

## Executive Summary NHS Facilitation Report

Feb 1, 2009

*Dr. Chris Carruthers*

As a facilitator I was asked to identify ways and means to improve relationships between the medical staff, the board and hospital leadership.

I conducted several interviews with physicians, hospital leaders, and board members. Also I conducted an online survey of physicians. There is a high level of frustration within the medical staff which has been increasing over the last several months, culminating with the creation and approval of the Hospital Implementation Plan (HIP).

However, the breakdown of a positive relationship between the different groups is due to actions or inactions of all groups. As indicated by the survey and my interviews, there is a strong number of physicians who are anxious to move ahead in a collaborative approach in order to provide the best of care to their patients. The board and the hospital leadership are to be recognized for their leadership in the creation of the HIP.

### Summary of recommendations :

1. **Medical Bylaws-** Immediately update the bylaws to reflect the new environment. Ensure that the existing bylaws are followed appropriately. Key issues to be addressed are; length of terms of Senior Responsible Physician leaders, selection process of Chiefs including Acting Chiefs, mandatory attendance at NHS department / division meetings.
2. **Communication-** Address ways and means of improving transparent communication with the medical staff. This will be part of addressing the trust and transparency concerns.
3. **HIP-** Move forward with a collaborative, transparent organizational structure to implement the plan.
4. **Medical Staff Association-** The role of the MSA needs to be reviewed. Of particular importance is identifying MSA leadership candidates to ensure these roles are filled at all times by interested and qualified candidates.

5. **Dissent-** Address the issue of on-going public dissent by physicians which may affect the quality of patient care. This is particularly when the hospital collectively has made a decision to move in a direction but there is still a minority who continue to aggressively oppose this decision.
6. **Site Implementation and Leadership Committee-** Review the necessity of these committees. This is within a review of the need for site committees and site positions both medical and administrative, when the ideal structure is NHS positions and only a site day to day operational committee.
7. **Standardization of Care-** Increase the use of care pathways and standard equipment and implants for all sites.
8. **Quality of Care-** Review of quality of care should be part of the regular NHS department and division meetings.
9. **Physician Human Resources-** Create a plan for physician recruitment, retention, and recognition. This would include a physician management skills educational program.

## NHS Facilitation Report by Dr. Chris Carruthers

Feb 1 , 2009

Dr. Carruthers was engaged by the board of the NHS. The terms of reference are:

*Dr. Carruthers is being engaged as a facilitator **by the Board of Trustees** to understand the reasons for this non confidence motion, to identify concerns of the medical staff and provide recommended actions to be implemented both in the short term and the long term.*

*Dr. Carruthers, will through consultation and his recommendations , try to improve relations between the medical staff and the hospital leadership. Consultation would include within the NHS and outside as appropriate ( e.g OHA and OMA), review of information e.g bylaws and other material .*

*The leadership includes the CEO, Chief of Staff and the hospital board. It is recognized that this report, addressing leadership issues, will concentrate on relations between the medical staff and The Chief of Staff.*

*Dr Carruthers report will outline the environment past and present, and include suggested solutions, and will comment on the leadership challenges going forward.*

The process consisted of meeting with many physicians both individually and in groups. Also members of the senior management team including the CEO, COO, Vice Presidents and Chief of Staff were interviewed. Virtually any physician or others who wished to talk to me I tried to accommodate. Though by far not an exact account more than 35 interviews were carried out. A meeting with the MAC was held. Site meetings with physicians at one time or another were held at Welland, Niagara, and Fort Erie. Regular discussions were held with Dr. Ken Reddy and Dr. Peter Willard key MSA members.

A comprehensive survey was also conducted. Though the returns could have been better there were several obstacles. The prime communication obstacle is the hospital does not have a list of the physicians' email addresses. Today a critical communication medium is email. However, the survey did provide a lot of information particularly from the individual written answers. There was not a significant difference between the issues discussed at the interviews and the survey results.

The report is structured with first an outline on the key areas of interest. The survey results are then included. Finally, a list of recommendations are submitted with the responsible leadership.

**A. Hospital Improvement Plan (HIP)** The announcement of the plan was effectively the lightning rod that triggered the push back by physicians. Discontent amongst some physicians had existed prior to the HIP. It has been suggested that the vote of non confidence was an attempt to further the hope to have the new hospital moved to a more central location. However, the motion to move the hospital was virtually a draw yet the motion of non confidence was passed by a significant majority of those who attended. There were many physicians e.g consulting staff , who attended this meeting wanting to vote but were unable to do so as according to the bylaws only active physicians can vote and these physicians were not active attending. Clarity and communication on MSA voting rights is necessary .

The HIP plan was created by the NHS in a very short time period, the time line mandated by the LHIN. A short time period left little time for broad consultation and there is a price to pay for limited consultation. However, many components of the HIP had been proposed in the past so the HIP suggestions should not have been a surprise to many. However, that fact that these consolidation suggestions may actually be implemented probably stirred those who were opposed to some or all consolidation.

However, though time was limited for consultation those designing the plan were often instructed not to consult with key physicians i.e the department or division front line physicians. This lack of transparency and perceived secretive back room decisions has in itself upset many physicians. With the

political environment in Niagara being somewhat unique and volatile the secrecy approach can be understood, but again there is a price on the other side for this approach.

It is important, despite some process issues, that the board, administration leadership and physician leaders have forged ahead despite significant opposition to develop the HIP. This has not been easy and they are to be congratulated.

Now that the LHIN has approved the plan, the future planning particularly the planning structure, should be done in a very transparent and open approach as possible.

The implementation of the HIP will significantly affect how some physicians practice. This may well affect their incomes in the short term and their site of practice including their office location in the future. This must be recognized and addressed as best as possible. However, this inevitable change must also be accepted by physicians and they must be leading participants in the development of the implementation plan.

## **B. Medical Bylaws**

A key issue, and the issue most often discussed, was related to the medical bylaws. Particularly, failure of medical leadership to follow the bylaws.

These bylaws are the bylaws passed at the amalgamation of the hospitals to form the NHS.

Bylaws, with their rules and regulations, outline on how the Board, administration, and the physicians interact. These are the “*rules of the game*”. If the bylaws are not up to date to address the new environment or not followed, leading to an ad hoc approach, this situation can create suspect and distrust amongst the medical staff.

Overall the original bylaws are thorough, however there are gaps. Bylaws are a living document which must be changed to respond to a rapidly changing health care environment.

The bylaws are created by consultation with the medical staff, recommended by the Medical Advisory committee, and finally approved by the Board. A key aspect of the bylaws is outlining how the physician leadership is selected. Physician leaders are critical as they interact with the physicians, administration and the Board. Physician leaders are ultimately chosen by the Board.

1. The medical bylaws have not been revised since the merger. There were attempts initiated to revise the bylaws but these endeavors were not completed. In January 2007 the Medical Staff Association asked that the bylaws be reviewed and changes brought forward by October 2007. They repeated their request in June 2007. As of today there is a strong necessity to revise the bylaws but the revision process has not started. The first step in the process is establishing a medical bylaws committee of the MAC. Membership would include physicians and administration. This delay has led to a lack of bylaws to address critical issues within the NHS. It has also led to an ad hoc interpretation of the bylaws and these changes are not officially approved by the board ( e.g appointment of acting heads). Another key point is the length of term of physician leaders. The bylaws state the terms should be maximum of two 3 year terms. Effective January 2009, 5 leadership position's terms expire and there has not been any action to address this issue. The assumption is that they will continue in their positions, while the bylaws state their terms have expired. The MAC physicians have taken on challenging leadership positions . As a transition I would suggest the board extend these positions, which technically have expired, another year until the issue of length of terms and the evaluation process is addressed by a change in the bylaws.
2. The present bylaws are not being followed as intended. This is for two reasons. Convenience and ambiguity of existing bylaws.
  - a. *“ The board shall appoint as Senior Responsible Physician of each Program, Service, Division or Department, a physician who is on the Active Staff or eligible for appointment to the Active Staff, after considering the recommendations of a Selection Committee, which shall*

*have given consideration to the recommendations of the MAC*” . It appears department chiefs are appointed following

the structured search committee indicated by the bylaws. It appears this search process is not the case with site chiefs, program heads, and division chiefs. Presently the division chiefs are appointed by the department chief. This situation can create issues as physicians better support medical leaders when they have had input into the selection of their leadership. However, medical leadership, in these situations, is not by popular vote. If the leadership is appointed by one person, either the department chief or Chief of Staff, some physicians can resent the appointment and particularly if the selection was not followed by due process. This resentment can occur even if the appointed candidate is the best available.

b. *Senior Responsible Physicians “subject to annual renewal of appointment by the board, The appointment of a Senior Responsible Physician shall for a term of three (3)years or until a successor is appointed”* I believe documented structured annual evaluation is not performed. There is not a written process for evaluation at the end of 3 years to recommend reappointment. There should be a documented process for review of the incumbent at the end of three years including consultation with the members of the department and division. This also could include an outside review of the department. There should be a letter of understanding with the chief going forward as to the expectations during their next term. There also should be a documented annual evaluation of the performance of each physician leader particularly those receiving a stipend from the hospital for their duties.

c. Acting Head Selection Process

The process for selection of an acting chief is not addressed in the bylaws. There should be a time limit on the acting position

e.g one year. This gives an opportunity to review, at the end of a year , if it is appropriate to continue with an acting chief . Their acting appointment should be approved by the Board. One issue within this area is that The Chief of Staff has been the acting Chief of Psychiatry for a few years which has caused discontent within the department. The psychiatry chief search committee is not active.

A process that appears to be appropriate due to the times can be misinterpreted. Presently the Chief of Staff nominates Acting Department or Site Chiefs. Often the selection committee is not operational for several months ( eg, Acting Chief of Surgery appointed May 2008 the search committee is not yet established) . As such the Acting Chief becomes de facto the permanent chief . An acting chief in place for sometime has a distinct advantage when they apply for the permanent position relative to other potential candidates. At the time of the selection committee's request for candidate applications other members will not likely step forward if the Acting Chief has been in place for a long period of time. As such the Acting Chief, selected by the Chief of Staff, becomes the permanent Chief . Though most often the acting chief is the best candidate, this process can be seen as not inclusive by the members of the department. It can be seen by them that decisions were made in the 'back room' and did not include the front line physicians. It also can be interpreted that those appointed reflect the thinking of the existing hospital leadership and may not be willing to speak up publicly if they disagreed with administration on a particular issue. Also, they may not speak up on other controversial issues important to the department members.

The ideal process is for an Acting Chief to be appointed for a short period while the search committee is immediately established. Often the Acting Chief , where possible, is not a candidate for the full time position. The Acting Chief should

be recommended by the Chief of Staff in consultation with department members. A decision may well be then made by the established selection committee to just entertain internal candidates if satisfactory internal candidates can be identified, or in addition look external for candidates. As it can take up to a year to recruit a physician from outside of the hospital the formal search committee should be struck quickly and begin its deliberations.

There is a real perception in all hospitals that those holding an Acting position do not have a mandate to introduce significant changes. This is directly related to the title "Acting". As such time is of the essence.

I realize this is an ideal process and a challenge in smaller departments and divisions, but it is an ideal process that NHS should try to achieve.

3. SILC- Site Implementation and Leadership Committees. These committees as functioning are not recognized in the bylaws. Membership can include all physicians at the site or just a selected number. When it does not include all of the physicians how are those who sit on the committee selected? A committee may well be necessary to address only site operational issues. However, without standard and appropriate terms of reference the SILCs have the high risk of continuing to promote site issues within the NHS exclusively and not assume interest or responsibilities for issues at other sites.
  
4. *"The Medical Staff/Dental Staff of each Department, Division, Services or Program shall meet at least 4 times per year"*. Though many if not most departments/divisions meet regularly it appears some have not met at all since the merger. Some physicians routinely attend few meetings and in some departments / divisions, though the meetings are held some members virtually never attend. Members are expected to attend 50% of these meetings. Minutes with attendance are to be kept

and a copy to be forwarded to the MAC. Site meetings of specialists do meet but NHS department or division meetings are not consistent. Regular meetings with consistent attendance is important.

5. *Reappointment process-* The annual reappointment process is inconsistent and needs to be better implemented and structured. Physician reappointments continue into June with MAC approving them including late submitted reappointments. Almost all other Ontario hospitals have a rigid reappointment schedule with their annual appointments lasting from April 1 to March 31. Physicians must have their application and documents submitted in time for approval by the end of March. Though the present NHS system functions within the Public Hospital Act the prolonged paper work and acceptance of late applications leads to an inefficient and time consuming process. Most important is that there is probably not consistency of evaluation and approval of the physicians reappointment by their department or division chiefs. The process today is a very inefficient . This inconsistent and inefficient process can lead to missing the key issue at reappointment—*how competent is this physician who is asking for reappointment ?*

Department chiefs do not meet with each of their members annually nor perform as stated in the bylaws the 5 yr more in depth review of the physician, I don't believe this has been done at all since the merger.

An improved process will allow better communication between chiefs and their members and also allow the chief to discuss the expectation for the department/division member for the next year.

6. *Age of retirement-* Bylaw 8-4 page 10 states *Any members of the Medical Staff/Dental Staff 65 years of age or older who applies for reappointment to the Medical Staff/Dental Staff shall be required to undergo an enhanced peer review, as more fully described in the Rules and Regulations . Such enhanced peer review shall, without limitation, be performance-based and shall include an evaluation of the role played by the applicant in the context of the*

*Corporation's requirements and Human Resources Plan.* This bylaw in principle is very good. However, it has not been implemented over the past years and now violates Ontario laws as it discriminates against those over the age of 65. The bylaws are out of date with regards to age of retirement legislation. The removal of mandatory age of retirement in Ontario has existed since December 2006. This makes it necessary for the medical bylaws to be changed to ensure older physicians and surgeons continue to be capable practitioners. This also applies to younger physicians who may demonstrate potential difficulties. Physician competency is a major responsibility for the MAC and Board through the Chief of Staff.

It is important for physicians to provide substantial notice of their retirement plans. Recruiting new physicians can take months and even a year or two. As such physicians nearing an anticipated retirement age should be asked to disclose their plans so that the hospital can plan ahead.

If this process is improved physicians within each department will have a better idea of future recruits and particularly recruiting a physician with skills not presently available in the department.

**C. Lack of Communication-** This is a serious issue. There is a strong feeling of lack of transparency and secretive activities by the hospital leadership. This feeling is reinforced by comments such as this in the MAC minutes Sept 20, 2007 "not appropriate to widely distribute the minutes". There was a regular communication with the medical staff on MAC activities for sometime in the past, but this has not been sent out for the last four months.

However, for efficient communication the administration needs the email addresses of the physicians. Many physicians have been reluctant to provide their email address to the hospital. This medium of communication is very important. Today, in my opinion, your email address is similar to your office address. In the past you could not apply for appointment or reappointment without providing your office address and today mandatory provision of an email address should be enforced. Administration cannot be expected to mail a hard copy of every communication to each physician. Mailing is inefficient, not timely, and expensive.

Communication plans must also include informing family physicians in the Niagara area, without hospital privileges, of the hospital's activities.

The Board of the hospital must create an appropriate communication plan with their physicians and others. Those developing the plan would include the Board, CEO, COS and physician MSA and MAC members. However, it should be noted that the Board's role is more than just delegating this responsibility to administration but includes appropriate evaluation as to the communication plan's effectiveness.

**D. Quality of Care and the Board-** Physicians sitting on the Board in the past express frustration that the Board, up to now, has spent little time discussing patient quality and safety issues. Recognizing this is being addressed, an acceptable standard for boards is to spend 25-50% of their time discussing quality issues. An active quality committee of the board is imperative. A review of quality initiatives and minutes of the Quality Council and Quality Committee of the board does indicate the hospital is well along the road of establishing a good quality program.

**E. Medical Staff Association (MSA) -** Unfortunately the MSA is dysfunctional. At present there are no identified candidates for the position of MSA President and Vice President. There are two MSA Board positions that are now vacant. These positions are important for providing an opportunity for physician issues to be heard at the Board and for communication. Similarly these MSA leadership positions sit on the MAC to allow input. With these vacancies, physicians concerns, particularly related to patient care, may not be provided the opportunity or a forum to be heard. These vacancies are an issue for the Board and medical staff to address as soon as possible. (*It is noted that these MSA positions have just recently been filled*)

Most of these MSA positions were unfilled when the proposed HIP development process was presented to the MAC in June (*Though the President position was filled the vice-president position was vacant and had been for sometime*). This was an opportunity for the physicians to ask questions about the process. A review of the MAC minutes indicates no questions on the process were asked or recorded. The physicians failed to use this opportunity. In essence they were given an opportunity to ask questions and provide input on the HIP development process but did not take

advantage of the opportunity by deciding not to have members at the MAC table.

Medical staff associations in all hospitals are struggling to identify their role today. I would suggest that a mini retreat be held with the medical staff leadership, key board members, and administration to identify the issues around MSA function and to mutually agree on its role into the future. A key outcome will be the identification of physician MSA leadership candidates and to provide them with the appropriate support and mentorship. Several physicians in their survey response did say they would be willing to consider to stand for a MSA position. As such potential physician leaders do exist at NHS.

Physician leadership roles are an added burden to physicians existing clinical responsibilities. Department members must be supportive of their leaders and this includes accommodating changes in their clinical responsibilities to better perform their leadership duties.

Those physicians who have today and in the past assumed MSA and medical staff leadership positions are to be recognized, congratulated, and thanked for their efforts to support the MSA and the hospital. Many physicians complain but few step up to help resolve these issues. By far most physician leaders step forward in a true belief that they want to make the NHS a better hospital. There is a sacrifice to assume these positions, yet to have personal gratification when they see they can make a difference is a key benefit from these roles.

**F. Trust and Transparency-** The lack of trust is another significant issue in the minds of the physicians. In the past there have been attempts to consolidate services. These processes included a lot of time involvement by physicians and administration in the development of the plans. In the end the plans were put aside. The reasons for this inaction was often outside the control of the Board and administration. However, these past failures have lead to a feeling by physicians of limited future success of any initiatives which includes physicians in their development. Also it is often felt decisions have already been made and the collaborative engaging process is charade. As such physicians withdraw from participation.

This lack of transparency also relates to decisions by administration to not disclose to physicians or others several previous consultation reports or reviews. Some physicians expressed frustration in the number of independent consultations engaged by NHS over the last several years, including my engagement, without disclosure of the reports and little action taken as recommended in these reports. It would appear that a policy on disclosure of such consultation reports and other information would be appropriate.

It should be noted that not all consultant's recommendations were supported by the physicians. However, there is also an identified problem that there is a reluctance to move ahead on appropriate recommendations if a small number of physicians object. The status quo then remains which is unsatisfactory. There is no doubt that some difficult decisions need to be made that may well be disruptive to physician's practice plans but are in the best interest of patient care. However, key beneficial recommendations need to be implemented.

A key aspect to improve trust and transparency is meeting with key stakeholders. Recognized as difficult because of several sites and the distances between them, it is important that senior administration including CEO and COS, reach out and meet face to face with more stakeholders including physicians at the different sites on a regular basis.

Technology, that includes videoconferencing, should be used to improve access to meetings with the senior leadership. The CEO and COS could consider the use of a blog.

Similarly town forums at the different sites are imperative.

**G. Site vs NHS approach** – There are still many medical leadership activities and positions that are site specific when in reality they should be NHS specific. Physician recruitment should be to the department within the NHS with specific assignment or access to resources at one site. Physicians when given an appointment to the NHS includes an appointment to all of its sites, Resource allocation or privileges can be site specific e.g operating room time. However, physicians being recruited should realize their obligations are to the department first and then the site. The medical organization structure should be reviewed to minimize the need for site specific positions with site specific activities and maximize duties

and accountabilities of the medical leadership positions to the NHS with each site member accountable for the NHS responsibilities. Medical site issues should be owned by the NHS department and not exclusively the individual sites. However, it should be recognized, due to the many sites and distances between them, the NHS medical structure will be more extensive than other hospitals. There will maybe associated increased stipend costs ( more time needed for the position) and secretarial support costs due to this more extensive organizational structure.

The organizational structure rule “*form follows function*” should be kept in mind as the medical organizational structure is evaluated. A similar review should be carried out by administration on their structure .

Because many decisions are site based it can lead to inconsistency of approaches to addressing issues across the system e.g Welland site pays for a family doctor to be on call as a surgical assistant but St Catherines site does not. There needs to be more consistency across the hospital in addressing these and similar issues.

Other steps that should be taken to create one hospital vs several sites (which are perceived by many as individual hospitals)

- a. Review the organizational structure both administrative and medical to minimize the number of purely site responsible positions.
- b. If possible re-title position names to minimize the use of site and identify the positions as a NHS position.
- c. Minimize the number of site meetings and their agenda . These meetings should only address site specific day to day operational issues .
- d. Medical departments and divisions should meet regularly and address site issue collectively. This includes operational issues and medical coverage issues. Operational site issues may well be resolved with support from the other sites, and medical coverage issues similarly resolved by support by the physicians at other sites. All members of the department or division must take ownership of these issues. These meetings could be

associated with a program meeting to minimize the number of meetings .

- e. Meetings e.g Board, senior management, medical administration, department, and divisions should be held where possible at different sites throughout the year . A rotational schedule could be established.
- f. Recognize all patient care equipment belongs to the hospital and not the site and move the equipment as needed (presently it appears good equipment lies unused at one site though badly needed at other sites). There is a feeling by some the site owns the equipment and it cannot be moved. This is directly related to fundraising continuing to be for a specific site and not hospital wide.. The lack of adequate equipment is a key physician concern. Duplicating equipment purchases because idle equipment at one site cannot be moved to another is inappropriate. *This issue must be addressed*

**H. Standardization of Care-** Standardized care pathways are important. Improved quality of patient care and economies of scale can be achieved. Cancer Care Ontario (CCO) is already a prime mover in this direction. CCO is directing standard of care throughout the LHINs . NHS in many areas does not have standards across all sites. I would suggest that steps are taken to identify the top 4-5 areas which should be addressed. This would include the same care pathway at all sites. When the pathway for example includes implants e.g orthopaedics total joints, than steps should be made to standardize the implants across NHS. There are significant savings to be achieved by standard purchase of implants etc. Though it can be a challenge, the creation of standard pathways is another means of physicians from all sites working together to improve patient care. The process in itself will improve a collaborative environment within NHS and common clinical pathways will facilitate the movement of health professionals between the sites.

**I. Vice President of Medical Affairs / Chief of Staff** – Successful hospitals need to have a strong supportive relationship between the office of the Chief Executive Officer and the Chief of Staff. Physician leaders may assume responsibilities in two areas. First is being accountable for the

quality of physician care under the Public Hospital Act. For this responsibility they report to the Board through the Chief of Staff. Physician leaders may also assume operational responsibilities as a program chief . For these accountabilities they would report to the CEO. In larger hospitals program chiefs report often to a VP Medical Affairs who reports to the CEO. Most smaller hospitals do not have a Vice President of Medical Affairs or a full time Chief of Staff. NHS has a full time Chief of Staff . It is my understanding in the NHS situation the COS is assuming some operational reporting responsibilities in addition to the role of responsibility for physician quality of care. For physician quality of care he would report directly to the board but for operational issues program chiefs may report to him and he would report to the CEO. It appears the position description of the office of Chief of Staff does not adequately address these dual lines of accountability. If the present position is full time than some component of its activities could be within a VP medical affairs position and accountable through the CEO for the operational issues . This needs to be better defined in the position description.

This uncertainty also leads to the physicians not understanding how or who makes certain decisions. The unknown was reflected in the survey (question 18) . It also leads to uncertainty of the roles and accountabilities of physicians who assumes both a program chief and department chief position. This lack of understanding has lead to frustration for physicians at the front line who do not know which avenues to follow to help resolve their clinical problems or challenges.

The reporting relationships of program chiefs needs to be defined and the role of the office of Chief of Staff in operational responsibilities and accountabilities, if any, needs to be clearly defined.

#### **J. Physicians relationship with Senior Management Administration**

Physicians feel a lack of contact or interaction with senior management including the CEO. A barrier here is the location of the corporate offices outside of an active care in patient site. This lack of contact may be as simple as lack of attendance by Senior management at important meetings of physicians, to a direct lack of input into decision making by physicians. An example of the latter is the role of the physician program head. Many hospitals will include the physician program heads at the senior management table. This allows them to contribute to the decisions that will affect their program. The reporting relationships of program heads at NHS as stated before is not well defined. There needs to be a better defined accountability

structure for physician program heads dealing with operational issues which includes them sitting at a senior management decision making table.

The operational deficit can only be successfully addressed with the co-operation of administration, the physicians, and others. Ownership of this challenge belongs to all who work at the hospital. As such all must work together to resolve the financial challenges. However, the structures to achieve this collaboration must be in place.

There is also a strong feeling amongst physicians that if there are definitive steps or cut backs to be implemented to address the on going hospital financial deficit a review must also include the administrative operational structure to identify potential savings here. This may well be the review of the administrative layers of decision making .

A review of administrative structures must support and improve relationships between nursing and the physicians.

### **K. Chief Executive Officer and Chief of Staff**

Physicians and others reported that felt the relationship between these two positions was not ideal. This may well be directly related to not a full understanding of the apparent dual responsibilities and accountability expectations of the role of Chief of Staff ( and VP medical affairs similar duties) . Successful hospitals must have the CEO and COS working closely together to achieve the vision of the hospital. There must be active steps to improve the working relationship and the first step would be a better definition of the expectations of the office of the Chief of Staff regarding operational accountabilities.

### **L. Management of Dissent**

The hospital has to improve their culture and expectations in management of dissent amongst physicians. Firstly, there must be appropriate avenues for physicians to express concerns over proposed management decisions. Any significant decision needs to be fully addressed, including the positives and negatives. Many initiatives in the Ontario hospital environment have failed as they were not adequately challenged at the beginning. Inclusiveness and an opportunity to speak are very important. Presently, some of these avenues

are closed leading to physician frustration e.g lack of MSA representation on the Board or MAC, and the lack of an adequate medical and administrative organizational structure to allow physician input.

However, once these avenues are available to challenge and fully discuss proposals, the issue of prolonged disruptive dissent needs to be addressed. Once a board or hospital administration has made a decision, a decision that may well not be the one a minority of physicians support, the hospital must move on. For physicians to continue to attack publicly these decisions, including the involvement of the press and politicians in their cause, in my opinion is potentially disruptive. This is of concern when steps to improved the quality of patient care are impeded by continuing disruptive actions.

The NHS physician code of conduct policy, which has been in development for sometime, needs to be completed and accepted by each member of the medical staff at time of appointment or reappointment.

### **M. Physician Quality of Care**

The competency of physicians is becoming more and more a direct MAC and Board responsibility. There is concern of a lack of timely physician quality of care reviews. The lack of implementation of a proactive process to deal with the older physician or the younger one with potential skills deficit increases risk to the public. The public today are expecting more aggressive and timely action by the hospital in dealing with physician quality of care issues. Some physicians expressed concern on how potential physician quality of care issues were being handled, particularly not in a timely manner. This is a challenge for all hospitals and as several reports have stated (Windsor and Miramichi) immediate action is more appropriate than the historical bureaucratic approach when dealing with physician quality of care issues. I have concerns that NHS is still addressing these issues in the historical approach. Not addressing these issues aggressively also risks the successful creation of a cohesive medical department or division. However, I have not fully explored any specific case.

### **N. Fundraising**

It is important that issues relating to physicians are resolved and that physicians take an active part in the necessary and virtually mandatory

fundraising that needs to be done. Additional equipment is one of the prime fundraising causes. It is my understanding that only about 20 % of the annual requests for new capital equipment are funded. A complicating fact is that requests are often duplicated because services are not consolidated. Successful fund raising includes financial contributions by physicians and their active participation in fundraising activities. The present environment is not supportive of physician involvement. In the survey, when asked to identify NHS successes the purchase of new equipment or technology was a success most often mentioned.

### **O. Academic Mandate**

This issue was only lightly referred to in my discussions. However, as Universities develop their distributive educational program community hospitals, such as NHS, must address the University's requests carefully. There can be a significant cost and impact on the NHS health care professionals by assuming an increased teaching load. All health professionals are significantly stretched today performing their existing clinical and administrative duties. If there is a desire to have health professionals increase their teaching obligations than this must be studied carefully with all the health professionals at the table to study the feasibility of the request. . Similarly, a hospital in significant debt must realize and fully understand the additional financial obligations which maybe expected with additional students within the hospital.



# Survey Results

## ***Niagara Health System Physician Survey December 2009***

*1. Select the medical staff category you belong to:*

**Active -66 on line (plus 24 written)**  
**Associate- 1**  
**Courtesy -2**  
**Consulting**  
**Honorary**  
**Temporary**  
**Locum Tenens**

*Total 66 active plus 24 written total of 90/ 367 or 25 % of active attending*

*2. Does your Department or Division hold regular site meetings (e.g. minimal 4 per year were members discuss quality indicators and operational issues)?*

**Yes meet regularly- 84 %**  
**Only meet occasionally- 9 %**  
**Never meet- 7.5 %**

**3. Does your Department or Division hold regular hospital-wide (all sites together) meetings (e.g. monthly meeting to discuss quality indicators and operational issues)?**

**Yes meet regularly- 55 %**

**Only meet occasionally- 27 %**

**Never meet- 19 %**

**4. Do you participate in regional (NHS) Department or Division quality of care initiatives (e.g. reviews of length of stay or return to operating room rate)?**

**Yes often- 21 %**

**Yes rarely- 13 %**

**No- 65 %**

**5. What are the three steps that could be done to improve physician's attendance at the Niagara Health System Departmental and/or Divisional meetings?**

**6. Are you aware, in a timely matter, of the activities of the Medical Advisory Committee, including its recommendations?**

**Yes will informed- 22 %**

**Informed but could be better- 46 %**

**Not informed- 32 %**

**7. Are you aware, in a timely matter, of the activities, including recommendations, of the Medical Staff Association?**

**Yes will informed- 35 %**

**Informed but could be better- 51 %**

**Not informed- 13 %**

**8. *Are you aware, in a timely matter, of the Niagara Health System Board recommendations that may affect physician's practices?***

**Yes will informed- 18 %**

**Informed but could be better- 31 %**

**Not informed- 50 %**

**9. *As a member of a Department or Division, were you consulted or given an opportunity to provide input into the selection of your Department or Division Chief?***

**Yes had input- 30 %**

**None or little input- 70 %**

**10. *As a member of a site, were you consulted or given an opportunity to provide input into the selection of your Site Chair?***

**Yes had input- 29 %**

**None or little input - 71 %**

**11. *I am a member of the Department/Division (name your Department or Division):***

**12. *I practice primarily at the following Site:***

**SCG- 17**

**GNG- 19**

**WHS- 13**

**DMH- 6**

**PCG -6**

**OSS- 2**

***13. Would you stand for a Medical Staff Association position?  
Informed but could be better***

**Yes- 22 % (15)**

**No- 77 %**

***14. If you have answered no to Question #13, please specify why not.***

***15. Would you stand for a Department or Division Chief or Site Chair position?***

**Yes- 45 % (29)**

**No - 55 %**

***16. If you have answered no to Question #15, please specify why not.***

***17. Do you feel you are engaged in the decision making process concerning clinical issues?***

**Yes engaged- 24 %**

**Engaged but could be better- 27 %**

**Not engaged- 50 %**

***18. I am clear on how decisions that affect my work are made at the Niagara Health System.***

**Yes- 18 %**

**Sometimes- 28 %**

**No- 54 %**

***19. Would you personally benefit from more management/organizational education programs?***

**Yes- 66 %**

**No- 34 %**

***20. What three recent positive changes or developments at the Niagara Health System has improved the quality of care for your patients?***

***21. What are your top three issues that the Niagara Health System should address?***

***22. When a hospital improvement plan is approved, what role or participation do you see for yourself to improve the quality of patient care in the Niagara Health System?***

***23. Do you have other thoughts or suggestions to improve health care in the Niagara Health System?***

### **Summary of Key Results**

Approximately 25 % of eligible active physicians responded to the survey. This is a good number, and not an unusual low number with physician surveys (*for comparison The Ottawa Hospital has about 25 % response even after several years of conducting a survey*). The survey represented a very good sample from each site and the different specialties. As mentioned before a challenge ongoing is there is not a complete list of email addresses of physicians who hold privileges at the hospital. Future surveys can be conducted with potential improved returns with access to these addresses. All responses, both written and on line, were read however the statistics presented is predominantly from the on line responses.

The responses indicate communications could be significantly improved across the organization .

Physicians continue to attend site meetings but not their regional or hospital department or division meetings.

Because the regional meetings are not being held or are poorly attended there is little quality of patient care reviews occurring within the departments or divisions.

A significant negative response is the lack of input or consultation of the members in selecting the leadership of their site, department, or division Chiefs. Physicians must, through a democratic consultative process, have input into the selection of their leadership. However, the selection of a chief is not an popular vote process by the members .

Encouragingly there are physicians willing to step forward and assume physician leadership roles, if the environment is right.

How or who makes decisions within the NHS is not widely understood nor do many physicians believe they are engaged in the decision making process.

There is a strong interest for more medical management education.

The individual answers for some specific questions are summarized. The summary of those questions, where physicians wrote answers themselves, represents a diversity of responses. The listing does not represent the frequency the comments were made or are they in rank order.

**Question 5 ( 133 responses)To improve meeting attendance the following initiatives are suggested (sample comments)**

1. Better structure agendas
2. Efficient use of time
3. Address pertinent issues
4. Meetings of value
5. Issues discussed are addressed or responded by either medical or administrative leadership.
6. Attendance mandatory
7. Department heads should be elected
8. Department heads receptive to physician needs
9. Make the meetings relevant
10. Provide stipends
11. Rotate site of meetings
12. Convenient time of day for meetings
13. Accessible meeting location
14. Meeting agenda should be patient centered
15. Better time of day for meetings
16. Corporate staff to attend to address issues
17. Provide meals
18. Interest is shown in physician's opinions
19. Listen to the physicians

**Question #14 – 16 ( 85 responses) Why would you not stand for a leadership position ( sample comments )**

1. Too much time commitment
2. Toxic milieu
3. Young family, too busy clinically

4. Not qualified
5. No faith that changes would be implemented
6. Recommendations historically ignored
7. No positive rewards for participation
8. Lack of effectiveness
9. Never reached out or included dentistry
10. Takes too much time
11. Treated poorly in the past
12. Any concerns of my department will not get to the board
13. NHS demands political conformity
14. Chiefs are appointed not elected

**Question #20 ( 102 responses ) Three positive changes in NHS ( sample comments)**

1. PACS
2. Computer use-system wide computer record
3. Support of family health teams
4. Can't think of any
5. Introduction of hospitalist program
6. Meditech
7. New equipment
8. Improved infection control program
9. Quality of care is deteriorating
10. MORE OB program
11. Recruitment of new ER physicians
12. Hiring of stroke clinical nurse specialists
13. Colorectal screening program
14. Support for concept of single maternity ward
15. Rapid assessment unit
16. Adding a second MRI
17. The NHS has come into being
18. Pacemaker program at Welland

**Questions #21 – ( 175 responses) Top three issues NHS should address (sample comments)**

1. Money for capital equipment
2. Leadership-administration
3. Reinstating the lab at OSS

4. Decrease mortality
5. Poor morale among staff
6. Patient care
7. Hospital bylaws
8. Reorganization of the corporate structure
9. The total democracy in selecting site and regional chiefs
10. Financial issues, adequate resources for delivery of services
11. Communication with physicians
12. Support of physician education
13. Open and transparent running of the NHS
14. Timeliness of diagnostic testing and reporting
15. Implement the HIP and sort out all corporate financial issues
16. Visibility of COS
17. Shortage of beds
18. Way too much bureaucracy
19. Remove present leadership
20. Recruitment and retention of physicians
21. Better co-operation between sites
22. Determining who does what and accountability for decision making
23. Need for open forums
24. Shortage of nurses
25. Regional chiefs should act in the best interest of all the sites and not the site they he/she works; regional vs municipal thinking
26. Sincerity
27. Consolidate as appropriate

**Question #22 ( 60 responses )***When a hospital improvement plan is approved, what role or participation do you see for yourself to improve the quality of patient care in the Niagara Health System? (sample comments)*

1. Will all anesthesiologist be able to work at the new hospital ?
2. Increase CME events
3. None at present. Need a significant change in attitude by the board towards its independent medical staff

4. Willing to provide input and meet if I felt that things were being addressed in a timely and efficient manner
5. Quality assurance committee to improve patient outcomes
6. Active role to implement the HIP plan
7. None I feel the decisions are made at the top with little input
8. Vocal opponent

**Questions 23 ( 55 responses ) Other thoughts or suggestions to improve NHS healthcare . (sample comments)**

1. Transparency
2. Start thinking of patients and how to make things better for them
3. Get rid of the NHS
4. Continue to seek out excellence and settle only for high quality results
5. As HIP implemented will need the fire side chats a la FDR
6. Better site for the regional hospital
  
7. New regional equipment
8. Duplication of services in not cost-effective and services should be centralized
9. Adequate nursing home beds in the community
10. Keep on doing great work
11. Break down the silos
  
12. Provide the physicians with state of the art technology and instruments
13. If the doctors from other sites could unite and be a little more tolerant maybe things can get done
14. Standardize everything
15. Further input to improve quality of care
16. I do not know
17. I have serious concerns of quality of care in the proposed distribution of services

18. I would like to play a role in implementing program in Fort and Port.
19. My plan is to focus on out-patient care
20. Thank you for inviting this feedback. This is exciting !

## **Recommendations**

### **1. Medical Bylaws**

A review of the bylaws be started immediately. This would include the establishment of a MAC bylaws committee. This could be done in two phases.

**First phase** to address the important issues that need immediate attention e.g

- a. Terms of office for medical leadership.
- b. Approval process for Acting Heads.
- c. Process for evaluation of physician leaders at the end of their first term.
- d. Process for extending their term in unusual circumstances.

Associated with this phase is following the existing bylaws for the appointment of division and site chiefs .

**Second Phase** to address other aspects of the bylaws

- e. Bylaws to address the competency of older physicians
- f. Mandatory attendance at department or division meetings

Responsibility- Board, COS and MAC.

### **2. Medical Organizational structure**

A review of the medical organizational structure including its programs. The goal would be to reduce the size of the organizational structure, minimize site roles, and identify the reporting relationship of program heads and others .

Responsibility- Board, COS and CEO

### **3. HIP (Hospital Improvement Plan)**

In collaboration with the MAC and other physicians identify the decision making structure and committee representatives as the plan is developed to be implemented . The specific committees to address specialty consolidation should be multidisciplinary, but I would suggest lead by a physician and an administrative lead.

Responsibility- CEO and COS.

### **4. SILCs**

Define the need and the terms of reference including reporting lines of these committees. This would be first addressed by identifying which decisions are exclusively site specific and if a committee is needed, indicate the membership of the committee.

Responsibility- CEO and COS

### **5. NHS designation**

Review all names, committees, position descriptions which are site specific to see if they are necessary going forward. The goal is to have all site issues that need a hospital wide contribution and solution addressed at one NHS committee. A goal is to minimize site titles.

Responsibility- CEO and COS

## **6. Medical Staff Association**

Hold a retreat which would include Board members, CEO, and COS and senior physician leaders to address the role of the MSA within the NHS. An outcome would also be to identify possible MSA leaders. Once these leaders are selected by the medical staff provide the leaders with appropriate education on their leadership role and as a member of the Board.

Responsibility- Physician leaders, COS, CEO, and Board Chair

## **7. Code of Conduct Policy**

Complete this policy and submit it to the physicians for input and ultimately to the MAC for approval. All physicians will need to agree to this policy to be appointed or re-appointed.

Responsibility- COS

## **8. Communication Plan**

Develop a communication plan to inform physicians and others of activities and decisions at the MAC, MSA, Board and Senior administration level e.g consider MAC minutes should be available to all physicians. Reinstate regular communications ie MAC newsletter with all physicians. Associated with this, develop a disclosure policy to address such issues as consultant reports, accreditation reports etc. This policy should be created to disclose all except in unusual circumstances . These circumstances that can be indicated .

Senior leadership should create a plan to have increased presence on all sites .

Responsibility- CEO, COS, President of the Medical Staff and Board chair.

### **9. Quality of Care Initiatives**

Insist all departments and divisions meet regularly and review appropriate quality of care metrics . This could be the discussion of site specific quality metrics by all department members or a roll up the metrics. Physicians should understand how to bring forward their quality issues to administration and the Board, and to receive appropriate feed back

Responsibility- COS and CEO

### **10 . Attendance at Departmental or Divisional meetings**

Develop ways of improving physician attendance at these meetings. Some aspects will be addressing time and rotating meetings between sites plus the use of technology. Enforcement of mandatory attendance at a certain number of meetings should be considered.

Responsibility- COS and MAC

### **11. Standardize Equipment, Implants and Procedures**

Create task forces (e.g orthopedic joint task force) with appropriate representation to address the issue of standardization with the goal to have standard equipment, implants, and care maps at all appropriate sites.

Responsibility – CEO and COS

## **12. Physician Human Resources**

Continue to develop and execute a plan to improve physician recruitment, retention, and recognition.

Responsibility- COS, CEO and board

## **13. Physician Education**

Develop an ongoing program for physician management education. This will include creating an appropriate budget . Particular emphasis should be given to physicians new in a leadership position.

Physicians, as others in the organization, are in the process of a significant change process. Education in the challenges of such a change process and how to manage it should be considered.

Responsibility- COS

## **14. Program Physician Heads**

Explicitly define their responsibilities and accountabilities. Define the role of COS, if any, for program accountability. Identify an appropriate management table for program heads to collectively sit at.

Responsibility – COS and CEO

### **15. Position Descriptions**

All physician leadership positions should have an in depth position description outlining their responsibilities and accountabilities. This would include a description of an appropriate annual evaluation process.

Included is an understanding of the physician leadership roles with regards to their physician quality of care responsibilities and their responsibility and accountability for operational issues. This will be important in the position description for the Chief of Staff.

Responsibility-Board, COS in collaboration with CEO

### **16. Information Technology**

Ensure there is structured physician input into IS/IT development and acquisitions

Responsibility – CEO and COS

### **17. Re-appointment Process**

The process needs to be streamlined with appropriate cut off dates enforced. The Board must be satisfied of the competency of a physician when the department or division chief signs off the reappointment.

Physicians must provide their email address at the time of reappointment

Responsibility- Board, COS

*Respectively submitted Chris C. Carruthers MD*

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