yukon hospitals | whitehorse dawson city watson lake

YUKON HOSPITAL CORPORATION

MEDICAL STAFF RULES

TABLE OF CONTENTS

YUKON HOSPITAL CORPORATION 1

MEDICAL STAFF RULES 1

TABLE OF CONTENTS 2

PREAMBLE 4

AUTHORITY TO PROMULGATE AND AMEND THE RULES 4

PURPOSE OF THE MEDICAL STAFF ORGANIZATION 4

DEFINITIONS 5

PART 1 – CHIEF OF MEDICAL STAFF – APPOINTMENT, ROLE AND RESPONSIBILITIES, SUSPENSION AND TERMINATION 8

1.1 APPOINTMENT OF THE CHIEF OF MEDICAL STAFF 8
1.2 ROLE AND RESPONSIBILITIES OF THE CHIEF OF MEDICAL STAFF 9
1.3 SUSPENSION OR TERMINATION OF CHIEF OF MEDICAL STAFF 10

PART 2 – ASSOCIATED CHIEF OF MEDICAL STAFF – APPOINTMENT, RESPONSIBILITIES AND DUTIES 10

2.1 APPOINTMENT OF THE ASSOCIATE CHIEF OF MEDICAL STAFF 10
2.2 RESPONSIBILITIES AND DUTIES 10

PART 3 – YHC MEDICAL ADVISORY COMMITTEE 11

3.1 MAC APPOINTMENTS 11
3.2 MEMBERSHIP OF THE YHC MEDICAL ADVISORY COMMITTEE 11
3.3 CHAIR OF THE MEDICAL ADVISORY COMMITTEE 11
3.4 REPRESENTATIVES OF THE MEDICAL STAFF ON THE MAC 12
3.5 DUTIES OF THE YHC MEDICAL ADVISORY COMMITTEE 12

PART 4 – MEMBERSHIP AND APPOINTMENT 15

4.1 APPOINTMENT OF THE MEDICAL STAFF AND OTHER PROFESSIONAL STAFF 15
4.2 QUALIFICATION FOR MEMBERSHIP OF THE MEDICAL STAFF AND OTHER PROFESSIONAL STAFF 15
4.3 PROCESS FOR RECRUITMENT 16
4.4 PROCEDURAL PRIVILEGES 18
4.5 TEMPORARY MEDICAL STAFF AND OTHER PROFESSIONAL STAFF APPOINTMENTS AND TEMPORARY PRIVILEGES 18

PART 5 – POSTGRADUATE TRAINING PROGRAMS AND CLINICAL TRAINEES 19

5.1 MEDICAL/SURGICAL RESIDENT 19
5.2 CLINICAL FELLOWS 20
5.3 CLINICAL TRAINEES 20

5.4 MEDICAL/NURSE PRACTITIONER/MIDWIFERY STUDENTS 20
5.5 PRE-MEDICAL STUDENTS 21
5.6 OBSERVERS 21

PART 6 – MEDICAL STAFF AND OTHER PROFESSIONAL STAFF RESPONSIBILITIES FOR PATIENT CARE 21

6.1 ADMISSION, DISCHARGE AND TRANSFER OF CARE BY MEDICAL STAFF MEMBERS 21
6.2 DENTAL STAFF RESPONSIBILITIES FOR PATIENT CARE 26
6.3 OPTOMETRIST STAFF RESPONSIBILITIES FOR PATIENT CARE 26
6.4 NURSE PRACTITIONER STAFF RESPONSIBILITIES FOR PATIENT CARE 26
6.5 QUALITY IMPROVEMENT 27
6.6 HEALTH RECORDS 27
6.7 PRENATAL RECORD 28
6.8 COMPLETION OF HEALTH RECORDS 28
6.9 INFORMED CONSENT 30
6.10 CONFIDENTIALITY OF QUALITY MANAGEMENT INFORMATION 31
6.11 EMERGENCY CARE 31
6.12 MEDICAL ORDERS 31
6.13 PRE-PRINTED ORDERS AND MEDICAL DIRECTIVES 31
6.14 RESPONSIBILITY FOR PROVISION OF ON-CALL AND SERVICE COVERAGE FOR PATIENTS 32
6.15 POST-OPERATIVE/POST PROCEDURAL CARE 33
6.16 DELEGATED FUNCTIONS 34
6.17 ORGAN DONATION AND RETRIEVAL 34
6.18 INFANT AND MATERNAL TRANSPORT TEAMS 35
6.19 PRONOUNCEMENT OF DEATH, AUTOPSY AND PATHOLOGY 35

PART 7 – MEDICAL STAFF ASSOCIATION 35

7.1 MEDICAL STAFF ASSOCIATION 35
7.2 PURPOSE 35
7.3 ELECTED OFFICERS OF THE MEDICAL STAFF 36
7.4 ELECTION PROCEDURE 36
7.5 DUTIES OF THE PRESIDENT OF THE MEDICAL STAFF 36
7.6 DUTIES OF THE VICE-PRESIDENT OF THE MEDICAL STAFF 37
7.7 DUTIES OF THE SECRETARY-TREASURER OF THE MEDICAL STAFF 37
7.8 DUTIES OF THE PAST PRESIDENT OF THE MEDICAL STAFF 38
7.9 RECALL, REMOVAL AND FILLING OF VACANT OFFICES 38
7.10 MEETINGS OF THE MEDICAL STAFF ASSOCIATION 38
7.11 MEMBERSHIP DUES 40

PART 8 – AMENDMENTS 40

PART 9 – APPROVAL OF RULES 42

PREAMBLE

The Yukon Hospital Corporation ("YHC") Medical Staff Rules ("Rules") are prepared in accordance with the YHC's Medical Staff Bylaws ("Bylaws"). The Rules outline Medical Staff and YHC obligations with respect to patient care. The Rules provide the means to implement and give effect to the Medical Staff Bylaws, and govern the day to day management of Medical Staff and Other Professional Staff affairs, and nothing in them shall alter the intent and purpose of the Bylaws.

These Rules are applicable to all appointed Medical Staff and Other Professional Staff Members practicing in YHC facilities and/or using YHC programs and services.

YHC shall involve the Medical Staff and Other Professional Staff in the creation and revision of YHC policies which are applicable to the Medical Staff and Other Professional Staff.

Individual facilities, programs or services may have policies/procedures governing aspects of Medical Staff and Other Professional Staff practice which are specific to the facility, program or service. In those cases, the facility policies are subsidiary to the Rules. In the event of conflict or contradiction between these Rules or the Bylaws and subsidiary Medical Staff and Other Professional Staff policies of a facility, program or service, the Bylaws and Rules will prevail.

Singular and plural terms include both as the context implies. Similarly, the use, or lack of use, of capital letters does not change the interpretation of words which are specifically defined in this document.

Medical Staff and Other Professional Staff Members are responsible to review and remain informed regarding new and revised Bylaws, Rules and YHC policies which are applicable to, or of importance to, the Medical Staff and Other Professional Staff. Notification of new and revised Bylaws, Rules and YHC policies is the responsibility of the Chief of Medical Staff.

AUTHORITY TO PROMULGATE AND AMEND THE RULES

The YHC Board of Trustees has the authority to approve these Rules on the recommendation of the Medical Advisory Committee (MAC). Revisions to these Rules will be made periodically to ensure these Rules reflect contemporary organization of the Medical Staff and Other Professional Staff as well as to ensure high quality patient care.

Once approved by the Board, a copy of these Rules shall be sent to all Medical Staff and Other Professional Staff Members, after which all members shall be deemed to be conversant with them. Each new Medical Staff and Other Professional Staff Member will also be given a copy of these Rules. A copy of the most recent approved revision of these Rules signed by the Chair of the Board, and the Chair of the MAC may be given in evidence without any further proof of authenticity.

PURPOSE OF THE MEDICAL STAFF ORGANIZATION

In addition to the general purpose outlined in the Bylaws, the purpose of the Medical Staff organization is to apply the regulatory authority of the Board to all Medical Staff and Other Professional Staff Members who are granted privileges annually by the Board to practice within YHC facilities and programs, and to access YHC services and to maintain and support the rights and privileges of the Medical Staff and Other Professional Staff as provided herein. The objective is to ensure YHC provides high quality patient care, education of Medical Staff and Other Professional Staff members and research in the health disciplines.

The organization allows the Medical Staff and Other Professional Staff to provide advice to the Board in order to achieve the mission, vision, values and strategic directions of YHC.

DEFINITIONS

Affiliation Agreement: An agreement between the YHC Board of Trustees and the Board of Governors of a post-secondary educational institution.

Appointment: The process by which a physician, midwife, nurse practitioner, optometrist or dentist becomes a member of the Medical Staff and Other Professional Staff of the YHC. Appointment does not constitute employment.

ATIPP: *Access to Information and Protection of Privacy Act,* RSY 2002, c.1, as amended or replaced from time to time.

Board: The YHC Board of Trustees as established pursuant to the *Hospital Act*.

Chief Executive Officer (CEO): The person appointed by the Board who is responsible to the Board for the day-to-day management of the YHC in accordance with the corporate bylaws and policies of the Board pursuant to s.7(1) and (2) of the *Hospital Act*.

Chief of Medical Staff: A physician member of the medical staff, appointed by the CEO and approved by the Board, accountable to the CEO for the management of the medical affairs of the hospital.

Clinical Fellow: A physician or dentist temporarily attached to facilities or programs operated by the YHC for the purpose of postgraduate training in accordance with an Affiliation Agreement.

Clinical Trainee: A Medical Staff and Other Professional Staff Member temporarily attached to the YHC for the educational purpose of gaining additional experience or training.

Consultant: A Medical Staff Member who has been asked to evaluate a patient and provide recommendations for care (consultation only), write orders for care and follow up (consultation with ongoing care) or assume the entire care of the patient and become the Most Responsible Practitioner (consultation with transfer of care).

Coroner's Act: The *Coroner's Act,* RSY 2002, c.44, as amended or replaced from time to time.

Credentials: Refers to the qualifications, professional education and training, clinical experience and experience in leadership, research, education, communication and teamwork that contribute to the Medical Staff and Other Professional Staff Member's competence, performance and professional suitability to provide safe, high quality healthcare services.

Quality Assurance Committee: Any properly constituted committee established or designated in accordance with section 13 of the Yukon *Evidence Act*. This means medical staff committees established under section 13 of the Yukon *Evidence Act*, and quality review committees designated by the YHC Board for the purpose of improving hospital based care or practice.

Dentist: A Professional Staff Member who is duly licensed to practice dentistry in the Yukon.

Designate: A Medical Staff and Other Professional Staff Member who has the appropriate credentials and privileges afforded to them by the Bylaws or as an Intern, Resident, and Clinical Fellow/Trainee under the direct supervision of the Most Responsible Practitioner.

Evidence Act: The *Evidence Act*, RSY 2002 c.78, as amended or replaced from time to time.

Facility: A health care facility operated by YHC.

Health Professions Act and Regulations: The *Health Professions Act,* RSY 2002, c.24, as amended or replaced from time to time.

HIPMA: *Health Information and Privacy Management Act,* SY 2014, c.16.

Hospital: A health care facility owned and operated by YHC pursuant to the Yukon *Hospital Act* and Regulations.

Hospital Act and Regulations: The *Hospital Act,* RSY 2002, c.111, and Regulations, as amended or replaced from time to time.

Human Tissue Gift Act: The *Human Tissue Gift Act,* c.117, as amended and replaced from time to time.

In-Depth Review: A performance evaluation of a Medical Staff and Other Professional Staff Member.

Locum Tenens: Locum tenens Medical Staff and Other Professional Staff Members are appointed for a specified period of time not to exceed twelve (12) months for the purpose of replacing or working in conjunction with a member of active, provisional, or visiting consulting staff categories.

Medical Advisory Committee (MAC): The advisory committee appointed by and reporting to the Board and/or CEO on medical matters as described in clause 2.23 of the Bylaws.

Medical Care: For the purposes of this document, medical care includes the clinical services provided by Medical and Other Professional Staff.

Medical Staff: The organized body composed of all physicians and midwives who have been granted privileges to practice medicine in the facilities and programs operated by the YHC.

Medical Staff Association: The organization established pursuant to Part 2 of the Bylaws.

Medical Staff Bylaws (Bylaws): The Rules and Regulations approved by the Board governing the day to day management of the Medical Staff and Other Professional Staff in YHC facilities and programs.

Medical Staff Member: Member of the Medical Staff.

Medical Staff Rules (Rules): The Rules and Regulations approved by the Board governing the day to day management of the Medical Staff and Other Professional Staff in YHC facilities and programs.

Medical Student: An undergraduate medical student attached to YHC for the educational purpose of gaining practical clinical experience during a specified rotation administered by the university in which they are registered.

Midwife (RM): A Medical Staff member who is duly licensed to practice midwifery in Yukon by the Yukon Registrar of Midwives.

Minister: The Yukon Minister of Health and Social Services.

Most Responsible Practitioner (MRP): The Medical Staff Member who has the overall responsibility for the management and co-ordination of care of the patient at any given time.

Nurse Practitioner: A Professional Staff Member who is duly licensed to practice as a nurse practitioner in Yukon.

Other Professional Staff: Dentists, Nurse Practitioners and Optometrists appointed and privileged by the Board, whose professional activities within the facilities of YHC are managed by the Medical Bylaws and Rules.

Optometrist: A Professional Staff Member who is duly licensed to practice optometry in Yukon.

Physician: A Medical Staff Member who is duly licensed by the Yukon Medical Council and who is entitled to practice medicine in the Yukon Territory.

President of YHC Medical Staff: The Medical Staff member representing the Medical Staff to the Board and the MAC and is elected by and responsible to the Medical Staff.

Privileges: A permit to practice medicine/midwifery/dentistry/optometry in the facilities and programs operated by YHC and granted by YHC to a Medical Staff or Other Professional Staff Member, as set forth in the *Hospital Act* and Regulations. Privileges describe the extent of clinical practice of an individual member based on the member's credentials, competence, performance and professional suitability. Privileges are based on the needs of the programs and communities supported by YHC and capacity of the facilities and programs to support the member's scope of clinical practice.

Procedural Privileges: A permit granted by the Board to a Medical Staff or Other Professional Staff Member authorizing a member to perform specific procedures within the scope and limits of each Medical Staff or Other Professional Staff Member's permit to practice in a YHC facility.

Programs: Ongoing care delivery systems under the jurisdiction of YHC for coordinating a specified type of patient care.

Regulations: The Regulations made under the authority of the *Hospital Act* and its Regulations and Standards.

Resident: Means a Physician temporarily working in a YHC facility for the purpose of postgraduate training in medicine in accordance with an Affiliation Agreement.

Signature: An authentic signature and/or electronic sign off.

Temporary Privileges: A permit to practice in a YHC facility and programs that is granted Medical Staff and Other Professional Staff membership for a specified period of time in order that they may provide a specific service.

Vital Statistics Act: The *Vital Statistics Act,* RSY 2002, c.225, as amended or replaced from time to time.

Year: The fiscal year adopted by YHC, defined currently as April 1 of a given year to March 31 of the following year.

PART 1 – CHIEF OF MEDICAL STAFF – APPOINTMENT, ROLE AND RESPONSIBILITIES, SUSPENSION AND TERMINATION

1.1 APPOINTMENT OF THE CHIEF OF MEDICAL STAFF

1.1.1 The CEO shall appoint a physician to the position of Chief of Medical Staff subject to confirmation of the YHC Board.

1.1.2 Where a vacancy exists or following a resignation in the position of Chief of Medical Staff, a search for a Chief of Medical Staff shall be conducted.

1.1.3 A Search Committee shall be established by the Chief Executive Officer and be composed of:

a) the CEO;

b) two members of the MAC;

c) two working members of the Active Medical Staff;

d) one member of the Senior Management Team of YHC selected by the CEO; and

e) one member of the Board.

1.1.4 The Search Committee shall invite applications from active Medical Staff Members to fulfil the role of Chief of Medical Staff. The Medical Staff Association may nominate active Medical Staff Members for consideration by the Search Committee.

1.1.5 In the event that a suitable candidate from the active Medical Staff is not identified by a Search Committee then a physician eligible for appointment to the active Medical Staff may be considered.

1.1.6 The Search Committee shall:

a) review applications;

b) interview selected applicants; and

c) seek the advice of the Medical Staff Association or other physicians or persons about the suitability of prospective candidates.

1.1.7 The Search Committee shall present its recommendations and advice to the CEO.

1.1.8 The person appointed to the position of Chief of Medical Staff shall exercise any or all of the powers and responsibilities of the Chief of Medical Staff.

1.1.9 Appointment as Chief of Medical Staff and compensation for the position shall be detailed in a contract outlining the role description, position responsibilities, objectives of the role and accountabilities.

1.2 ROLE AND RESPONSIBILITIES OF THE CHIEF OF MEDICAL STAFF

1.2.1 The role and responsibilities of the Chief of Medical Staff include, but are not limited to:

a) ex-officio membership on the YHC Executive Team. This includes participation in management discussions and decisions including, but not limited to, discussions and decisions regarding strategic planning, financial and program planning, human resources planning, the development, implementation and evaluation of patient care programs and services and resource allocation;

b) developing, maintaining and updating Medical Staff Bylaws and Rules and policies and procedures pertaining to Medical Staff and Other Professional Staff activities within YHC facilities, programs and services;

c) providing leadership and direction on matters pertaining to clinical organization, new and existing health and information technology and other relevant Medical Staff and Other Professional Staff administrative matters;

d) participating in YHC committees, as required;

e) providing leadership, direction, and effective coordination and cooperation among the MAC and all standing and ad hoc committees of the Medical Staff and Other Professional Staff so as to integrate the activities of the various programs and committees with each other and with the goals of YHC;

f) ensuring that appropriate Medical Staff and Other Professional Staff appointment, privileging, reappointment, modification of privileges and discipline processes are in place and consistent with applicable law and legislation and with these Rules;

g) ensuring participation of Medical Staff and Other Professional Staff Members in quality assurance, quality improvement, patient safety, risk management and utilization management activities within YHC facilities and programs;

h) ensuring that patient or staff concerns regarding the quality of medical care are investigated and resolved in a timely manner;

i) responding to physician concerns regarding patient safety and the quality of clinical care in a timely manner;

j) contributing to a Medical Staff and Other Professional Staff human resource plan for YHC facilities;

k) providing leadership and direction on matters pertaining to physician recruitment, orientation and retention;

l) encouraging, promoting and fostering the professional and ethical conduct of Medical Staff and Other Professional Staff Members in relation to their practice, teaching, research and interactions with others;

m) addressing concerns arising from the professional and ethical conduct of Medical Staff and Other Professional Staff Members;

n) encouraging, promoting and fostering participation in continuing Medical Staff and Other Professional Staff education on an ongoing basis;

o) identifying and addressing the management and leadership development needs of Medical Staff and Other Professional Staff Members;

p) encouraging, promoting and fostering teaching and research within the YHC;

q) ensuring that appropriate processes and protocols are in place for the consideration and approval of Medical Staff and Other Professional Staff research proposals and compliance thereto; and

r) delegating responsibilities to others as required.

1.3 SUSPENSION OR TERMINATION OF CHIEF OF MEDICAL STAFF

1.3.1 The CEO may, on the confirmation of the Board, suspend or terminate the appointment of the Chief of Medical Staff. Prior to such suspension or termination, notice shall be given in accordance with the Chief of Medical Staff's contract with YHC and the MAC members shall be notified.

1.3.2 Suspension or termination of an appointment as Chief of Medical Staff does not affect appointment to the medical staff or privileges.

PART 2 – ASSOCIATED CHIEF OF MEDICAL STAFF – APPOINTMENT, RESPONSIBILITIES AND DUTIES

2.1 APPOINTMENT OF THE ASSOCIATE CHIEF OF MEDICAL STAFF

2.1.1 The Chief of Medical Staff shall appoint a member(s) of the Medical Staff, or a person(s) eligible for appointment to the Medical Staff, to the position of Associate Chief(s) of Medical Staff after giving consideration to the recommendations of the CEO and the Board.

2.2 RESPONSIBILITIES AND DUTIES

2.2.1 The Associate Chief(s) of Medical Staff shall assist the Chief of Medical Staff in fulfilling their duties. Without limiting the authority of YHC relative to its administrative structures, the responsibilities of the Associate Chief(s) of Medical Staff include, but are not limited to:

a) performing all duties assigned to him/her by the Bylaws and these Rules,

b) performing duties delegated to them by the Chief of Medical Staff;

c) acting for the Chief of Medical Staff in their absence and as their designate for those duties assigned to the Chief of Medical Staff by the Bylaws and these Rules;

d) advancing the perspective, advice and resource requirements of the Medical Staff and Other Professional Staff within YHC; and

e) advocating for the provision of high quality and safe patient care within YHC.

PART 3 – YHC MEDICAL ADVISORY COMMITTEE

3.1 MAC APPOINTMENTS

3.1.1 The MAC is appointed by the Board and makes recommendations to the Board with respect to granting, cancellation, suspension, restriction, non-renewal, or maintenance of the appointments and privileges of all Medical Staff and Other Professional Staff Members to practice within YHC facilities and programs.

3.2 MEMBERSHIP OF THE YHC MEDICAL ADVISORY COMMITTEE

3.2.1 The membership of the MAC shall include:

Voting members:

a) Chair of the MAC;

b) President of the Medical Staff; and

c) medical staff representatives from each of YHC's health facilities including two members of the Active Medical Staff of Whitehorse General Hospital, and one member of the Active Medical Staff from each of Watson Lake Hospital and Dawson City Hospital.

Non-voting members:

a) Chief of Medical Staff;

b) Associated Chief(s) of Medical Staff;

c) YHC CEO; and

d) other senior administrative or Medical Staff or Other Professional Staff of the YHC as determined by the MAC to carry out its duties and responsibilities.

3.2.2 A Vice Chair may be selected from the voting members of the MAC.

3.3 CHAIR OF THE MEDICAL ADVISORY COMMITTEE

3.3.1 The Chair of the MAC is appointed by the Board who shall consider nominations made by the Medical Staff Association at its AGM.

3.3.2 The Chair will be selected from among the members of the Active Medical Staff.

3.3.3 The Chair of the MAC is appointed for a term of not more than two (2) years and may be reappointed.

3.3.4 The Chair of MAC, or their designate, shall provide a report to the Board and CEO on a regular basis.

3.3.5 The Chair of the MAC, or their designate, shall attend meetings of the Board, and the appropriate committee of the Board, to participate in discussion pertaining to proposed amendments to the YHC Medical Staff Bylaws and/or Rules.

3.3.6 The Chair of MAC shall:

a) preside at all meetings of the MAC;

b) give such notice, as required in the Bylaws, of all meetings of the MAC;

c) in consultation with the members, develop the agenda for MAC meetings; and

d) maintain the attendance records and minutes of all meetings of the MAC.

3.4 REPRESENTATIVES OF THE MEDICAL STAFF ON THE MAC

3.4.1 Representatives of the Medical Staff of MAC will be nominated annually by the Medical Staff at the Annual General Meeting or Special meeting of the Medical Staff.

3.4.2 Those nominated representatives of the Medical Staff will be presented to the Board for appointment on MAC.

3.5 DUTIES OF THE YHC MEDICAL ADVISORY COMMITTEE

3.5.1 With respect to Medical Administration, MAC shall:

a) appoint chairs and members of standing or ad-hoc committees, and ensure these committees function effectively including recording minutes of meetings;

b) make recommendations to the Board on the development, maintenance and updating of these Rules, policies and procedures pertaining to medical care provided within the YHC facilities and programs; and

c) advise on matters pertaining to clinical organization, medical technology and other relevant medical administrative matters.

3.5.2 With respect to Medical Staff and Other Professional Staff Appointments and Privileges the MAC shall:

a) review recommendations concerning the appointment and review of Medical Staff and Other Professional Staff members including the delineation of privileges;

b) make recommendations to the Board concerning the appointment and review of the Medical Staff and Other Professional Staff;

c) make recommendations to the Board regarding disciplinary measures for violation of the Bylaws, these Rules, policies of the Medical Staff, or applicable YHC policies;

d) if necessary, require a Medical Staff or Other Professional Staff Member to appear before the MAC; and

e) if necessary, require a Medical Staff or Other Professional Staff Member to undergo an In-Depth Review.

3.5.3 With respect to a hearing in the context of a Complaint Review, the MAC shall appoint the members of the Hearing Committee which may or may not be the members of the MAC.

3.5.4 With respect to Quality of Care the MAC shall:

a) receive, review and make recommendations on reports from quality review bodies and committees concerning the evaluation of the clinical practice of Medical Staff and Other Professional Staff Members including but not limited to:

i. reviews of patient clinical outcomes;

ii. reviews of adverse clinical events arising from patient care (harmful or near-harmful);

iii. review of morbidity and mortality;

iv. appointing medical reviewers to evaluate deaths and complications;

v. reviewing medication policies, the hospital formulary and other therapeutic modalities, ensuring annual updating of facility pharmacies, advising on all phases of drug therapy within a YHC facility or program and making recommendations from the standpoints of safety, economy, rationality and legality;

vi. reviewing and recommending revisions to policies and procedures related to Infection Control, including but not limited to: investigation, control and prevention of infections, isolation policies and procedures, and sterilization procedures; and

vii. care provision, including but not limited to periodic reviews of hospital charts to determine the adequacy and timeliness of medical record completion.

b) make recommendations concerning the establishment and maintenance of professional standards in YHC facilities and programs in compliance with all relevant legislation, bylaws, rules, and polices of the Medical Staff and Other Professional Staff;

c) submit regular reports and recommendations to the Board and CEO on the quality, effectiveness, efficiency and availability of medical care provided, in relation to professional standards, in YHC facilities and programs; and

d) make recommendations, where appropriate, concerning the availability and adequacy of resources to provide appropriate patient care in the YHC.

3.5.5 With respect to Medical Staff and Other Professional Staff Resource Planning the MAC shall:

a) make recommendations to the Board and CEO regarding human resource requirements required to meet the medical needs of the population served by the YHC; and

b) collaborate with the Board on Medical Staff and Other Professional Staff human resource planning.

3.5.6 With respect to Professional and Ethical conduct of Medical Staff and Other Professional Staff Members of the MAC shall:

a) review and report on any concerns related to the professional and ethical conduct of Medical Staff and Other Professional Staff Members to the Board, and, where appropriate, report those concerns to the relevant professional licensing authority; and

b) investigate any breach of ethics or deviation from acceptable standards of practice or non-compliance with the YHC Medical Staff Bylaws and these Rules that are reported and act upon the findings, including recommending disciplinary action when warranted.

3.5.7 With respect to Continuing Medical Education the MAC shall:

a) advise on and assist with the development of formally structured ongoing programs in continuing medical education;

b) advise on and assist with programs in continuing education of other health care providers in the YHC facilities and programs; and

c) advise on and make recommendation concerning the teaching role of the YHC.

3.5.8 With respect to Medical Staff and Other Professional Staff Members' health and well-being, the MAC shall work with the Chief of Medical Staff to:

a) promote *health* and wellness amongst Medical Staff Members;

b) encourage a healthy, respectful workplace;

c) establish mechanisms to identify Medical Staff and Other Professional Staff Members at risk of mental illness, substance dependency or severe professional fatigue;

d) develop strategies and supports for timely respectful intervention for medical professionals with compromised health and well-being; and

e) support Medical Staff and Other Professional Staff Members through development of specific programs to promote the members' well-being.

3.5.9 The list of Standing Committees shall be reviewed annually by the MAC and recommendations for revision shall be presented to the Board, as necessary.

3.5.10 Each Standing Committee shall review its Terms of Reference annually and make recommendations to the MAC for changes, if any.

3.5.11 In addition to these Standing Committees, the MAC may recommend to the Board the formation of additional standing/ad hoc committees, as it deems necessary.

PART 4 – MEMBERSHIP AND APPOINTMENT

4.1 APPOINTMENT OF THE MEDICAL STAFF AND OTHER PROFESSIONAL STAFF

4.1.1 The process of appointment and granting of privileges to a Medical Staff and Other Professional Staff Member of YHC shall include the assessment of:

a) professional credentials, competence, performance, professional suitability;

b) YHC service requirements; and

c) the capacity of the available YHC resources to support the scope of practice.

4.1.2 Privileges including Procedural Privileges are approved in conjunction with an appointment to the Medical Staff or Other Professional Staff. Authorization to exercise some or all of a Medical Staff or Other Professional Staff Member's privileges in a specific facility is granted based on the recommendation(s) of the MAC and facility Medical Staff and Other Professional Staff, who may be affected by the granting of those privileges and to ensure there is a local need for the member to exercise those Privileges and that the member's practice will complement the local medical services.

4.1.3 Subject to the review and appeal procedures described in the Bylaws and these Rules, the Board makes the final decision regarding every appointment. The Board may refuse to appoint or reappoint a person to the Medical Staff or Other Professional Staff, or may modify, suspend, or revoke Appointments and Privileges of any Medical Staff or Other Professional Staff Member in accordance with the Bylaws on such grounds as may be specified by the Board, including but not limited to: availability of resources, professional incompetence, unprofessional, disruptive or unethical conduct, inadequacy of professional liability insurance, breach of these Rules, failure to comply with all relevant legislation or the Bylaws, or with orders, directions, and requests of the Board or CEO that arise as a consequence of disciplinary action.

4.1.4 The process for Appointment and basic criteria for membership of the Medical Staff and Other Professional Staff are outlined in the Bylaws.

4.1.5 The Board, Chief Executive Officer, or the Chief of Medical Staff, may suspend, restrict or revoke the appointment of privileges of any member of the Medical Staff and Other Professional Staff in accordance with Part 7 of the Bylaws.

4.2 QUALIFICATION FOR MEMBERSHIP OF THE MEDICAL STAFF AND OTHER PROFESSIONAL STAFF

4.2.1 Refer to Part 4 of the Bylaws for the detailed membership appointment procedures.

4.2.2 The following shall be the minimum qualifications physicians must possess to be eligible for membership on the medical staff:

a) Medical degree;

b) Licentiate Certificate of Medical Council of Canada;

c) Certificate of Rotating Internship if graduated prior to 1993; and

d) Certification of the College of Family Physicians of Canada, or proof of successful completion of two (2) years post-graduate training in an approved program that includes eight (8) weeks in each of the following specialities: Medicine, Surgery, Paediatrics, and Obstetrics/Gynaecology.

OR

a) Medical degree; and

b) Fellowship of the Royal College of Physicians and Surgeons of Canada or Canadian Speciality Certificate.

OR

a) Medical degree; and

b) A special license issued pursuant to section 11.1 of the *Medical Profession Act* of the Yukon.

OR

a) Education

- Bachelor Degree in Midwifery; or
- Successful completion of an International Educated Midwifery Bridging Program (IEMBP); or
- Equivalent assessment through a Prior Learning Experience Assessment (PLEA) program, in a Canadian province; and

b) Licensed under Yukon Midwifery Registrar.

4.2.3 The following shall be the minimum qualifications dentists must possess to be eligible for membership on the Professional Staff:

a) Possess a certificate of qualification by the National Dental Examining Board.

4.2.4 The following shall be the minimum qualifications optometrists must possess to be eligible for membership on the Professional Staff:

a) Possess an optometry degree from a recognized training institution.

4.2.5 The following shall be the minimum qualifications nurse practitioner must possess to be eligible for membership on the Professional Staff:

a) Possess a nurse practitioner certification from an approved nurse practitioner program.

4.3 PROCESS FOR RECRUITMENT

4.3.1 Application Process When Vacancy Is Declared By The MAC

a) Recruitment will occur in the following steps:

i. after a vacancy is declared a process will be developed by the MAC. This may include:

a. a request to the YG Specialist Review Committee for assistance with the search and selection of potential candidates to fill the vacancy; or

b. appointing a YHC internal Search Committee.

b) If a YHC internal Search Committee is formed then:

i. applicants will be invited to apply for the position by providing a letter of interest with proposed services expected to be delivered, curriculum vitae (CV) and names of three (3) referees;

ii. a shortlist of potential candidates will be chosen who may then receive a comprehensive release form to sign allowing additional information and references to be gathered. All shortlisted candidates will be interviewed;

iii. the Search Committee will select a preferred candidate or candidates using preset criteria to guide the process;

iv. the selected candidate(s) will receive an application package for appointment to the Medical Staff of YHC;

v. those who are not selected will be notified in writing that the position(s) available has been offered to other candidates; and

vi. the Chief of Medical Staff will review the completed materials of the selected candidate(s) to ensure the individual(s) meet credentialing requirements and then submit the list of candidates to the MAC.

c) The completed application package(s) for appointment to Medical Staff of YHC will be submitted to the MAC to ensure the selected candidate(s) has the proper credentials.

d) The MAC will make its recommendation in accordance with the process set out in Part 4 of the Bylaws.

4.3.2 Application Process When No Vacancy Is Declared

a) The process for an application for Appointment to the Medical Staff is as set out in Part 4 of the Bylaws.

b) Unsolicited letters of intent or applications will be reviewed by the Chief of Medical Staff to ensure the individual is duly qualified, and that there is a need for the applicant's expertise within YHC facilities.

c) If there is no vacancy, the applicant will be contacted in writing informing him/her that there is no vacancy and confirming whether or not the applicant wishes the application to proceed.

4.4 PROCEDURAL PRIVILEGES

4.4.1 Medical Staff or Other Professional Staff Members, who are being or have been, appointed to the Medical Staff, may also apply for Procedural Privileges. All Procedural Privileges require documentation of training and experience. This documentation must be kept and become part of the Medical Staff and Other Professional Staff Member's appointment or reappointment application.

4.4.2 Certain Procedural Privileges may be defined by the MAC, and may be automatically granted to all Medical Staff or Other Professional Staff Members within a defined service area. The procedural privileges will be reviewed and amended periodically by the MAC.

4.4.3 The granting of Procedural Privileges to a Medical Staff or Other Professional Staff Member is dependent on the training, experience and qualifications of the member requesting such privilege, as well as the service needs of YHC and the ability of YHC to provide adequate resources and staff to perform such a procedure.

4.4.4 Specific Procedural Privileges are granted by the Board upon the recommendation of the MAC.

4.4.5 Individual Procedural Privileges require an individual application process in the following situations:

a) the introduction of new technology for which education and training has not previously been available to the specialty;

b) a request for Procedural Privileges outside the applicant's specialty area;

c) a request by a non-Specialist for Procedural Privileges in a specialty area; or

d) a request for Procedural Privileges generally not included in a specific staff category as defined in the Bylaws.

4.4.6 The Chief of Medical Staff will determine and evaluate the training and experience required or gained by an applicant to support his or her request for specific Procedural Privileges. This may include supervision of the procedure by qualified physicians *for a number of cases.*

4.4.7 The training and experience requirements for specific Procedural Privileges will be established as a minimum standard for all new applicants.

4.4.8 In exceptional circumstances, the Chief of Medical Staff may determine and evaluate the training and experience on an individual basis if the applicant does not meet the standard for new applicants but can demonstrate training and experience of a similar validity supportive of comparable competency.

4.4.9 Procedural Privileges may be granted to a Medical Staff and Other Professional Staff Member based on adequate documentation provided by an academic training centre, another Health Authority or facility where that member has obtained such privileges.

4.5 TEMPORARY MEDICAL STAFF AND OTHER PROFESSIONAL STAFF APPOINTMENTS AND TEMPORARY PRIVILEGES

4.5.1 A temporary appointment with temporary privileges, including individual Procedural Privileges, may be granted to a duly qualified practitioner.

4.5.2 The Chief of Medical Staff will inform the MAC of all Temporary Staff appointments. The MAC will recommend Appointments to the Board.

4.5.3 The interim nature of the temporary appointment to the Medical Staff or Other Professional Staff shall be clearly indicated to the practitioner and, where applicable, indicated as such on all notices and correspondence regarding an applicant's appointment.

4.5.4 The granting of a temporary appointment provides no preferential access to an Active, Provisional, or other appointment at a later time.

4.5.5 The temporary appointment to the Medical Staff or Other Professional Staff must be ratified or terminated by the Board at its next meeting.

4.5.6 If the next Board meeting falls in advance of the next MAC meeting to consider the temporary member's application for appointment, the Board may, on the advice of the CEO, extend the temporary appointment until the next scheduled Board meeting.

4.5.7 In the event that the Board terminates the temporary appointment to the Medical Staff or Other Professional Staff, the applicant shall cease all clinical activity in facilities and clinical programs and immediately transfer the ongoing care of any patient under their care to an appropriate Medical Staff or Other Professional Staff Member.

4.5.8 Temporary appointments with temporary privileges may be granted, without application, to qualified practitioners for limited situations such as organ retrieval, infant and maternal transport, education and demonstration of medical equipment.

4.5.9 Under such circumstances, the practitioner may be granted a temporary appointment to the Medical Staff with appropriate temporary privileges by the Chief of Medical Staff.

4.5.10 Temporary appointments with temporary privileges granted without application shall be granted by the CEO on the advice of the Chief of Medical Staff based on their assessment of the need to grant such temporary appointment with temporary privileges and of the appropriate training and experience of the individual.

PART 5 – POSTGRADUATE TRAINING PROGRAMS AND CLINICAL TRAINEES

5.1 MEDICAL/SURGICAL RESIDENT

5.1.1 Privileges for Resident Staff shall be granted by the Chief of Medical Staff in conjunction with a recognized Faculty of Medicine.

5.1.2 Residents may attend patients under the supervision of an Active, Provisional, or Visiting Consulting Medical Staff Member who is responsible for supervision of their work in the facility. They may carry out such duties as are assigned to them by the Medical Staff Member to whom they have been assigned and their cases will be reviewed by their

preceptor within a reasonable time. (Further details of Resident Staff roles and responsibilities are contained in the Residents Manual available through the office of Medical Postgraduate Education of their University of affiliation).

5.2 CLINICAL FELLOWS

5.2.1 Clinical Fellows are Physicians who have applied to and been accepted by the YHC for further training in a clinical discipline. They must have adequate medical liability insurance, be licensed by the Yukon Medical Council and be registered with a Faculty of Medicine. Clinical Fellows shall be accepted only if supported by a Medical Staff Member and if recommended by the Chief of Medical staff and approved by the MAC.

5.2.2 Clinical Fellows may attend patients under the supervision of an Active, Provisional, or Visiting Consulting Medical Staff Member. They may carry out such duties as are assigned to them by the Medical Staff Member or delegate to whom they have been assigned. They may not be a patient's MRP nor are they allowed to vote at Medical meetings.

5.3 CLINICAL TRAINEES

5.3.1 Clinical Fellows are Physicians who have applied to and been accepted by the YHC for further training in a clinical discipline. They must have adequate medical liability insurance, be licensed by the Yukon Medical Council and be registered with a Faculty of Medicine. Clinical Fellows shall be accepted only if supported by a Medical Staff Member and if recommended by the Chief of Medical staff and approved by the MAC.

5.3.2 Clinical Fellows may attend patients under the supervision of an Active, Provisional, or Visiting Consulting Medical Staff Member. They may carry out such duties as are assigned to them by the Medical Staff Member or delegate to whom they have been assigned. They may not be a patient's MRP nor are they allowed to vote at Medical meetings.

5.4 MEDICAL/NURSE PRACTITIONER/MIDWIFERY STUDENTS

5.4.1 All Medical/Nurse Practitioner/Midwifery Students who are working within a YHC facility, must be registered with a recognized Faculty of Medicine, Nursing or Midwifery and require an educational license from their relevant Yukon regulatory authority. Medical/Nurse Practitioner/Midwifery Students will receive practical clinical experience and may attend patients under the direct supervision of an Active, Provisional, Visiting Consulting Medical Staff or Other Professional Staff Member in YHC facility who shall be responsible for their training program. History and physical/progress notes must be countersigned by the supervising preceptor within 24 hours. Medical/Nurse Practitioner/Midwifery Students must ensure that orders are countersigned by the supervising Medical Staff Member, Resident or Clinical Fellow prior to implementation. Medical Students shall not sign certificates of death and shall not discharge patients

without appropriate review by a qualified Medical Staff Member. Medical, Nurse Practitioner and Midwifery students are approved by the Chief of Medical Staff.

5.5 PRE-MEDICAL STUDENTS

5.5.1 Pre-medical school students will have completed a Bachelor Degree or a recognized pre-medical program, and have contemplated entering or have been accepted into a recognized Medical School. Pre-medical school students, who are working within a YHC facility, must be under direct constant supervision of an Active, Provisional, or Visiting Consulting Medical Staff Member accepting the pre-medical school student. The pre-medical students are there for observational purposes and learning. They are not permitted to take histories, undertake physical examinations, write progress notes, write orders, assist or carry out procedures or assist in the operating theatre. Pre-medical students are approved by the Chief of Medical Staff.

5.6 OBSERVERS

5.6.1 Observers are individuals who have expressed an interest in the study of medicine. They must be under direct constant supervision of an Active, Provisional, or Visiting Consulting Medical Staff Member. They are there for observational purposes and learning. They are not permitted to take histories, undertake physical examinations, write progress notes, write orders, assist or carry out procedures or assist in the operating theatre. Observers are approved by the Chief of Medical Staff.

PART 6 – MEDICAL STAFF AND OTHER PROFESSIONAL STAFF RESPONSIBILITIES FOR PATIENT CARE

6.1 ADMISSION, DISCHARGE AND TRANSFER OF CARE BY MEDICAL STAFF MEMBERS

6.1.1 Pre-Admission Requirements for Elective Patients

a) The admitting Medical Staff Member is responsible for pre-admission requirements for elective patients; the medical history, physical examination, diagnosis, investigations, appropriate consultations, special tests, documentation of special precautions and patient consent.

b) The Admitting Department shall inform the Most Responsible Practitioner of the expected time for elective admissions.

6.1.2 Admissions

Patients shall be admitted to a YHC facility for investigation or treatment only upon the order of a Medical Staff Member who holds the requisite appointment and privileges. Patients admitted for dental services shall be co-jointly admitted by a Medical Staff Member who holds the requisite appointment and privileges and a member of the dental staff who holds the requisite appointment and privileges.

6.1.3 Most Responsible Practitioner (MRP)

a) The admitting Medical Staff Member shall be deemed to be the MRP until a clear transfer of care occurs (see below, Transfer of Care, Clause 6.1.7).

b) Where two (2) or more Medical Staff Members are involved with the care of the patient, one (1) member must be identified as the MRP. The MRP shall:

i. be aware of each patient for whom they are responsible;

ii. assess and examine the patient, document the findings and issue applicable orders as warranted by the patient's condition but within twenty-four (24) hours of admission or acceptance of transfer of care;

iii. communicate the patient's status to the patient, family/legal guardian and other members of the healthcare team, as appropriate;

iv. ensure each patient is seen by a Medical Staff Member daily, more frequently if warranted, until the patient is no longer designated acute care;

v. complete progress notes at least: every day in the acutely ill or maternity patients; every three (3) days in stable patients, and; every week in long term care patients;

vi. initiate consultations or transfer of care as required; and

vii. be available by appropriate communication channels in person or through an appropriately privileged and qualified designate twenty- four (24) hours per day, seven (7) days per week.

6.1.4 Emergency Admissions

a) The MRP will document the severity of the patient's condition and any circumstances necessitating special consideration.

b) The admitting Medical Staff Member 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, communicable infections, drug reactions and allergies.

c) All patients must have a record of their history and physical examination placed on the patient health record within twenty-four (24) hours of admission.

d) Patients admitted where the admitting Medical Staff Member does not have the requisite appointment and privileges and who do not have an identified family physician shall be admitted under a designated family physician with the requisite appointment and privileges.

6.1.5 Admissions for Surgery

a) All patients admitted for surgery must have a history and physical examination recorded on the patient health record before surgery takes place.

b) Dental admissions: A Medical Staff Member, who will be the MRP, must admit patients admitted for dental treatment. The attending dental surgeon shall be responsible for the patient's dental care.

6.1.6 Discharge

a) Only the MRP or their designate may authorize discharge of patients from the facility.

b) In exceptional circumstances, a patient may be discharged by the Chief of Medical Staff.

c) Discharge planning begins at the time the decision is taken to admit the patient.

d) The Medical Staff Member shall, when possible, flag the planned discharge on the day prior to discharge. Discharge orders shall be written for all patients as early as possible on the day of discharge.

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

f) Should a patient demand to be allowed to leave the facility against the MRP's advice, the patient or their legal representative shall be asked to sign a release on the prescribed form. Refusal to sign this release must be noted in the medical record. Patients who have been absent without a pass for six (6) hours past the end of an official pass period, are deemed "Discharged Against Medical Advice". Certified psychiatric patients are excluded from this rule. If certified psychiatric patients are absent without a pass and their whereabouts are unknown, notification shall be given to the appropriate authorities.

g) A discharge summary shall be dictated within fourteen (14) days of a patient's discharge. Issues significant to the patient's immediate follow-up shall be communicated by the MRP at the time of discharge directly to relevant health care professionals who will be involved in care pending receipt of the discharge report.

6.1.7 Transfer of Responsibility

a) Medical Staff Members will ensure continuous coverage for their patients in the facility.

b) Any Medical Staff Member who will not be available by direct communication shall indicate the name(s) of the member(s) assuming responsibility for the patient's care. This pertains to the MRP and to any Consultants actively involved in 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 member shall inform the patient and arrange for another member with appropriate qualifications from within the same specialty to assume responsibility for the care of the patient prior to withdrawing from care.

d) A patient has the right to request a change in the MRP or Consultant. The MRP shall co-operate in transferring responsibility for care to another Member

appropriate for and acceptable to the patient. If an acceptable alternative Member cannot be found, the MRP will discuss the issue with the Chief of Medical Staff who shall ensure that care for the patient is provided until the patient can be transferred to a member who agrees to accept responsibility for the care of the patient and who is acceptable to the patient.

e) When the transfer of a patient to another facility is initiated by the MRP, the MRP or designate shall ensure, prior to the patient being transferred, that there is a Medical Staff member at the receiving facility who is fully informed about the patient's condition and is prepared to assume responsibility for the patient's care. The Medical Staff Member shall identify relevant documentation from the patient's clinical record to be sent to the receiving facility.

6.1.8 Transfer of Care

a) When an inpatient transfer of care is deemed appropriate by the MRP, an order must be written in the patient's health record for a request to transfer to another MRP. There must be a recorded response from the Medical Staff Member accepting the transfer of care.

b) The MRP shall personally contact the intended accepting Medical Staff member to obtain agreement to accept the transfer of care.

c) A Medical Staff Member may decline to accept responsibility of MRP from a transferring MRP.

d) The transfer of care takes place upon the written acceptance of the transfer by the receiving Medical Staff Member.

e) The accepting Medical Staff Member who now becomes the MRP, or their designate, shall assess and examine the patient, document the findings and issue applicable orders as soon as warranted by the patient's condition, but no longer than twenty-four (24) hours after accepting the transfer.

6.1.9 Medical/Surgical Consultations

a) Consultations shall be initiated by the MRP or other Medical Staff Member involved in the care of the patient by direct communication with the consultant.

b) The Consultant shall examine the patient, record the findings, opinions and recommendations on the patient medical record.

c) Consultations may be for the purpose of:

i. consultation only (opinion only);

ii. consultation with directive care (write relevant orders); or

iii. consultation with continuing care (transfer of care).

d) Consultations shall be required by Medical Staff when a patient necessitates care that is beyond the privileging or required competencies in the areas including but not limited to:

i. in any case of seriously ill patients where the diagnosis is obscure or there is doubt as to the best therapeutic method to be utilized;

ii. in any case in which the patient exhibits suicidal behaviour and the attending physician is not a certified psychiatrist;

iii. in cases where a territorial ordinance recommends or requires consultation;

iv. in cases of confirmed or suspected child abuse;

v. prior to all caesarean sections;

vi. pregnancy with major complications i.e., breech, toxemia, serious medical conditions; and

vii. all patients admitted to the Intensive Care Unit.

e) Consultations will be required in cases where the MRP does not have the requisite privileges to manage the patient.

f) All inpatient consultations shall be recorded on the patient record and the records shall be signed by the consultant.

g) The Medical Staff shall obtain a written consultation whenever requested to do so by the Chief of Medical Staff/Designate or the Chief Executive Officer.

h) A consultation may be performed by a specialist, a Medical Staff member, dentist, optometrist, mental health nurse or registered psychologist whose opinion has been requested by a member of the Medical Staff. The consultant is not encouraged to write orders unless specifically requested except in an emergency which is verified on the record. When operative procedures are involved consultation notes shall be recorded prior to the operation.

i) A satisfactory non-specialist consultation shall include:

i. the written request of the attending Medical Staff member;

ii. a report of examination of both the patient and the medical record by the consultant;

iii. a written report of the consultant's finding; and

iv. opinion and recommendations signed and dated by the consultant.

j) The Medical Staff member requesting a consultation is responsible for contacting the consultant and informing them of the priority of the request.

k) If a Medical Staff member declines a consultation, the reasons shall be documented in the chart.

6.2 DENTAL STAFF RESPONSIBILITIES FOR PATIENT CARE

6.2.1 Admission

a) The Dental staff shall not admit patients.

b) Patients who are to receive dental services requiring admission to a YHC facility shall be admitted upon the order of an active, provisional or locum member of the Medical Staff who shall assume responsibility for all medical care of such patients and the preparation of the medical record.

6.2.2 Patient Management

a) The dentist shall make a written record of the dental history, examination, and dental procedures performed on each patient, which shall become part of the medical record.

6.3 OPTOMETRIST STAFF RESPONSIBILITIES FOR PATIENT CARE

6.3.1 Admission

a) Optometrists shall not admit patients.

b) Patients who are to receive optometrist services requiring admission to Hospital shall be admitted upon the order of an active or provisional member of the Medical Staff who shall assume responsibility for all medical care of such patients and the preparation of the medical record.

6.3.2 Patient Management

a) The optometrist shall make a written record of the history, examination, and procedures performed on each patient as it pertains to their field of expertise, which shall become part of the medical record.

b) Optometrists' practice in the Hospital will be limited to consultation and advice to Medical Staff members when specifically requested; assisting the visiting consultant ophthalmologist, including triaging of referrals, arranging necessary investigations prior to being seen by, or at the request of the visiting ophthalmologist, and initial assessment of patients referred to the visiting ophthalmologist.

c) Optometrists are expected to limit the care they provide at WGH to their scope of practice as defined in the *Optometrists Act* and Regulations.

6.4 NURSE PRACTITIONER STAFF RESPONSIBILITIES FOR PATIENT CARE

6.4.1 Admission

a) Nurse Practitioners shall not admit or discharge patients.

6.4.2 Patient Management

a) An MRP, by writing an order on the chart, may designate a Nurse Practitioner to attend, investigate and treat patients. Once designated, the NP may, within the

limits of their competence, scope of autonomous practice as defined in the Registered Nurses Profession Act, and within the limits of their privileges:

i. take histories and perform physical examinations;

ii. order diagnostic tests;

iii. make referrals; and

iv. order medications or therapies.

6.5 QUALITY IMPROVEMENT

6.5.1 Quality improvement activities are an integral component of the Medical Staff and Other Professional Staff function and responsibility.

6.5.2 All Medical Staff and Other Professional Staff Members will participate, as required by the *Hospital Act* and Regulations and as requested by the Chief of Medical Staff, in quality improvement activities including, but not limited to, utilization management, critical incident reviews, mortality and morbidity rounds and specific program related activities.

6.6 HEALTH RECORDS

6.6.1 The MRP involved in the patient's care shall be responsible for the preparation of the medical component of the health record for each patient. The record shall include the following items, where applicable:

a) Admission History

The MRP shall ensure that every patient admitted to a YHC facility shall have within twenty-four (24) hours after admission, and prior to every delivery or operation except in extreme emergency, an adequate clinical history and physical examination and provisional diagnosis recorded in the health record. If the admission history is dictated, then a brief written note must be placed in the chart indicating the relevant history and indicating a complete admission history has been dictated.

b) Progress Notes

The progress notes shall be legible and be sufficient to describe changes in the patient's condition, reasons for change of treatment and outcome of treatment and shall be written as frequently as the patient's condition warrants.

c) Operative Notes

i. If a history and physical examination are not recorded before the time slated for operation, the operation shall be cancelled unless the Medical Staff Member states that such delay would result in mortality or significant morbidity. Such cases shall be reviewed by the Chief of Medical Staff.

ii. A legible hand written note summarizing the operative procedure, the

operative findings and complications, and post-operative orders must be placed on the chart prior to the patient leaving the post anesthetic recovery unit.

iii. Prior to any anesthetic procedure, a pre-anesthetic assessment must be recorded on the anesthetic sheet by the anesthetist. The anesthetic record must be completed prior to the patient leaving the operating room or the post anesthetic recovery unit.

iv. All operations shall be described fully by the operating surgeon and dictated within twenty-four (24) hours of surgery.

6.7 PRENATAL RECORD

6.7.1 The prenatal record is considered to be an integral part of the health record, and the information will be submitted in accordance with YHC policies.

6.8 COMPLETION OF HEALTH RECORDS

6.8.1 All health records must be fully updated according to the YHC's health record policies that have been formally accepted by the MAC. If the MRP is no longer available to sign orders, the clinical record will be reviewed by the Chief of Medical Staff.

6.8.2 After thirty (30) days, unsigned health records are deemed to be authorized.

6.8.3 Each Medical Staff or Other Professional Staff Member is responsible for notifying the YHC, through administration, of planned absences prior to their occurrence. Following appropriate notification, the member will be responsible for the completion of outstanding health records within fourteen (14) working days of return from such leave or absence.

6.8.4 The patient's health record should be fully updated at the time of discharge.

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

a) the Medical Staff or Other Professional Staff Member is notified of incomplete charts monthly. The notification shall include a list of all the deficiencies in the health record incomplete for greater than 21 days;

b) failure to comply with this notification will result in notification to the MRP indicating that suspension of elective admission privileges will follow if charts are not completed within a time period defined in the letter. Failure to complete charts within this period of time will result in suspension of privileges. The affected Medical Staff or Other Professional Staff Member shall continue to be responsible for their current in-hospital patients and on-call/emergency responsibilities;

c) the suspension of elective admission privileges is removed when the health records are completed;

d) if charts are not completed within a reasonable period (normally 30 days) after

elective admission privileges are suspended, the matter will be forwarded to the MAC who may recommend to the Board revoking the appointment and privileges of the Medical Staff and Other Professional Staff Member. This will lead to a letter being sent to the member advising that their appointment and privileges have been revoked. The member will arrange transfer of their patient's care to an appropriate Member. If the individual wishes to re-apply, they will be required to apply as a new applicant;

e) members who have elective admission privileges suspended more than three (3) times in a consecutive 12 month period will be interviewed by the Chief of Medical Staff and the repeated suspensions may be grounds for discipline up and including revocation of their appointment on the Medical Staff or Other Professional Staff;

f) Locum Tenens, Temporary Medical Staff and Other Professional Staff Members are responsible for completion of clinical records, and are subject to the same disciplinary consequences as other Medical Staff or Other Professional Staff Members when medical records are not completed as prescribed above. Should the Locum Tenens/Temporary Medical Staff or Other Professional Staff Member fail to complete the clinical records as required, the member arranging for the Locum Tenens/Temporary Medical Staff or Other Professional Staff Member will be responsible for reviewing any outstanding records to ensure continuity of care, dictating a summary of care provided and marking the report as a "Review Summary After Discharge". This indicates the individual was not directly responsible for the care of the patient and that the summary was a product of a chart review.

6.8.6 Ownership and Access

a) Health records are the property of the YHC and are not to be removed from its facilities except as directed by management or ordered by the courts or otherwise in accordance with the Hospital Standards Regulations (s.11).

b) Confidentiality of patient information is paramount. Access to and copies of the health record or information contained therein must be strictly controlled with audit controls in place to track access and, aside from Medical Staff and Other Professional Staff Members involved in the past or present care of the patient, can only be obtained by:

   i. the Coroner's office upon presentation of a warrant to seize;

   ii. patient requests for their own record in accordance with ATIPP and Section 11.6 (c)(i) of the Hospital Standards Regulations;

   iii. a court order, warrant, or subpoena;

   iv. written patient authorization (or authorization by the patient's personal representative where the patient is deceased) for release of information to third parties, or as otherwise authorized in accordance with ATIPP and HIPMA;

   v. a written request by the patient's Physician for transfer of medical treatment and patient care accompanied by a release signed by the patient or the

patient's next of kin/guardian if there is no previous record of that Physician's involvement in care of the patient or of that Physician being consulted by a known involved Physician;

vi. a request of the YHC Legal Counsel;

vii. a written request of the Medical Staff and Other Professional Staff Members Yukon Regulatory Authority in accordance with applicable legislation;

viii. a written request of the Chief of Medical Staff for purposes of review;

ix. a written request of the CEO or designate of another hospital upon the transfer of a patient to that hospital for the purpose of transfer;

x. Medical Staff and Other Professional Staff Members who are actively providing care to the patient;

xi. Clinical Fellows, Clinical Trainees, Residents, Medical Students, Nurse Practitioner Students, and Midwifery Students who are responsible to Medical Staff or Other Professional Staff Members involved in the care of the patient;

xii. Medical Staff or Other Professional Staff Members carrying on a bona fide study of research upon application and approval by the CEO;

xiii. Medical Staff or Other Professional Staff Members or administration carrying out medical quality assurance, medical audits and utilization review upon application and signed approval of the Manager of Health Records under the sanction of the Board and subject to section 13 of the *Evidence Act*, where applicable (i.e. should be members of designated section 13 committees); or

xiv. Medical Staff or Other Professional Staff Members / Clinical Fellows, Clinical Trainees, Residents, Medical Students, Nurse Practitioner Students, and Midwifery Students seeking information from Health Records for the purposes of medical rounds and other educational purposes upon authorization from the appropriate Clinical Service Area Physician Leader or Designate.

6.9 INFORMED CONSENT

6.9.1 Examination, treatment, procedure or operation, other than in the case of an emergency which may be life, limb or organ threatening to the patient, 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 YHC policy and governing legislation.

6.9.2 The MRP or relevant Consultant is responsible for obtaining the informed consent of the patient prior to carrying out any examination, treatment, procedure or operation. Informed consent must be documented in accordance with YHC policy.

6.9.3 The YHC consent form and the procedures for obtaining consent from patients shall be developed in consultation with the Medical Staff and Other Professional Staff.

6.10 CONFIDENTIALITY OF QUALITY MANAGEMENT INFORMATION

6.10.1 Access to quality assurance/improvement data for projects, research and preparation of publications, or administrative reasons shall comply with YHC policy regarding ownership and applicable legislation such as ATIPP and HIPMA, and may be restricted under section 13 of the *Evidence Act*.

6.10.2 Access by other personnel must be authorized by the chair of the appropriate committee in consultation with the CEO, and in accordance with ATIPP, HIPMA and may be restricted under section 13 of the *Evidence Act*.

6.10.3 All written communication between Medical Staff quality improvement committees shall be identified specifically as being for the purpose of the committees involved in order to preserve the protection of section 13 of the *Evidence Act*.

6.10.4 In all circumstances, the communication of 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 and Other Professional Staff Members, and other personnel who were involved with the case.

6.10.5 Information gathered under section 13 of the *Evidence Act* cannot be provided to individuals or organizations that request the information under ATIPP or HIPMA.

6.11 EMERGENCY CARE

6.11.1 In an emergency, any Medical Staff Member is expected to provide medical care until the patient's MRP assumes responsibility.

6.12 MEDICAL ORDERS

6.12.1 All Medical Staff and Other Professional Staff Members' orders for treatment shall be written and signed, and must include the time and date of the order. Names should be printed or a stamp used under the signature to ensure legibility.

6.12.2 In an emergency, a Medical Staff or Other Professional Staff Member may give verbal orders for treatment to a nurse or a pharmacist, who shall transcribe the order onto the chart under the name of the Medical Staff or Other Professional Staff Member per the writer's printed name and signature.

6.12.3 The Medical Staff Member who decides a patient requires admission shall provide orders necessary for the patient's care at the time of admission. Medical Staff Members are expected to comply with medication order policies.

6.13 PRE-PRINTED ORDERS AND MEDICAL DIRECTIVES

6.13.1 Pre-printed Medical Staff orders and medical directives may be developed for patients under the care of Medical Staff or Other Professional Staff Members. The MAC shall review and approve these orders in accordance with the clinical standards approved

by the MAC. A Member must sign the pre-printed order for each patient under their care.

6.14 RESPONSIBILITY FOR PROVISION OF ON-CALL AND SERVICE COVERAGE FOR PATIENTS

6.14.1 Each Medical Staff Member shall ensure safe and effective service coverage for the Patients for whom they are the MRP. Medical Staff Members, when unavailable for whatever reason, will make arrangements with another Member(s) for the care of their Patients. This may be accomplished by specific arrangements or by participating in an on-call roster with other Members who have similar and appropriate Clinical Privileges at YHC Facilities.

6.14.2 Each Medical Staff Member and the Chief of Medical Staff shall jointly establish and maintain reasonable and effective on-call schedules in order to provide safe and effective coverage and care to Patients. Responsibilities of an on-call Member include but are not limited to:

a) Responding appropriately to calls and requests from other Medical Staff Members and other health professionals regarding patients for whom they are responsible while on-call or about whom they have been consulted. Members shall attend patients appropriately, in a timely fashion. Such calls and requests may originate from within the YHC Facilities, including emergency departments, and externally from patient referral and transfer call lines, community offices and clinics, or other sources.

b) Coverage for patients without a designated family physician.

c) Discussing with a referring or consulting Medical Staff Member the urgency of the consultation and, when possible, offering advice to a referring Member in advance of the consulting Member attending the patient. Such discussion may include arranging in-person attendance at an appropriate time and location, and follow-up of cases not requiring emergent assessment.

d) Working collaboratively with a referring Medical Staff Member to stabilize the patient and provide urgent care, if applicable and as required, and consistent with the level of resources available.

e) Working collaboratively with a referring Medical Staff Member to coordinate the timely admission or appropriate transfer of the patient, as required, and in accordance with these Rules and relevant YHC policies. This includes communicating directly with the receiving Physician.

6.14.3 It is understood that in smaller YHC facilities, provision for an on-call roster may not be possible however, it is mandatory to ensure that a Medical Staff Member is available 24 hours a day for admitted and emergency patients.

6.14.4 When a Consultant has participated in the care of an inpatient, that Consultant must continue to be available to respond to care needs arising for that patient or must specify

another qualified and privileged Consultant to be available for any period that they themselves are not available.

6.14.5 All Medical Staff Members shall participate equitably in on-call rosters, including weekend call rosters, except in special circumstances as approved by the Chief of Medical Staff and the MAC.

6.14.6 The YHC facility or community resources assigned to a Medical Staff member may be reduced with the reduction of on-call responsibilities.

6.14.7 Medical Staff Members will be expected to maintain acceptable levels of availability when on-call.

6.14.8 On-call limits do not supersede the ethical and professional responsibilities of Medical Staff Members.

6.14.9 It is expected that a referring Medical Staff Member will limit evening and night- time consultations to urgent or emergent cases. Referrals for non-urgent/non- emergent cases should be arranged during day-time hours. A non-urgent acute care consultation shall be completed within twenty-four (24) hours of the request, unless otherwise agreed to by the referring and consulting Medical Staff Member.

6.14.10 Medical Staff Members and YHC Medical Administrative Leaders shall work jointly to ensure that on-call rosters do not place work demands on individual Medical Staff Members that prevent the Member from providing safe Patient care and service coverage. YHC Medical Administrative Leaders shall work collaboratively with Members to resolve such situations when they arise.

6.14.11 Medical Staff Members shall manage their other concurrent clinical activities in order to ensure that they can safely and appropriately fulfil their on-call duties and responsibilities. Members, initially amongst themselves, and, if required, with the Chief of Medical Staff, shall work collaboratively to resolve any issues or disputes related to appropriate on-call coverage and/or on-call schedules. If unsuccessful, the issue or dispute shall be referred to the MAC for resolution as required.

6.15 POST-OPERATIVE/POST PROCEDURAL CARE

6.15.1 Post-Operative or post procedural care is the responsibility of the Medical Staff or Other Professional Staff Member who performed the intervention unless an alternate responsible Member(s) is/are identified on the order sheet and on an information sheet provided to the patient at the time of discharge, including discharge from Day Care Surgery.

6.16 DELEGATED FUNCTIONS

6.16.1 Medical Staff or Other Professional Staff Members may delegate certain functions that have been approved by senior management. Medical functions may be delegated to a variety of health professionals following the process outlined below.

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

6.16.3 A delegated medical act may be defined through YHC policies or protocols, standing orders, medical directives, or orders made on the patient chart by the Medical Staff or Other Professional Staff Member.

6.17 ORGAN DONATION AND RETRIEVAL

6.17.1 Temporary privileges may be granted by the Chief of Medical Staff, to Medical Staff Members of the Organ Retrieval Team.

6.17.2 The criteria for neurologic death for organ donation established by the Canadian Council for Donation and Transplantation will be followed in accordance with the *Human Tissue Gift Act*.

6.17.3 In the event of possible organ donation, responsibility for the physiological maintenance of the organ donor after the declaration of neurological death may be transferred, at the discretion of the MRP to a Member of the Organ Retrieval Team.

6.17.4 In accordance with the *Human Tissue Gift Act*, RSY 2002, c.177, and Regulations, the determination of appropriateness for organ donation will be done by the referring Medical Staff Member. 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 for corneas and tissue.

6.17.5 If the referring Physician determines the patient is medically suitable for organ, cornea or tissue donation, then approach for consent of the family will be made, usually by a physician, nurse, nurse practitioner, social worker or other trained individual.

6.17.6 Written consent for organ donation shall be obtained in accordance with the *Human Tissue Gift Act*. Consent shall be obtained after the declaration of neurological death. Consent must be documented on the appropriate consent form. Telephone consent requires two witnesses (physician, nurse practitioner or nurse).

6.17.7 In the event of eye and/or tissue donation only, after cardiac death, consent shall be obtained in accordance with the *Human Tissue Gift Act* after cardiac death, by a Medical Staff Member. Consent must be documented on the appropriate consent form.

6.17.8 In the case of organ donation, after the declaration of brain death, and in the event that the MRP 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 or a respiratory therapist for the physiological maintenance of the donor. Any deviation from standing orders protocol will be discussed in consultation with the MRP or Consultant.

6.17.9 In the case of organ donation, the criteria for the diagnosis of neurological death published by the Canadian Council for Donation and Transplantation (2003) will be followed in accordance with the *Human Tissue Gift Act*.

6.18 INFANT AND MATERNAL TRANSPORT TEAMS

6.18.1 The MRP may transfer responsibility to a Member of the Transport Team for the physiological maintenance of the patient while the patient remains under the care within a YHC facility. The Transport Team is authorized to give verbal orders to the nurse or respiratory therapist to ensure optimal physiological maintenance of the patient during preparation for transport.

6.19 PRONOUNCEMENT OF DEATH, AUTOPSY AND PATHOLOGY

6.19.1 A Medical Staff, Nurse Practitioner Member or Designate must pronounce death.

6.19.2 No autopsy shall be performed without order of the Coroner or written consent of the appropriate relative or legally authorized agent of the patient on the appropriate consent form and approval of the CEO.

6.19.3 Where autopsy is appropriate, the MRP or Consultant shall make all reasonable efforts to obtain permission for the performance of an autopsy.

6.19.4 All tissue or material of diagnostic value shall be sent to the pathologist used by the YHC for examination, storage and/or disposal.

6.19.5 Pathology specimens including body tissues, organs, materials and foreign bodies shall not be released to any agency or person without due authorization of the Clinical Pathologist or Designate.

6.19.6 The MRP shall comply with the *Vital Statistic Act* concerning the completion of the medical certificate of death or the medical certificate of stillbirth except in those deaths identified as falling under the jurisdiction of the Coroner.

6.19.7 Unanticipated deaths shall be reported to the Coroner in accordance with the requirements of the *Coroner's Act*.

PART 7 – MEDICAL STAFF ASSOCIATION

7.1 MEDICAL STAFF ASSOCIATION

7.1.1 The YHC Medical Staff Association shall consist of all Medical Staff Members. The Medical Staff Association may be subdivided at the level of individual YHC facilities. The operation and structure of the Medical Staff Association shall be in accordance with the Bylaws and these Rules as approved and adopted by its members.

7.2 PURPOSE

7.2.1 The objectives of the Medical Staff Association include the promotion and advancement of member involvement in the provision of the organization's medical services and to represent and advocate for the interests of patients and the YHC Medical Staff.

7.3 ELECTED OFFICERS OF THE MEDICAL STAFF

7.3.1 The elected officers of the Medical Staff are:

a) President;

b) Vice-President;

c) Secretary/Treasurer

7.3.2 All elected officers shall be Active Medical Staff Members.

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

a) Meetings – regular, annual, special

b) Appointing special subcommittees, as required.

7.4 ELECTION PROCEDURE

7.4.1 A slate of nominated officers may be proposed by a committee constituted for this purpose; consisting of three (3) members of the Medical Staff Association to be appointed by the elected officers of the Medical Staff.

7.4.2 The elected officers of the Medical Staff shall be elected at an annual meeting of the Medical Staff and shall hold office for a period of two (2) years. Officers may be re-elected.

7.4.3 The elections shall be by acclamation or by a majority vote by Active Medical Staff members eligible to vote and casting ballots.

7.5 DUTIES OF THE PRESIDENT OF THE MEDICAL STAFF

7.5.1 The President of the Medical Staff shall:

a) convene and chair all meetings of the general Medical Staff;

b) be a voting member of the MAC and ex-officio member of all other committees of the Medical Staff;

c) receive information as deemed appropriate from the MAC, clinical programs, the Board, the CEO, YHC senior management, the Chief of Medical Staff or others and disseminate this information to the Medical Staff and local community physicians;

d) communicate all recommendations and matters of concern from the Medical Staff to the Chief of Medical Staff, MAC and the YHC senior management, as

appropriate;

e) represent the collective interests of the Medical Staff;

f) represent the opinion of the Medical Staff on medical administrative matters to the Board through the CEO;

g) in consultation with the Executive of the Medical Staff Association appoint or nominate for appointment all Medical Staff Members of committees and where necessary to appoint a chairperson;

h) call and preside at all meetings of the medical staff;

i) represent the Medical Staff in general and speak for the individual Medical Staff Member in particular. In the case of disciplinary action taken with respect to a Medical Staff Member, to inform the member of their rights under the Bylaws; and

j) bring forward to MAC and/or other committee, as appropriate, any resolution duly passed at a meeting of the Medical Staff.

7.6 DUTIES OF THE VICE-PRESIDENT OF THE MEDICAL STAFF

7.6.1 The Vice-President of the Medical Staff, in the absence of the President or the inability of the President to perform the duties of that office, shall assume all the duties and authorities of the President.

7.6.2 Perform such duties as the President of the Medical Staff may delegate to them.

7.7 DUTIES OF THE SECRETARY-TREASURER OF THE MEDICAL STAFF

7.7.1 The Secretary-Treasurer shall:

a) give notice and keep minutes, with the assistance of YHC administration, of all meetings of the general Medical Staff;

b) attend to all correspondence, with the assistance of YHC administration, of the general Medical Staff;

c) receive and properly disburse such funds as may be the property of the Medical Staff Association;

d) cause a financial statement of the Medical Staff funds to be prepared for presentation to the annual meeting; and

e) perform such other duties pertaining to the office of the Secretary-Treasurer as may be required, including assumption of the duties and authorities of the Vice-President in the absence of the Vice-President or inability of the Vice- President to perform the duties of that office.

7.8 DUTIES OF THE PAST PRESIDENT OF THE MEDICAL STAFF

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

7.9 RECALL, REMOVAL AND FILLING OF VACANT OFFICES

7.9.1 Elected officers of the Medical Staff may be recalled and removed in accordance with the following:

a) Upon receipt of a petition seeking recall of an elected officer, signed by one third of Members eligible to vote, the President of the Medical Staff shall call a special meeting of the Medical Staff to be held within thirty (30) days of receipt of the petition. In the case of recall of the President, the Past President shall call and chair this meeting. If at this meeting, with a quorum present, two- thirds of eligible voters' present vote in favor of recall, the office shall be declared vacant. An election for the vacant office must be held within one (1) month.

b) In the event of death, removal or resignation of an elected officer during the term of office, another Member may be elected at a regular or special meeting to fill the balance of the expired term. Otherwise, the duties of that office shall be assumed by the remaining officers as specified in the duties of the officers.

c) 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. In the absence of the Past President the Medical Staff Association shall be elected to fulfill this function.

7.10 MEETINGS OF THE MEDICAL STAFF ASSOCIATION

7.10.1 All meetings of the Medical Staff Association shall be conducted according to Robert's Rules of Order, most recent version. Records of all meetings shall be kept.

7.10.2 Annual General Meeting

a) The annual meeting shall be held in the month of December of each year at which time elections shall be held for positions of officers of the Medical Staff Association whose terms are expiring.

b) The President shall post a notice for members of the Medical Staff Association at least fourteen (14) days prior to the annual meeting announcing the time and place of the meeting.

c) All Active and Provisional Medical Staff Members shall attend, or give prior notice to the President of the Medical Staff Association. Attendance may be in person or by teleconference.

d) Representatives from the YHC senior administration shall be invited to attend.

e) Representatives from the Board may be invited to attend.

f) An annual report from the officers and committees of the Medical Staff Association may be presented in writing.

g) One-half of the Active Medical Staff Members shall constitute a quorum. Motions shall be passed by a simple majority.

h) Method of voting at all meetings will be by show of hands unless otherwise requested. Those Members attending by teleconference or videoconference shall indicate whether they are in favor, against or abstaining from a motion.

7.10.3 Regular Meetings

a) Regular meetings of the Medical Staff Association should be held at least ten (10) times a year, in addition to the Annual General Meeting, or more frequently as deemed appropriate by the President or officers of the Medical Staff Association.

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

c) The CEO and the Chief of Medical Staff shall be given notice of the meeting and they or their delegates shall attend all meetings of the Medical Staff.

d) The business of regular meetings shall include informing the Medical Staff Association of actions recommended by YHC Medical Advisory Committee.

e) Committee reports may be presented at these meetings.

f) Non-attendance at these meetings without reason may be cause for disciplinary action which may include a suspension of privileges.

7.10.4 Clinical Meetings

a) Clinical meetings should be held at least ten (10) times a year.

b) Clinical meetings held, as provided for under the Medical Staff Bylaws and the Medical Staff Rules, shall constitute a review and analysis of clinical work done within a YHC facility or program including consideration of deaths, unimproved cases, infections, complications, errors in diagnosis, selected cases in a YHC facility at the time of the meeting, selected cases discharged, selected emergency and outpatient cases, and audits of charting and documentation for completeness.

c) Clinical meetings should include the analysis of any clinical reports and significant statistical reports of analysis of YHC facility services including rates of mortality, consultation, autopsy and YHC facility infections, and other evidence of the volume, variety, and quality of the professional work undertaken in YHC facilities.

d) Clinical meetings shall be conducted so as to comply with section 13 of the *Evidence Act*.

e) Non-attendance at these meetings without reason may be cause for disciplinary action which may include a suspension of privileges.

7.10.5 Quorum

a) The quorum shall be a minimum of 50% of the members of the Active Medical Staff eligible to vote.

7.10.6 Proxy Votes

a) Active Medical Staff Members are entitled to vote at a duly constituted meeting may appoint a proxy holder as that member's nominee to attend and act at the meeting in the manner, to the extent and with the power conferred by the proxy. A proxy vote may be executed only in elections and on motions where advanced notification is provided. A member may also appoint one or more alternate proxy holders to act in the place and stead of an absent proxy holder.

b) A form of proxy shall be in writing and signed by the member appointing the proxy holder. A proxy holder must be a voting member of the meeting.

c) Unless any other statute or law which is applicable to the YHC Medical Staff requires any other form of proxy, a proxy will be in the form detailed in Appendix 1, but may also be in any other form that the President of the Medical Staff or the chair of the meeting may approve.

d) Every proxy may be revoked by the member giving the same or by that member's attorney authorized in writing; and delivered to the President of the Medical Staff or chair of the meeting prior to the commencement of the meeting at which the proxy is to be used or in any other manner provided by law.

e) A proxy will cease to be valid at the closing of the meeting or the adjourned meeting for which the proxy was given.

7.11 MEMBERSHIP DUES

a) Each Active and Provisional Medical Staff Member shall pay an annual membership fee, if required, as determined by a simple majority of members in attendance at the annual meeting on recommendation of the elected officers of the Medical Staff Association. This annual fee is due and payable each year and is a requirement in order to remain on the Medical Staff.

PART 8 – AMENDMENTS

The Board, upon the recommendation of the MAC, may make amendments to these Rules.

The Medical Staff shall be provided with any and all proposed amendments and afforded the opportunity to discuss and consult on any proposed amendments prior to the proposed amendments being forwarded to the Board for a final decision. The Board will be informed of the results of the consultation with the Medical Staff prior to making a final decision. The results of any vote take by the Medical Staff in response to such a consultation shall be forwarded to the Board via the Chair of MAC, or the Chair's delegate. The amended Rules become effective when adopted by the Board.

These Rules shall be reviewed and amended periodically as necessary to maintain consistency with the YHC Medical Staff organization structure and with territorial legislative and regulatory changes.

Should amendments to these Rules be initiated by the Board, the Board must consult, in writing, with the Medical Staff concerning the proposed amendment prior to adoption by the Board.

These Rules shall be reviewed no less frequently than every five (5) years, revised as necessary and dated accordingly.

PART 9 – APPROVAL OF MEDICAL STAFF RULES

These Medical Staff Rules become effective only when first adopted and approved by Yukon Hospital Corporation Board of Trustees.

THIS IS TO CERTIFY THAT:

These Medical Staff Rules of Yukon Hospital Corporation were adopted by Yukon Hospital Corporation Board of Trustees on:

Date: January 31, 2022

Signed by:

Allan Lucier, Chair
Yukon Hospital Corporation Board of Trustees

Dr. Owen Averill, Chair, Medical Advisory Committee
Yukon Hospital Corporation

Jason Bilsky, Chief Executive Officer
Yukon Hospital Corporation

Appendix 1: Proxy

THE YUKON HOSPITAL CORPORATION MEDICAL STAFF

The undersigned, being a voting member of the above named Medical Staff, hereby appoints _____or failing that person_____as proxy holder for the undersigned to attend, act and vote for and on behalf of the undersigned at the duly constituted meeting of the Medical Staff to be held on the_____day of_____,_____, and at any adjournment thereof.

Signed this _____ day of _____ , _____.

_____

Signature of member