Observer Policy with Medical Affairs – Credentials
Hamilton Health Sciences & St. Joseph's Healthcare Hamilton

A. PURPOSE:

To identify the process for providing Observers with educational opportunities to observe and gain insight into how healthcare is provided and/or how various hospital departments function.

To clarify the roles and responsibilities of the Observer while engaged in an observership at Hamilton Health Sciences and/or St. Joseph's Healthcare Hamilton.

To clarify the roles and responsibilities of the supervising Professional Staff (the "Sponsor") to ensure that Observers are provided with the appropriate supervision and are involved in activities that are appropriate to their role.

B. OBSERVERS:

Eligible applicants for an observership include:

- Canadian or International Medical Doctor
- International Medical Graduates (IMGs) who have been accepted to the McMaster University Post Graduate Medical Education Program
- International Medical Graduates (IMGs) who have completed the Medical Council of Canada QE1 examination (MCCQE1)

Ineligible applicants are as follows:

- All Medical Students (CA/US/International)
- All Medical Residents (CA/US/International)
- Undergraduate students or student learners

** Should be supported through McMaster University's electives program*

C. PROCEDURES:

All applicants requesting an observational experience must meet the requirements set out below and must be met with the approval of the Department Chief and Professional Staff Sponsor. It is the Observer's responsibility to secure a Sponsor for the term of their observership. Once a Professional Staff member agrees to be the designated Sponsor, he/she will advise the Observer to contact the Credentials Office to obtain the required paperwork.

All documentation related to the application must be completed by the Observer and submitted to the Credentials Office a minimum of two weeks in advance of the anticipated or requested start date.

Each applicant will submit the following documentation to request an observership:

- Observership Request Form (Appendix A)
- Statement of Agreement and Acknowledgement of Role & Responsibilities (Appendix B)
- Confidentiality Agreement (Appendix C)
- Completion of Preplacement Observation Health Forms (Appendix D)
- Copy of Curriculum Vitae
- Copy of Degree
- Passport Size Photo
- Payment of the Observer Application Fee (fees not applicable to Canadian bases actively practicing physicians)

D. DEFINITIONS:

"Observer" means an individual attending either Hospital for their specific purpose of gaining knowledge about the provision of healthcare and/or the practice of medicine in Canadian hospitals.

"Professional Staff" means a member of the Medical, Dental Midwifery or Extended Nursing Staff to whom hospital privileges have been granted.

"Sponsor" means the Professional Staff member who has taken on the responsibility of supervising an observer throughout the duration of their observership.

"Department Chief" means the medical leader of the department in which the observership is occurring.

E. Roles & Responsibilities of a Sponsor:

The Sponsor must provide adequate supervision and support to the Observer which includes:

- Ensuring the Observer is accompanied at all times
- Being able to explain the various procedures, processes or clinical interactions being observed and willing to answer any questions the Observer may have
- Being able to intervene and/or prevent the Observer from behaving in a way that is unsafe, inappropriate or in contravention of each hospitals respective policies, procedures or expectations.

If the Observer will be present during any contact with a patient, the Sponsor must introduce the Observer to the patient as a visiting Physician/IIMG (as appropriate) and explain the reason for their presence.

In accordance with Personal Health Information Protection Act, 2004, the Supervisor must obtain express consent from the patient, or the patient's substitute decision-maker where applicable, before permitting the Observer to observe patient care, or to have access to patient records. Consent can be oral, but must be recorded in the patient's medical record. Each patient is entitled to withhold or withdraw consent. A patient's decision to provide, withhold, or withdraw consent must not alter their patient's access to healthcare in any manner.

In addition to complying with this Policy, a Sponsor must comply with the applicable policies, guidelines and/or expectations of his/her regulatory College.

F. Roles & Responsibilities of an Observer:

An Observer is **not** permitted, in any circumstance, to provide or participate in patient care. Treatment of patients includes, but is not limited to:

- Taking medical history
- Conducting physician examinations
- Diagnosing or treating a patient's condition
- Ordering, preparing or administering drugs
- Documenting in patients' health records, either in electronic or hard copy format
- Having independent access to health records, either in electronic or hard copy format
- Performing or assisting in surgical procedures, or diagnostic patient interventions
- Obtaining consent
- Providing healthcare advice

When on hospital premises, an Observer must be accompanied by his/her Sponsor at all times. The Sponsor must be within proximity to monitor the Observer in order to intervene and/or prevent the Observer from behaving in a way that is unsafe, inappropriate or in contravention of each hospitals respective policies, procedures or expectations.

An Observer is **not** considered an employee of Hamilton Health Sciences or St. Joseph's Healthcare Hamilton and therefore is not:

- Entitled to salary, benefits, reimbursement of expenses or other forms of compensation
- Covered under the Workplace Safety and Insurance Board (WSIB)
- Covered under either organization's liability insurance
- Entitled to receive educational credit or certification from the organization for time spent observing
- Entitled to access Occupational Health Services

G. Refusal or Termination of Observership

Hamilton Health Sciences, St. Joseph's Healthcare Hamilton and/or the Sponsor may refuse or terminate an observership at any time at their sole discretion.

Concerns regarding the appropriateness of the Observer's conduct or behaviour will be addressed by the Sponsor, and if necessary, by the Sponsoring Department Chief.

H. Computer Access & Dictation

Observers are not permitted to have computer access at the Hospital as they are not permitted to participate in any direct patient care. Observers are also not permitted to dictate any patient records.

DEVELOPED BY:	Medical Affairs – Credentials
APPROVAL:	Joint Common Credentials Committee - HHS/SJHH Medical Advisory Committee – HHS Medical Advisory Committee - SJHH
DISTRIBUTION:	All Professional Staff, All Observers
REVIEW:	Annual
REVISED:	April 2017

Observership Criteria & Application Checklist

To determine if you are eligible to apply for an observership, please consult the following list of recognized applicants:

- ☑ Canadian or International Medical Doctor
- ☑ International Medical Graduates (IMGs) who have been accepted to the McMaster University Postgraduate Medical Education Program
- ☑ Internal Medical Graduates (IMGs) who have completed the Medical Council of Canada QE1 examination (MCCQE1)
- ☑ Other Healthcare Practitioners, which includes MD's from outside of Canada

Once you have been approved and accepted by a Sponsor, the following documentation must be completed and submitted to the Common Credentials Office a **minimum of two weeks** in advance of the anticipated/requested observership start date:

- ☑ Observership Request Form (Appendix A)
- ☑ Statement of Agreement and Acknowledgement of Role & Responsibilities (Appendix B)
- ☑ Confidentiality Agreement (Appendix C)
- ☑ Completion of Preplacement Observership Health Forms (Appendix D)
- ☑ Copy of Curriculum Vitae
- ☑ Copy of Degree
- ☑ Passport Size Photo
- ☑ Payment of the Observer Application Fee *(fees not applicable to Canadian based actively practicing physicians)*

As an observer, you will be responsible for the following:

- ☑ All financial cost incurred arising from your observation experience
- ☑ Accommodations during visit
- ☑ Health Insurance
- ☑ Liability Coverage

APPENDIX A

Observership Request Form

Contact Information:

Name of Observer: _____ _____
Last Name *First Name(s)*

Address: _____

City: _____ **Country**: _____ **Postal Code**: _____

Phone: _____ **Fax**: _____ **Email**: _____

Observership Information:

Visiting From: _____
(University/Hospital) *(Province/Country)*

Date (s) of Observership: _____ - _____
Start Date *End Date*

**Observership appointments are for a period of up to 4 weeks, renewable to a maximum of 12 weeks [3 months]*

Sponsoring Physician(s): _____

Department: _____ **Service:** _____
(if applicable)

Observership Location:
Please select the facility and/or facilities that apply to your request for observership:

- ☐ Hamilton Health Sciences: Site(s): _____
- ☐ St. Joseph's Healthcare Hamilton Site(s): _____

Briefly indicate the purpose of your visit and/or specific learning objectives:

_____

_____

_____

_____

Additional Requirements:

Please ensure the following documents are included with your observership application request:

- ☑ Copy of Curriculum Vitae
- ☑ Copy of Degree
- ☑ Passport Size Photo
- ☑ Receipt of Payment - Observer Application Fee *(fees not applicable to Canadian bases actively practicing physicians)*

APPENDIX B

Statement of Agreement and
Acknowledgement of Roles & Responsibilities

Prior to commencing an observership with Hamilton Health Sciences and/or St. Joseph's Healthcare Hamilton, you are required to sign this Agreement. This document outlines your roles and responsibilities during your observership experience and other important information you should know. By signing, you agree to the following:

1. This experience is strictly observational and you may not participate in patient care at any time.
2. Your observation experience cannot compromise the patient care and service objectives of Hamilton Health Sciences and/or St. Joseph's Healthcare Hamilton. Each patient has the right to refuse to be a participant in your observation experience and must be respected at all times.
3. You will act in accordance with the terms of the Observer Policy of Hamilton Health Sciences and St. Joseph's Healthcare Hamilton and abide by each hospital's respective rules and regulations.
4. It is a condition of your observership that you must provide Occupational Health and Safety Services with satisfactory documentation of 2-step TB testing and immunity of rubella, measles and chicken pox prior to your start date. Failure to provide such documentation will delay your start date.
5. You are responsible for the following:
    a. All financial cost incurred arising from your observership including, but not limited to, the cost of meals, uniforms, uniform laundering, accommodations, parking and transportation;
    b. Meeting the required standards and obtaining the necessary certifications, registrations and licenses applicable;
    c. Obtaining all authorizations required to participate in the observation experience in Canada in accordance with Canada's Immigration and Refugee Protection Act and its related regulations if applying from out of country.
6. You are not entitled to salary, benefits, or other forms of compensation during your observation experience.
7. Hamilton Health Sciences and St. Joseph's Healthcare Hamilton does not carry insurance that would provide you with coverage in the event of accidental injuries or damages. You are responsible for obtaining such coverage for yourself.

My signature below confirms that I have read and understand the roles and responsibilities aforementioned and will comply to the Terms of Agreement.

Signature of Observer: _____

Date: _____

APPENDIX C

Confidentiality Agreement

Please select the organization(s) of observership:

- ☐ Hamilton Health Sciences
- ☐ St. Joseph's Healthcare Hamilton

I, _____ hereby declare that I will abide by the policies, procedures and expectations of confidentiality in my interactions with people, materials, records, ideas, and discussions as outlined in the Hamilton Health Sciences/St. Joseph's Healthcare Hamilton Policy and Procedures regarding Confidentiality in the Workplace. I understand that as a learner participating in an observational experience, I am ethically bound to keep all information confidential and to treat patients and staff members with dignity, which includes treating their information with discretion and confidentiality. I understand that misuse, failure to safeguard, or the disclosure of confidential information without appropriate approvals may be cause for termination of observership or loss of affiliation with Hamilton Health Sciences and/or St. Joseph's Healthcare Hamilton.

My signature below confirms my commitment to uphold the expectations, policies and ethical practice of confidentiality in all of my involvement with Hamilton Health Sciences and/or St. Joseph's Healthcare Hamilton. This includes any information I may be privy to regarding patients, patient-related discussions, patient-related records, and/or plans for patient care.

Signature of Observer: _____

Signature of Witness: _____

Date: _____

APPENDIX E

Internal Hospital Approvals

Observer Information:

Name of Observer: _____ _____
Last Name *First Name(s)*

Date of Occupational Health Clearance: _____

Sponsor Approval:

I agree that it is safe and appropriate for the above individual to assume an Observer role and acknowledge my roles and responsibilities as Sponsor.

Sponsoring Physician(s): _____
Print Name

Signature of Approval: _____ _____
Date

Department Chief Approval:

Department Chief:_____
Print Name

Please select your recommendation for the requested observership below:

- ☐ **Approved**
- ☐ **Not Approved**

Signature of Approval: _____ _____
Department Chief *Date*

Signature of Approval: _____ _____
Head of Service (if applicable) *Date*

Term > 12 weeks: The Department Chief is asked to provide justification for requesting an observership term that exceeds 12 weeks and assurance that resource utilization by the Observer will not burden the Hospital(s).

Please provide your explanation below:

_____

_____

_____

_____

Appendix D

Observership Preplacement Health Form

Name: _ _____ **D.O.B.**_____/_____/_____
Please Print *First* *Last* *Day / Month / Year*

Address: _____

Profession: _____

Contact information: [phone # or e-mail]:_____

Indicate facility applying to: ☐ HAMILTON HEALTH SCIENCES ☐ ST. JOSEPH'S HEALTHCARE HAMILTON

The Communicable Disease Surveillance Protocols for Ontario Hospitals was developed by the Ontario Hospital Association and the Ontario Medical Association; approved by the Ministry of Health and Long Term Care and endorsed by the Canadian Medical Protective Association, pursuant to Regulation 965/90 Section 4 of the Public Hospitals Act, which requires known immune status on all health care workers. This includes physicians, dentists, midwives and special professional staff.

1. **MMR -- Measles, Mumps and Rubella Vaccination**

   If you have received 2 doses of MMR vaccine, given at least 4 weeks apart on or after your first birthday, provide proof, complete the dates below and move to step 5.
   Date MMR #1 _____
   Date MMR #2 _____

   If you have not had 2 documented MMR vaccinations, please complete sections 2, 3, and 4.

2. **Measles:**
   ☐ Laboratory evidence of measles immunity – Attach report (Requisition enclosed, if required)
   OR
   ☐ Documented evidence of immunization with 2 doses of measles virus vaccine on or after the first birthday
   Date/Name of vaccine #1 _____
   Date/Name of vaccine #2 _____

3. **Mumps: Evidence to Mumps immunity required:**
   ☐ Laboratory evidence of mumps immunity -- Attach report (Requisition enclosed, if required)
   OR
   ☐ Documentation of receipt of 2 doses of mumps vaccine (or trivalent measles-mumps-rubella (MMR) vaccine) given at least 4 weeks apart on or after the first birthday
   Date/Name of vaccine #1 _____
   Date/Name of vaccine #2 _____

4. **Rubella :**
   ☐ Laboratory evidence of rubella immunity -- Attach report (Requisition enclosed, if required)
   OR
   ☐ Documented evidence of immunization with rubella vaccine on or after your first birthday
   Date/Name of vaccine _____

5. Varicella :

☐ Laboratory evidence of varicella immunity-- Attach report (Requisition enclosed, if required)
OR
☐ Documentation of 2 doses of Varicella vaccine given at least 4 weeks apart:

(1) _____/_____/_____ (2) _____/_____/_____

6. Hepatitis B: Although not required, protection against Hepatitis B is strongly recommended and the vaccine is available free of charge through the Employee Health Offices.

Hepatitis B Immunization Series:
Dose #1 Date: _____
Dose #2 Date: _____
Dose #3 Date: _____

If you have post vaccination documentation of Hepatitis B antibodies greater than 10 IU/ml, you are immune.
☐ Laboratory proof of immunity hepatitis B antibody titre -- Attach report

If you do not have proof of immunity by serology, and wish to have antibody testing done, requisition enclosed. You will be notified if your serology does not demonstrate immunity
☐ Elected to have serological testing of immunity -- Requisition enclosed

☐ Not vaccinated against Hepatitis B

7. Tetanus Diphtheria Acellular Pertussis Vaccine(Tdap):
The pertussis immunization status for all Health Care Workers must be documented.

All adult healthcare workers, regardless of age, should receive a single dose of tetanus diphtheria acellular pertussis (Tdap), for pertussis protection if not previously received in adulthood (18 and over).The adult dose is in addition to the routine adolescent booster dose. The interval between the last tetanus diphtheria booster and the Tdap vaccine does not matter.

Please provide the date and name of any pertussis-containing vaccine received.
Date/Name of last Pertussis vaccine _____

Routine vaccination with Tetanus and Diphtheria is recommended at 10 year intervals.
Tetanus and Diphtheria Vaccination:
Date of last Td booster _____

If acceptable history or documented immunity to measles, rubella, mumps, pertussis, hepatitis B or varicella is not provided, appropriate immunization should take place and is available free of charge at Employee Health Offices at Juravinski, McMaster, General, Charlton and West 5th Campuses.

Vaccinations and TB skin tests must not be given by you and must be administered and recorded by another qualified health professional.

I am having blood drawn for:	AT:
☐ Measles ☐ Rubella ☐ Varicella ☐ Hepatitis B ☐ Mumps	☐ Hamilton Health Sciences ***OR*** ☐ St. Joseph's Healthcare Hamilton

Employee Health Offices are open Monday to Friday 0800 to 1600

If you have any questions please contact one of the following Employee Health Offices:

Hamilton Health Sciences:	(905) 521-2100
General Site	ext. 46307
Juravinski Site	ext. 42314
McMaster Site	ext. 75573
St. Joseph's Healthcare Hamilton:	(905) 522-1155
Charlton Campus	ext. 33344
West 5th Campus	ext. 36361

8. Tuberculosis Screening

If tuberculin status is negative, documentation of a two-step TB skin test is required.
Complete one of the following options A,B or C.
Pregnancy is not a contraindication to tuberculin skin testing.

Option A ☐ Provide documentation of a previous two-step TB skin test -- if the second step is within the last 12 months no additional testing is required

Option B ☐ Provide documentation of a previous two-step TB skin test – if the second step is dated longer than 1 year ago —an additional single step TB skin test is required

Single Step TB Skin Test	Date Given	Date Read	Induration /mm	Interpretation	Health Care Providers Signature
Step 1					

Option C ☐ Completion of a 2 step TB skin test

2 Step TB Skin Test	Date Given	Date Read	Induration /mm	Interpretation	Health Care Providers Signature
Step 1					
Step 2					

Tuberculin Skin Test Positive:

Complete the following if you have a documented history of a positive TB skin test and provide a copy of the chest x-ray.

Positive TB Skin Test	Date Given	Date Read	Induration /mm	Chest X-ray Date	Chest X-ray Result

☐ Chest x-ray attached

BCG Status:
☐ Never immunized
☐ Immunized -- Date: _____

☐ Previously treated for Latent or Active TB
Treatment provided and dates: _____

NOTE:
A determination regarding your exposure risk to tuberculosis and further testing will be dependant on the areas that you work in and the type of activities you perform.
Tuberculin Skin Testing (TST) within 6 months or annually may be requested.
Example: Respirologists performing bronchoscopy -- (high risk activity) TST every 6 months
Emergency Room Physician -- (moderate risk activity) TST annually
Family Physician/Midwife -- (generally low risk activity) post exposure TST (Contact tracing)

To the best of my knowledge the preceding information is true and correct.

Print Name: _____

Signature: _____ **Date:** _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
Between
Hamilton Health Sciences and St. Joseph's Healthcare Hamilton

I, _____ authorize **Employee Health Offices of Hamilton Health Sciences and St. Joseph's Healthcare Hamilton to release and share the following:**

- Copy of the completed Pre-placement/Observation/Pre-appointment Health Form for Professional Staff and relevant chest x-ray and/or lab results

I understand this information will become part of my confidential health file.

Date: _____ Signature: _____

Date: _____ Witness Signature: _____