# ALBERTA HEALTH SERVICES MEDICAL STAFF RULES

Approved and Effective as of Aug. 16, 2024



Alberta Health Services

## TABLE OF CONTENTS





Alberta Health Services

## PART 1 – GENERAL PROVISIONS

### 1.0 PREAMBLE

1.0.1 The Alberta Health Services (AHS) Medical Staff Rules (the Rules) are prepared in accordance with Article 1.5.1 of the AHS Medical Staff Bylaws (the Bylaws), as adopted and approved.

1.0.2 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 affairs, and nothing in them shall alter the intent and purpose ofthe Bylaws.

1.0.3 The Rules shall also govern the conduct of the Medical Staff as it relates to Zones, Facilities, Programs and Professional Services operated by AHS.

1.0.4 Additional details and procedures for operations may be described in the policies of individual Zone Clinical Departments and/or Zone Clinical Sections, and the terms of reference of committees that theymay establish. If there is a conflict between any provisions of these Rules and the rules or policies of a Zone Clinical Department or Zone Clinical Section, or a related committee, the provisions of these Ruleshall prevail.

1.0.5 AHS is committed to involving the Medical Staff in the creation and revision of AHS policies which are applicable to the Medical Staff.

1.0.6 Practitioners are responsible to review and remain informed regarding new or revised Bylaws, Rules and AHS policies which are applicable to, or of importance to, the Medical Staff. Notification of new and revised Bylaws, Rules and AHS policies is the responsibility of the Portfolio of the Executive Vice President& Chief Medical Officer (Chief Medical Officer) and its Medical Affairs Office through the Medical Affairs Office website and e-mail/fax notifications.

1.0.7 Medical Staff with questions or comments regarding the Bylaws, Rules and/or AHS policies may bringthem to the attention of their Zone Clinical Department Head or their Zone Medical Director.

### 1.1 DEFINITIONS

1.1 Unless otherwise provided herein, all defined terms have the same meaning as that ascribed to them in the Definitions section of the Bylaws. Definitions as found in the Bylaws are attached as an Appendix and are subject to any amendments to the Bylaws. They are provided solely for the convenience of the reader.

1.2 Additional Definitions as found in these Rules:

| | |
|---|---|
| Care Team: | Care team defines a group of Practitioners who are members of the AHS Medical Staff and have the requisite privileges at an AHS facility who organize themselves as a team to provide care to their defined group of patients withinan AHS facility. They are individually responsible for the care they provide to their patients and collectively responsible for organizing knowledge transfer aswell as their care and call schedules to provide coverage appropriate to the needs of their patients. |
| Category | Any one of the categories of Appointment to the Medical Staff referred to inArticle 3.1 of the Bylaws. |
| Continuing Care Facility | A residential facility operated by AHS. |

| | |
|---|---|
| Facility Administrator | An AHS administrative leader, designated as a Facility Vice-President, Facility Executive Director, Facility Director, or Facility Manager, and responsible forthe overall management of the Facility. |
| Facility or Community Director | A Practitioner designated by the Zone Medical Director as the most senior Medical medical administrative leader for a particular Facility or community. In some cases, particularly in some of the smaller locations, this individual may have responsibilities that encompass more than one Facility or community. |
| Impact Analysis | An assessment that estimates the effect on available resources of a change or proposed change in the Practitioner Workforce Plan, or an individual Practitioner's Clinical Privileges, or a new Procedure or new Program orProfessional Service. |
| Legal Representative | Person(s) other than the Patient who are legally authorized to make decisions in partnership with, or in substitution for, the Patient as described in the AHS consent policy and procedures, and pursuant to relevant legislation including,but not limited to, the *Alberta Guardianship and Trusteeship Act* (Alberta), the *Personal Directives Act* (Alberta) *and the Mental Health Act* (Alberta). |
| Medical Student | A student on the Student Register of the College of Physicians and Surgeons of Alberta and registered in an approved undergraduate medical training program. |
| Minor | A person under the age of majority (18 years of age). |
| Most Responsible Practitioner | The single, designated Practitioner within the same scope of patient care/practice specialty who has individually assumed the primary responsibilityfor the care of a Patient within a Facility. |
| Practitioner-supervised Health Professional<br>` | A health professional employed or contracted by AHS who provides Patient care and clinical services as supervised by, and as a designate of, a supervising Practitioner(s). Practitioner-supervised Health Professionalsmay include, but are not limited to, clinical and surgical assistants, clinical associates, physician extenders, physician assistants, nurse practitioners and physicians undergoing practice readiness assessments required for licensurein Alberta. |
| Personal Directive | A personal directive of a Patient related to health care under the *Personal Directives Act (Alberta)*. |
| Resident | A Physician trainee on the Provisional Register – Postgraduate Training of the College of Physicians and Surgeons of Alberta in an approved postgraduate training program, or a postgraduate trainee in a program approved by the Alberta Dental Association and College. |
| Transfer of Care | Transfer of Care has occurred when one Practitioner has handed off the care of a patient to another Practitioner or care team and has agreed to become theMost Responsible Practitioner for that patient. |
| Witness Advisor | A person who provides support and assistance to a witness pursuant to these Bylaws. |

1.3 Where the contents so require, words importing the singular number shall include the plural and viceversa, and words importing persons shall include corporations and vice versa.

# PART 2 – MEDICAL ORGANIZATIONAL STRUCTURE OF AHS

## 2.0 ORGANIZATIONAL STRUCTURE

2.0.1 The organizational structure of the Medical Staff includes, but is not limited to:

a) Medical administrative leadership positions: The Chief Medical Officer, Associate Chief Medical Officers, Zone Medical Directors, Associate Zone Medical Directors, Facility and Community Medical Directors, Zone Clinical Department Heads, and Zone Clinical Department Facility Chiefs (the roles and responsibilities of these positions are described in the Bylaws) as well as the SeniorMedical Officer of Health, Zone Medical Officers of Health, Dental Officer of Health, Senior Medical Directors, Deputy Zone Clinical Department Heads, and Zone Clinical Section Chiefs (the roles and responsibilities for these positions are described in these Rules);

b) Provincial and Zone committees: The Provincial Practitioner Executive Committee and its subcommittees including the Medical Staff Bylaws and Rules Review Committee, Hearing Committees, the Immediate Action Review Committee; the Zone Medical Administrative Committees and their subcommittees including the Zone Application Review Committees; and

c) Zone Clinical Departments, their sub-components, Zone Clinical Sections, and their committees including the Zone Clinical Department Executive Committee (described in the Bylaws).

2.0.2 These groups shall be subject to the collective responsibilities identified in the Bylaws and these Rules, and the appointed leaders of these groups will be responsible for ensuring that these responsibilities arecarried out.

2.0.3 The appointment and accountability, responsibilities and duties of the Chief Medical Officer, Associate Chief Medical Officers, Zone Medical Directors, and Zone Clinical Department Heads are found in Part 2 ofthe Bylaws.

2.0.4 The purpose of the Provincial Practitioner Executive Committee and the Zone Medical Administrative Committee are found in Part 2 of the Bylaws.

## 2.1 MEDICAL ADMINISTRATIVE LEADERSHIP POSITIONS

### 2.1.1 GENERAL PROVISIONS – SEARCH COMMITTEES

Unless otherwise specified in the vacancy posting, search committees shall be constituted according tothe following principles:

a) Search committees for the provincial level positions of Associate Chief Medical Officers, Senior Medical Directors and Zone Medical Directors shall be established by the Chief Medical Officer ordesignate.

b) Search committees for the Zone level positions of Associate Zone Medical Director, Zone Clinical Department Head, Deputy Zone Clinical Department Head, Zone Clinical Section Chief, Facility Medical Director and Community Medical Director shall be established by the Zone Medical Director or designate.

c) Search committees for other Zone level positions may be established at the discretion of theZone Medical Director.

d) Search committees shall consist of a minimum of three persons with representation dependanton the position being filled.

e) Representation shall, as a minimum, include members from the portfolio of the Chief Medical Officer and/or the Zone Medical Director, the relevant AHS operational portfolio, department ordivision, and at least one member of the Medical Staff, identified by the Zone Medical Staff Associations.

f) Search Committees shall make recommendations to the AHS medical administrative leader responsible for the appointment of a Practitioner to the position in question. The medical administrative leader shall not be bound by the search committee's recommendations.

### 2.1.2 GENERAL PROVISIONS – TERM OF APPOINTMENT

Unless otherwise specified in the vacancy posting, the term of appointment for AHS medicaladministrative leadership positions shall be up to five years, renewable once.

## 2.2 SENIOR MEDICAL OFFICER OF HEALTH

### 2.2.1 APPOINTMENT AND ACCOUNTABILITY

a) The Senior Medical Officer of Health is the most senior public health Practitioner in AHS and shallbe appointed by the Chief Medical Officer.

b) The Senior Medical Officer of Health shall be directly accountable to the Chief Medical Officer.

c) The Senior Medical Officer of Health shall liaise and collaborate with the Provincial (Alberta Health & Wellness) Chief Medical Officer of Health. For some matters and responsibilities, as specified in the *Public Health Act*, the Senior Medical Officer of Health shall be accountable to theProvincial Chief Medical Officer of Health.

### 2.2.2 RESPONSIBILITIES AND DUTIES

Without limiting the authority of AHS relative to its administrative structures, the responsibilities of theSenior Medical Officer of Health include, but are not limited to:

a) the duties and authority prescribed by the *Public Health Act*.

b) responsibility for all population and public health operational and strategic issues and decisions requiring Practitioner input or leadership.

c) the duties of Provincial Clinical Department Head, Public Health; and

d) other duties as may be assigned by the Chief Medical Officer.

## 2.3 ZONE MEDICAL OFFICERS OF HEALTH

### 2.3.1 APPOINTMENT AND ACCOUNTABILITY

a) One or more Zone Medical Officers of Health shall be appointed by the Senior Medical Officer ofHealth.

b) In each Zone one of the Zone Medical Officers of Health will be designated by the Senior MedicalOfficer of Health as being the Zone Lead Medical Officer of Health.

c) The Zone Medical Officer(s) of Health shall be directly accountable to the Senior Medical Officerof Health and shall liaise with the respective Zone Medical Director.

### 2.3.2 RESPONSIBILITIES AND DUTIES

Without limiting the authority of AHS relative to its administrative structures, the responsibilities of theZone Medical Officers of Health include, but are not limited to:

a) assisting the Senior Medical Officer of Health in carrying out his/her duties (particularly at a Zonelevel).

b) provincial population and public health roles and/or responsibilities as assigned by the SeniorMedical Officer of Health;

c) acting for the Senior Medical Officer of Health in his/her absence;

d) carrying out responsibilities as outlined in the *Public Health Act* in collaboration with AHS staffand the Medical Staff; and

e) other duties as may be delegated by the Senior Medical Officer of Health.

## 2.4 DENTAL OFFICER OF HEALTH

### 2.4.1 APPOINTMENT AND ACCOUNTABILITY

a) The Dental Officer of Health is the most senior oral and dental public health Practitioner in AHSand shall be appointed by the Senior Medical Officer of Health in consultation with the Chief Medical Officer.

b) The Dental Officer of Health shall be directly accountable to the Senior Medical Officer of Health.

### 2.4.2 RESPONSIBILITIES AND DUTIES

Without limiting the authority of AHS relative to its administrative structures, the responsibilities of the Dental Officer of Health include, but are not limited to:

a) responsibility for all oral and dental population and public health operational and strategic issuesand decisions requiring Practitioner input or leadership; and

b) other duties as may be assigned by the Senior Medical Officer of Health.

## 2.5 CHIEF MEDICAL LABORATORY OFFICER

### 2.5.1 APPOINTMENT AND ACCOUNTABILITY

a) The Chief Medical Laboratory Officer is the most senior laboratory medicine Practitioner in AHSand shall be appointed by the Chief Medical Officer and the Chief Executive Officer, Alberta Precision Laboratories ( or its successor) .

b) The Chief Medical Laboratory Officer shall be directly accountable to the Chief Executive Officer,Alberta Precision Laboratories (or its successor) and indirectly accountable to the Chief Medical Officer, AHS for matters relating to the Medical Staff Bylaws or Medical Staff Rules .

### 2.5.2 RESPONSIBILITIES AND DUTIES

The Chief Medical Laboratory Officer shall be accountable for strategic and operational issues and decisions requiring Practitioner input or leadership arising in the provincial portfolio. In particular, this includes the effective integration of medical laboratory services and workforce with AHS clinical serviceneeds.

## 2.6 SECTOR MEDICAL DIRECTORS, LABORATORY MEDICINE

### 2.6.1 APPOINTMENT AND ACCOUNTABILITY

a) Two Sector Medical Directors, Laboratory Medicine will be appointed, one for North Sector andone for South Sector.

b) The Sector Medical Directors, Laboratory Medicine shall be directly accountable to the ChiefMedical Laboratory Officer and shall liaise with the respective Zone Medical Directors.

### 2.6.2 RESPONSIBILITIES AND DUTIES

Without limiting the authority of Alberta Public Laboratories relative to its administrative structures, the responsibilities of the Sector Medical Directors, Laboratory Medicine include, but are not limited to:

a) Those duties generally associated with Zone Clinical Department Heads as outlined in section 2.7.2 of the Bylaws;

b) assisting the Chief Medical Laboratory Officer of Health in carrying out his/her duties (particularlyat Zone levels);

c) Efficiently integrating medical laboratory service needs of AHS with medical laboratory services delivered by Alberta Precision Laboratories, in particular through regular consultation and collaboration with respective Zone Medical Directors.

d) acting for the Chief Medical Laboratory Officer of Health in his/her absence;

e) other duties as may be delegated by the Chief Medical Laboratory Officer.

## 2.7 SENIOR MEDICAL DIRECTORS

### 2.7.1 APPOINTMENT AND ACCOUNTABILITY

a) The Senior Medical Director is the most senior medical administrative leader of one of thespecified provincial AHS portfolios.

b) Senior Medical Directors shall be appointed by the Chief Medical Officer after consideration of the recommendation of a search committee pursuant to the processes specified in these Rules.

c) Senior Medical Directors shall be directly accountable to the Chief Medical Officer but will alsotake direction from their portfolio executive vice-president.

### 2.7.2 RESPONSIBILITIES AND DUTIES

The Senior Medical Directors shall be accountable for strategic issues and decisions requiring Practitionerinput or leadership arising in the provincial portfolio.

## 2.8 DEPUTY ZONE CLINICAL DEPARTMENT HEADS

### 2.8.1 APPOINTMENT AND ACCOUNTABILITY

a) As required, a Deputy Zone Clinical Department Head shall be appointed by the Zone Clinical Department Head after consideration of the recommendation of a search committee pursuant tothe process specified in the Rules.

b) A Deputy Zone Clinical Department Head may concurrently hold another medical administrative leadership position within the AHS Medical Organizational Structure.

c) The Deputy Zone Clinical Department Head shall be directly accountable to the Zone Clinical Department Head.

### 2.8.2 RESPONSIBILITIES AND DUTIES

a) The Deputy Zone Clinical Department Head shall assist the Zone Clinical Department Head incarrying out their duties.

b) The Deputy Zone Clinical Department Head shall act for the Zone Clinical Department Head in their absence and as their designate for those duties assigned to the Zone Clinical DepartmentHead or designated by the Bylaws and these Rules.

c) In addition, the Deputy Zone Clinical Department Head will be responsible for all Practitioner-related matters delegated to them by the Zone Clinical Department Head. They will have the duty to provide recommendations to the Zone Clinical Department Head regarding delegateddepartmental issues and decisions.

d) Other duties as may be delegated by the Zone Clinical Department Head.

## 2.9 ZONE CLINICAL SECTION CHIEFS

### 2.9.1 APPOINTMENT AND ACCOUNTABILITY

a) Zone Clinical Departments may create intradepartmental sub-units called Zone Clinical Sectionsled by a Zone Clinical Section Chief. The Zone Clinical Section Chief shall be a member, or be eligible to be a member, of that Zone Clinical Section.

b) The Zone Clinical Section Chief shall be appointed by the Zone Clinical Department Head uponthe recommendation of a search committee pursuant to the process specified in these Rules.

c) The Zone Clinical Section Chief shall be directly accountable to the Zone Clinical DepartmentHead.

### 2.9.2 RESPONSIBILITIES AND DUTIES

The Zone Clinical Section Chief shall have responsibility for the overall function and structure of the ZoneClinical Section, and shall be responsible through the Zone Clinical Department Head for matters within

the Zone Clinical Section. Without limiting the authority of AHS relative to its administrative structures,the responsibilities of the Zone Clinical Section Chief include, but are not limited to:

a) recommending Medical Staff Appointments and Clinical Privileges, as well as changes to Appointments and Clinical Privileges to the Zone Clinical Department Head;
b) developing policies for the Zone Clinical Section;
c) in keeping with the objectives and goals of AHS, assigning duties and responsibilities to membersof the Zone Clinical Section, and to promote and represent the activities of the Zone Clinical Section;
d) supervising the clinical work of all Zone Clinical Section members;
e) assisting in the development of AHS-wide criteria for procedures new to AHS;
f) promoting educational programs for Zone Clinical Section members and other staff associatedwith the Zone Clinical Section;
g) developing and promoting departmental research activities;
h) ensuring that Zone Clinical Department policies regarding quality of Patient care and safety are developed and implemented;
i) performing Triggered Initial Assessments and Triggered Reviews as delegated by the Zone Clinical Department Head pursuant to Part 6 of the Bylaws;
j) assisting the Zone Clinical Department Head in performing Periodic Reviews for members of theZone Clinical Section pursuant to Part 5 of the Bylaws;
k) acting as a designate for the Zone Clinical Department Head for those duties assigned to the ZoneClinical Department Head or designate by the Bylaws or these Rules; and
l) other duties as may be delegated by the Zone Clinical Department Head.

## 2.10 PROVINCIAL AND ZONE COMMITTEES

### 2.10.1 GENERAL PROVISIONS

#### 2.10.1.1 TERMS OF REFERENCE

Each provincial and Zone committee shall develop such terms of reference as required for its effective functioning, consistent with the provisions of the Bylaws and these Rules. Terms of reference shall includebut are not limited to: purpose, composition including alternative members if any, duties and responsibilities, decision-making processes, and reporting and notification requirements.

#### 2.10.1.2 MEETING FREQUENCY

Each committee shall meet at least quarterly and more frequently at the call of the chair, unless otherwise set forth in the committee's terms of reference, the Bylaws or these Rules.

#### 2.10.1.3 COMMITTEE MEMBERS

a) To assure responsible deliberation and decision making, a broad provincial and system-wide perspective is required of committee members regardless of their individual practice type andgeographic location;

b) Unless otherwise specified, committee members shall be appointed for a term of two years, andshall serve until the end of this period or until the member's successor is appointed, unless the member resigns or is removed from the committee;

c) All committee members shall:

I. display ethical and business-like conduct;
II. avoid and declare conflicts of interest, and maintain the confidentiality of the committee's business necessary for its effective functioning;
III. participate constructively in committee activities and treat, as paramount, the efforts ofthe committee to fulfill its mandate and achieve its objectives;
IV. treat other committee members and AHS staff with respect, co-operation;
V. demonstrate a willingness to address all matters openly and transparently;
VI. be accountable to their committee;
VII. exercise the powers and discharge the duties of their office honestly, in good faith, andin the best interests of the committee;
VIII. exercise the degree of care, diligence and skill that a reasonably prudent person wouldin comparable circumstances;
IX. attend meetings on a regular and punctual basis;
X. be familiar with the committee terms of reference, relevant AHS policies, and the AHS organizational structure, as well as the rules of procedure and proper conduct of a meeting; and
XI. actively discourage inappropriate conduct by other committee members.

d) The Chief Medical Officer or designate(s) shall, unless otherwise specified, be ex-officio, non-voting member of all provincial committees specified in the Bylaws and these Rules;

e) The relevant Zone Medical Director or designate(s) shall, unless otherwise specified, be ex-officio, non-voting member of all Zone committees specified in the Bylaws and these Rules.

#### 2.10.1.4 REMOVAL

If a member of a committee ceases to be a member of the Medical Staff, fails to discharge their responsibilities as a committee member pursuant to section 2.8.1.3 c) of these Rules, or if other reasonable grounds exist, that member may be removed by the Chief Medical Officer (for provincialcommittees) or Zone Medical Director (for Zone committees) as applicable to the committee.

#### 2.10.1.5 VACANCIES

a) Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made until the completion of that member's term;

b) In an exceptional circumstance, the Chief Medical Officer or Zone Medical Director may appointan interim replacement member to fulfill a member's committee term until the vacancy can be filled in the same manner in which an original appointment to such committee was made.

#### 2.10.1.6 COMMITTEE CHAIR

a) Provincial level committees - Except as otherwise specified in the Bylaws or these Rules, the Chief Medical Officer or designate, in conjunction with committee members, shall jointly confer and select the committee chair. The committee chair may or may not be selected from amongst themembers of the committee. A vice chair may be appointed by the committee, and if so, the vicechair shall be appointed from amongst the voting committee members.

b) Zone level committees - Except as otherwise specified in the Bylaws or these Rules, the Zone Medical Director or designate, in conjunction with committee members, shall jointly confer andselect the committee chair. The committee chair may or may not be selected from amongst the

members of the committee. A vice chair may be appointed by the committee, and if so, the vicechair shall be appointed from amongst the voting committee members.

#### 2.10.1.7 QUORUM AND MANNER OF ACTION

a. Except as otherwise specified in the Bylaws or these Rules, the quorum for a committee shall be fifty percent plus one of the members entitled to be present and vote.

b. Except as otherwise specified in the Bylaws or these Rules, the actions of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of thecommittee. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, provided any action taken is approved by at least amajority of the required quorum for such meeting, or such greater number as may be specificallyrequired by the Bylaws and these Rules.

c. Except where otherwise provided for in the Bylaws and these Rules, committee meetings may be conducted in-person, by teleconference or videoconference. Committee actions arising from a meeting, such as a recorded vote, may be conducted in-person, by e-mail or other electronic means, teleconference or videoconference.

#### 2.10.1.8 MINUTES

Minutes of meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and the vote taken/agreement on matters (where recording is required). A copyof the minutes shall be signed by the committee chair of the meeting and forwarded to the Medical Affairs Office. The conduct of meetings shall be guided by an agreed standard of meeting guidelines, such as Robert's

#### 2.10.1.9 CONDUCT OF MEETINGS

Rules of Order (current version ) as determined by the Committee members.

## 2.11 PROVINCIAL PRACTITIONER EXECUTIVE COMMITTEE

### 2.11.1 ESTABLISHMENT

The Provincial Practitioner Executive Committee is established pursuant to section 2.8 of the Bylaws and is accountable to the Chief Medical Officer.

### 2.11.2 COMPOSITION

The Provincial Practitioner Executive Committee shall be composed of the following persons:

#### 2.11.2.1 VOTING MEMBERS

The following members shall attend and vote on all issues for discussion at Provincial Practitioner Executive Committee meetings:

a) a Chair, selected by the voting members who may or may not be selected from amongst the members of the committee, and who shall only vote in the event of a tie
b) the chairs of the five Zone Medical Administrative Committees
c) five Members from the Medical Staff, one identified by each of the five Zone Medical Staff Associations
d) the five Zone Medical Directors

#### 2.11.2.2 EX-OFFICIO NON-VOTING MEMBERS

The following shall attend all meetings of the Provincial Practitioner Executive Committee but may notvote:

a) the Chief Medical Officer
b) the Associate Chief Medical Officers
c) four of the Senior Medical Directors selected by the Chief Medical Officer
d) the Senior Medical Officer of Health
e) the Chief Medical Laboratory Officer, Alberta Precision Laboratories
f) one of the Zone Clinical Section Chiefs, Dentistry and Oral & Maxillofacial Surgery, or another representative, as selected by the Chiefs
g) the Senior Vice-President, Medicine of Covenant Health
h) the Chief Medical Officer, Recovery Alberta.

#### 2.11.2.3 EX-OFFICIO NON-VOTING MEMBERS, OPTIONAL ATTENDANCE

The following may attend all meetings of the Provincial Practitioner Executive Committee but may notvote:

a) the CEO of AHS
b) the Senior Program Officer, Portfolio of the Chief Medical Officer
c) the Executive Directors, Medical Affairs

### 2.11.3. DUTIES AND RESPONSIBILITIES

A. The Provincial Practitioner Executive Committee shall consider, advise and report to AHS and theChief Medical Officer on all matters at a provincial level pertinent to Patient care and to the Medical Staff, and on all items referred to it. These matters include but are not limited to:

a) quality and safe Patient care
b) interdisciplinary Patient care and teamwork
c) AHS service planning and delivery
d) Practitioner workforce planning
e) Practitioner satisfaction
f) all other responsibilities and duties assigned to it by the Bylaws and these Rules

B. The Provincial Practitioner Executive Committee shall oversee:

a) the overall functioning of Zone Medical Administrative Committees
b) the overall functioning of the Bylaws and these Rules
c) the AHS Provincial Clinical Department, Public Health
d) the AHS Provincial Clinical Department, Laboratory Medicine; and
e) the Provincial Clinical Department, Recovery Alberta.

### 2.11.4 SUBCOMMITTEES

The Provincial Practitioner Executive Committee may, from time to time, establish any subcommittees or ad hoc subcommittees for specific assignments it determines are necessary to assist in fulfilling its dutiesand responsibilities.

The terms of reference of any subcommittee or ad hoc subcommittee will be specified at the time ofcreation and amended as required.

### 2.11.5 STANDING SUBCOMMITTEES

These shall be as follows, or as amended from time to time by the Provincial Practitioner Executive Committee, pursuant to section 2.9.4 of these Rules:

a) Provincial Practitioner Workforce Planning Committee

## 2.12 MEDICAL STAFF BYLAWS AND RULES REVIEW COMMITTEE

### 2.12.1 ESTABLISHMENT

The Medical Staff Bylaws and Rules Review Committee is established pursuant to sections 1.5 and 1.6 of the Bylaws.

### 2.12.2 COMPOSITION

The Medical Staff Bylaws and Rules Review Committee shall be composed of the following voting members:

a) all Associate Chief Medical Officers, one of whom shall act as chair
b) the chairs of the five Zone Medical Administrative Committees
c) five Members from the Medical Staff, one identified by each of the five Zone Medical Staff Associations.
d) additional Medical Staff representatives at large equal to the number of Associate Chief MedicalOfficers and selected by the Zone Medical Staff Associations after non-binding consultation withthe Zone Medical Directors.

The following exclusion criteria apply to the Medical Staff representatives at large:

a) Member of council of a professional regulatory body
b) Alberta Medical Association (AMA) Board member
c) AMA section president
d) AMA geographic representative to Representative Forum
e) Practitioner with a contracted AHS administrative/ leadership position

An AMA geographic representative or a Practitioner with an AHS contracted administrative position maybe considered by the Zone Medical Staff Associations as candidates but may be appointed only if approved by the Chief Medical Officer.

Non-Voting, Ex-Officio Members:

f) The Senior Vice President, Medicine of Covenant Health
g) One Zone Medical Director, appointed by the Chief Medical Officer

### 2.12.3 DUTIES AND RESPONSIBILITIES

a) The Medical Staff Bylaws and Rules Review Committee shall fulfill the duties tasked to it pursuantto sections 1.5 and 1.6 of the Bylaws.

b) Without limiting the foregoing, the Medical Staff Bylaws and Rules Review Committee shall review and study in any manner it deems appropriate proposed amendments to the Bylaws andthese Rules recommended by itself and the parties specified in sections 1.5 and 1.6 of the Bylaws, shall confer with the relevant Colleges and other parties as appropriate, and make suchrecommendations as it deems necessary;

c) Pursuant to section 1.6.4 of the Bylaws, amendments to the Bylaws put forth to the Medical Stafffor consideration shall be posted on the Medical Affairs Office web site and notice of the amendment communicated to all Medical Staff by e-mail/fax at least sixty days before being voted upon by ballot conducted through the Medical Affairs Office and the Zone Medical Staff Associations.

## 2.13 HEARING COMMITTEES, IMMEDIATE ACTION REVIEW COMMITTEE AND POOL MEMBERSHIP SECTION PROCESS

2.13.1 A Hearing Committee shall be established as required pursuant to sections 6.5 and 6.7 of the Bylaws. The designated chair and members of each Hearing Committee shall be drawn from a provincial pool of Hearing Committee designates.

2.13.2 An Immediate Action Review Committee shall be established pursuant to section 6.7 of the Bylaws.

2.13.3 Beginning on or about 1 April of each year or as required, the Zone Medical Director and the Zone MedicalStaff Association President of each Zone shall jointly select designates for a provincial pool of Hearing Committee members. Four shall be selected from each of the North, Central and South Zones, and nine designates shall be selected from each of the Edmonton and Calgary Zones. The thirty designates selectedshall constitute a provincial pool of Hearing Committee designates.

2.13.4 Out of this provincial pool of Hearing Committee designates, the applicable Zone Medical Director and Zone Medical Staff Association President shall jointly select a standing three-person, provincial ImmediateAction Review Committee which shall include a chair.

2.13.5 The Zone Medical Director and the Zone Medical Staff Association President of each Zone shall also be responsible for jointly selecting replacement designates for their Zone upon the completion of a designates term or resignation.

2.13.6 The criteria for selection of the thirty provincial pool designates shall include but are not limited to: representation from a cross section of specialties; geography within each Zone; representation of variouspractice settings; not currently serving in an AHS or Zone Medical Staff Association or other Practitioner advocacy organization leadership position; possessing an interest in/experience with disciplinary processes/hearing committees; having a reputation for fairness; and extensive clinical experience.

2.13.7 The term of the provincial pool of Hearing Committee designates shall be for three years renewable once.

2.13.8 The Zone Medical Director and the Zone Medical Staff Association President of each Zone may determine their own process for selecting their roster of Zone designates using the criteria specified in section 2.11.6above.

2.13.9 The Medical Affairs Office shall be responsible for the orientation, training and remuneration of the provincial pool of Hearing Committee designates. The payment of honoraria and expenses to designatesassigned to a specific Hearing Committee shall be in accordance with relevant AHS policies.

2.13.10 The Zone Medical Director and the Zone Medical Staff Association President of each Zone shall be responsible for drawing a designated chair and two other members from the provincial pool of Hearing Committee designates for each specific Hearing Committee established pursuant to sections 6.5 and 6.7

of the Bylaws. The criteria that they shall use may include but are not limited to: members practicing inthe same or related specialty area and knowledge of the practice setting of the Affected Practitioner.

2.13.11 The Zone Medical Director and the Zone Medical Staff Association President of each Zone shall also be responsible for considering any objection to the composition of a Hearing Committee established pursuant to section 2.11.10 above provided by an Affected Practitioner. Prior knowledge of the subject matter of the Hearing does not automatically disqualify a designate from being a member of the Hearing Committee. Should the relevant Zone Medical Director and the Zone Medical Staff Association President jointly in their sole discretion determine that the objection of the Affected Practitioner is with merit, theyshall jointly designate a replacement designate(s) for that Hearing Committee.

2.13.12 A Hearing Committee so established pursuant to the Bylaws and these Rules may meet in the Affected Practitioner's Zone or may meet in another Zone as determined by the Hearing Committee. The Hearing Committee may hear evidence via electronic measures and/or in person. The quorum for each Hearing Committee shall be three members including the Chair.

2.13.13 Notwithstanding sections 2.11.1 and 2.11.4 above, if the Affected Practitioner is a Dentist, Oral & Maxillofacial Surgeon, Podiatrist or Scientist Leader, and the Hearing Committee or the Immediate ActionReview Committee so established pursuant to section 6.5 or 6.7 of the Bylaws do not include a Dentist, Oral & Maxillofacial Surgeon, Podiatrist or Scientist Leader Practitioner respectively as drawn from the provincial pool of Hearing Committee designates, the relevant Zone Medical Director and Zone Medical Staff Association President shall substitute one of the Hearing Committee members with a suitably qualified Dentist, Oral & Maxillofacial Surgeon, Podiatrist or Scientist Leader Practitioner as applicable.

## 2.14 HEARING COMMITTEE

### 2.14.1 ESTABLISHMENT

A Hearing Committee is established pursuant to sections 6.5 and 6.7.9 of the Bylaws.

### 2.14.2 COMPOSITION

A Hearing Committee shall be composed of three (a designated chair and two voting members) all of whom are drawn from the provincial pool of Hearing Committee designates following the Hearing Committee and pool selection process pursuant to section 2.11 of these Rules. The Zone Medical Directormay exercise discretion to increase the Hearing Committee to a maximum of five members.

### 2.14.3 DUTIES AND RESPONSIBILITIES

The purpose of the Hearing Committee is to consider a Concern referred to it in respect to an Affected Practitioner by receiving information and hearing evidence, and shall make recommendations pursuant tosection 6.5 of the Bylaws. A Hearing Committee shall fulfill its duties in a fair and impartial manner.

### 2.14.4 CONDUCT OF MEETINGS

a) Meetings of the Hearing Committee may be held in person, by videoconference or teleconference provided that hearings shall require the personal attendance of members.

b) Meetings of the Hearing Committee shall be held in the Zone of the Affected Practitioner oranother Zone as the Hearing Committee in its sole discretion may determine.

c) A Hearing Committee shall determine such procedures it deems appropriate and in its solediscretion provided that such procedures do not conflict with and are not inconsistent withsection 6.5 of the Bylaws.

d) Unless the Affected Practitioner agrees otherwise, a Hearing shall be closed to the public, andonly the following persons may attend:

I. The Affected Practitioner, the Affected Practitioner's legal counsel and/or an Advisor.
II. Legal counsel for the Hearing Committee.
III. Staff necessary to support the Hearing Committee.
IV. The relevant Zone Medical Director(s) or designate(s);
V. AHS legal counsel.
VI. Witnesses and their Advisors, but only for the duration of their testimony unless otherwise entitled to attend; and
VII. Any other person(s) agreed to by the Hearing Committee, the Affected Practitioner andAHS.

e) Only the Hearing Committee members and Chair, its legal counsel, and the Hearing Committeesupport staff shall be present when the Hearing Committee deliberates, formulates recommendations and reviews draft reports.

## 2.15 IMMEDIATE ACTION REVIEW COMMITTEE

### 2.15.1 ESTABLISHMENT

The Immediate Action Review Committee is established pursuant to section 6.7 of the Bylaws.

### 2.15.2 COMPOSITION

The Immediate Action Review Committee shall be composed of three members pursuant to section 2.11.4 of these Rules.

### 2.15.3 DUTIES AND RESPONSIBILITIES

The purpose of the Immediate Action Review Committee is to receive and consider all relevant information and evidence that led to the Immediate Action including any written submission from theAffected Practitioner, and prepare a report and recommendation regarding the disposition of the Immediate Action in respect to an Affected Practitioner pursuant to section 6.7 of the Bylaws.

### 2.15.4 CONDUCT OF MEETINGS

a) The Immediate Action Review Committee shall fulfill the duties tasked to it pursuant to section 6.7 of the Bylaws.

b) Meetings of the Immediate Action Review Committee may be held in person, electronically, by videoconference or teleconference, and may be held in the Zone of the Affected Practitioner oranother Zone as the Immediate Action Review Committee in its sole discretion may determine.

c) The Immediate Action Review Committee shall determine such procedures it deems appropriateand in its sole discretion provided that such procedures do not conflict with and are not inconsistent with section 6.7 of the Bylaws.

## 2.16 ZONE MEDICAL ADMINISTRATIVE COMMITTEE

### 2.16.1 ESTABLISHMENT

The Zone Medical Administrative Committee is established pursuant to section 2.10 of the Bylaws.

### 2.16.2 COMPOSITION

The Zone Medical Administrative Committee shall be composed of the following persons:

#### 2.16.2.1 VOTING MEMBERS

The following members shall attend and vote on all issues for discussion at Zone Medical Administrative Committee meetings:

a) all Zone Clinical Department Heads

b) Zone Medical Staff Association representatives pursuant to the following provisions:

- Zones with 9-10 Zone Clinical Departments - 5 Zone Medical Staff Association representatives
- Zones with 11-12 Zone Clinical Departments - 6 Zone Medical Staff Association representatives
- Zones with 13-14 Zone Clinical Departments - 7 Zone Medical Staff Association representatives
- Zones with 15-16 Zone Clinical Departments - 8 Zone Medical Staff Association representatives

Should the number of Zone Clinical Departments change, the number of Zone Medical StaffAssociation representatives shall be adjusted according to the provisions above.

On each Zone Medical Administrative Committee, two of the Zone Medical Staff Association representatives will be from the membership at large. The rest of the Zone Medical Staff Association representatives shall be from the Zone Medical Staff Association Executive. The twomembers at large shall be selected by the Zone Medical Staff Association, after non-binding consultation with the Zone Medical Director and the chair of the Zone Medical Administrative Committee.

If a position cannot be filled by a member of the Zone Medical Staff Association Executive, then the Zone Medical Staff Association shall select another member at large to fill the seat, using thesame selection process as described above for the two members at large.

#### 2.16.2.2 EX-OFFICIO NON-VOTING MEMBERS

The following members shall attend all meetings of the Zone Medical Administrative Committee but may not vote:

- the Zone Medical Officer of Health
- the Zone Clinical Section Chief, Dentistry and Oral & Maxillofacial Surgery
- the Zone Medical Director, Emergency Medical Services
- the Zone Medical Director
- the Associate Zone Medical Director(s)
- the Zone Medical Affairs Director/Manager
- the Zone Vice President
- the relevant Acute Care Senior Vice President(s)
- up to two (2) other AHS operational administrative leaders of the Zone as selected by the Committee
- the applicable Vice President and Chief Health Operations Officer for the area

#### 2.16.2.3 EX-OFFICIO NON-VOTING MEMBERS OPTIONAL ATTENDANCE

The following members may attend all meetings but may not vote on any issues for discussion at ZoneMedical Administrative Committee meetings:

a) the Chief Medical Officer
b) all Associate Chief Medical Officers
c) the Senior Operating Officer, Portfolio of the Chief Medical Officer
d) the Deans or designates of the Faculty of Medicine (University of Calgary)/Faculty of Medicineand Dentistry (University of Alberta) only for the Calgary and Edmonton Zone Medical Administrative Committees respectively
e) one representative from Covenant Health appointed by the Senior Vice President, Medicine ofCovenant Health

### 2.16.3 DUTIES AND RESPONSIBILITIES

The Zone Medical Administrative Committee shall:

a) consider, advise and report to the Zone Medical Director and the Provincial Practitioner Executive Committee on all matters pertinent to Patient care and to the Medical Staff at theZone level and on all items referred to it. These matters include but are not limited to:

   I. quality and safe Patient care
   II. Zone-level service planning and delivery
   III. Zone input into Practitioner workforce planning
   IV. interdisciplinary Patient care; and
   V. Zone-level interaction with respect to the Medical Staff Bylaws and Rules;

b) advise the Chief Medical Officer and Zone Medical Director concerning Medical Staff Appointments, Clinical Privileges, and changes to Medical Staff Appointments and Clinical Privileges of the Medical Staff;

c) promote interdisciplinary teamwork; and

d) fulfill all other responsibilities and duties assigned to it by the Bylaws and these Rules.

### 2.16.4 SUBCOMMITTEES

The Zone Medical Administrative Committee may, from time to time, establish any subcommittees or ad hoc subcommittees for specific assignments it determines are necessary to assist in fulfilling its duties and responsibilities.

The terms of reference of any subcommittee or ad hoc subcommittee appointed will be specified at thetime of creation and amended as required.

### 2.16.5 STANDING SUBCOMMITTEES

These shall be as follows, or as amended from time to time by the Zone Medical Administrative Committee, pursuant to section 2.14.4 of these Rules:

a) Zone Application Review Committee

## 2.17 ZONE APPLICATION REVIEW COMMITTEE

### 2.17.1 ESTABLISHMENT

Each Zone shall have a Zone Application Review Committee and the committee is established pursuant to section 2.11 of the Bylaws.

### 2.17.2 COMPOSITION

2.17.2.1 The Zone Application Review Committee shall be composed of the following persons:

a) two Zone Clinical Department Heads;
b) two Members from the Medical Staff, selected by the Zone Medical Staff Associationand the Zone Medical Director; and
c) the Zone Medical Director.

2.17.2.2 The applicable Zone Clinical Department Head shall be invited to attend the committee meetingfor the period during which any initial Application(s) and any Request(s) to Change a Medical Staff Appointment and Clinical Privileges related to his/her Department is(are) under discussion.

2.17.2.3 At the discretion of the Zone Clinical Department Head identified in section 2.15.2.2 above, a relevant Zone Clinical Section Chief: may be invited to attend with respect to a particular Application(s) or Request(s) to Change related to his/her Section. In the case of an Application(s)or Request(s) to Change related to a Dentist, Oral & Maxillofacial Surgeon, or Podiatrist, the relevant Zone Clinical Section Chief shall be invited to attend.

### 2.17.3 DUTIES AND RESPONSIBILITIES

The purpose of the Zone Application Review Committee is to review all initial Applications to the MedicalStaff and prepare a written recommendation (to accept, deny, or amend the application) after initial review by a Zone Clinical Department(s); and to review all Requests to Change a Medical Staff Appointment and Clinical Privileges and prepare a written recommendation (to accept, deny, or amend the Request for Change) after initial review by a Zone Clinical Department(s).

### 2.17.4 CONDUCT OF MEETINGS

a) The Zone Application Review Committee shall fulfill the duties tasked to it pursuant to sections 3.4, 3.5 and 3.6 of the Bylaws;

b) Meetings of the Zone Application Review Committee may be held in person, electronically, by videoconference or teleconference; and

c) The Zone Application Review Committee shall determine such procedures it deems appropriateand in its sole discretion provided that such procedures do not conflict with and are not inconsistent with sections 3.4, 3.5 and 3.6 of the Bylaws.

### 2.17.5 ZARC MEMBERSHIP RENEWAL

Zone Medical Staff Rules may describe how turnover and renewal of ZARC membership may be accomplished, including:

a) Term of membership, including maximum number of terms if applicable
b) Desired membership renewal per year
c) Candidate selection processes and criteria

# PART 3 - RULES APPLICABLE TO ALL AHS ZONES

## 3.0. PREAMBLE

Part 3 of these Rules are applicable to all Zones and complement the provisions of Part 3 of the MedicalStaff Bylaws.

## 3.1 UNIVERSAL PROGRAMS AND PROFESSIONAL SERVICES

### UNIVERSAL PROGRAMS AND PROFESSIONAL SERVICES – PHYSICIANS AND ORAL & MAXILLOFACIAL SURGEONS

3.1.1 Universal Programs and Professional Services are programs and professional services available to all Alberta Physicians and Oral & Maxillofacial Surgeons within their respective scope of practice but withoutthe need for an AHS Medical Staff Appointment or grant of Clinical Privileges.

3.1.2 Universal Programs and Professional Services are as listed below, or as may be amended from time totime by the Provincial Practitioner Executive Committee, pursuant to section 1.5 of the Bylaws:

a) Basic laboratory - Haematology, Chemistry, Coagulation, and Microbiology tests subject to section 3.1.6 of these Rules.

b) Basic diagnostic imaging – Plain x-rays, CT, MRI and ultrasound of the head and neck areas,

c) Referral to AHS Home Care and community rehabilitation programs and services- All community rehabilitation referrals are included, including those available within a hospital. Includes:

I. physiotherapy related to the head and neck
II. occupational therapy
III. speech therapy
IV. dietetic services
V. home care services

d) Provincial Electronic Health Care Repositories, subject to applicable legislation and regulations.

3.1.3 Some laboratory and diagnostic imaging tests currently, or will, require the pre-approval of a laboratoryor diagnostic imaging physician, another specialist Practitioner (in a relevant discipline), and/or an AHS administrative leader. Such approval processes apply whether or not the ordering Physician and Oral & Maxillofacial Surgeons has an AHS Medical Staff Appointment.

### UNIVERSAL PROGRAMS AND PROFESSIONAL SERVICES – DENTISTS

3.1.4 Universal Programs and Professional Services are services and professional programs available to all Alberta Dentists within their respective scope of practice but without the need for an AHS Medical StaffAppointment or grant of Clinical Privileges.

3.1.5 Universal Programs and Professional Services are as listed below, or as may be amended from time totime by the Provincial Practitioner Executive Committee, pursuant to section 1.5 of the Bylaws:

a) Basic laboratory - Haematology, Chemistry, Coagulation, and Microbiology tests subject tosection 3.1.6 of these Rules.

b) Basic diagnostic imaging – Plain x-rays, CT, MRI and ultrasound of the head and neck areas, andNuclear Medicine subject to section 3.1.6 of these Rules.

c) Referral to AHS Home Care and community rehabilitation programs and services - All community rehabilitation referrals are included, including those available within a hospital. Includes:

I. physiotherapy related to the head and neck
II. occupational therapy
III. speech therapy
IV. dietetic services
V. home care services

d) Provincial Electronic Health Care Repositories , subject to applicable legislation and regulations . .

3.1.6 Some laboratory and diagnostic imaging tests currently, or will, require the pre-approval of a laboratoryor diagnostic imaging physician, another specialist Practitioner (in a relevant discipline), and/or an AHS administrative leader. Such approval processes apply whether or not the ordering Dentists has an AHS Medical Staff Appointment.

### UNIVERSAL PROGRAMS AND PROFESSIONAL SERVICES - PODIATRISTS

3.1.7 Universal Programs and Professional Services are services and professional programs available to all Alberta Podiatrists within their respective scope of practice but without the need for an AHS Medical Staff Appointment or grant of Clinical Privileges.

3.1.8 Universal Programs and Professional Services are as listed below, or as may be amended from time totime by the Provincial Practitioner Executive Committee, pursuant to section 1.5 of the Bylaws:

a) Basic laboratory - Haematology, Chemistry, Coagulation, and Microbiology tests subject tosection 3.1.9 of these Rules.

b) Basic diagnostic imaging – Plain x-rays, CT, MRI and ultrasound of the lower extremity, andNuclear Medicine subject to section 3.1.9 of these Rules.

c) Referral to AHS Home Care and community rehabilitation services - All community rehabilitationreferrals are included, including those available within a hospital. Includes:

I. physiotherapy
II. occupational therapy
III. home care services

d) Provincial Electronic Health Care Repositories , subject to applicable legislation and regulations . .

3.1.9 Some laboratory and diagnostic imaging tests currently, or will, require the pre-approval of a laboratoryor diagnostic imaging physician, another specialist Practitioner (in a relevant discipline), and/or an AHS administrative leader. Such approval processes apply whether or not the ordering Podiatrist has an AHSMedical Staff Appointment.

## 3.2 PRACTITIONER WORKFORCE PLAN AND RECRUITMENT

### 3.2.1 AHS PRACTITIONER WORKFORCE PLAN

a) AHS shall have a Practitioner Workforce Plan which shall provide information and projectionswith respect to the recruitment and retention of a sufficient number and appropriate mix of Practitioners with the required skill sets and in the required communities and Sites of ClinicalActivity.

b) The AHS Practitioner Workforce Plan shall be updated annually according to the sequence ofsteps outlined in sections 3.2.1 d) to 3.2.1 g) inclusive of these Rules.

c) The AHS Provincial Practitioner Executive Committee shall determine the overarching principles to be used to develop Zone-level Practitioner Workforce Plans. These principles shall include, butare not limited to, Patient access, the distribution of the Practitioner workforce, available resources, service delivery changes within AHS, and Practitioner input.

d) The Zone-level Practitioner Workforce Plans shall consider the needs of:

I. each Zone Clinical Department as determined through the recommendations of each Zone Clinical Department Executive Committee, and as forwarded to the Zone Medical Administrative Committee; and
II. the Zone as reviewed by the respective Zone Medical Administrative Committee.

e) Each Zone Medical Administrative Committee shall submit its Zone-level Practitioner Workforce Plan to its Zone Medical Director for approval. The Zone Medical Director shall ensure the submission complies with the process and methodology established by the Provincial PractitionerExecutive Committee, and considers the needs of all Zone Clinical Departments and the Zone, before forwarding the submission to the Provincial Practitioner Executive Committee.

f) The Zone submissions shall be compiled and reconciled by the Provincial Practitioner Executive Committee into an overall AHS Practitioner Workforce Plan for approval by the Chief Medical Officer.

g) Positions within the AHS Practitioner Workforce Plan are identified by Zone, Zone Clinical Department(s), Zone Clinical Section(s) (if applicable), Facilities, Clinical Sites of Clinical Activity,and AHS Programs and Professional Services, as well as being categorized as either new or replacement positions and resource-neutral or resource-requiring.

### 3.2.2 RECRUITMENT

a) With the exception of applicants to the Community and Locum Tenens Staff categories (who are exempted from the requirements of this provision), the following process shall be used to coordinate Practitioner recruitment according to the approved AHS Practitioner Workforce Plan:

I. Proposed positions for recruitment will be categorized by the Zone Clinical Department(s) as being either new or replacement positions, and as being resource-neutral or resource-requiring.
II. For each proposed position, an Impact Analysis that identifies the required resources, operational impact and the impact on other Zone Clinical Departments shall be completed by the Zone Clinical Department Head(s) as well as the relevant Facility and/or Community Medical Director(s) and Facility Administrator(s).

III. Zone Clinical Department lists of proposed positions for recruitment, accompanied by anImpact Analysis for each proposed position, will be reviewed by the relevant Zone Medical Director(s), Facility and/or Community Medical Director(s) and Facility Administrator(s) in order to prioritize recruitments and to verify that the required resources are, or can be made, available.

IV. Approval of all proposed positions shall be linked to the AHS budget process and to the availability of required resources and funding in the fiscal year in which the position is expected to be filled.

V. Based upon the defined priorities and available resources, the Zone Medical Director approves proposed positions for inclusion in the Zone-level Practitioner Workforce Plan.

VI. Only after approval shall recruitment to positions be initiated by the Zone Clinical Department(s).

b) The solicitation of potential recruits may occur through the Zone Clinical Department, with theassistance of the Medical Affairs Office if required, and/or through the assistance of provincialsupports external to AHS.

c) After an initial review of interested persons by the Zone Clinical Department Head(s) or designate(s), all potential recruits to be considered further shall be interviewed by the Zone Clinical Department Head(s) or designate(s) and such other persons as the Zone Clinical Department Head(s) determine are appropriate for the position being considered. The interviewshall be organized by the Zone Clinical Department(s) and may be conducted by electronic media. Relevant references shall also be obtained.

d) The recruitment must comply with the AHS Recruitment Incentive Policy.

e) The Medical Affairs Office will only provide Medical Staff Application forms to the selected/preferred candidate for an approved position.

### 3.2.3 EXCEPTIONAL CIRCUMSTANCES

Pursuant to section 3.8 of the Bylaws, under exceptional circumstances as determined and approved by the Chief Medical Officer or designate, a Zone Clinical Department may undertake an active recruitmentwithout completing the steps outlined in section 3.2.2 of these Rules.

## 3.3 ACCOUNTABILITY TO ZONE CLINICAL DEPARTMENT HEAD

Each Practitioner is accountable to their Zone Clinical Department Head(s) in the first instance for the responsibilities and obligations contained in the Bylaws and these Rules.

## 3.4 MEDICAL STAFF APPOINTMENT AND CLINICAL PRIVILEGES

### 3.4.1 CRITERIA FOR APPOINTMENT TO THE MEDICAL STAFF

a) Generally a Medical Staff Appointment is conditional upon:

I. the verification, to the satisfaction of AHS, of the applicant's training, experience and qualifications,

II. an assessment of the applicant's suitability, ability and willingness to accept and discharge his/her responsibilities as a condition to join the Medical Staff, and

III. with the exception of applications to the Community Staff and Locum Tenens categories,a determination by AHS that the Appointment is warranted within the AHS Practitioner Workforce Plan and supportable after completion of an Impact Analysis.

b) Each applicant must:

I. be licensed to practice Medicine, Dentistry, Oral & Maxillofacial Surgery or Podiatry inthe province of Alberta without supervision, or be a Scientist Leader with a medical administrative leadership position;
II. be a member of the Canadian Medical Protective Association, Canadian Dental ServicePlans Inc., or have suitable alternative liability insurance to the satisfaction of AHS;
III. possess appropriate educational qualifications as identified by the relevant Zone Clinical Department(s)' Executive Committee
IV. be willing to participate in teaching and training of Medical Students and Residents, nursing, paramedical and other health sciences personnel as reasonably required andsupported by each Zone;
V. be willing to perform administrative and Medical Staff functions as reasonably requiredand supported by the relevant Zone Clinical Department(s) and Zone(s).

The activities outlined in 3.4.1 b) IV. and V. above shall not place undue burden on any individual Practitioner and will be based upon mutually agreed upon levels of participation.

c) Consideration of each Application for an Appointment shall include an assessment of the applicant's:

I. clinical experience, qualifications, ability and character;
II. ability to interact professionally and appropriately with his/her peers, and to work effectively with other staff and in a team environment;
III. demonstrated judgment and ethical conduct;
IV. demonstrated professional competence; and
V. willingness and ability to meet the responsibilities and accountabilities of Practitionersas described in section 4.2 of the Bylaws.

### 3.4.2 APPLICATION PROCESS FOR A MEDICAL STAFF APPOINTMENT AND GRANT OF CLINICAL PRIVILEGES

a) All individuals involved in the granting of Appointments and Clinical Privileges shall act and makethe necessary recommendations with due dispatch.

b) All applications shall be made on the Medical Staff Appointment and Clinical Privileges Application form (the Application). A specific Application shall be used for applicants to theCommunity Staff and Locum Tenens categories.

c) On request for an Application to the Medical Staff, the Medical Affairs Office shall first determinewhether the prospective applicant has been selected for recruitment pursuant to the AHS Practitioner Workforce Plan, or is applying in the Community Staff or Locum Tenens categories. Only if the prospective applicant has been selected to an approved recruitment position, or is applying to the Community Staff or Locum Tenens categories, shall the prospective applicant be given an AHS Application to complete. Otherwise, the Application shall not be accepted, and the prospective applicant shall be advised that no relevant positions are currently approved and referred to the relevant Zone Clinical Department Head(s) for further information or advice.

d) If an Application is provided, the applicant shall indicate:

I. the Zone(s), the Zone Clinical Department(s) [and Zone Clinical Section(s)] where applicable in which he/she wishes an Appointment (or, in the case of the Senior and Zone Medical Officers of Health, the AHS Provincial Clinical Department, Public Health),
II. the category of Medical Staff Appointment being sought, and
III. the Clinical Privileges (if any) being requested for the Zone(s).

e) This Application shall be accompanied by:

I. The names of three referees who can attest to the character and professional competence of the applicant based on firsthand knowledge obtained within the previous four years. A prospective partner or principal shall not be eligible as a referee.This exclusion shall not apply to the members of a Zone Clinical Department in which aResident was trained and is now applying.
II. A certificate of good standing/practice permit from the applicant's current licensingbody;
III. Proof of membership in the Canadian Medical Protective Association, Canadian DentalService Plans Inc., or have suitable alternative liability insurance to the satisfaction of AHS;
IV. A signed waiver and release to permit collection of the information required for Application.

f) An Application will be considered incomplete until such time as all required items specified in sections 3.4.2 d) and e) of these Rules have been received and have been considered to fully andsatisfactorily meet the outlined standards of AHS Medical Staff membership. Any failure to provide complete information to the satisfaction of the Medical Affairs Office will render the Application null and void and no further processing will occur.

g) The Zone Clinical Department Head(s) or designate shall include an evaluation of the applicant's qualifications and an Impact Analysis on a form provided by the Medical Affairs Office.

### 3.4.3 CLINICAL PRIVILEGES

a) A delineation of Sites of Clinical Activity and AHS Programs and Professional Services that the Practitioner is eligible to access, the term of the privileges where applicable, and the Proceduresthat the Practitioner is deemed to be competent and eligible to perform, within a Zone(s) will bedefined by the Clinical Privileges granted by AHS to that Practitioner.

b) If AHS Programs and Professional Services or clinical services and related resources are transferred between Sites of Clinical Activity or otherwise altered, AHS may accordingly transfer,and/or adjust if necessary, the Clinical Privileges of the Practitioner(s) affected, after approval bythe relevant Zone Application Review Committee, and provided:

I. reasonable notice is given to the Practitioner(s) affected; and
II. due consideration is given to any representations received in response to such notice;and
III. the Practitioner(s) affected is (are) afforded the opportunity to appeal the change inClinical Privileges pursuant to section 3.6 of the Bylaws.

c) Consideration of each application for Clinical Privileges shall include an assessment of the demonstrated ability and willingness of the Practitioner to meet the criteria for Appointment

specified in section 3.4.1 of these Rules, including documented experience in categories oftreatment areas or specific procedures and current competence; and shall be based upon:

I. the needs of AHS, the AHS Practitioner Workforce plan, the resources available and the Facilities required for the requested procedures and access to AHS Programs and Professional Services; and

II. general recommendations drawn from quality assurance and other quality improvementactivities and reviews.

d) Within the Clinical Privileges granted, Practitioners are expected to practice within the scope oftheir specialty and the limits of their formal training and experience.

e) No recommendation on Clinical Privileges is meant to prevent any licensed Practitioner from performing any medical procedure on any person in an emergency situation where failure toperform that procedure may result in death or serious injury or harm to the person.

f) List of Procedures for Clinical Privileges – Process for Establishment, Maintenance, and Changespursuant to section 3.2.6 of the Bylaws.

I. Each Zone Clinical Department shall develop a list of Procedures for Clinical Privilegeswith input from its members and through a process determined by each Zone ClinicalDepartment.
II. This list shall be reviewed by the Zone Clinical Department at a minimum of every twoyears.
III. The list of Procedures for Clinical Privileges shall include the core procedures expectedof Zone Clinical Department members with Canadian residency training, and those which require extra training and supervision beyond that normally expected in a Canadian residency training program; those procedures which are resource intensive; and those Procedures whose utilization needs to be monitored for quality control and Patient safety reasons.
IV. Each list of Procedures for Clinical Privileges for a Zone Clinical Department shall be reviewed by the respective Zone Medical Administrative Committee for consistencywith provisions of the Bylaws and between Zone Clinical Departments. The Zone Medical Administrative Committee may make such changes as it may determine.
V. Each Zone Medical Administrative Committee shall submit its lists of Procedures for Clinical Privileges for its Zone Clinical Departments to the Provincial Practitioner Executive Committee. The Committee shall review all submissions to ensure consistencywithin and between Zone Clinical Departments and Zones and for consistency with provisions of the Bylaws.

g) Process to Add Procedures New to AHS and Requiring a Grant of Clinical Privileges pursuant tosection 3.2.6.2 of the Bylaws.

I. From time to time, new technologies and procedures will become available. It is the responsibility of each Zone Clinical Department to develop a list of proposed Proceduresnew to AHS and requiring a grant of Clinical Privileges. Input is required from its members through a process determined by each Zone Clinical Department. Input will also be sought from the applicable AHS health technology assessment and product evaluation portfolios.
II. This list shall include an assessment of the need for the proposed Procedure, the abilityof AHS to support the Procedure, and the proposed credentialing criteria.

III. This list shall be reviewed by the respective Zone Medical Administrative Committee which shall make a recommendation for introduction of a new Procedure within AHS tothe Provincial Practitioner Executive Committee. Final approval by the Chief Medical Officer is required.

### 3.4.4 INFORMATION REQUIRED FOR CONTINUATION ON THE MEDICAL STAFF

3.4.4.1 Each Practitioner, as a condition of their continuation on the Medical Staff, shall submit a properly completed and signed information verification and attestation form to the Medical Affairs Office within 12 months of being appointed to the Medical Staff and annually thereafter.The Practitioner's completed and signed information verification and attestation form shall be returned to the Medical Affairs Office and accompanying information will include, but not be limited to, the following information:

a) Proof of current membership in the Canadian Medical Protective Association, Canadian Dental Service Plans Inc., or have suitable alternative liability insurance to the satisfaction ofAHS;
b) current practice permit or equivalent from the relevant College;
c) evidence as to the legal right to live and work in Canada for non-citizens and permanent residents; and
d) any professional liability judgments, orders or arbitration decisions involving the Practitionerwith details about any such instances.

3.4.4.2 In addition to the annual completion of an information verification and attestation form pursuantto section 3.4.4.1, each Practitioner shall, as soon as possible after becoming aware, disclose in writing to the Zone Medical Director:

a) any proceedings regarding the Practitioner's professional status which have resulted in sanctions including, but not limited to:
   I. restrictions on licensure, privileges and/or appointments;
   II. practice permit restrictions;
   III. disciplinary or professional restrictions;
   IV. imposition of monitoring requirements;
   V. a requirement to undergo counselling or treatment;
   VI. a requirement to undertake upgrading or further education;
   VII. a requirement to undertake remedial measures in cases of unprofessional or unethical behaviour, unbecoming conduct, or improper or disruptive conduct; and/or
   VIII. any other recommendation considered appropriate to ensure public or patientsafety.
b) Any changes in physical or mental health that affect the performance of the Practitioner's responsibilities specified in these Bylaws and Rules, and the safe and competent exercise ofthe Clinical Privileges granted.
c) Any criminal convictions arising from the Criminal Code of Canada or the Controlled Drugsand Substances Act; and/or
d) Criminal charges arising from Part V or Part VIII of the Criminal Code of Canada or the Controlled Drugs and Substances Act.

3.4.4.3 Upon receipt and review of a completed information verification and attestation form as provided for in Section 3.4.4.1, or upon receipt of written disclosure from a Practitioner as

provided for in Section 3.4.4.2, the Zone Medical Director shall determine if any further investigation or action is required.

3.4.4.4 Should the Zone Medical Director determine that no further investigation or action is required,the information verification and attestation form or the written disclosure, as the case may be,shall be placed in the Practitioner's file. In the case of any written disclosure provided in accordance with Section 3.4.4.2, the document shall be placed in an envelope, sealed and marked "confidential" and shall not be reopened without the Practitioner's consent.

3.4.4.5 Should the Zone Medical Director determine that further investigation or action is required, theZone Medical Director shall meet with the Practitioner, within fourteen (14) days of receipt of the information, to discuss the Zone Medical Director's concerns., or unless otherwise mutuallyagreed. The Practitioner shall be entitled to be accompanied by an Advisor and the contents of the meeting, or further information arising at the meeting, shall not be disclosed by the Zone Medical Director in the context of any subsequent proceedings or otherwise without the consentof the Practitioner.

3.4.4.6 If, following the meeting pursuant to Section 3.4.4.5 of these Rules, the Zone Medical Director determines no further investigation or action is required, or if the Zone Medical Director and theAffected Practitioner are able to agree on an appropriate resolution of the issues, the information verification and attestation form or the written disclosure, as the case may be, shall be placed in the Practitioner's file. In the case of any written disclosure provided in accordance with Section 3.4.4.2 of these Rules, the document shall be placed in an envelope, sealed and marked "confidential" and shall not be reopened without the Practitioner's consent, or, where aresolution has been agreed to, as long as the Affected Practitioner abides by the agreed resolution.

3.4.4.7 If, following the meeting pursuant to Section 3.4.4.5 of these Rules, the Zone Medical Director determines that further investigation or action is required but the Zone Medical Director and theAffected Practitioner are unable to agree on an appropriate resolution of the issue, then the Zone Medical Director shall proceed in accordance with Section 6.1.5 of the Bylaws, and the matter will be treated as a Concern initiated on behalf of AHS, in which case an Associate Chief Medical Officer shall perform the functions otherwise assigned to the Zone Medical Director in accordance with the Bylaws, and the Zone Medical Director shall have no further involvement in the process.

## 3.5 PERFORMANCE ASSESSMENT TO MOVE FROM PROBATIONARY STAFF TO ACTIVE STAFF

a) Pursuant to sections 3.1.9.2 and 3.1.9.3 of the Bylaws, an Appointment to the Probationary Staff category shall be considered a time during which the Practitioner's competence, capabilities, andcontribution shall be evaluated by the appropriate Zone Clinical Department.

b) After a full evaluation, as outlined in the following performance assessment procedure, the Practitioner may be appointed to the Active, or Locum Tenens Staff category.

c) This performance assessment shall include an assessment of the demonstrated ability and willingness of the Practitioner to meet the criteria for Appointment specified in section 3.4.1 ofthese Rules, and shall include a review of:

I. AHS Programs and Professional Services accessed by the Practitioner, the procedures performed and performance in the Sites of Clinical Activity to which access has been granted;
II. information on continuing professional development during appointment to the Probationary Staff category;
III. clinical performance as judged by clinical audit;
IV. contribution to and participation in other clinical and administrative responsibilities as assigned;
V. resource utilization patterns; and
VI. contribution to and participation in teaching programs and activities.

## 3.6 PERIODIC REVIEW

a) In the context of the Practitioner's Appointment to the Active or Locum Staff category and Clinical Privileges, Periodic Reviews provide the Practitioner and the Zone Clinical DepartmentHead(s) or designate(s) with an opportunity to review the Practitioner's professional performance, to determine planned or considered changes to the Practitioner's practice including Clinical Privileges, to identify professional development goals, and to exchange information regarding the functioning of the Zone Clinical Department.

b) Until age 65, Periodic Review of Practitioners in the Active Staff category will occur every threeyears, or more frequently as specified in the grant of Clinical Privileges. At age 65 and older, a Periodic Review of all Practitioners will be conducted annually.

c) A Periodic Review of Practitioners in the Locum Tenens Staff category shall be undertaken at the conclusion of the first year of Appointment and every three years thereafter. After each locum placement the requesting Practitioner shall complete and submit an assessment form to the relevant Zone Medical Director who shall ensure that it is placed on the Practitioner's Medical Affairs Office file for use during the next Periodic Review. During each Periodic Review for members on the Locum Tenens Staff an assessment as to whether they should be moved to the Probationary or the Active Staff category shall also occur.

d) For Practitioners in the Locum Tenens medical staff category and those in the Active or Probationary to Active or Probationary to Locum Tenens medical staff categories, the requestingPractitioner shall, after each locum placement, complete and submit an assessment form to the relevant Zone Medical Director who shall ensure that it is placed on the Practitioner's Medical Affairs Office file for use during the next Periodic Review.

e) The Medical Affairs Office shall by 31 March of each year prepare an annual schedule of Periodic Reviews which are required to be performed in the next twelve months. A monthly schedule shall be provided to each Zone Medical Director and Zone Clinical Department Head. The Zone Clinical Department Head or designate(s) shall provide each Practitioner with sixty days' notice ofhis/her planned Periodic Review.

f) The Periodic Review shall be initiated by the Zone Clinical Department Head or designate of the Zone to which the Practitioner has his/her primary assignment, and shall be conducted betweenthe Practitioner and the Zone Clinical Department Head(s) or designate(s), the Facility and/or Community Medical Director(s), or such other designates as determined by the applicable Zone Medical Director(s). Where a Practitioner has Clinical Privileges in more than one Zone, the ZoneClinical Department Head(s) or designate(s) of the Zone to which the Practitioner has his/her

primary Appointment shall confer with the relevant medical administrative leaders of the otherZone(s).

g) The Periodic Review must include all matters relevant to the Active or Locum Tenens Staff category of Appointment and Clinical Privileges granted to the Practitioner.

I. The Medical Affairs Office in consultation with each Zone Clinical Department or ZoneClinical Section will develop an information package of items to be provided to the Practitioner and to the Zone Clinical Department Head or designate at least sixty daysprior to the scheduled Periodic Review. This information package shall contain documentation related to sections 3.6 h) and 3.6 i) below.

II. Prior to the Periodic Review, the Practitioner and the Zone Clinical Department Head or designate shall, compile sufficient relevant information to appropriately inform a discussion about the matters referenced in sections 3.6 h) and 3.6 i) below.

h) A Periodic Review shall include an assessment of the demonstrated ability and willingness of the Practitioner to meet the criteria for Appointment specified in section 3.4.1 of these Rules, and shall include a review of:

I. the terms, conditions and major responsibilities contained in the Practitioner's MedicalStaff Letter of Offer, and any amendments subsequently made to its terms and conditions; and

II. actions arising from the previous Periodic Review.

i) The matters which may be reviewed during a Periodic Review include, but are not limited to:

I. a review of objective quality data (non-identifiable as to Patient source) for the Practitioner as they relate to past performance and potential changes to his/her medicalpractice;

II. a collated assessment (non-identifiable as to source) of the Practitioner by relevant health care teams, other Practitioners and Patients with respect to his/her ability to interact professionally and effectively with peers, AHS administrative leaders and staff,and Patients. Such assessments shall consist of written feedback following a process developed by the Zone Medical Administrative Committee and approved by the Provincial Practitioner Executive Committee;

III. a discussion of the Practitioner's involvement in the administrative and Medical Staff activities of AHS which shall include attendance at meetings and participation in and contribution to the activities of the Zone, Zone Clinical Department, Zone Clinical Section (if applicable), and Site(s) of Clinical Activity; and

IV. a discussion of the utilization of AHS resources and compliance with AHS quality initiatives.

V. A discussion of the practitioner's approach to and compliance with requirements for documentation of patient care in support of good patient outcomes.

j) Where an assessment of a Practitioner by relevant health care teams, other Practitioners andPatients pursuant to section 3.6 h) II. above occurs, the assessment shall be done utilizing objective, evidence-based methods as developed or adopted by the Zone Clinical DepartmentExecutive Committee, and approved by the Provincial Practitioner Executive Committee.

k) The results of the Periodic Review shall be documented by the Zone Clinical Department Head or designate of the Zone in which the Practitioner has his/her primary assignment, and a copy provided to the Practitioner and included in the Practitioner's file within fourteen days of the

completion of the Periodic Review. A copy will also be provided to the Zone Clinical Department Head of all (if any) other Zone Clinical Departments to which the Practitioner is appointed. Exceptas required by law or permitted by the Bylaws, the written summary of the Periodic Review prepared by the Zone Clinical Department Head(s) or designate(s), together with recommendations, plans and/or Practitioner's comments shall be confidential and shall not be disclosed to any person or entity without the express consent of the Practitioner.

## 3.7 ORIENTATION AND ACTIVATION OF CLINICAL PRIVILEGES

a) Each new Practitioner shall be oriented to relevant AHS systems and processes and their Sites ofClinical Activity. This is a joint responsibility of each new Practitioner, AHS and the relevant Zone Clinical Department Head(s) or Facility or Community Medical Director(s).

b) Activation of Clinical Privileges or access to certain AHS resources requires the successful completion of:

i. Current, up to date, AHS Information Security and Privacy Training module (certificate provided to AHS medical affairs);
ii. Training in relevant IT/IM systems
iii. Workplace Health and Safety Assessments ( e.g. Communicable Disease)
iv. Criminal Record Checks

c) This orientation will vary depending on the Practitioner's prior association with and knowledge of AHS and the Site(s) of Clinical Activity and Zone Clinical Department(s), and aside from exceptional circumstances as approved by the Zone Medical Director or designate, the activationof Clinical Privileges shall not occur until the completion of the orientation. In general, it should ensure that the Practitioner has been:

I. given access to a copy of the Bylaws and these Rules of the Medical Staff, the AHS Medical Staff orientation package, and relevant AHS policies and procedures, and hashad an opportunity to review them;
II. oriented to the reporting relationships pertinent to their Appointment both within andexternal to their Zone Clinical Department(s);
III. oriented to the physical plan of the relevant Site(s) of Clinical Activity and the range ofAHS Programs and Professional Services offered in the Site(s) of Clinical Activity.
IV. oriented to Health Records and requirements for recorded care; and,
V. oriented to the ambience, philosophy, and general operating procedures of the relevantSite(s) of Clinical Activity.

d) The orientation will be provided by one or more of the following and a checklist will be completed

I. Zone Clinical Department Head(s) or designate(s);
II. The Facility and/or Community Medical Director(s) or designate(s);
III. The Facility Administrator(s) or designate(s);
IV. Facility operational staff;
V. Others as may be required.

A checklist will be completed during the orientation and placed in the Practitioner's file, and the Zone Medical Director shall be notified by the Zone Clinical Department Head(s) or designate(s).

## PART 4 – AHS PATIENT CARE AND PRACTITIONER-RELATED PROVISIONS COMMON TO ALL ZONES

This section of the Rules describes care of patients admitted to a Practitioner as defined under the Medical Staff Bylaws and Practitioner-related provisions which are common to all Zones. Each Practitioner shall also be governedby AHS governance documents which include, but are not limited to: AHS policies and procedures, AHS Zone and local facility Rules, care guidelines and procedures and other similar documents.

### A. PATIENT CARE

#### 4.1 ADMISSION OF PATIENTS

4.1.1 A Patient whose clinical condition warrants admission shall be admitted to an appropriate Facility by a Practitioner with appropriate Clinical Privileges. Upon requesting or accepting such an admission and careof the Patient, the Practitioner shall be designated as the Patient's Most Responsible Practitioner.

4.1.2 All Patients admitted to Facilities require a provisional diagnosis, and shall be categorized by the Most Responsible Practitioner(s) as emergent or scheduled. These categories are defined as follows:

a) Emergent - The Patient's condition necessitates immediate admission.
b) Scheduled - The Patient's condition warrants admission when accommodation in the Facility is available.

4.1.3 A Practitioner who wishes to admit a scheduled patient to a Facility shall book these admissions accordingto established Facility admitting procedures.

4.1.4 A Patient requiring emergent admission shall be:

a) Assigned to the Practitioner requesting or accepting the admission and care of the Patient; or
b) Assigned temporarily to an emergency department Physician who may:
    I. admit the patient and remain the Most Responsible Practitioner, provided that he/shehas appropriate Clinical Privileges;
    II. admit as the Most Responsible Practitioner, then transfer care to another Practitioner pursuant to section 4.15.2 of these Rules, provided that the receiving Practitioner is available and accepts the admission and care of the Patient (in most instances, this should include a personal conversation with the receiving Practitioner); or
    III. refer the Patient prior to admission to another Practitioner who has appropriate Clinical Privileges to admit and care for the patient (in most instances this should include a personal conversation with the potential receiving Practitioner); or
c) Assigned to the Practitioner on-call for the most appropriate admitting service.

4.1.5 The Most Responsible Practitioner shall indicate to the staff caring for the Patient, and in the Patient's health record, that they are the Most Responsible Practitioner and part of the Care Team.

4.1.6 No Patient shall be admitted to a Practitioner without that Practitioner's agreement. If an appropriate Practitioner willing and able to accept the admission and care of the Patient cannot be identified by the time of admission in the Facility is available, the relevant Zone Clinical Department Head or designate, orthe relevant Facility or Community Medical Director or designate, shall assign a Most Responsible Practitioner or Care Team.

4.1.7 The Most Responsible Practitioner or Care Team and any other Practitioner providing care to the patient shall provide any information available to staff as may be necessary to ensure protection of other Patientsor Facility staff, or to ensure protection of the admitted Patient from self-harm.

## 4.2 ATTENDANCE UPON PATIENTS

4.2.1 Each Patient shall receive timely and professional care appropriate to his/her condition. The frequency of attendance will be determined having regard to the condition of the Patient, Zone Clinical Department requirements, Zone Rules and these Rules.4.2.2 Each Patient in an acute care Facility, except those awaiting rehabilitation or placement in a Continuing Care Facility, shall be attended at least daily by the Most Responsible Practitioner or designate. A Patient awaiting rehabilitation or placement shall be visited at least weekly.

4.2.2 Practitioners should conduct daily acute care Patient care rounds in a manner consistent with optimal patient care. Patient care rounds should occur at appropriate times, respecting patients' needs and theflow, routines and rhythms of care on the patient care unit as well as the other practitioners working onthe patient care unit.

4.2.3 Patients in a Continuing Care Facility or awaiting rehabilitation or placement shall be visited by the Most Responsible Practitioner on a frequency required by the applicable service and appropriate to the Patient's clinical condition and as specified by the Facility. If the Most Responsible Practitioner is unableto attend the Continuing Care Facility at the required intervals, then he/she shall transfer care to a Practitioner who is able to attend as required.

4.2.4 Sections 4.2.2, 4.2.3 and 4.2.4 of these Rules do not obviate the responsibility of the Most Responsible Practitioner/Care Team or consulting Practitioner(s) to respond or assess Patients who require more frequent visits because of their condition or upon staff request.

## 4.3 INFORMED PATIENT CONSENT

4.3.1 Practitioners shall be governed by the AHS consent policy and procedures, as well as by relevant legislation including, but not limited to, the *Adult Guardianship and Trusteeship Act* (Alberta), the *PersonalDirectives Act* (Alberta), and the *Mental Health Act* (Alberta).

4.3.2 Observation, assessment, examination, treatment, detention and control of persons admitted through anadmission certificate shall be as set out in the terms of the *Mental Health Act*.

## 4.4 LEAVING AGAINST ADVICE

If a competent Patient leaves a Facility without the prior order or authorization of the Most Responsible Practitioner/Care Team or designate:

a) Written acknowledgment by the Patient and/or his/her Legal Representative that the patient isleaving against advice shall be requested when possible, and
b) The Most Responsible Practitioner/Care Team or designate shall make a notation on the Patient's health record that the Patient has left the Facility against the Practitioner's advice.

## 4.5 DISCHARGE PLANNING/BED MANAGEMENT/BED UTILIZATION

4.5.1 Practitioners shall work together with AHS staff, administrative leaders and medical administrative leaders, to ensure that inpatient beds are managed in an effective and efficient manner within, andacross, all Facilities and Zones. Bed utilization and management should ensure that:

a) Patient access to Facilities in the Zone is granted on the basis of need;
b) Patients are treated in the most appropriate Facility to meet their particular needs;
c) Standards of Patient care are continually evaluated to improve the quality of Patient care andoptimize Patient lengths of stay; and
d) Patients are discharged from Facilities, including emergency departments and other acute care treatment areas, in an appropriate and timely manner.

4.5.2 Patient discharge planning shall commence at the time of admission to an acute care or rehabilitation Facility. Where possible, for elective admissions or inter-Facility transfers, discharge plans and arrangements should be made prior to admission. It is the responsibility of the Most Responsible Practitioner/Care Team, and consulting Practitioners (if appropriate) to anticipate and begin early planning for discharge with AHS staff, including nursing, home care, social services and other relevant health care professionals. Discharge planning must involve the Patient and the Patient's family as well asearly consultation with receiving Facilities (if the patient is expected to require transfer to another Facility) and/or the personal or referring Practitioner. It also includes timely transmission of sufficient Patient information to facilitate safe and responsible care after discharge.

4.5.3 The Patient shall be discharged only on the order of the Most Responsible Practitioner/Care Team or designate.

4.5.4 Most Responsible Practitioners or Care Teams are required to discharge Patients according to policy set by AHS, the Zone Medical Administrative Committee, their Zone Clinical Department(s) and/or the Facility. Wherever feasible, discharge orders shall be written in advance of the planned day of discharge inorder to facilitate the process of discharging a Patient.

4.5.5 The Facility or Community Medical Director and the Facility Administrator shall be responsible for overseeing the effective utilization of Facility beds. With Practitioner input, they shall develop mechanisms to:

a) Allocate Facility beds on the basis of need;
b) Review health records to assess the appropriateness of admissions as well as the ongoing effectiveness and progress of discharge planning;
c) Oversee the implementation of any recommended changes to current bed utilization policies or processes.

## 4.6 ADVANCE CARE PLANNING AND GOALS OF CARE DESIGNATION

Practitioners shall be aware of and compliant with the AHS Advance Care Planning and Goals of Care DesignationPolicy and Procedures.

4.6.1 Practitioners shall be governed by the applicable AHS policy and procedure. .

4.6.2 The Most Responsible Practitioner or Care Team will confirm in the Patient's record that he/she has discussed with the Patient (or his/her Alternate Decision Maker if one is in place) his/her diagnosis, prognosis, and decisions with respect to the applicable Goals of Care Designation, and will take into account, where appropriate, previously ordered goals of care, relevant instructions in a Personal Directive(including any requests with regard to organ donation), and the best interests of the Patient.

4.6.3. Additional information may be found in the relevant policy to provide guidance for Practitioners.

## 4.7 PATIENT DEATH

4.7.1 Practitioners are expected to comply with medical, legislative and regulatory responsibilities following thedeath of a patient.

4.7.2 Pronouncement of death must be made by a Physician or Designate or when death is expected, bynursing staff if this is in keeping with nursing practice on that unit.

4.7.3 As soon as is practical following the death of a Patient, the Most Responsible Practitioner/Care Team or designate will notify the next of kin and determine whether the Medical Examiner should be notified; consider the medical suitability of organ/tissue donation and notify the donation organization as required;whether an autopsy is to be requested and performed; and whether the Zone Medical Officer of Health is to be notified;

4.7.4 The Medical Examiner will be notified in all circumstances required by the *Fatality Inquiries Act* (Alberta).

4.7.5 The Most Responsible Practitioner/Care Team or designate must complete a death certificate withinforty-eight hours, unless directed otherwise by the Medical Examiner.

4.7.6 The Most Responsible Practitioner/Care Team shall be sensitive to the patient or family's interest in opportunities for donation and if requested should inform the organ donation coordination team at thatfacility.

## 4.8 AUTOPSIES

Autopsies may be requested and performed in cases where the Medical Examiner is not involved. In addition:

a) No autopsies shall be performed without consent.
b) All autopsies shall be performed by a qualified pathologist or his/her designate.
c) As soon as it is available, a copy of the autopsy report will be included in the Patient's health record.

## 4.9 ORGAN AND TISSUE PROCUREMENT

4.9.1 Practitioners will follow all applicable AHS organ and tissue donation policies and procedures.

4.9.2 Where appropriate, it is the responsibility of all Practitioners to discuss options of organ and tissue donation with the Patient and/or his/her Legal Representative and to include the necessary informationoutlined in section 4.8.7.

# B. PRACTITIONER-RELATED

## 4.10 ON-CALL AND SERVICE COVERAGE

4.10.1 Each Practitioner shall arrange safe and effective on-call coverage for the Patients for whom they are theMost Responsible Practitioner. Pursuant to sections 4.2.7 c) and d) of the Bylaws, Practitioners, when unavailable, will make arrangements with another Practitioner(s) for the care of their Patients. This may be accomplished by specific arrangements or by participating in an on-call schedule with other Practitioners who have similar and appropriate Clinical Privileges at the Facility (ies).

4.10.2 Pursuant to section 4.1.3 of the Bylaws, Practitioners and their Zone Clinical Department Head(s) or designate(s) and/or Facility or Community Medical Director shall jointly establish and maintain reasonableand effective on-call schedules in order to provide safe and effective coverage and care to Patients . Responsibilities of an on-call Practitioner include but are not limited to:

a) Responding appropriately to calls and requests from other Practitioners and other health professionals regarding Patients for whom they are responsible while on-call or about whom they have been consulted. Practitioners shall attend Patients appropriately, in a timely fashion, and in accordance with Zone Rules and Zone Clinical Department policy. Such calls and requestsmay originate from within the Facility (ies), including emergency departments, and externally from Patient referral and transfer call lines, community offices and clinics, or other sources.

b) Discussing with a referring or consulting Practitioner the urgency of the consultation and, whenpossible, offering advice to a referring Practitioner in advance of the consulting Practitioner 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.

c) Working collaboratively with a referring Practitioner to stabilize the Patient and provide urgentcare if applicable and as required, and consistent with the level of resources available.

d) Working collaboratively with a referring Practitioner to coordinate the timely admission or appropriate transfer of the Patient as required and in accordance with Zone Rules and ZoneClinical Department policies. This includes communicating directly with the receiving Practitioner.

4.10.3 It is expected that a referring Practitioner 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.

4.10.4 A non-urgent acute care Facility consultation shall be completed within twenty-four hours of the request,unless otherwise agreed to by the referring and consulting Practitioners.

4.10.5 Pursuant to section 4.1.3.3 of the Bylaws, Practitioners and AHS medical administrative leaders shall workjointly to ensure that on-call schedules do not place work demands on individual Practitioners that prevent the Practitioner from providing safe Patient care and service coverage. AHS medical administrative leaders shall work collaboratively with Practitioners to resolve such situations when they arise.

4.10.6 Pursuant to section 4.2.7 b) of the Bylaws, Practitioners should ensure that he/she can safely and appropriately fulfil his/her on-call duties and responsibilities. This includes managing any concurrent activities for the services for which they are on call

4.10.7 Practitioners, initially amongst themselves, and, if required, subsequently with their Zone Clinical Department Head(s) or designate(s) and/or Facility or Community Medical Director shall work collaboratively to resolve any issues or disputes related to appropriate on-call coverage and/or on-callschedules. If unsuccessful, the issue or dispute shall be referred to the Zone Medical Director for resolution as required.

## 4.11 SUPERVISION OF MEDICAL STUDENTS AND RESIDENTS

4.11.1 Information about Practitioner orders prepared by Medical Students and Resident Physicians can befound in section 4.20.6...

4.11.2 At any given time, each Medical Student and Resident Physician shall have one Practitioner in the Facilityor the community designated as the supervisor of that trainee's experience.

4.11.2 Recognizing that Medical Students and Resident Physicians will become progressively more independentthrough the course of their training, the Most Responsible Practitioner must in all cases maintain

sufficient knowledge of the Patient to ensure the Patient is receiving safe and appropriate care, and mustremain readily available to assist the Medical Student or Resident, or intervene if necessary.

4.11.3 When involved in the education of trainees (Medical Students, Resident Physicians and other health care learners), Practitioners shall supervise all Procedures undertaken by a trainee. However, if the trainee hasobtained and demonstrated the necessary skills, and is considered competent to perform Procedures, thesupervising Practitioner or designate shall only be required to be readily available.

4.11.4 When involved in the education or supervision of trainees (as described in 4.12.3), Practitioners mustensure that the trainees are aware they have the following responsibilities:

a) to explain his/her role in the Patient's care to the Patient and/or his/her Legal Representative;
b) to inform the Patient and/or his/her Legal Representative of his/her name and that of the MostResponsible Practitioner;
c) to notify the supervising Practitioner and/or the Most Responsible Practitioner when a Patient'scondition is deteriorating, the diagnosis or management is in doubt, or where a Procedure with possible serious adverse effects is planned;
d) to inform the Most Responsible Practitioner and/or supervising Practitioner when discharge is appropriate and planned;
e) to notify the Most Responsible Practitioner and/or supervising Practitioner of all Patients assessed on behalf of the Practitioner; and
f) to assess all referrals and consultations in a timely fashion as appropriate to the Patient's condition.

## 4.12 PRACTITIONER-SUPERVISED HEALTH PROFESSIONALS

4.12.1 At any given time, each Practitioner-supervised Health Professional shall have one Practitioner in theFacility or Site of Clinical Activity designated as his/her supervisor.

4.12.2 In all cases involving supervision of a Practitioner-supervised Health Professional, the Most Responsible Practitioner must maintain sufficient knowledge of the Patient to ensure the Patient is receiving safe and appropriate care, and must remain readily available to assist the Practitioner-supervised Health Professional, or intervene if necessary. The Practitioner-supervised Health Professional may only undertake services for which their supervising Practitioner has current privileges.

4.12.3 Practitioners shall supervise all Procedures undertaken by a Practitioner-supervised Health Professional. However, if the Practitioner-supervised Health Professional has obtained and demonstrated the necessaryskills, and is considered competent, to perform Procedures, the supervising Practitioner shall only be required to be readily available to consult, assist or intervene if necessary.

4.12.4 When supervising a Practitioner-supervised Health Professional, the Practitioner must ensure that the Practitioner-supervised Health Professional is aware of his/her responsibilities which may include, but arenot limited to, one or more of the following:

a) to explain his/her role in the Patient's care to the Patient and/or his/her Legal Representative;
b) to inform the Patient and/or his/her Legal Representative of his/her name and that of the MostResponsible Practitioner;
c) to notify the supervising Practitioner and/or the Most Responsible Practitioner when a Patient'scondition is deteriorating, the diagnosis or management is in doubt, or where a Procedure withpossible serious adverse effects is planned;
d) to inform the Most Responsible Practitioner and/or supervising Practitioner when discharge is appropriate and planned;

e) to notify the Most Responsible Practitioner and/or supervising Practitioner of all Patients assessed on behalf of the Practitioner; and

f) to assess all referrals and consultations in a timely fashion as appropriate to the Patient's condition.

## 4.13 PHYSICIANS UNDERGOING PRELIMINARY CLINICAL ASSESSMENT

4.13.1 Physicians undergoing College of Physicians and Surgeons of Alberta (CPSA) mandated clinical assessmentwho will enter Alberta Health Services facilities as part of their supervised assessment are not members ofthe AHS Medical Staff and will require separate access agreements to allow access to AHS facilities and contact with patients.

4.13.2 Physicians who are acting as CPSA Assessors must supervise the physician undergoing assessment at alltimes while they are in AHS facilities as they are not licensed for independent practice.

## 4.14 DESIGNATION OF MOST RESPONSIBLE PRACTITIONER/TRANSFER OF RESPONSIBILITY

### 4.14.1 IDENTIFICATION OF MOST RESPONSIBLE PRACTITIONER

a) Every Patient admitted to a Facility, or who receives emergent, urgent or scheduled evaluation or treatment on an ambulatory or "Day Procedure" basis in a Facility, shall have an identified Most Responsible Practitioner. The identity of the Most Responsible Practitioner shall be documented in the Patient's health record at the time of admission and the Patient shall be informed of his/her name by the Practitioner, his/her designate, or the nursing staff responsible for the Patient's care. The Most Responsible Practitioner has the duty, responsibility and authority to direct all medical care for that Patient while in the Facility, and to make reasonable efforts to ensure continuity of care following discharge. The Most Responsible Practitioner may be part ofan on-call Care Team which accepts responsibility for patient.

b) The Most Responsible Practitioner/Care Team will assess the Patient as soon as required by the Patient's condition but within twenty-four hours of admission in the case of an acute care Facility, and within seven days in a Continuing Care Facility. The Most Responsible Practitioner/Care Team should, when appropriate, notify and consult with the Patient's personal/family physician and/or other Practitioners whom the Patient identifies as providing continuing care.

c) The Most Responsible Practitioner/Care Team may designate any agreeable Practitioner(s) toprovide concurrent care where this will provide benefit to the Patient. However, such designation will not have the effect of transferring ultimate responsibility for the Patient fromthe Most Responsible Practitioner/Care Team.

### 4.14.2 TRANSFER OF RESPONSIBILITY

a) The designation and responsibilities of the Most Responsible Practitioner may be transferred from one Practitioner or Care Team to another provided that the receiving Practitioner agreesand has the appropriate Clinical Privileges.

b) Care Teams are required to have explicit processes dealing with accountability and clarity of responsibility so that at a given time it is clear which member of the team is responsible for thepatient.

c) The Most Responsible Practitioner/Care Team or designate shall ensure the Patient and/or his/her family, the Patient's Legal Representative, and other Practitioners involved in providingcontinuing care to the Patient are informed of the transfer.

d) The Most Responsible Practitioner/Care Team shall make reasonable efforts to inform the Patient's personal/family physician, and other Practitioners providing care to the Patient in the community, of the Patient's course in hospital, disposition and treatment plan following discharge.

## 4.15 ABSENCE FROM CLINICAL PRACTICE IN SITES OF CLINICAL ACTIVITY

a) During an absence from a Site(s) of Clinical Activity, a Practitioner shall ensure requirements are met for coverage of all his/her responsibilities, and shall identify an alternative Practitioner or callgroup to assume those responsibilities and to serve as Most Responsible Practitioner for his/her admitted Patients. The Practitioner providing coverage must have the appropriate Clinical Privileges. The Practitioner will document the identity of the covering Practitioner or call group inthe Patient's health record. In cases of official leave of absence as described in (d) below shall inform the Patient, and/or his/her family and/or the Patient's Legal Representative.

b) Coverage for Patients during a Practitioner's absence of less than or up to ninety-six hours maybe provided through the on-call schedule of the service or group in which the Practitioner participates, or by alternative but specific prior arrangement.

c) During an absence of greater than ninety-six hours, the provisions of section 4.15.2 of these Rules for the formal transfer of responsibility must be fulfilled. In addition, other than in larger centres and when the Practitioner is not scheduled to provide clinical care in the period of planned absence, notification of the absence and the identity of the covering Practitioner will beprovided to the relevant Zone Clinical Department Head(s) and Facility or Community Medical Director(s), who shall then forward this information to the Medical Affairs Office and any other relevant Zone Clinical Department Head(s) and Zone Clinical Section Chief(s).

d) For a planned absence of greater than forty-two consecutive days, Practitioners must provide notice requesting a formal leave of absence (please see the table below for required notice periods). A leave of absence must be approved in advance by the Zone Medical Director or designate upon the recommendation of the Zone Clinical Department Head(s) or designate(s). The recommendation and approval to grant a leave of absence will be based on consideration ofthe reason(s) for the request, the responsibilities of the Practitioner, workforce needs and the Practitioner Workforce Plan, and any other relevant matters. Only in exceptional circumstanceswill the length of a leave of absence exceed one year.

| Duration of Planned Absence | Minimum Notice Required (days) |
|---|---|
| 42 days | 42 days |
| 43-60 days | 90 days |

| | |
|---|---|
| 61-90 days | 120 days |
| 91 – 180 days | 180 days |
| >180 days | Notice period determined by ZCDH with ZMD approval |

### 4.16 MEDICAL ETHICS

Ethical considerations are an integral part of health care at all levels. Practitioners may seek the advice of the Zone or Facility clinical ethics committee or team in difficult decisions or relationships that are relatedto human and Patient rights, health and safety of the Patient or staff and other Practitioners, multiculturalism, issues of spirituality, faith and religion or other ethical considerations.

### 4.17 DISRUPTIVE BEHAVIOUR IN THE HEALTH CARE WORKPLACE

Practitioners shall be familiar with the relevant guidelines or policies of their respective College with respect to disruptive behaviour, such as the College of Physicians and Surgeons of Alberta document "Managing Disruptive Behaviour in the Health Care Workplace" as well as with relevant AHS policies regarding workplace respect and conduct. Such documents will be applied as a framework when addressing complaints/allegations of disruptive behaviour by Practitioners within the AHS health care workplace. Where a College has not adopted such guidelines or policies, then to the extent possible, its
Practitioner members shall adhere to the principles contained in the College of Physicians and Surgeons ofAlberta document. Where a College has adopted such guidelines and policies, and where they differ from those of the College of Physician and Surgeons of Alberta guidelines or policies, the higher standard shall prevail.

## C. DOCUMENTATION, RECORDS AND RECORD KEEPING

### 4.18 PRACTITIONER'S ORDERS

#### 4.18.1 GENERAL STANDARDS

a) All Practitioners making entries into a Patient's health record shall do so in the format and manner required by AHS and in accordance with the facility protocol. If an electronic health record is in use at the site or sites where a Practitioner provides patient care services, it must beused to document patient care.

b) Entries in a patient health record shall include documentation of the date and time of the entry,the Practitioner's role/title and, in the case of written entries, an identifiable signature, preferably accompanied by his/her printed name. If and when it becomes the use of the electronic signature is available, its use is mandatory. A handwritten, original signature is required in all other circumstances (with the exception of existing delegated authentication processes).

4.18.2 Medication and treatment orders shall be in compliance with applicable AHS policies and procedures.

4.18.3 All orders shall be either written in the Patient's health record on the approved order sheet or entered directly into the Patient's electronic health record (if applicable). Where electronic order entry is available, utilization of the system is mandatory. If orders are in writing, they shall be written using dark ink, on the appropriate form and shall be legible, complete, dated, timed, signed by the Most ResponsiblePractitioner or designate, and accompanied by the Practitioner's printed name. A ballpoint or similar penshall be used.

4.18.4 Most Responsible Practitioner:

a) It shall be the duty of the Most Responsible Practitioner to review the orders for their Patients ona regular basis.

b) Where the patient is being cared for by a designated Care Team, responsibility for patient careand documentation will be as described in Rule 4.16 (Most Responsible Practitioner)

c) Requests for consultations shall be in writing on the appropriate consultation request form or shall be entered directly into the Patient's electronic health record (where applicable), and shallinclude the reason for consultation, the desired input from the Consultant, a brief history, and specific timelines in which the consultation is to be provided (based upon the nature of the Patient's condition and circumstances). Direct Practitioner to Practitioner discussion shall occur in urgent cases, and is preferable in all cases. The College of Physicians and Surgeons' Standardof Practice *Referral Consultation Process* will provide additional guidance for both the referring and consulting Practitioners and shall be complied with.

4.18.5 Consultants:

a) On receipt of a consultation request, the Consultant shall document their receipt of the request,their assessment of the patient, and recommendations for management of the Patient.

b) A consulting Practitioner (or designated Medical Student or Resident) may write orders if he/shehas appropriate Clinical Privileges in the relevant Site of Clinical Activity and has been asked to participate in the Patient's care and has been asked to write orders.

c) Consulting Practitioners who have an AHS appointment but do not have privileges at a specific Continuing Care Site of Clinical Activity may attend patients at the site for purposes of examiningand provide consultation and treatment recommendations to the Most Responsible Practitioner/Care Team, but may not issue patient care or treatment orders.

d) Consultants' Orders must be written in the appropriate form by consulting Practitioners. Consulting Practitioners will consider the express request for consultation in preparing their orders, but may elect to leave suggestions for orders if that meets the request. In this case, the orders will not be executed until ordered or countersigned by the Most Responsible Practitioneror designate.

4.18.6 . Orders entered by Medical Students shall be countersigned and approved by the Most ResponsiblePhysician within 24 hours and shall not be acted upon before that time.

4.18.7 Orders prepared by Physicians undergoing assessment must be countersigned by the CPSA Assessorbefore being implemented.

4.18.8 Verbal Orders:

a) Because of the inherent risks, verbal orders are acceptable only when they enhance quality andsupport patient-centered care.

b) Telephone orders

i. Telephone orders should be limited to those situations in which prompt or immediate direction for Patient care is required and the ordering Practitioner is not able to accessthe Patient's health record or electronic order entry in a period of time appropriate forthe circumstances requiring an order.

ii. Telephone orders communicated by a third party acting on behalf of the Practitioner shall not be accepted unless the third party is another Practitioner or Resident or the situation is emergent and the Practitioner cannot personally provide a telephone order.
In these cases

iii. Facsimile (fax) transmission of orders written by the ordering Practitioner is preferred to telephone orders. Faxed orders must include the ordering Practitioner's legible signature, preferably accompanied by his/her printed name.

c) Verbal and telephone orders shall only be accepted and recorded by persons authorized to do soand in accordance with AHS policy.

d) Verbal and telephone orders must be repeated back to the ordering Practitioner and, accordingto AHS policy, will be signed by the authorized person to whom they were dictated, along with the name of the ordering Practitioner.

e) Verbal and telephone orders shall be deemed to have been countersigned by the ordering Practitioner unless corrected within twenty-four hours or, in the case of a Continuing Care Facility, at the time of the ordering Practitioner's next visit to the Facility. Verification of verbaland telephone orders shall be the responsibility of the ordering Practitioner and must comply with AHS policy.

f) Order sets shall be signed by the Practitioner for each Patient to whom they are applied. Order sets must be approved and periodically reviewed by the Zone Clinical Department in accordancewith Zone Rules and AHS policy.

## 4.19 HEALTH RECORDS

### 4.19.1 GENERAL GUIDELINES:

a) All Practitioners shall complete their health records within the specified period(s) of time usingthe systems made available for dictation and electronic signature.

b) AHS has a legal obligation to protect health information. The information belongs to the Patient, but AHS is the legal custodian of the health record. Original or copies of health records are not tobe removed from a Facility unless authorization is received from AHS Health Information Management, or unless in compliance with a legally valid Subpoena Duces Tecum or a legally valid Search Warrant.

c) Community-based health records may travel with the Patient, family members (authorized in writing by the Patient) and/or the Patient's Legal Representative during the provision of care incompliance with formally documented processes and relevant legislation.

d) Confidentiality of Patient medical information is paramount. Practitioners must respect andadhere to relevant AHS policies governing privacy and access to health records.

## 4.19.2 DOCUMENTATION STANDARDS

### 4.19.2.1 GENERAL CHARACTERISTICS

A health record shall be maintained for each Patient who is evaluated or treated, or who receives emergency, inpatient or ambulatory care within any Facility. All significant clinical information pertainingto a Patient shall be incorporated in the Patient's health record.

### 4.19.2.2 ADMISSION (HISTORY AND PHYSICAL) NOTE

a) The Most Responsible Practitioner is responsible for an admission note documenting the history, pertinent physical examination, provisional diagnosis and treatment, and plan of managementfor all Patients admitted under his/her care.

b) Completion of an admission note may be delegated to another provider. The Most Responsible Practitioner, nevertheless, remains responsible for ensuring the recorded information is complete and accurate.

c) Admission Note Requirements:

I. Every inpatient must have an admission note completed within twenty-four hoursfollowing admission, except in the case of a surgical emergency, in which case theadmission note must be completed prior to the surgical operation.

II. For Patients re-admitted to the same hospital within thirty days of discharge for the same or related problem, a copy of the previous/most recent complete admission note, accompanied by a note documenting the changes that have occurred since discharge, will suffice. The Most Responsible Practitioner shall affirm the admission note continuesto be accurate, other than the documented changes.

III. If a complete assessment (history and physical) has been performed within one year prior to admission to the same , such as in the office of a Practitioner, a copy of this report may be used as an admission note in the Patient's health record, provided therehave been no subsequent changes in the Patient's condition or any changes have beenrecorded at the time of admission. The Most Responsible Practitioner or his/her designate shall affirm the admission note continues to be accurate, other than the documented changes, within twenty-four hours of admission.

IV. For obstetrical Patients an original or reproduction of the prenatal record is acceptable as an admission note but must be affirmed by the Most Responsible Practitioner or theirdesignate.

V. For Patients transferred from one Facility to another, a note detailing the reasons for the transfer and the condition of the Patient upon arrival at the receiving Facility, together with a copy of the admission note from the sending Facility, shall constitute an admission note for the record for the receiving Facility. Copies of the Patient's completehealth record from the sending Facility, or the relevant portions of it, should be includedas part of the Patient's health record in the receiving Facility.

d) Recommended minimum content of an Admission Note:

I. Identification information with respect to the Patient

II. The reason(s) for admission, or chief complaint.

III. Details of present illness, including, when appropriate, assessment of the Patient's emotional, behavioural and social status.
IV. Relevant past medical history, review of body systems, current medications, presence orabsence of allergies, and relevant past social and family histories appropriate to the age of the Patient.
V. Details of a complete physical examination.
VI. Documentation of relevant recent or available laboratory or diagnostic imaging tests.
VII. A comprehensive list of active Patient care problems/issues with an appropriate differential diagnosis for each problem as required.
VIII. A statement of the conclusions drawn from the admission history and physical examination and an initial plan of management for the active problems.
IX. Level of care designation or a summary or copy of the Patient's personal directive if appropriate
X. Estimated length of stay and documentation of patient issues or circumstances that mayprolong the length of stay or will require advanced discharge planning.

### 4.19.2.3 PROGRESS NOTES

a) The Most Responsible Practitioner is responsible for recording and maintaining progress notes for Patients under his/her care. Progress notes must serve as a pertinent chronological record of the Patient's course in hospital as well as any change in condition, interpretation of the results ofdiagnostic tests and the effect of treatment.

b) Documentation and maintenance of progress notes may be delegated to a Medical Student or Resident. The Most Responsible Practitioner, nevertheless, remains responsible for ensuring therecorded information is complete and accurate. The Most Responsible Practitioner must co-signthe progress notes of Medical Students but not those of a Resident.

c) Daily progress notes are recommended for Patients in acute care Facilities, unless the Patient is awaiting placement in a Continuing Care Facility in which case a weekly note is recommended. For Patients in Continuing Care Facilities, progress notes should be documented at least monthly.Notwithstanding these guidelines, progress notes shall be completed whenever there is a significant change in the Patient's condition or management, and whenever unexpected events or outcomes occur.

d) Recommended minimum content of Progress Notes:

I. Response to treatment.
II. Acute or unexpected changes in the Patient's condition.
III. Adverse reactions to drugs and/or other treatments.
IV. Interpretation of the results of diagnostic tests, particularly significant or unusual test results.
V. Fundamental decisions about ongoing management including but not limited to medication, invasive procedures, consultations, treatment goals, and decisions regarding level of care/resuscitation.
VI. Invasive procedures not performed in an operating room.
VII. Discharge plans.
VIII. Documentation in the event of death, including the date and time of death.
IX. Any other information as may be pertinent, such as temporary leaves, refusal of treatment or leaving against advice.

### 4.19.2.4 OPERATIVE/PROCEDURE REPORTS

a) Operative/Procedure reports are to be dictated or electronically entered in the health recordwithin twenty-four hours of surgery.

b) Recommended minimum content of operative/Procedure Reports:

I. Identification information with respect to the Patient
II. title of the operation/Procedure performed
III. pre-operative diagnosis/indication for the operation/Procedure
IV. proposed operation/Procedure (if different from procedure performed)
V. post-operative/Procedure diagnosis
VI. type of anaesthesia
VII. diagnostic specimens collected/removed during the operation/Procedure
VIII. operative/Procedure findings
IX. description of operation/Procedure (including the condition of the Patient during and atthe conclusion of the operative procedure, and estimated blood loss)

### 4.19.2.5 ANAESTHETIC RECORDS

The anaesthetist shall record a pre-anaesthetic assessment on the anaesthetic record prior to the administration of any anaesthetic and shall complete and sign the anaesthetic record at the end of the operation/Procedure.

### 4.19.2.6 CONSULTATION REPORTS

a) Consultation reports are to be written, dictated and/or electronically entered in the healthrecord within twenty-four hours of assessment of the Patient.

b) Recommended minimum content for Consultation Reports:

I. identification information with respect to the Patient
II. findings of the consultation and recommendations for management of the Patient

### 4.19.2.7 TRANSPLANTATION RECORD

a) When an organ or tissue is obtained from a living donor for transplantation purposes, the health records of the donor and recipient shall fulfill the requirements for an operative report pursuantto section 4.19.2.4.

b) When a donor organ or tissue is obtained from a deceased Patient, the health records of the donor must include the date and time of death, documentation by and identification of the physician who determined the death, and documentation of the removal of the organ or tissue.

### 4.19.2.8 PATHOLOGY REPORTS

Recommended minimum content of Pathology Reports:

a) Identification information with respect to the Patient
b) Site of origin of tissue and/or operation/Procedure and date performed/collected.
c) The gross descriptions which shall contain adequate information regarding:
I. Type, size and/or weight of lesion/specimen(s)
II. Measurements of gross lesion/specimen(s)

III. Description of gross lesion/specimen(s) margins
IV. Relationship of gross lesion/specimen(s) to surgical margins

d) The gross and microscopic findings that support the diagnosis.
e) The final diagnosis in tumour cases and sufficient information as to grade of tumour, where appropriate, and extent of disease for use in standard systems of grading and staging neoplasms.If a grading system is used, the name of the grading system shall be documented, and the resultsindicated in the report.

### 4.19.2.9 DISCHARGE SUMMARIES

a) The Most Responsible Practitioner at the time of discharge of the patient from the Facility is responsible for completing a discharge summary.

b) Completion of discharge summaries may be delegated to a Resident or other authorized person.The Most Responsible Practitioner, nevertheless, remains responsible for ensuring that the discharge summary is accurate and comprehensive.

c) Completion Requirements:

I. A discharge summary is required for each admission in a manner that is conducive to electronic access and distribution (i.e. dictation, direct electronic entry, and/or scanning).
II. Discharge summaries should be completed within fourteen days after the chart is made available to the Practitioner post-discharge.

d) Recommended minimum content of a Discharge Summary:

I. Identification information with respect to the Patient.
II. history of present illness.
III. brief description of the clinical problems and events leading to admission.
IV. course in hospital.
V. a brief summary of the management of each of the active clinical problems during admission, including operations/Procedures and major investigations, treatments andoutcomes.
VI. most responsible diagnoses.
VII. secondary diagnoses.
VIII. the condition of the Patient at the time of discharge.
IX. discharge plan, including further investigations or consultations to be completed, medications on discharge, recommended physical activity, instructions to other caregivers, and follow-up (if any) by the Most Responsible Practitioner or consultingPractitioners.
X. any specific instructions given to the Patient and/or his/her family, as pertinent.

### 4.19.2.10 AUTOPSY REPORTS

When an AHS autopsy is completed, an autopsy report shall be included in the health record. AHS shalltake reasonable action to endeavour to obtain the reports of autopsies undertaken by the Medical Examiner and have them included in the Patient's health record.

#### 4.19.2.11 EMERGENCY DEPARTMENT NOTES AND AMBULATORY/OUTPATIENT REPORTS

a) All entries on emergency and ambulatory Patients must be documented by the Practitioner onthe approved forms and shall include the time, date and identifiable signature, preferably accompanied by his/her printed name.

b) The Most Responsible Practitioner shall ensure the emergency department notes and ambulatory/outpatient records of all Patients in his/her care are completed.

c) Completion of emergency notes or ambulatory/outpatient records may be delegated to Residents and other authorized persons. The Most Responsible Practitioner, nevertheless,remains responsible for ensuring the recorded information is complete and accurate.

d) Completion Requirements

I. Every emergency department Patient must have an emergency department note and every ambulatory Patient must have an ambulatory/outpatient record completed withintwenty-four hours.

II. To facilitate the ongoing provision of care, for each Patient who receives continuing ambulatory/outpatient care, a summary outlining the changes that have occurred sincethe last visit is required.

e) Recommended minimum content of emergency department notes and ambulatory/outpatientrecords:

I. The reason(s) for the visit.
II. The relevant history of the present illness or injury and the physical findings, including the Patient's vital signs as clinically appropriate.
III. Diagnostic and therapeutic orders.
IV. Clinical observations, including the result of treatment.
V. Reports of diagnostic tests and surgery and Procedures, and their results.
VI. Reports of any consultations or telephone/verbal advice obtained.
VII. Final diagnosis or impression.
VIII. Patient disposition and any instructions given to the Patient and/or his/her family forcare.
IX. Allergies and medications, both current and prescribed.
X. Referrals to another Practitioner and/or an AHS or Universal Programs or Professional Services.

### 4.19.3 HEALTH RECORD COMPLETION GUIDELINES

All members of the Medical Staff shall complete health records within the following timelines using thesystems made available for handwritten records, dictation, electronic entry, and signature.

| TYPE OF REPORT | TIMELINES FOR COMPLETION |
|---|---|
| Admission Note (History, Physical Examination, Impressionand Plan) | Within twenty-four hours following admission except in a surgical emergency, in which case the Admission Note is to be completed, if at all possible, prior to the surgical procedure. Elective AdmissionNotes may predate admission by up to one year; all such Admission Notes must be updated and validated by the admitting Practitioner within twenty-four hours of admission. |
| Verbal Practitioner Orders | Verified within twenty-four hours. |

| | |
|---|---|
| Operative Report | Within twenty-four hours of surgery. |
| Anaesthetic Record | At the time of surgery. |
| Discharge Summary | Within fourteen days of chart being made available for dictation. |
| Emergency Notes | Within twenty-four hours of visit. |
| Ambulatory/Outpatient Records | Within twenty-four hours of visit. |
| Consultation Reports | Within twenty-four hours (preferably upon completion of the consultation). |
| Progress Notes | Daily progress notes are recommended for Patients in acute care Facilities, unless the Patient is awaiting placement in a Continuing Care Facility in which case a weekly note is recommended. For Patients in Continuing Care Facilities, progress notes are recommended at least monthly. Notwithstanding these guidelines, progress notes shall be completed whenever there is a significant change in the Patient's condition or management, and whenever unexpected events or outcomes occur. |

### 4.19.4 CURTAILMENT OF CLINICAL PRIVILEGES FOR INCOMPLETE HEALTH RECORDS:

4.19.4.1 Curtailment of Clinical Privileges for incomplete health records.

a) Zone Medical Affairs and the Zone Medical Administrative Committee shall be responsible for establishing a process to ensure Practitioners are aware of outstanding incomplete records andthe risk of impending curtailment.

b) AHS Health Information Management staff at each AHS Facility will monitor the completion of Patients' health records by Practitioners.

c) After a Patient has been discharged from a Facility, the Patient's health record will be made available to the Practitioner in the designated health record completion area of the Facility.

d) If the health record is incomplete fourteen days after it is made available post-discharge, Health Information Management will send a notification to the Practitioner.

e) If at any time, the Practitioner accumulates ten or more Patient health records that have been incomplete for more than twenty-eight days after they have been provided to the Practitionerfor completion, or any four (4) Patient health records have remained incomplete more than ninety days after it has been provided to the Practitioner for completion, the Facility or Community Medical Director or designate shall notify the Practitioner and the Zone Medical Director. Unless the Zone Medical Director determines that there are extenuating circumstances, he/she shall, fourteen days later, curtail the Practitioner's Clinical Privileges within the Zone as described in section 4.21.4.3 of these Rules. This curtailment in Clinical Privileges shall continue until all outstanding health records are completed.

f) Curtailment of Clinical Privileges encompasses all inpatient and ambulatory activity within allSites of Clinical Activity.

g) Notwithstanding any allowances for extenuating circumstances the ZMD may have made, a Practitioner's non-completion of patient records may be pursued as a Concern under Part 6 ofthe AHS Medical Staff Bylaws

4.19.4.2 During the period of curtailment, the Practitioner in default shall be permitted and expected to:

a) Continue to care for his/her own Patients (including any surgical care) admitted prior to the dateof curtailment of Clinical Privileges.

b) Fulfill his/her obligations with regard to on-call responsibilities during which time the Practitionermay treat, admit and consult on emergent cases and provide coverage for Patients under the care of his/her Zone Clinical Department service / colleagues.

c) Provide care for his/her personal maternity and newborn cases including admission where necessary.

4.19.4.3 During the period of curtailment, the Practitioner in default shall not be permitted to:

a) Admit Patients, other than his/her own maternity and newborn Patients, while not on-call.

b) Write orders (except while on-call) on his/her personal Patients who are admitted under the careof another Practitioner.

c) Treat Patients in his/her Site(s) of Clinically Activity except to continue to care for Patients forwhom he/she was the Most Responsible Practitioner prior to the administrative suspension.

d) Perform surgery or Procedures, assist in performing surgery or Procedures or administer anaesthetics, except within the conditions described in sections 4.21.4.3 a), b) and c) above.

e) Provide consultative services, except within the conditions described in section 4.21.4.2 b) above.

f) Accept transfers of Patients from within or outside the Facility, except within the conditions described in b) above.

4.19.4.4 End of the Period of Curtailment

All Clinical Privileges will be reinstated upon completion of all incomplete Patient health recordsthat led to curtailment. If the Practitioner fails to complete the Patient health records that led tothe curtailment within fourteen days of the curtailment being imposed, the Zone Medical Director or Zone Medical Advisory Committee may exercise other options under Bylaws , including but not limited to , a Concern or Immediate Action .

## D. OTHER

### 4.20 DISASTER PLANNING/EMERGENCY PREPAREDNESS

As required, and according to AHS and Facility Disaster/ Emergency Preparedness Plans each Practitioner shall participate in disaster and emergency preparedness planning/exercises, and in the actual activation/implementation of plans in the event of an external/internal disaster or public healthemergency, including those resulting in major service disruption.

### 4.21 PHARMACY

Each Practitioner shall be governed by AHS policies regarding the use of drugs and therapeutic agents. These include policies and procedures introduced by the Provincial Pharmacy and TherapeuticsCommittee and its subcommittees, and those related to the Provincial Formulary.

## 4.22 COMMUNICABLE DISEASES

a) Practitioners shall provide care within their area of expertise to all Patients, including those known or suspected of having transmittable infections. Practitioners shall also ensure that allappropriate precautions are taken to prevent transmission of these infections to others, including themselves.

b) It is the duty of all Practitioners to take appropriate action to protect themselves and Patients from known, suspected or possible transmittable infections and conditions. Such action shall include compliance with basic infection control strategies, referred to as routine practices (alsoknown as standard or universal blood and body fluid precautions), for every patient encounter.Additional precautions may be necessary for patients with pathogens transmitted by contact, droplet or airborne routes. As determined by an AHS occupational health physician and/or a Zone Medical Officer of Health, alteration and/or restriction of Practitioner duties or, when necessary, exclusion of the Practitioner from work may also be required as defined by the
Practitioner's susceptibility to, and potential for transmission of, a communicable disease.

c) Practitioners shall follow the current AHS hand washing policy and procedure and the currentAHS isolation policy and procedure.

d) The Most Responsible Practitioner shall be accountable for notifying the Zone Medical Officer ofHealth of all cases of communicable disease where such notification is required by law.

## PART 5 – RULES APPLICABLE TO AN INDIVIDUAL ZONE OR ZONES

5.1 A Zone, through its Zone Medical Administrative Committee, may develop Zone Rules where necessary toreflect circumstances unique to the Zone, provided that such Zone Rules do not conflict with and are not inconsistent with the Bylaws, Part 3 of these Rules (Rules Applicable to all AHS Zones), or Part 4 of these Rules (AHS Patient Care and Practitioner-related Provisions Common to all Zones).

5.2 Zone Rules so developed shall follow the approval process pursuant to section 1.5 of the Bylaws.

5.3 These Zone Rules shall govern the day-to-day management of Medical Staff activities within the Zone, andnothing in them shall alter the intent and purpose of the Bylaws or Parts 1 through 4 of these Rules inclusive.

## PART 6 - ISSUES AND CONCERNS MANAGEMENT

It is intended that Part 6 of these Rules will be developed to complement Part 6 of the Bylaws. To the extent there is an inconsistency between any Part 6 Rules developed and the Bylaws, the provisions in the Bylaws govern.

# PART 7 – PROVINCIAL CLINICAL DEPARTMENTS

## 7.0 PREAMBLE

The Bylaws and Rules apply to each provincial clinical department defined in Part 7 and the Appendices of these Rules unless otherwise noted.

## A. PROVINCIAL CLINICAL DEPARTMENT, RECOVERY ALBERTA

### 7.1 COMPOSITION

The Provincial Clinical Department of Recovery Alberta is comprised of physicians and dentists providing medical services to Albertans related to mental health, addictions and care while in provincial correctional facilities.

### 7.2 MEDICAL LEADERSHIP STRUCTURE

#### 7.2.1CHIEF MEDICAL OFFICER, RECOVERY ALBERTA

**a) APPOINTMENT & ACCOUNTABILITY**

The Chief Medical Officer, Recovery Alberta is the most senior Practitioner responsible for the scope of clinical services delivered by Recovery Alberta. For Bylaws matters only, the Chief Medical Officer, Recovery Alberta shall be accountable to the AHS Chief Medical Officer.

**b) RESPONSIBILITIES & DUTIES**

The Chief Medical Officer shall be accountable for strategic and operational issues and decisions requiring Practitioner input or leadership arising in the Recovery Alberta portfolio. This includes the effective management of addiction, mental health, and correctional health service needs.

#### 7.2.2 ASSOCIATE CHIEF MEDICAL OFFICER RECOVERY ALBERTA

**a) APPOINTMENT & ACCOUNTABILITY**

The Chief Medical Officer, Recovery Alberta may from time to time choose to appoint one or more Associate Chief Medical Officers.

**b) RESPONSIBILITY & DUTIES**

An Associate Chief Medical Officer Recovery Alberta may be assigned any duties the Chief Medical Officer Recovery Alberta deems appropriate. These duties will typically be strategic planning and/or operational management related.

#### 7.2.3 MEDICAL DIRECTORS

**a) APPOINTMENT AND ACCOUNTABILITY**

The Chief Medical Officer, Recovery Alberta may choose to appoint one or more Medical Directors. These positions might be clinically, facility or geographically based. Appointment to these positions will be after consideration of the recommendation of a search committee pursuant to the processes specified in these Rules. The Medical Directors shall be directly accountable to the Chief Medical Officer, Recovery Alberta or another Medical Director (the reporting to be made clear at the time of appointment) and shall liaise with the respective AHS Zone Medical Directors, AHS Zone Clinical Department Heads and leaders in other Provincial Clinical Departments.

**b) RESPONSIBILITIES AND DUTIES**

Without limiting the authority of Recovery Alberta relative to its administrative structures, the responsibilities of the Medical Directors include, but are not limited to:

i. those duties generally associated with Zone Clinical Department Heads as outlined in section 2.8.2 of the Bylaws;
ii. assisting the Chief Medical Officer in carrying out their duties;
iii. efficiently delivering integrated mental health, addiction and provincial correctional facility service needs for Albertans;
iv. acting for the Chief Medical Officer, Recovery Alberta in their absence; and
v. other duties as may be delegated by the Chief Medical Officer, Recovery Alberta.

## 7.3 DUTIES AND RESPONSIBILITIES OF RECOVERY ALBERTA

Recovery Alberta shall generally fulfill the equivalent duties and responsibilities of Zones and Zone Clinical Departments pursuant to the Bylaws and Rules, with the exception of:

a) The responsibilities and duties of the Zone Medical Director shall be fulfilled by the Chief Medical Officer, Recovery Alberta.
b) The responsibilities and duties of the Zone Clinical Department Head shall be fulfilled by a Medical Director.

## 7.4 PROVINCIAL APPLICATION REVIEW COMMITTEE

For Medical Staff Applications related to Recovery Alberta, applications will be reviewed, and recommendations made to the AHS CMO for decision by a Recovery Alberta Provincial Application Review Committee (PARC) instead of a ZARC.

### 7.4.1COMPOSITION

The PARC shall be composed of the following members:

a) the Chief Medical Officer, Recovery Alberta who shall be the PARC chair
b) an equivalent number of Recovery Alberta Medical Directors and Recovery Alberta Medical Staff who do not hold a medical leadership position (members at large).

### 7.4.2 DUTIES AND RESPONSIBILITIES

The purpose of the PARC is to:

a) review all initial Applications to the Medical Staff and prepare a written recommendation (to accept, deny, or amend the application) after initial review by a Medical Director; and
b) to review all Requests to Change a Medical Staff Appointment and Clinical Privileges and prepare a written recommendation (to accept, deny, or amend the Request for Change) after initial review by a Medical Director.

### 7.4.3 CONDUCT OF MEETINGS

a) The PARC shall fulfill the duties tasked to Zone Application Review Committees pursuant to sections 3.4, 3.5 and 3.6 of the Bylaws;
b) Meetings of the PARC may be held in person, electronically, by videoconference or teleconference or asynchronously by other means of technology; and
c) The PARC shall determine such procedures it deems appropriate and in its sole discretion provided that such procedures do not conflict with and are not inconsistent with sections 3.4, 3.5 and 3.6 of the Bylaws.

## 7.5 DEVELOPMENT OF DEPARTMENTAL POLICIES AND PROCEDURES

a) Departmental policies and procedures developed by Recovery Alberta shall be considered as Provincial Rules pursuant to section 1.5 of the Bylaws.

b) Only sections 1.5.1, 1.5.2, 1.5.3 and 1.5.5 of the Bylaws shall apply to the development and approval of departmental policies and procedures for Recovery Alberta.

### 7.6 PROVINCIAL DEPARTMENT EXECUTIVE COMMITTEE, RECOVERY ALBERTA

a) Recovery Alberta shall establish a Department Executive Committee pursuant to section 2.6.7 of the Bylaws.

b) The Department Executive Committee shall be composed of the Chief Medical Officer, Recovery Alberta, who shall act as chair; the Associate Chief Medical Officer(s) (if appointed), the Medical Directors appointed, and appropriate other medical and other administrative leaders relevant to Recovery Alberta's services.

c) The purpose of the Provincial Department Executive Committee shall be to assist the Chief Medical Officer, Recovery Alberta in fulfilling their responsibilities and duties under the Bylaws and Rules; to promote joint decision-making with medical and other administrative leaders; and to coordinate the work of Recovery Alberta across AHS and other health system structures.

**Appendix A – AHS POLICIES AND PROCEDURES APPLICABLE TO PRACTITIONERS**

AHS will develop a process to ensure practitioner have opportunity to review all relevant AHS policies

**APPENDIX B – DEFINITIONS FROM THE MEDICAL STAFF BYLAWS**

| | |
|---|---|
| Academic Physician | A physician Practitioner who also possesses an appointment as a Full-Time Faculty or Clinical Faculty member with either the Faculty of Medicine & Dentistry of the University of Alberta or the Faculty of Medicine of the University of Calgary. |
| Active Staff | The Practitioners who are appointed to the Active Staff category pursuant to theseBylaws. |
| Advisor | A person, lay or professional, who provides guidance, support, or counsel to a Practitioner pursuant to these Bylaws. |
| Affected Practitioner | A Practitioner who is the subject of a Triggered Initial Assessment, Triggered Review or Immediate Action. |
| AHS Agent | A person, other than an AHS employee, Senior Officer or board member, who is authorized to bind AHS, purports to bind AHS or who directly or indirectly controlsAHS funds. |
| AHS Code of Conduct | The code of conduct established by AHS. |
| AHS Conflict of Interest Bylaw | The conflict-of-interest bylaw established by AHS. |
| AHS Programs and Professional Services | Diagnostic and treatment services and programs operated by or for AHS to which Practitioners with relevant Clinical Privileges can refer Patients. |
| AHS Representative | An AHS employee, Senior Officer, Agent or board member. |
| AHS Senior Officer | The Chief Executive Officer, president or vice-presidents of AHS, any other executive directly accountable to the Chief Executive Officer or president of AHS, andany other person so designated by the Chief Executive Officer or board of AHS. |
| Alberta Health Services Alberta | The health authority established pursuant to applicable legislation for the Provinceof |
| Application Privileges | The forms and process used to apply for a Medical Staff Appointment and Clinical in the manner specified in these Medical Staff Bylaws and the Medical Staff Rules. |
| Bylaws and Rules Review Committee | A committee established as such pursuant to these Bylaws. |

| | |
|---|---|
| Chief Executive Officer | The chief executive officer appointed by the board of AHS to have overall or CEO administrative responsibility for AHS. |
| Clinical Privileges | The delineation of the Procedures that may be performed by a Practitioner, the Sitesof Clinical Activity in which a Practitioner may perform Procedures or provide care toPatients; and the AHS Programs and Professional Services that are available to a Practitioner in order to provide care to Patients. |
| College | The relevant regulatory body which governs the Practitioner. Community Physician, A Physician, Dentist, Oral & Maxillofacial Surgeon or Podiatrist with a scope of Dentist, Oral & practice limited to community office or clinic practice. Maxillofacial Surgeon or Podiatrist |
| Community Staff | The Practitioners who are appointed to the Community Staff category pursuant tothese Bylaws. |
| Complainant | A Patient or his/her legal representative(s), a member of the public, or another Practitioner(s) who initiate(s) a Concern. |
| Concern | A written complaint or concern from any individual or group of individuals about a Practitioner's professional performance and/or conduct, either in general or in relation to a specific event or episode of care provided to a specific Patient. |
| Consensual Resolution | A consensual and confidential process to resolve a Concern. Consensual Resolution includes the Affected Practitioner, the relevant AHS medical administrative leader(s), and any other relevant person(s). |
| Dentist or Oral & Maxillofacial Surgeon | A person licensed in independent practice and in good standing with the Alberta Dental Association and College pursuant to the Health Professions Act (Alberta). |
| Executive Vice President Medical Officer or Chief Medical Officeror CMO | The most senior medical administrative leader of AHS, appointed by the CEO.& Chief |
| Facilities | Approved hospitals, continuing care facilities, community health, urgent care, andpublic health centres, and any other facilities operated by AHS. |
| Hearing | The process of addressing Concerns where a Triggered Initial Assessment and Consensual Resolution have not resolved the matter or are not considered appropriate means to resolve the matter. |
| Hearing Committee | A committee established as such pursuant to these Bylaws. |

| | |
|---|---|
| Immediate Action | An immediate suspension or restriction of a Practitioner's Medical Staff Appointment and/or Clinical Privileges without first conducting a Triggered Reviewpursuant to these Bylaws. |
| Immediate Action Review Committee | A committee established as such pursuant to these Bylaws. |
| Locum Tenens | A Practitioner temporarily placed into an existing practice and/or Facility in orderto facilitate the short-term absence of another Practitioner, or to address a temporary shortfall in Practitioner workforce. |
| Medical Affairs Office | An operational and organizational office of the Executive Vice President & Chief Medical Officer portfolio. |
| Medical Director | The Practitioner who is the medical administrative leader of a Zone (Zone Medical Director); one or more Facilities (Facility Medical Director), one or more communities (Community Medical Director), an AHS provincial portfolio or program (Senior Medical Director or Medical Director); or a Zone program (Zone Program Medical Director). |
| Medical Organizational Structure | The medical organizational structure of AHS aligned with these Bylaws and the Rules. |
| Medical Staff | Collectively, all Practitioners who possess a Medical Staff Appointment pursuantto these Bylaws. |
| Medical Staff Appointment or Appointment | The admission of a Practitioner to the AHS Medical Staff. |
| Minister | The member of the Executive Council of Alberta who is charged with carrying outthe statutory responsibilities conferred on him as Minister of Health and Wellness. |
| Medical Staff | An offer to join the Medical Staff which specifies the category of Appointment, Letterof Offer assignment to a Zone(s) Clinical Department(s), delineation of specific Clinical Privileges (if applicable), and the details of major responsibilities and roles. |
| Other Providers | Corporations, partnerships or legal entities other than AHS which own and/or operate approved hospitals, continuing care facilities, or community health, urgent care or public health centers within the Province of Alberta and/or whooffer diagnostic and treatment services and programs. |
| Patient | An individual receiving health services from a Practitioner. |

| | |
|---|---|
| Periodic Review | A periodic review of the professional performance and all matters relevant to the Appointment and Clinical Privileges of a Practitioner with an Appointment in the Active and Locum Tenens Staff categories. |
| Physician | A person licensed in independent practice and in good standing with the Collegeof Physicians and Surgeons of Alberta pursuant to the Health Professions Act (Alberta). |
| Podiatrist | A person licensed in independent practice and in good standing with the Alberta Podiatry Association pursuant to the Podiatry Act/Health Professions Act (Alberta). |
| Policies | Administrative and operational objectives, plans, values, principles, practices and standards established by AHS with respect to its operations and Facilities, programs and services. |
| Practitioner | A Physician, Dentist, Oral & Maxillofacial Surgeon; Podiatrist, or a scientist leader,who has an AHS Medical Staff Appointment. |
| Practitioner Workforce | An AHS plan which provides projections and direction with respect to the Plan recruitment, retention and organization of an appropriate number, mix and location of Practitioners with the required skill sets. |
| Primary Zone Clinical Department | The Zone Clinical Department in which a Practitioner undertakes the majority of his/her Medical Staff responsibilities and roles, and through which changes in Appointment, Periodic Reviews, and other administrative actions pursuant tothese Bylaws will be managed. |
| Probationary Staff | The Practitioners who are appointed to the Probationary Staff category pursuantto these Bylaws. |
| Procedure | A diagnostic or therapeutic intervention for which a grant of Clinical Privileges is required. |
| Professional Codes of Conduct | The Code of Conduct established by the College of Physicians and Surgeons of Alberta, the Code of Conduct established by the Alberta Podiatry Association, and the Code of Ethics established by the Alberta Dental Association and College. |
| Provincial Practitioner Executive Committeeor PPEC | A committee established as such pursuant to these Bylaws. |
| Request to Change | A request to change the category of Appointment and/or the Clinical Privilegesof a Practitioner pursuant to these Bylaws. |
| Rules | The specific provisions established as Medical Staff Rules pursuant to these Bylaws. |

| | |
|---|---|
| Scientist Leader | A person other than a Physician, Dentist, Oral & Maxillofacial Surgeon or Podiatristwho holds a doctorate degree in a recognized health-related scientific or biomedical discipline, and who is an AHS medical administrative leader responsible for, and accountable to, Physician, Dentist, Oral & Maxillofacial Surgeon and/or Podiatrist Practitioners. |
| Sites of Clinical Activity | The locations and programs, listed in the grant of Clinical Privileges, where a Practitioner may perform Procedures or provide care or services to Patients. TheSites of Clinical Activity may include Zones, Facilities, specific AHS Programs and Professional Services within Facilities, and/or Telemedicine. |
| Telemedicine | The provision of services for Patients, including the performance of Procedures,via telecommunication technologies, when the Patient and the Practitioner are geographically separated. This may include Practitioners in Alberta, as well as those outside Alberta who are on the Telemedicine Register of the College of Physicians and Surgeons of Alberta. |
| Temporary Staff | The Practitioners who are appointed to the Temporary Staff category pursuantto these Bylaws. |
| Triggered Initial Assessment | An investigation and initial assessment of a Concern or other information/complaints about a Practitioner. |
| Triggered Review | A review undertaken in response to a Concern about a Practitioner's professional performance and/or conduct. |
| Universal Programs Professional Services | Those diagnostic and therapeutic services and programs available, within theirAnd respective scope of practice, to all Alberta Physicians, Dentists, Oral & Maxillofacial Surgeons and Podiatrists without the need for an AHS Medical Staff Appointment or grant of Clinical Privileges. |
| Zone | A geographically defined organizational and operational sub-unit of AHS, the boundaries of which may be revised from time-to-time by AHS. |
| Zone Application Review Committee or ZARC | A committee established as such pursuant to these Bylaws. |
| Zone Clinical Department | An organizational unit of Practitioners established by the Zone Medical Directorand or ZCD Zone Medical Administrative Committee to which members of the Zone Medical Staff are assigned. |
| Zone Clinical Department or ZCDH | The Practitioner who is the leader of a Zone Clinical Department.Head |
| Zone Clinical Department Chief | The Practitioner who is the leader of Zone Clinical Department members at aSite particular Facility or Site. |

| | |
|---|---|
| Zone Clinical Section | An organizational sub-unit of a Zone Clinical Department established by the Zone Medical Director and the Zone Medical Administrative Committee. |
| Zone Clinical Section | The Practitioner who is the leader of a Zone Clinical Section.Chief |
| Zone Medical Administrative Committee or ZMAC | A committee established as such pursuant to these Bylaws. |
| Zone Medical Staff | Collectively, all Practitioners who are assigned to Zone Clinical Departments within a particular Zone. |
| Zone Medical Staff Association or ZMSA | An association of the Zone Medical Staff. |

## APPENDIX C - FLOWCHART FOR A MEDICAL STAFF APPOINTMENT AND A GRANT OF CLINICAL PRIVILEGES

Is there an approved position in the Practitioner Workforce Plan and has theZone Clinical Department(s)identified a preferred/ selected candidate ? there an approved position in the Practitioner

NO

No application will be provided

NOTE: Streamlined process used for applicant to Community Staff &LocumTenens categories

Yes

Medical Staff Appointment & Clinical Privileges form provided by Medical Affairs Office to the applicant .

Form completed and all required information provided by the applicant including designation of :

- Zone(s) , Zone Clinical Department(s),Zone Clinical Section including thePrimary Zone Clinic Department
- Medical Staff category
- Clinical Privileges

Application not processed if an incomplete Applicationsubmitted

Applicant notified of unfavourable recommendation from PZCD and /or ZARC

Application reviewed by Primary Zone Clinical Department(PZCD) Head and Executive Committee and forwarded to the Zone Application Review Committee (ZARC ) with a recommendation

At PZCD level :

- Amendments to application-Resolution negotiated by applicant and PZCD . Result reviewed by ZARC
- Unfavourable recommendations of PZCD reviewed by ZARC

Application and the recommendation of the Primary Zone Clinical Departmentreviewed by Zone Application Review Committee

Zone Application Review Committee recommendation forwarded to ChiefMedical Officer ( CMO for decision

At ZARC level :

- Amended recommendation forwardedto CMO for decision
- Unfavourable recommends of ZARC may be appealed to Zone Medical Administrative Committee (ZMAC)

*Approval:*

1. Letter of Offer ( LoO) issued to applicant by Medical Affairs Office
2. Letter of Offer signed and returned by applicant
3. Appointment and Clinical Privileges activated on effective date(or later ) and only after completion of orientation :

*Denial*

Applicant notified by Medical Affairs Office of denial of a Medical Staff Appointment

At ZMAC level :

- ZMAC considers the appeal by the applicant
- Recommendation forwarded to CMO for

**APPENDIX D-FLOWCHART FOR A PERIODIC REVIEW**

Frequency of Periodic Review ( PR )

- Practitioner in Active Staff category -every 3 years (or more frequently as specified in (Letter of Offer )
- Locum Tenens – after first year and then every 3 years
- Practitioner having reached 65 years of age – annually

Sixty days' notice provided to Practitioner prior to PR

PR package prepared by Primary Zone Clinical Department ( ZCD)with input from other ZCDs and other AHS staff / leaders

Package provided for review by Practitioner and Zone Clinical Department Health ( ACDH ) or designate

PR meeting between ZCDH or designate and Practitioner held to discuss the Practitioner's professional performance, to identify goals, and to exchange information regarding health issues

If significant issue or concerns are identified :

PR Summary reviewed by Zone Medical Director for consideration of possible TriggeredInitial Assessment and/ or Triggered Review

Written PR Summary prepared which may include follow-upitems and written comments provided by Practitioner

Copy of Summary provided to Practitioner and placed in Practitioner's file

**APPENDIX E – FLOWCHART FOR A TRIGGERED INTITIAL ASSESSMENT, TRIGGERED REVIEW AND HEARING**

Triggered Initial Assessment (TIA) initiated by receipt of:
- a Concern from a Complainant or from AHS
- other information/complaints

⇩

Zone Medical Director (ZMD) or designate:
- shall conduct a TIA when in receipt of a Concern
- may conduct a TIA when in receipt of other information/complaints

⇩

Based on findings of the TIA, the ZMD or designate may:
- Dismiss the Concern
- Decide no further action required
- Refer the Concern to the appropriate body if it does not pertain to the expectations and responsibilities of the Practitioner's Appointment
- Request further investigation and/or refer it or a portion of it to an external reviewer
- Refer the Concern to an Associate Chief Medical Officer (CMO) if the Affected Practitioner is an AHS medical administrative leader
- Request that the Practitioner participate in Consensual Resolution
- Refer the matter directly to a Hearing
- Refer the Concern to the relevant College

⇨

At the conclusion of Consensual Resolution process between Affected Practitioner and relevant AHS medical administrative leader(s)
- Written report with findings and recommendation prepared
- Report submitted to ZMD who may accept it or request clarification
- Final report forwarded by ZMD to Affected Practitioner
- If Affected Practitioner accepts the report, its recommendations are implemented, and the report placed on the Affected Practitioner's file.
- If Affected Practitioner rejects the report, he/sheshall meet with ZMD. If no resolution after doing so, the matter shall be referred to a Hearing

⇩

Hearing Committee may dismiss the Concern orrecommend one or more of the following:
- No further action
- A caution or reprimand be issued and placed in the Affected Practitioner's file
- The Affected Practitioner undertake upgrading orfurther training and/or a period of clinical supervision
- The Affected Practitioner undertake treatment orremedial measures
- Temporary suspension or permanent change ofAffected Practitioner's Clinical Privileges
- Change in category of Affected Practitioner's Appointment
- Termination of Affected Practitioner's Appointment
- Other action or sanctions as appropriate
- Other recommendations

⇨

At the conclusion of a Hearing:
- Written report with findings andrecommendations prepared
- Report submitted to ZMD and shared withAffected Practitioner
- If the Affected Practitioner accepts the report, it issubmitted to the CMO for a final decision
- If the Affected Practitioner rejects the report, he/she may appeal to the Zone Medical Administrative Committee (ZMAC) if he/she contends that the findings were inconsistent withevidence, there were breaches of process, the Hearing Committee erred in law and/or there is new evidence

After receipt of the report andrecommendations of Hearing Committee and/or ZMAC, finaldecision rendered by CMO

**APPENDIX F – CREATION, MODIFICATION AND DISSOLUTION OF ZONE CLINICAL DEPARTMENTS ANDCLINICAL SECTIONS**

Changes to Zone Clinical Department and Clinical Section structure shall be made according to the followingprovisions:

a) The Zone Medical Director will periodically assess the Zone Clinical Department and Clinical Section structure to determine whether any change is required (creating, combining, or dissolving Zone ClinicalDepartments and/or Zone Clinical Sections) to improve Patient care and/or the efficiency of the Zone Medical Organizational Structure.

b) In addition,

i. one or more Zone Clinical departments may request that the Zone Medical Director considerchanges to the Zone Clinical Department and/or Clinical Section structure.

ii. a group of Practitioners who satisfy the criteria for Zone Clinical Department or Clinical Section designation, as set forth below, may request consideration of such designation by petitioning the Zone Medical Director and/or the Zone Medical Administrative Committee in writing and providing appropriate supporting documentation for such a designation.

c) In addition to the criteria and factors described in sections 2.6.1, 2.6.2 and 2.6.4 of the Bylaws, thefollowing factors shall be considered by the Zone Medical Director and the Zone Medical Administrative Committee in determining whether the creation of a Zone Clinical Department or Clinical Section warrants imposing the responsibilities and expectations of a Clinical Department orClinical Section (pursuant to the Bylaws and these Rules) upon the proposed members:

i. the number of Medical Staff who would be available and who are willing to be appointed to theproposed Zone Clinical Department or Clinical Section as determined by the Zone Medical Director; and

ii. the level of clinical service and activity that will be provided by the proposed Clinical Departmentor Clinical section

d) In addition to the criteria and factors described in sections 2.6.1, 2.6.2 and 2.6.4 of the Bylaws, the following factors shall be considered by the Zone Medical Director and the Zone Medical Administrative Committee in determining whether the dissolution or amalgamation of a Zone ClinicalDepartment(s) or Clinical Section(s) is warranted:

i. there is no longer an adequate number of Medical Staff in the Zone Clinical Department or Clinical Section to enable it to accomplish the functions set forth in the Bylaws and these Rules;

ii. there is insufficient clinical service and Patient activity to warrant the imposition of the responsibilities and expectations of a Zone Clinical Department or Clinical Section (pursuant to

the Bylaws and these Rules) upon the members of the Zone Clinical Department or ClinicalSection;

iii. the Zone Clinical Department or Clinical Section fails to fulfill all designated responsibilitiesand functions;

iv. no qualified individual is willing to serve as Zone Clinical Department Head or Clinical SectionChief; and/or Alberta Health Services Medical Staff Rules.

v. the Zone Clinical Department or Clinical Section fails to meet on at least a quarterly basis.

e) Prior to creating, modifying or dissolving a Zone Clinical Department or Clinical Section, the Zone Medical Director shall consult with all affected Practitioners and existing Zone Clinical DepartmentHeads and/or Zone Clinical Section Chiefs.

f) Changes to Zone Clinical Department and Clinical Section structure require the approval of the ZoneMedical Director and a majority of voting members present at a duly constituted meeting of the Zone Medical Administrative Committee.

**APPENDIX G – TERMS OF REFERENCE, PROVINCIAL CLINICAL DEPARTMENT, PUBLIC HEALTH (16AUGUST 2010)**

**ESTABLISHMENT OF THE DEPARTMENT**

The Alberta Health Services (AHS) Provincial Clinical Department, Public Health is established pursuant to section 2.11.3 B c) of these Rules.

**COMPOSITION OF THE DEPARTMENT**

The AHS Provincial Clinical Department, Public Health shall be composed of the AHS Senior Medical Officer of Health / Senior Medical Director, Population and Public Health, the AHS Dental Officer of Health, the AHS MedicalDirector Emergency/Disaster Management and all AHS Zone Medical Officers of Health.

**DUTIES AND RESPONSIBILITIES OF THE DEPARTMENT**

a) The AHS Provincial Clinical Department, Public Health shall generally fulfill the duties and responsibilities ofa (Zone) Clinical Department pursuant to the AHS Medical Staff Bylaws and Rules, with the modification/ exception of the following sections of the Bylaws:

- The responsibilities and duties of the Zone Medical Director as they relate to the AHS ProvincialClinical Department, Public Health shall be fulfilled by the Chief Medical Officer or an Associate Chief Medical Officer.
- The responsibilities and duties of the Zone Clinical Department Head as they relate to the AHSProvincial Clinical Department, Public Health, shall be fulfilled by the Senior Medical Officer ofHealth.
- The responsibilities and duties of the Facility or Community Medical Director and the Zone Clinical Section Chief as they relate to the Provincial Clinical Department, Public Health shall befulfilled by the Zone Lead Medical Officer of Health for each Zone.
- The responsibilities and duties of the Zone Medical Administrative Committee as they relate tothe AHS Provincial Clinical Department, Public Health shall be fulfilled by Provincial Practitioner Executive Committee.
- The responsibilities and duties of the Zone Application Review Committee as they relate to theAHS Provincial Clinical Department, Public Health shall be fulfilled by the Provincial PractitionerExecutive Committee.
- The Senior Medical Officer of Health and the members of the AHS Provincial Clinical Department,Public Health may consider membership in the Zone Medical Staff Association of the Zone in which he/she resides or, in the case of members, the Zone to which they are assigned as Zone Medical Officers of Health.

b) The AHS Provincial Clinical Department, Public Health shall be considered the Primary Zone Clinical Department for the Senior Medical Officer of Health, the Dental Officer of Health and all Zone Medical Officers of Health. Members of the AHS Provincial Clinical Department, Public Health who provide services toPatients unrelated to their responsibilities and duties as Senior or Zone Medical Officers of Health must hold a secondary Medical Staff Appointment(s) and Clinical Privileges in an appropriate Zone Clinical Department(s).

**DEVELOPMENT OF DEPARTMENTAL POLICIES AND PROCEDURES**

a) Departmental policies and procedures developed by the AHS Provincial Clinical Department, Public Healthshall be considered as Provincial Rules pursuant to section 1.5 of the Bylaws.

b) Only sections 1.5.1, 1.5.2, 1.5.3 and 1.5.5 of the Bylaws shall apply to the development and approval of departmental policies and procedures for the AHS Provincial Clinical Department, Public Health.

**PROVINCIAL CLINICAL DEPARTMENT EXECUTIVE COMMITTEE, PUBLIC HEALTH**

a) The AHS Provincial Clinical Department, Public Health shall establish a Department Executive Committee pursuant to section 2.6.7 of the Bylaws.

b) The AHS Provincial Clinical Department Executive Committee, Public Health shall be composed of the Senior Medical Officer of Health, who shall act as chair; the Dental Officer of Health, the Zone Lead MedicalOfficers of Health; and appropriate AHS medical and other administrative leaders relevant to the AHS Provincial Clinical Department, Public Health.

c) The purpose of the AHS Provincial Clinical Department Executive Committee shall be to assist the Senior Medical Officer of Health in fulfilling his/her responsibilities and duties as a (Zone) Clinical Department Head under the AHS Medical Staff Bylaws and Rules; to promote joint decision-making with AHS medical and otheradministrative leaders; and to coordinate the work of the AHS Provincial Clinical Department, Public Health within AHS.

**APPENDIX H – TERMS OF REFERENCE, PROVINCIAL CLINICAL DEPARTMENT, LABORATORY MEDICINE (31MAY 2018) ESTABLISHMENT OF THE DEPARTMENT**

The Alberta Health Services (AHS) Provincial Clinical Department, Laboratory Medicine is established pursuant to section 2.11.3 B (d) of these Rules.

**COMPOSITION OF THE DEPARTMENT**

The AHS Provincial Clinical Department, Laboratory Medicine shall be under the direction of the AHS whollyowned subsidiary Alberta Precision Laboratories (or any successor organization). It is composed of the ChiefMedical Laboratory Officer; North Sector Medical Director, Laboratory Medicine; a South Sector Medical Director, Laboratory Medicine; Regional and Urban Laboratory Medicine Site Chiefs, Provincial Program Medical/Scientific Directors, Clinical Laboratory Section Chiefs, as well as all laboratory physicians practicingwithin the department.

**DUTIES AND RESPONSIBILITIES OF THE DEPARTMENT**

a) The AHS Provincial Clinical Department, Laboratory Medicine shall generally fulfill the duties and responsibilities of a (Zone) Clinical Department pursuant to the AHS Medical Staff Bylaws and Rules, withthe modification/ exception of the following sections of the Bylaws:

- The responsibilities and duties of the Zone Medical Director as they relate to the AHS ProvincialClinical Department, Laboratory Medicine shall be fulfilled by the Alberta Precision LaboratoriesChief Medical Laboratory Officer.
- The responsibilities and duties of the Zone Clinical Department Head as they relate to the AHS Provincial Clinical Department, Laboratory Medicine, shall be fulfilled by either the North or SouthSector, Medical Director, Laboratory Medicine.
- The responsibilities and duties of the Facility or Community Medical Director as they relate to the Provincial Clinical Department, Laboratory Medicine shall be fulfilled by the Laboratory Site Chief.
- The responsibilities and duties of the Zone Clinical Section Chief as they relate to the ProvincialClinical Department, Laboratory Medicine shall be fulfilled by the North and South or ProvincialClinical Section Chief(s).
- The responsibilities and duties of the Zone Medical Administrative Committee as they relate to theAHS Provincial Clinical Department, Laboratory Medicine shall be fulfilled by Provincial Practitioner Executive Committee.
- The responsibilities and duties of the Zone Application Review Committee as they relate to theAHS Provincial Clinical Department, Laboratory Medicine shall be fulfilled by the Provincial Practitioner Executive Committee.
- The Chief Medical Laboratory Officer and the members of the AHS Provincial Clinical Department, Laboratory Medicine may consider membership in the Zone Medical Staff Association of the Zone in which he/she resides or does the majority of his/her clinical work. b) The AHS Provincial Clinical Department, Laboratory Medicine shall be considered the Primary Zone Clinical Department for all members of the Department. Members of the AHS Provincial Clinical Department, Laboratory

medicine who provide services to Patients unrelated to their responsibilities and duties as laboratory medicine physicians must hold a secondary Medical Staff Appointment(s) and ClinicalPrivileges in an appropriate Zone Clinical Department(s).

**DEVELOPMENT OF DEPARTMENTAL POLICIES AND PROCEDURES**

a) Departmental policies and procedures developed by the AHS Provincial Clinical Department, Laboratory Medicine shall be considered as Provincial Rules pursuant to section 1.5 of the Bylaws.

b) Only sections 1.5.1, 1.5.2, 1.5.3 and 1.5.5 of the Bylaws shall apply to the development and approval of departmental policies and procedures for the AHS Provincial Clinical Department, Laboratory Medicine.

**PROVINCIAL CLINICAL DEPARTMENT EXECUTIVE COMMITTEE, LABORATORY MEDICINE**

a) The AHS Provincial Clinical Department, Laboratory Medicine shall establish a Department Executive Committee pursuant to section 2.6.7 of the Bylaws.

b) The AHS Provincial Clinical Department Executive Committee, Laboratory Medicine shall be composedof the Chief Medical Laboratory Office, who shall act as chair; the North and South Sector Medical Directors, Regional Laboratory Medicine Site Chiefs; and other appropriate medical and other administrative leaders relevant to the AHS Provincial Clinical Department, Laboratory Medicine.

c) The purpose of the AHS Provincial Clinical Department Executive Committee shall be to assist the Sector Medical Director in fulfilling his/her responsibilities and duties as a (Zone) Clinical DepartmentHead under the AHS Medical Staff Bylaws and Rules; to promote joint decision-making with medical and other administrative leaders; and to coordinate the work of the AHS Provincial Clinical Department, Laboratory Medicine within Alberta.

**PROVINCIAL CLINICAL SECTIONS, LABORATORY MEDICINE**

The Provincial Clinical Department, Laboratory Medicine will have the following Clinical Sections. Eachsection may, for operational purposes, be subdivided into North and South Sector working sections.

a) Microbiology

b) Hematopathology

c) Chemistry

d) Transfusion Medicine

e) Anatomic Pathology

f) General Pathology

**PROVINCIAL CLINICAL PROGRAMS, LABORATORY MEDICINE**

The Provincial Clinical Department, Laboratory Medicine will have the following Clinical Programs. Each Program may, for operational purposes, be subdivided into sub-programs, for example by North and SouthSector. a) Public Health (Laboratory Medicine ) b) Genetics and Genomics ( Laboratory Medicine) ZONE

**MEDICAL ADMINISTRATIVE COMMITTEE PARTICIPATION**

Each Zone Medical Administrative Committee (ZMAC) will include key local Laboratory Medicine leadership representation in its membership. In Calgary and Edmonton, this will include the South and North Sector Medical Directors, Laboratory Medicine respectively. In other Zones this will include Regional Laboratory Medicine Site Chiefs; Zone Medical Staff Rules will reflect this minimum Laboratory Medicine representation.