff	
New Section	<p>Departments / Divisions structure and function Role of VP Medicine office Medical Staff Wellness Department Head role / responsibilities Program and network directors</p>
Concerns	<p>8.4.2 - Each department shall meet at least five (5) times per annum and at the call of the Department head... add <i>“or as agreed upon by the department.”</i></p> <p>8.5 Medical Staff Wellness</p>

Department Heads, in collaboration with Senior Facility Medical Administration and Executive Medical Directors working on medical staff wellness and encourage these parties to work closely with the medical staff wellness committee to ensure priorities are aligned and communicated.

It is also recommend that a formal wellness training/resources/agreement document be created and shared between these parties and the medical staff wellness committees or MSAs where possible.

The element of reporting incidents to appropriate HA WP&S or other designate should be incorporated.

Some of the points in Article 8 could be achieved by ensuring Medical Staff complete essential safety procedures and training, while the organization should make these resources readily available. Key elements include physical and physiological safety measures, violence prevention training, proper fit testing for protective equipment, immunization programs, incident tracking systems, and relevant violence prevention training. This dual approach of providing accessibility and enforcing accountability ensures that all aspects of staff safety, from violence prevention to immunization, are thoroughly addressed and implemented across the organization while embedded within the MS Rules.

8.5.2 - Encourage and prioritize a healthy and respectful workplace.

8.5.6 – suggested wording “*collaborate with regional teams to develop and locally implement Medical Staff Wellness programs*”

8.5.6i - *The Medical Staff Wellness programs should encourage membership representation from all departments.*

	<p>8.5.6ii - <i>A member of the Medical Staff Wellness program should report to the MSA rep who reports to LMAC, RMAC and HAMAC.</i></p> <p>8.5.6iii - <i>The medical staff wellness program should encourage and advocate for physical space for medical staff mental and psychological wellness.</i></p> <p>8.5.6iv - <i>The medical staff wellness program should report to the Medical Executive committee once every 90 days.</i></p> <p>8.5.6v - <i>collaborate with regional teams to locally implement incident reporting and follow up for physical and/or psychological safety events</i></p> <p>8.5.6vi - <i>ensure Medical Staff are receive Occupational Health and Safety orientation and ongoing training related to elements of physical and psychological safety, based on possible hazards in their work area.</i></p> <p>8.7.13 – Should transition the responsibility to ensure completion of IHA EHR competency training is complete to the privileging department.</p> <p>8.9 - Would like to see some wording acknowledging the need for members of a medical department to be involved in the selection process of department head.</p> <p>8.9.3 - Would like to see some language around the process if the HAMAC declines the candidate put forth by the selection committee – we would advocate for an external review.</p>
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Article 9 – Discipline and Appeal	
New Section	<p>Alignment with new Performance Management Toolkit</p> <p>Procedural Fairness</p> <p>“Concern”</p>

	<p>Procedures for investigation and management Stage 1,2,3 and Crisis</p>
Concerns	<p>Article 9 – Discipline and Appeal</p> <p>More information should be known the official process for providing the subject matter with information regarding their rights, resources and supports. This would also include the process of selecting the appointed medical leader(s). We would also like to learn examples of behavior or actions that fall under each stage in the staged intervention. We would like to know who decides what stage an action or behavior falls under, and what the decision-making process is. We would also like to know the responsibility of the HAMAC and the appointed medical leader in responding to questions and statements by the subject matter and their attorney.</p> <p>What would be the ramifications if the Health Authority doesn't follow their own processes, and removes physicians' privileges without HAMAC approval, including the processes outlined in the Toolkit.</p> <p>9.1.2 - Interested in learning the process of a hearing, what steps occur prior to deciding a hearing is necessary, and who is the "judge" or decider at this hearing.</p> <p>9.1.3 – Change wording to "The parties have the right to legal counsel or an advisor <i>who may be present at meetings</i>".</p> <p>9.2.3 These should not be considered to a Concern:</p> <ul style="list-style-type: none"> - Pointing out departmental or system deficiencies. - Advocating for patients. <p>9.2.3.9 - Better definition to what actions are considered retaliatory. For example, would confiding in friends, sharing information in group forums be considered retaliatory?</p>

	<p>9.2.4 – Change wording to “The Complainant shall be notified <i>and acknowledge receipt of notification that the Concern....</i>”</p> <p>9.4.1 Stages of Intervention Recommends a medical staff wellness resource information be provided to medical staff during the early intervention stage, these resources should be shared with all department heads.</p> <p>9.4.2 ii - Why does RMAC needs to be involved. In the interest of confidentiality and decreasing exposure and discretion, we would like to know if there is any clear benefit to RMAC involvement, with respect to going straight to the HAMAC.</p> <p>9.5 d - Require clarification of the term intoxication by drugs. Does this refer to prescription medications?</p>
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Article 10 – HAMAC	
New Section	<p>Purpose and Authority</p> <ol style="list-style-type: none"> 1. Medical Administration 2. Quality of Care 3. Medical Staff Resource Planning 4. CME / Teaching Research <p>Membership Executive Committee Subcommittees as Appendices Reporting and Accountability to the Board RMAC / LMAC – officers, terms, structures, functions</p>
Concerns	10.3.1.11 - Make recommendations for the continuing personal development of members of the medical staff.

	<p>10.4 Membership</p> <p>We are interested in learning the reasoning behind the decided upon parties of the HAMAC membership. Is there specified protection for a number of physician seats (wrt NPs) or is it implied that every seat will be a physician unless otherwise specified?</p> <p>10.4.1 – Clarity on how (1) MSA members from each HSA will be elected.</p> <p>10.10 Annual Review and Planning Meeting</p> <p>Suggestion that this meeting be advertised for 90 days prior to the date it is on such that medical staff are able to relay their annual reports, and comment on annual workplan initiatives and ideas. We suggest the meeting minutes be shared.</p> <p>10.15.7.1. – Small medical staff will have difficulty meeting this (not less than 6 times a year).</p>
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Article 11 – Medical Staff Associations	
New Section	Structures / Roles / Functions Officers and Terms
Concerns	<p>Article 11 – MSA</p> <p>Overall the terms are very prescriptive and restrictive. Smaller sites will have difficulty conforming to the Rules. Perhaps having the ability to reduce meeting requirement to annually until there is interest from the medical staff.</p> <p>11.6.4.1 – Clarity required on what is to occur is MS members do not attend the required amount.</p>

	<p>11.6.6.2 – Mandatory dues is very prescriptive and a large departure from current practices.</p> <p>11.6.6.1. – Need a mechanism to continue to pass if 20% quorum.</p>
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Article 12 – Amendments	
New Section	<p>Timeline of review of Rules (every 3 years)</p> <p>Powers of the Board</p> <p>Authority</p>
Concerns	NA

Appendix C

Should be removed as the committee was dissolved five years ago.

IH Medical Staff Performance Management Toolkit

1. There must be legal definition of objectional conduct:
Objectional Conduct” examples must be specifically defined for each level of the Toolkit.
2. Presumption of innocence
the party conducting the investigation will:
 - a. make their findings in light of the principle that the burden of proving wrongdoing is on the party alleging it, and not on the party against whom it is alleged ; and
 - b. respect the rights of the individual against whom the allegations are made to provide full answer to the allegations.
3. Open identification of accuser
Anonymity not acceptable (there are already safe guards for the accuser process spoken to by the safe reporting policy)

4. Investigative process required for all accusations:
 - i. the investigator will make an initial determination as to whether the nature of the disclosure and the circumstances in which it is presented are such that it should be pursued
 - ii. should the allegation be pursued, merit assessment must be conducted.
 - a. merit assessment is essential in order to ascertain the facts;
 - b. review the alleged misconduct in the context of relevant policies and procedures;
 - c. determine whether there is substantive evidence of culpable action or a deliberate disregard of the expected standards of conduct.
 - iii. The allegations of wrongdoing must be presented to the responding party in writing and in advance of conducting an interview.
 - iv. Both the responding party and the complaining party should be made aware of and given the opportunity to any evidence that comes to light which could potentially lead to an adverse finding against them
5. Physician maintains the right of appeal
6. Allegations that are determined to be non-substantiated will be dismissed with no permanent record on the staff persons personnel file but will be recorded without identifying the staff person as a record of false allegations.
7. Staff have unimpeded right of access to their personnel file and capacity to speak to their permanent personnel file.
8. False accusations will be expunged from the permanent staff personnel file
9. The permanent personnel file be non-discoverable outcomes unless mandated by the CPSBC (this currently applies to Alternative Dispute Resolution)

how can stage 1 be confidential if then info is provided to complainant? This does not make sense
-right of appeal needs to be actually outlined, what mechanism is there? It should be situation of scrambling around to figure this out - the punitive roles are very clear - what are the supportive roles? Like wise - where are the resources, most of these are pretty vague, no local mentors, no specific courses, seems impractical if someone is looking for support...(and this is

actually part of CMTA recommendations - provide concrete, real supports when you are having these interventions with people)