PRIVATE & CONFIDENTIAL

Report to:

NIAGARA HEALTH

Per: **Lynn Guerriero, Chief Executive Officer**

August 14, 2023

RE: Systemic Review of Niagara Health's Physician Group

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1. Introduction and Mandate

On August 8, 2022, Niagara Health retained Rubin Thomlinson LLP to conduct a systemic review to identify any systemic barriers within Niagara Health's physician group, make findings, if possible, in relation to any specific allegations of systemic discrimination, and make recommendations based on these findings.[1]

We confirm that we carried out the review impartially and independently, without interference from the client.

2. Background Information

On June 7, 2022, the Medical Staff Association (MSA) at Niagara Health submitted a letter to the Niagara Health Board (the "Board"). In that letter, they informed the Board of complaints of discrimination that they had received from Niagara Health physicians over a 12-month period. Specifically, the MSA indicated that they had been approached by several female physicians regarding their experience of inequitable treatment at Niagara Health and that, as an executive, they were aware of incidents of discrimination based on race, colour, ethnicity, and religion. Based on these issues, the MSA expressed concerns of a systemic discrimination issue within the physician group at Niagara Health.

The MSA indicated that the physicians from whom they received complaints were not prepared to come forward individually and/or be named in a complaint due to a fear of reprisal. However, they were willing to participate in a larger review into the systemic issues. Consequently, the

[1] While we were made aware of specific allegations during this process, we have made no factual findings in this report with respect to those specific allegations due to an unwillingness of individuals to be named as complainants. We explain this throughout the report.

MSA requested an external third-party review into the concerns that have been raised about widespread discrimination at Niagara Health, for findings to be made with respect to those concerns, and for recommendations to be made regarding the issues identified. We were engaged by the CEO of Niagara Health to conduct the requested review.

As part of the mandate, Niagara Health made it clear that the anonymity of the physicians who participated in the review was to be maintained, both during the process and in the report, unless they expressly asked for their identity to be disclosed. We were also instructed that the process should afford all Niagara Health physicians an opportunity to participate confidentially and anonymously.

3. Anonymity in the Report

Throughout the entire process, we were presented with the very real concern of reprisal that some physicians had. The concern was shared with us by the MSA when we first met, and we heard the concerns from many physicians with whom we engaged during the process. In fact, there were individuals who expressed feeling anxiety and an increase in their heart rate while speaking to us because of their fear of reprisal. We will speak more later in this report on the theme of reprisal, but we raise it here to emphasize the importance of anonymity in this report.

We were asked by the MSA and other participants to give an assurance of anonymity, which we did. That said, given the MSA's request for factual findings, we did explain to them that our ability to make findings would be restricted if we are unable to test the information that we receive.[2] That

[2] In their letter to the Board, the MSA requested a process in which findings would be made. Accordingly, our mandate was to make findings, where possible. The caveat, "where possible," was included in the mandate, given our recognition at the outset of the limitation to make findings on specific allegations if we are not able to test the information received.

said, we indicated that the information that they (the MSA) provided would nonetheless assist us in identifying the areas that we needed to address in the process and also identify potential barriers, if any, and to make recommendations regarding how to address those barriers.

The MSA shared the particulars that they were aware of together with a list of individuals with whom they recommended that we speak.

4. Conduct of the Assessment

To initiate the process, the client issued a communication about the review process to the physicians in August 2022. The client's communication introduced us (Rubin Thomlinson) as the reviewers. Following the client's communication, we met with the MSA on three occasions between September and October 2022. This was our first step in the process because they had requested this process and had information regarding the potential issues of systemic discrimination at Niagara Health. In those meetings, we discussed the MSA's concerns and answered their questions about the process. On September 27, 2022, we received a detailed brief outlining the MSA's concerns and a list of individuals with whom they recommended that we speak. The list was a combination of individuals who reported concerns to them about personal experiences, individuals identified as having allegedly engaged in wrongful behaviour, and other individuals whom the MSA said had useful information for the review.

On September 19, 2022, we sent a communication to all Niagara Health physicians, via email, to introduce ourselves and inform them of the scope of our mandate for the process and the way they would be invited to

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This was explained to the MSA. However, we further clarified that, where the information received revealed potential barriers, we would be able to make recommendations on how to address those barriers, which we understand to be the primary goal of this review.

participate (anonymous survey and/or confidential interview). The client had provided us with a list of the Niagara Health physicians and their email addresses. Therefore, we were able to communicate with them directly to maintain our independence.

Interviews

Immediately after sending that introductory communication to the physicians, we began receiving requests for interviews from physicians. Therefore, we commenced conducting interviews on September 22, 2022, and continued to conduct physician interviews, whenever requested, until the end of the process. The last interview was conducted on June 7, 2023. There were individuals who requested an interview with us (we accepted all requests) and there were individuals whom we invited to an interview.

The individuals to whom we extended an invitation included Niagara Health physicians (former and current) and Niagara Health staff and/or administration (former and current). The pool of interviewees was determined based on information received from the MSA, from the administration, and based on information that we received from participants as we carried out the process. Ultimately, we conducted 78 interviews.

Survey

On November 14, 2022,[3] we also launched a survey which invited all Niagara Health physicians to share their experience and opinions about discrimination (in whatever form) in the workplace. A blank copy of the survey is attached as **Appendix A**. Given the scope of the mandate (i.e.,

[3] Before launching the survey, we interviewed several physicians who requested an interview with us as the information that they shared, together with the information received from the MSA, gave insight into the areas to cover in our survey.

systemic barriers within the physician group), the survey was limited to Niagara Health physicians. Physicians participated anonymously; however, they were invited to indicate if they also wanted to participate in a confidential interview, and asked to share their names and contact information if they did. The survey initially closed on November 25, 2022. However, we received communication from certain physicians asking for a further opportunity to complete the survey because they had missed the opportunity for various reasons. We discussed the request for an extension with the client and it was agreed that the survey would be reopened (to all physicians) and extended until December 16, 2022. Upon the survey closing, we reviewed the results. There were 214 survey participants, 42 of whom requested an interview. We reached out to all those individuals (except for two participants who did not share their identity or contact information) and offered an opportunity for an interview.[4] Some individuals accepted the invitation, some declined, and others did not respond. For those who responded and accepted the invitation, interviews were scheduled and conducted. They are included in the number of interviews mentioned above (78 in total).

Other sources of information

In addition to the survey and interviews, we received and reviewed multiple records and documentation relevant to matters under review. We received these records and documentation from the MSA, participants whom we interviewed, and Niagara Health. Some of the records we obtained took time for the sources to generate and share them. We received such records

[4] Our instructions from the client were to interview every physician who requested an interview.

and documentation throughout the entire process, the last of which we received from the client on April 26, 2023.

5. Comments on Independence of the Review

During the review, we were informed of the following concerns regarding the independence and reliability of our review:

(i) Some persons were concerned about the potential interference of the Niagara Health administration with our process and final report. They were concerned that our report would be edited to censor the information that we collect and/or that Niagara Health would have access to the information that we collect.

(ii) That the MSA had undue influence on the process because the MSA was apparently representing this review as an MSA-initiated review. Specific concerns that we received regarding the MSA were that:

(a) The MSA was motivated by personal issues with specific individuals and were using this review process to advance their own agenda.

(b) The MSA may have been bullying certain physicians into participating in this review and coercing them on the information that they were to share with us.

(c) That the concerns raised by the MSA (in the June 7 letter to the Board in which they requested this process) were in fact isolated to a few specific incidents but was inaccurately being presented by the MSA as a more widespread systemic issue.

In this section, we wish to address the overarching concern about the independence of this review by reiterating that we carried out this process impartially and independently without interference from either Niagara Health and/or the MSA. We confirm that the information shared in this report has not been censored, except by us to protect confidentiality. Further, we confirm that Niagara Health does not have access to any of the information that we have collected, except what is shared in this report or what we have received the consent of individuals to disclose to Niagara Health (particularly the CEO).

As it pertains to the MSA, we cannot comment on the validity of the specific concerns raised about the actions or motives of the MSA, but what we can confirm is that the MSA did not interfere with or have any undue influence over our process. By adopting an approach which allowed physicians across all of Niagara Health to participate either anonymously in a survey or in a confidential interview, and with the wide cross-section of participants that we had, we are satisfied that the information that we have collected allowed us to assess what was a widespread concern versus one that was isolated. We make this point with the hope of avoiding concerns about the MSA and/or the Niagara Health administration being a distraction from the pertinent issues which we seek to address in this report.

6. Data on Process Participation

Survey

The 214 survey participants were from a wide cross-section of departments and leadership at Niagara Health – anesthesia (14), diagnostic imaging (23), emergency medicine (43), family medicine (24), laboratory medicine (2), medicine (39), obstetrics and gynecology (11), oncology (7), pediatrics

(60), psychiatry/mental health (13), surgery (40) and other (2).[5] These participants were also from a wide cross-section of divisions within those respective departments. However, we will not detail the number of participants from each division as to do so may indirectly disclose who has participated. The participants included 151 active physicians, 40 associate physicians, 26 courtesy physicians, and four physicians operating in locum.[6] 74.53% of the participants have been working at Niagara Health for more than five years. 115 participants identified as male, 54 identified as female, and 15 preferred not to answer. 71 participants identified as racialized and 89 did not.[7]

Interviews

Similarly, the participants with whom we had one-on-one interviews were also from almost all the departments, of diverse credentialing status, and a combination of individuals who have been working at Niagara Health for more or less than five years.

7. Organizational Structure of Niagara Health[8]

Niagara Health is a regional hospital system with multiple sites – St. Catharines, Welland, Port Colborne, Niagara Falls, and Fort Erie. There are over 600 physicians that work at Niagara Health, and they work at one or multiple sites. Prior to the current structure, Niagara Falls, Welland, and St.

[5] We assume that some persons made multiple selections as we note the numbers add up to more that 214.
[6] These are the credentialing categories for physicians at Niagara Health.
[7] Some participants chose not to answer some demographic questions. Therefore, the number of responses vary.
[8] The information in this section was gathered from information provided to us by the client and from information collected during interviews.

Catharines were separate independent hospital systems, but they were amalgamated in 2005.[9]

Physicians are not employed by Niagara Health but are rather given hospital privileges which allows them to practice at the respective sites. The physicians are generally paid through OHIP. However, physicians who hold certain leadership positions receive payment from Niagara Health for their non-clinical leadership service.

The President and CEO of Niagara Health is Lynn Guerriero, who is our client contact and by whom we were retained to conduct this review. The Chief of Staff at Niagara Health is Dr. Johan Viljoen, who is also an Executive Vice-President. Dr. Viljoen has supervisory oversight over all the Niagara Health physicians. Ms. Guerriero and Dr. Viljoen both report to Niagara Health's Board of Directors.[10]

Attached as **Appendix B** is a list of the respective departments and subdivisions within those departments. It is our understanding that each program is headed by a departmental chief and the departmental chiefs report to the Chief of Staff, Dr. Viljoen. They (the departmental chiefs and the Chief of Staff) also sit on and comprise the Medical Advisory Committee (MAC).[11] The members of the MSA[12] also sit on the MAC. We further

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[9] This is relevant because some of the concerns raised during the process have to do with the amalgamation of the hospitals.
[10] However, we understand that there is an aspect of Dr. Viljoen's portfolio regarding which he reports to Ms. Guerriero.
[11] The *Public Hospitals Act*, R.S.O. 1990, c. P40, s. 35 (1) mandates that the Board of every public hospital must establish a medical advisory committee composed of such elected and appointed members of the medical staff as are prescribed by the regulations. The legislative function/duty of the MAC is to consider and make recommendations to the Board respecting medical staff appointment, hospital privileges etc. and perform such other duties as are assigned to it by or under the Act or any other Act or by the Board.
[12] The role and function of the MSA is not outlined in the Niagara Health policies, but what we understand from our interviews is that the MSA, essentially, provides support and representation for the Niagara Health physicians. The physicians pay dues to be members of the MSA.

understand that some departments have deputy department chiefs, some larger programs have "site chiefs" for each Niagara Health site, and some departments have subdivisions, each of which are headed by what is called a "head of service." The deputy chiefs, site chiefs, and heads of service report directly to the respective department chiefs of those programs.

8. Department Demographic

We received full data on the gender demographic of the respective departments at Niagara Health and partial data on the racial demographic. My understanding is that while gender-based data is formally recorded, race-based data is not. Therefore, the data available is limited in that regard. We have nonetheless included the gender-based data that was made available to us.[13] The data is attached as **Appendix C**.

9. Information Gathered from Survey and Interviews

In this section, we have summarized the information gathered from both the survey and interviews. We have arranged these by themes.

It is important to note that the information included in this report represents the subjective experiences of the individuals who participated. We have not tested the information, for example, by sharing information as allegations or by seeking responses, and we have not made factual findings related to the concerns. The information included in this section represents the concerns of participants as they have chosen to express them.

To assist in understanding the frequency with which issues or concerns were identified, in presenting the information in a summary fashion, we

[13] I have not indicated the source of any of the data to maintain anonymity.

have used the following ranges to denote frequency: “some” (1-5 people), “several” (6-9 people), and “many” (10 or more people).

When information is summarized in bullet lists, that information is presented in the words used by participants in the surveys or interviews, although in some instances, we have summarized or paraphrased the responses in the interest of clarity, confidentiality, and/or conciseness. As agreed at the time of the retainer and as mentioned above in this report, we have not attributed any information to a particular individual, nor have we presented physician experiences at a level of detail that might allow particular individuals to be identified as the source of the information. We have also not included every piece of feedback that we received during the review; we have focused this report on shared concerns and repeated themes of feedback.

a) Positive experience

Many participants indicated that they have had a positive experience in their time at Niagara Health. Some of these individuals were males, some were females, and some identified as people of colour. They were from different departments at Niagara Health. We heard that the individuals:

- Did not share the concerns expressed in the MSA letter that led to this review.
- They have been supported in their career advancements and have had access to opportunities.
- They have no fear of reprisal when reporting concerns.
- Females are supported when maternity leave is needed and are supported in their career advancement.

- Niagara Health is inclusive and has made positive diversity, equity, and inclusion ("DEI") steps.

In the survey, we noted that most participants are satisfied with their career advancement at Niagara Health, they feel supported, and they believe that career advancement opportunities at Niagara Health are equally available for all physicians at Niagara Health.

While individuals (in the survey and interviews) expressed that they have had a positive experience at Niagara Health, some of these individuals acknowledged that their experience might not be the experience of others.

What follows in the remainder of this section is a description of concerns that were identified by the participants.

b) Discrimination/Inequality

We heard from many participants that there was a problem with discrimination at Niagara Health. In the survey, we asked the participants if they believed that there is discrimination within the physician group at Niagara Health; 214 participants answered this question – 11.68% strongly agreed that there is discrimination, 17.76% agreed, 24.77% neither agreed nor disagreed, 22.90% disagreed that there is discrimination, and 22.90% strongly disagreed.

We asked the survey participants to rate the level of discrimination in the physician group at Niagara Health – 35.68% said non-existent, 36.62% said mild, 13.15% said extreme, and 15.96% were neutral.

We asked the survey participants to indicate the type of discrimination that exists in the physician group at Niagara Health. The following were the types indicated: race (20.10%), place of origin (11.27%), ethnic origin

(17.16%), colour (17.16%), age (22.06%), and sex/pregnancy (20.59%). 14.22% selected "other," and the following were some of the "other" types or basis of discrimination that were identified – specialty, favouritism, education background, seniority, and political status in the organization.

Of those who participated in the survey, 35.35% said that they either witnessed or personally experienced discrimination at Niagara Health. Of those who indicated that they have personally experienced or witnessed discrimination, 73.75% said that their experience was personal, 38.75% said that they witnessed it, and 35% said that they were told about discrimination at Niagara Health. We asked those participants to indicate the nature of discrimination that they experienced, witnessed, or heard about – 48.75% said systemic discrimination, 65% said discrimination by another physician, 36.25% said discrimination from a patient, and 23.75% indicated "other." Of those who indicated "other," the following were some of their experiences – discrimination from leadership, staff, regional chief, and "interdisciplinary discrimination."

We asked the participants to indicate the areas in which they may have experienced, witnessed, or heard about discrimination. We received 79 responses to this question and the following were the responses – hiring (24.05%), promotion (31.65%), salary/compensation (25.32%), discipline (45.57%), performance management (35.44%), access to training or other opportunities (24.05%), distribution of work (43.04%), and other (25.25%). Of those who indicated "other," the following were some of the areas that they identified – patient care, accessing operating room time or resources, and access to safe spaces.

Below are some of the specific comments that we received in the surveys and interviews for different grounds of discrimination that were identified.

i. Discrimination against elderly patients and physicians

We heard that elderly patients do not receive the same treatment as younger patients. We heard that they are kept waiting for long hours in the emergency department and are not given priority. It was explained that younger patients are more likely to complain and advocate for themselves while elderly patients are less likely to do so. We also heard that elderly physicians are not taken as seriously as younger physicians – their calls are not returned by other physicians and staff, and there is no communication when handing over patients. We heard that certain inappropriate comments are made. For example, comments like, "The doctor is old enough to be [their] father."

ii. Racial/ethnic discrimination

We heard from many participants that there is racial and ethnic discrimination at Niagara Health. The following is some of what we heard:

Barriers to opportunities:

- Certain department chiefs discriminate against racialized individuals in their department by failing to acknowledge or respond to their comments but acknowledge and respond to white counterparts who make the same or similar comments.

- Certain departments have never had and will never have a non-white chief.

- People of colour are denied employment opportunities. The emergency department was identified as one department where this has occurred.

- White people are unable to "connect" with racialized individuals in the same way that they connect with their white counterparts, and this has impacted the recruitment process at Niagara Health. We heard that the hiring committees at Niagara Health do not always have the expertise necessary for the position being hired, thus, the decision is sometimes based on a "connection" to the candidates interviewed and invariably their connection is with white physicians.

- People of colour are hired because they are needed, but if there is a choice between a candidate who is a person of colour and a white candidate, the white candidate will be chosen. This is due to the mindset that people who are not "like them" (i.e., white) are not good enough.

- People of colour appointed to leadership position are sometimes given less remuneration than white individuals who previously held the position.

- There are discriminatory practices with respect to the scheduling of operating room time.

Silenced:

- When persons of colour challenge decisions, they are described as "difficult," "aggressive" and "unprofessional," "troublemakers," and given the impression that they are to "stay in line." To avoid them being "difficult," persons of colour are sometimes excluded from processes, for example, hiring committees, or are required to take professionalism courses or remediation.

- Many physicians who identify as people of colour do not feel that they have the same opportunity to voice their concerns as their white counterparts.

Inappropriate comments:

- After being hired, some people of colour were asked where they are from and how long they have been in Canada – they were in fact born in Canada.

- Comments have been made to physicians, under the guise of a joke, that they would be deported.

- Staff make xenophobic comments regarding the culture or country of origin of physicians.

Lack of support:

- International medical graduates and non-white physicians are treated unfairly insofar as they do not receive the same support from the head of their department.

Pertaining to patients:

- Racialized patients are denied the same care as non-racialized patients.

- There is racial discrimination against physicians by patients. We heard that Niagara is a predominantly white rural area and that many of the patients do not accept or want care from faces that do not look like them.

Some of the further comments that we heard about how people of colour at Niagara Health are feeling are:

- People of colour at Niagara Health cope by saying, "Well, it's not so bad," or they just accept that discrimination is part of life and simply move on.

- People of colour do not want favouritism; they want to be considered equals.

We did, however, hear from one participant who identified as a person of colour that their perspective was that the "race card" is used by racialized physicians when they do not get their own way.

iii. Racial discrimination in complaint and disciplinary process[14]

We heard from many people that there is racial discrimination in the complaint and disciplinary process at Niagara Health. Specifically, we heard that racialized physicians are more disproportionately subject to complaints and subject to a review of their practice than non-racialized physicians.

In the survey, participants were asked if they believe that the disciplinary procedures for physicians at Niagara Health are transparent and equitable – 9.24% strongly disagreed that they were transparent and equitable, 16.30% disagreed, 49.46% neither agreed nor disagreed, 20.11% agreed that it was transparent and equitable, and 4.89% strongly agreed.

[14] Although also pertaining to racial discrimination, there were so many concerns related specifically to racial discrimination in the complaint and disciplinary process, we thought it more prudent to deal with it separately.

We noted that when asked if they were aware of the procedures that govern discipline for physicians at Niagara Health – 34.59% said yes, 34.05% said no, and 31.35% said somewhat.

As to some of the specific concerns – we heard that there was no transparency regarding how and when reviews are done. Several persons we spoke with said that they did not even know what the expected process was for reviews or investigations. They just knew that what they saw for racialized physicians was different from what they saw non-racialized physicians experiencing. In fact, they indicated that they were aware of other non-racialized physicians who had more serious problems with their patient cases, and they have not been subject to review. Additionally, they said, what they saw with racialized physicians was more "draconian" and excessive than the approach to non-racialized physicians. The following are some of thing things that we heard regarding racial discrimination in the complaint/discipline process:

- Racialized physicians are subject to harsher treatment/discipline process.
- Racialized physicians are traumatized by their experience in the review process. There is no compassion in how they are handled.
- White physicians who are known to have "disastrous" situations in patient care are not subject to review while racialized physicians are subject to review. White physicians are not held to account and are protected from disciplinary consequences.
- In response to complaints, racialized physicians are accused by the chief of staff (current and past) of making up stories.

- Racialized physicians are removed from practice before an investigation in the complaint is done and no conversation is had with them about the complaint that is made, nor is there an attempt to hear their response or version of events.

- There is a disproportionate number of Incident Report System (IRS) complaints against racialized physicians.

- Racialized physicians are judged by different standards and are requested to take unusually difficult steps as part of the review process.

- Review processes are exorbitantly lengthy. Thus, racialized physicians are subject to the uncertainties of a review for an extended period. They are sometimes not told for weeks what the complaint is about.

- Persons of colour are not given the benefit of the doubt when complaints are made against them. The benefit of the doubt is reserved for white physicians.

- There is no repercussion for vexatious complaints by white staff and physicians against racialized physicians.

- There is no established standard as to what causes an issue to be escalated to a review. It appears to be left to the subjective opinion of the chief of a department and Chief of Staff and the ultimate decision for discipline is made by the MAC, many of whom do not have the subject-matter experience and have no knowledge of the physician under view.

- The MAC has an inappropriate level of control in disciplinary matters. There is much unconscious bias and favouritism by the MAC.

- The Chief of Staff is removed from what happens in the respective departments. Therefore, he relies on what is said by the chief of the department. However, the opinion of the chief of the department ultimately depends on who is under review (referring to favouritism).

- There is predetermination of fault (by the Chief of Staff and department chiefs) when a complaint is received against a racialized physician from a non-racialized physician.

In addition to the above, we heard that racialized physicians are subject to more patient complaints than non-racialized physicians. However, despite those complaints being unsubstantiated, the complaints remain on their record and ultimately contribute to a later decision to subject them or their practice to review. In other words, the number of complaints received, though unsubstantiated, is used as a basis to subject racialized physicians to review.

In terms of complaints against racialized physicians that have to do with their conduct or behaviour, we heard that racialized physicians are described as explosive and aggressive, while similar behaviour by non-racialized physicians and staff are described as "miscommunication" or them being "passionate" about their patients.

iv. Disrespectful communication to females and persons of colour

We heard from many persons that female physicians are not treated with the same level of respect as male physicians at Niagara Health. Specifically,

they are spoken to in a condescending and disrespectful manner by other physicians and staff. We heard that:

- Persons in leadership, for example, certain chiefs or deputy chiefs, yell at females within their department.
- White male orthopedic physicians speak to female physicians aggressively and are more willing to provide consultation to male physicians.
- Older white male physicians yell at female physicians. This is often done by surgeons due to the culture that surgeons can get away with anything.
- Female physicians in the operating room are spoken to disrespectfully by male physicians.
- Females in obstetric surgery are asked to justify to male physicians from other specialities why their surgeries should be done.
- Females are discouraged from pursuing career opportunities because of their family status.
- Inappropriate sexual comments and actions have been made by a leader.
- Persons in leadership tell females in their department that they are unable to lead men.

We also heard about comments made to persons of colour by staff and patients. We heard of patients telling racialized physicians that they want to be treated by another physician. We also heard from some participants that persons who are higher in the hierarchy at the hospital tend to speak down

to persons considered to be in a lower rank. We heard that such hierarchical behaviour occurred generally against physicians but also against racialized and female physicians.

v. Gender discrimination

We heard from many participants that there is gender inequality at Niagara Health. The following are some of the concerns that we heard:

Disrespect and disregard of female physicians:

- People think that female physicians are nurses or physiotherapists.
- Females are introduced by their first name and not as "doctor," whereas that is not the case for male physicians.
- Male physicians tend not to give female physicians credit for their work. When the issue is reported, it is described as "poor management" and not gender bias.
- Female physicians are not respected by nursing staff in the way that male physicians are. For example, nurses seek to tell female surgeons how to use certain equipment. Female physicians must speak more firmly than their male counterparts in order to get attention and respect.
- Sexist comments are made by and between technicians.
- Female physicians who face personal, female-related health issues have been required to explain those personal issues to the Chief of Staff.

- Male physician leaders are not performance-managed, despite reports to leadership of their discriminatory behaviour.
- Male surgeons generally receive more referrals than female surgeons.
- Some female physicians are excluded from certain meetings and discussions, despite their roles.
- Female physicians are treated unfairly with respect to shift distribution.
- Female surgeons are asked by male surgeons to explain their decisions regarding their patients.
- Systemic discrimination between male orthopedic surgeons and female OBGYN's – the females are questioned about their work practice and decisions.

Female physicians are underrepresented in leadership

- While people of colour are represented in leadership, the female physician workforce is not represented in leadership. We often heard that there is only one female on the MAC.
- Female physicians are passed over for promotion or told not to apply for positions.
- Male physicians are sought out for positions, despite expressions of interest by qualified females.

Adverse impact because of pregnancy or family status

- There is a perception that women with young children need more time than male counterparts to spend at home and, therefore, are unable to take on leadership roles.

- Potential female leaders may not be identified as potential candidates or "shoulder-tapped" for opportunities because of their family positions.

- Even though there are established guidelines for interview panels, (specifically, they are clear on what questions cannot be asked during interviews), comments connected to those prohibited questions are nonetheless made by the interview panelists outside of the interview.

- Not all women are able to manage the job expectations because of their family obligations.

- Female physicians are belittled for needing to work less to tend to responsibilities at home.

- Females, especially female surgeons, have no place to breastfeed or us a breast pump. They are given a room with a glass window.

- Female physicians are asked to downgrade hospital privileges after returning from maternity leave. Return to full-time duties was subject to performance reviews and a probation period. Male physicians who take years off for leave retain their hospital status.

- The ability to matriculate from associate physician to active staff is adversely impacted if maternity leave is taken. Pursuant to the by-law, matriculation is to occur after two years, subject to review; however, that two years is protracted if maternity leave is taken during that initial two years. Matriculation if deferred until the next

review after return, which may be far away. Females who take maternity leave are, therefore, subject to a longer period of vulnerability regarding job security as an associate physician.

- In the surgery department, females lose their allotted operating room times when they take maternity leave and they do not get it back when they return from maternity leave. Inadequate operating time ultimately affects career opportunities because operating experience is considered when being considered for leadership opportunities.

vi. Discrimination based on seniority/age

We heard from some participants about the disparity in treatment between the more senior and less senior physicians. The following are some of the things that we heard:

- Newer physicians are required to participate in teaching and hospital administration while more established physicians are exempt from that requirement.

- Senior physicians protect access to lucrative opportunities while younger physicians are unable to access those opportunities – younger physicians are told that their "time will come."

- Younger physicians are threatened that they can be fired at anytime without reason.

vii. Religious discrimination

We heard from some participants that there is discrimination based on religion. For example, dismissive and offensive comments being made

about religious positions, events being held, or programming scheduled, without consideration for religious dietary restrictions or religious holidays.

viii. Adverse treatment of internationally trained students

We heard from some participants that international graduates are treated differently. Specifically, we heard that:

- They are sometimes excluded by leaders.
- They are denied equal access to work and compensation.
- They are told to, "Do as you are told, like the rest of the foreign graduates."

ix. Demographic of the wider Niagara community

We heard that some of the concerns of discrimination, particularly racial/ethnic discrimination might also be a result of the wider Niagara community in which Niagara Health operates. Specifically, we heard, in essence, that the Niagara community has not always been particularly diverse and the challenges in Niagara Health may be reflection of challenges in the community.

c) Underrepresentation

We heard from some participants that there is an underrepresentation of females and persons of colour in certain departments, for example, in surgery and in the emergency department. We also heard that there are no Indigenous people in the department of surgery.

d) Uncertain or inadequate processes and policies

i. Uncertain complaint process

Many participants expressed unawareness or uncertainty of Niagara Health's complaint process. In the survey, 44.86% of participants said that they were not aware of Niagara Health's reporting procedures if they needed to report a concern of discrimination, 21.08% said that they were aware, and 34.05% said that they were somewhat aware.

Where participants referred to Niagara Health's Incident Report System (IRS) as the mechanism to report a concern, several persons said that the IRS reporting process is uncertain. Specifically, we heard that:

- There is no response to an IRS complaint that is submitted. We heard some persons do not even receive an acknowledgement of receipt.

- The outcome of an IRS complaint is unknown. They may hear that Niagara Health is looking into the matter and then they hear nothing further. If they inquire, they are told that the process is confidential and that nothing further can be disclosed to them.

- Some persons expressed uncertainty regarding each step of the process. For example, they are unaware as to when an expression of concern may trigger an investigation versus what will lead to discussions about their concerns.

ii. Policies unknown

We heard from several persons that Niagara Health's policies are unknown to them. We heard that:

- The Professional Staff By-Law, which governs the physician group (the "by-law"), is not well known to physicians.
- General policies at Niagara Health are not well known by physicians.
- Policies regarding complaints and investigations are unknown.
- Policies regarding recruitment in the physician group, for example recruitment of site chiefs, are unknown.
- Policies regarding disciplinary processes are unknown.

iii. Inadequacy of physician by-law

We heard from several persons that the by-law is inadequate. Specifically, we heard that:

- The by-law is silent on the appointment process for site chiefs.
- The by-law is silent on the recruitment process for any non-chief leadership positions.
- There is no procedure or policy governing promotions at Niagara Health. Decisions are made on a subjective basis by the department chief and/or Chief of Staff.
- There is no process or procedure governing promotions.
- By-law is vague and unclear.

iv. MSA role is unclear

We heard from some participants that the role of the MSA is unclear. We heard that there is nothing in the by-law or any policy to govern or outline

the role of the MSA. We heard that the MSA is viewed to be like union representation for the Niagara Health physicians.

v. Non-discriminatory problems with the discipline process

In addition to the concerns described above regarding discrimination in the complaint and disciplinary process, we also heard of more general non-discriminatory concerns about the process. The following are some of the concerns that we heard:

- Some physicians were unfairly subject to a review of their practice without being informed of what triggered the review or the process that would be engaged. We heard that individuals were severely traumatized by their experiences, which often, we heard, lasted for years.

- Physicians on the MAC who were hired externally and who are not familiar with physicians under review are swayed by the opinion of other physicians on the MAC regarding the handling of the physician to be subject to review.

- The review process is unduly lengthy which results in physicians under review feeling pressured into a settlement.

- There is no opportunity for the MSA to intervene at an early stage before a physician is subject to review.

- MSA members, because they are few in number (three), are unable to fully represent the physicians who are subject to disciplinary processes as there over 600 physicians at Niagara Health.

e) Abuse of IRS system

We heard from some participants that the IRS system has been abused and used as a weapon against physicians. Specifically, we heard that it is being used to complain against physicians for just about everything. We also heard that when physicians complain or express objection about certain things to leaders in their department, the result is that they start to receive an inordinate number of IRS complaints against them. We heard that this is also specifically the experience of some racialized physicians, in that they feel that the IRS system is being used to target them, causing them to have their practice subject to review and scrutiny (an issue discussed separately under a separate heading).

f) Challenges regarding hiring and recruitment processes

i. Lack of transparency in hiring process

We heard many complaints about the lack of transparency in the hiring process; the concerns were in relation to the hiring of chief positions, the reappointment of chiefs, the hiring of site chiefs, and other leadership positions within the respective departments. As a general concern, we heard that while the by-law outlines the hiring process for chief of the departments, there is no established hiring process for any other leadership position within the respective departments. We heard that such "non-chief" leadership positions, such as site chief positions, are filled based on the subjective determination of the department chief of the day and that the department chief makes a recommendation to the Chief of Staff. We heard that there are some department chiefs who hold interviews for the position, while there are some who do not.

A. Reappointment of Chiefs of Department

Regarding the chief of department position, in the survey, we asked if people were aware of the hiring process for chief and deputy chief of department positions at Niagara Health – 30.65% said yes, 40.32% said no, and 29.03% said somewhat. We also asked them if they believed that the process for hiring chiefs of department at Niagara Health is transparent and equitable – 14.05% strongly disagreed that it is transparent and equitable, 16.76% disagreed, 36.22% neither agreed nor disagreed, 24.86% agreed that it is transparent and equitable, and 8.11% strongly agreed.

One of the primary concerns that we heard was in relation to the reappointment of chiefs to their position. Specifically, there was a recognition that the by-law establishes a five-year tenure for the chief of department position, but we heard that there is essentially no proper established process for the reappointment of chiefs to their position. We heard that reappointment is dependent on a recommendation by the Chief of Staff to the MAC, but that it is a basically "a given." We heard that it is very rare for someone not to be renewed. We further heard that there is no consideration or assessment of the individual's performance during their tenure and there is no consideration of the input of the physicians within the department who had to work with the chief who is being considered for reappointment. We heard that there are no criteria for reappointment and other physicians, including women, who are suitable for the position are denied the opportunity for appointment because of the lack of established process.

We heard from some individuals that they were not even aware that the by-law prescribed a tenure for persons to be appointed as chief of department. They said that they just hear when the chief is reappointed.

B. *Recruitment of Site Chiefs, Deputy Chiefs, and Heads of Service*

In the survey, we asked participants if they were aware of the hiring process for all other non-chief physician leadership positions at Niagara Health – 19.35% said yes, 48.39% said no, and 32.26% said somewhat. We also asked if they believed that the hiring process for such non-chief physician leadership positions at Niagara Health is transparent and equitable – 10.22% strongly disagreed that it is transparent and equitable, 16.13% disagreed, 43.55% neither agreed nor disagreed, 20.43% agreed that it is transparent and equitable, and 9.68% strongly agreed.

We heard that there is no established procedure for hiring into these positions, including deputy chief positions; except to say that the individual needs to be approved by the MAC and the Board, the by-law is silent on the recruitment process and there are no other policies that govern this. Therefore, we heard that recruitment into these positions is dependent on the department chief, who may or may not have a process that they choose to follow. We heard that some chiefs give a "call out" within their department for expressions of interest, some chiefs approach individuals who they think might be suitable (shoulder-tapping), some chiefs inquire from their department members who they think may be suitable, and some chiefs have interviews. Therefore, there is no standard transparent process at Niagara Health and the approach to recruitment varies for each department. We also heard that there is no set tenure for heads of service positions. For example, we heard that the head of plastic surgery and the deputy chief of radiology have held their positions (or traversed between positions) for 20 years.

C. Other departmental leadership positions

As it pertains to other leadership positions, we heard that each department similarly has their own process, as determined by the respective department chiefs. We heard from some participants that there is no process governing appointment to these roles, they are solely determined by the department chiefs. We heard that there is no tenure in place. Therefore, others in the department who have an interest in such leadership opportunities are barred from such opportunities. We heard that physicians have no avenue to challenge these issues and when they do, they are met with aggression, or they are ignored.

In addition to the above, we heard that even where there were interview panels in place, the panels were, in essence, a "formality" because the decision on the person to be hired was already predetermined. We also heard that individuals on the hiring committees were each given a question that they could ask the candidate and there was no deviation. In that way, we heard, the process was manipulated. It was also said that the members of the hiring committees are unfamiliar with the needs of the relevant department and/or how physicians have been impacted.

ii. Unawareness of career opportunities

We heard from some participants in our interviews that they are unaware of career opportunities when they become available. For example, some female participants indicated that they only became aware of an opportunity (in which they were functioning and had experience) when they learned that the opportunities were given to male colleagues. They were not aware of the process followed to appoint the male to the position. Other participants indicated that they only became aware of site chief positions because the outgoing site chief indicated that they were leaving and would

be replaced. There was no formal notification to the department of a vacancy.

In the survey, we asked participants if they are aware of career advancement opportunities at Niagara Health – 31.70% said that they were aware, 31.15% said that they were not aware, and 31.15% said that they were somewhat aware of those opportunities.

iii. No succession planning

We heard from some participants that there is no succession planning at Niagara Health. We heard from some leaders that they may have succession planning processes that they adopt, but that there is no official requirement for succession planning nor is there any formal process in place. We heard that succession for some leadership positions is determined subjectively by shoulder tapping.

iv. Difficulty hiring females

We heard from some persons that, while they recognize the disparity in female leadership at Niagara Health, there has been great difficulty in hiring females. Specifically, there is difficulty getting females to apply to or take on the respective positions. The following are some of the comments that we heard:

- Despite approaching multiple women for a position, none were interested, for varying reasons, including family commitments. The result is that males are hired externally.
- There are occasions where females are invited to interviews but then they withdraw from the application process.

- Sometimes, no females apply for vacant positions.
- Females do not feel safe to apply for leadership opportunities.
- The environment at Niagara Health is such that it is not conducive to females having a work/life balance. The schedule just does not allow for it.
- There is no attractive path to leadership for females.

Females feel that their role as a mother is a barrier to them taking on leadership roles at Niagara Health

v. Favouritism

We heard from several participants that there is an issue of favouritism at Niagara Health. We heard that access to opportunities is based on who the chief of department wants. In that way, the chief of department acts as a "filter" for advancement. We also heard that in certain departments, decisions are made by the chief of department and certain physicians within the department that the chief identifies.

vi. Barriers in the pool of candidates

We heard several concerns regarding the pool of candidates. Specifically, we heard:

- The hiring process or the criteria that is used to hire creates a barrier for physicians who are not academic. This was explained to mean that there is a great focus on academic factors such as publications. However, we heard, that this approach bars suitable physicians with relevant clinical experience.

- There is a focused effort to hire externally rather than internally, despite there being suitable candidates within Niagara Health.

vii. Insufficient information regarding vacant positions

We heard from some persons that there is insufficient information shared about vacant positions, particularly information regarding compensation for non-chief leadership roles such as site chiefs. Persons who raised this concern indicated that they did not know who made the decision regarding remuneration. However, what they did say was that information regarding remuneration was not disclosed by the chiefs of the department unless and until they expressed an interest in the position.

viii. Short staffed/unwillingness to accept positions

We did hear from some persons that, while they recognized certain disparities, for example, females in leadership, we heard that there is a great challenge to get internal physicians to accept leadership roles because they are sometimes unpaid and require a lot of work or for other personal reasons. We also heard that when there is a difficulty or inability to hire within, they have to look externally. We heard that there is a general problem of shortage of staff at Niagara Health and so when there is a shortage, and not enough applicants, the difficulty, in essence, is that they hire who is available.

g) Fear of reprisal

We heard from several persons that there was a great fear of reprisal for reporting and sharing their concerns. In the survey, participants were asked if they believe that reprisal for reporting concerns is a problem for physicians at Niagara Health – 11.63% strongly agreed that it is a problem,

21.86% agreed, 27.44% neither agreed nor disagreed, 26.51% disagreed that it is a problem, and 12.56% strongly disagreed.

In the survey comments, some participants pleaded with us not to share any aspect of their examples to avoid even the possibility of them being identified. One interview participant told us that they felt like they were having an anxiety attack just from speaking with us. Other participants said that they wanted to talk to us, but they were just so afraid of the repercussions if their participation gets back to the leaders in their departments. We heard from other participants that there were many other physicians who wanted to speak with us in this process but who decided not to because they did not have faith that this process was indeed confidential and that they were not willing to risk being identified to their leaders.

h) Reluctance to report complaints/concerns

We heard from many participants that they were reluctant or unwilling to report their complaints or concerns to Niagara Health. The following were some of the reasons that we heard:

- No faith that anything will be done because Niagara Health has never taken concerns of behaviour and discrimination seriously. There are individuals who changed their mind about speaking with us because they concluded that nothing would be done by Niagara Health to address their concerns.
- It is intimidating to go to the chief of a department with concerns.
- Human resources do not oversee physicians.
- Policies that refer to intolerance for bullying seems like “lip service.”

- IRS is cumbersome.
- IRS is like a “black hole.” There is no known outcome.
- The IRS lacks confidentiality. Some participants described their identity being disclosed to the subject of a complaint after which they were treated poorly. They no longer use the IRS.
- Nothing is done when reports are made to the chief of a department.
- Even when a policy is found to be in breach, nothing is done about it.
- The complaint process is too lengthy.
- Reporting to the chief or using IRS is a “waste of time” because the issue is not taken seriously. So, they learn to just move on.
- The usual recourse is to report concerns to the department chief or the Chief of Staff, but there is no recourse if the concern is in relation to them (the Chief of Staff or department chief).
- People who report are not treated fairly.
- For some, their concerns are not addressed but concerns raised about them are addressed.
- The rigours of the investigation process and having to defend a complaint is a deterrent to reporting.
- The disclosure of witness identities in investigation reports exposes participants to reprisal and deters reporting or participation.
- There is no real place for physicians to complain.

In the survey, we asked participants if the instances of discrimination that they identified were reported – 20.51% said yes, 46.15% said no, 19.23% indicated that they did not know, and 20.51% preferred not to answer the question.

Of those who did report the concern, we asked to whom the issue was reported – Chief of Staff (41.18%), CEO (23.53%), Division Chief (52.94%), Site Chief (29.41%), IRS (5.88%), and MSA (23.53%). We asked if they believed that the response to the complaint was adequate – 35.29% strongly disagreed that it was adequate, 41.18% disagreed, 11.76% neither agreed nor disagreed, 5.88% agreed that it was adequate, and 5.88% strongly agreed that it was adequate.

Of those who indicated that the matter was not reported, we asked them to indicate the reason – 26.47% said that they did not know to whom to report the matter, 70.59% did not believe there would be any response, 47.06% feared reprisal for reporting, 26.47% did not think that they would be believed, and 23.53% indicated "other." Of those who indicated "other," the following were some of the reasons given for not reporting – ongoing issues that are not dealt with, being verbally threatened several times, the interaction was subtle so it would be difficult to be believed, there was no one to whom the issue could be reported, and the issue was perceived as minor.[15]

i) Disrespectful communication

We heard from several participants that there is a culture of disrespectful communication and behaviour at Niagara Health. We heard that:

[15] Participants were asked to select all answer options that applied. Thus, there is overlap in the number of responses.

- Disrespectful comments are made to racialized physicians by patients and staff.
- Disrespectful comments are made to female physicians by male physicians and staff.
- Physicians yell at nurses and staff.
- Physicians are mean, aggressive, and condescending in their behaviour.

j) General lack of respect for physicians

We heard from some participants that there is a general lack of respect for physicians, which is not based on any human rights ground. They felt that the disrespect applies across the board. Some concerns that were raised were:

- Physicians within the department are not included in decision-making processes. Decisions are made by the chiefs of the department without their input, and they are simply told after the fact about their decision without any explanation or basis for the decisions made. Some of these decisions affect their income and day-to-day work. Physicians feel that they have no voice.
- We did hear about dissatisfaction about decisions or attempts to make decisions regarding how physicians are remunerated.
- Physicians are subject to retribution when they express differing or opposing opinions.

k) Additional concerns

i. Challenges caused by amalgamation of hospitals

During the process, we did hear about the amalgamation of the hospitals in the Niagara region that occurred a few years ago and the impact that that amalgamation had on some physicians. We heard that the coming together of the physicians from different sites presented challenges regarding communication, decision-making, income generation, and work distribution. We heard that these issues were exacerbated where department chiefs did not include all physicians within their department in the decision-making process or seek their input.

ii. Dual roles

We heard from some persons that some leaders have dual roles, whether within Niagara Health or also at other hospitals such as the Hamilton health system, and that such dual functions limit their ability to effectively carry out their leadership roles at Niagara Health and limit their understanding and awareness of what is happening in the department or how physicians are feeling. The result, we heard, is that the role is sometimes delegated to others who also do not effectively carry out the functions. One department in which we heard that this was a problem was the Radiology department. We also heard that, for some who have such dual functions, the work can become too much, resulting in them having to relinquish a role. We heard that this occurred in the Psychiatry department, for example.

iii. Impact of Hamilton health system

Although not directly connected to systems at Niagara Health, we did receive some feedback regarding what some perceive as an adverse impact of the Hamilton health system on Niagara Health. Specifically, we heard:

- Attempts to provide best patient care and to build the program in the Niagara region have been obstructed by physicians in Hamilton and the senior leadership there.[16]
- Recent job posting for strategic physician recruitment at Niagara Health was blocked by leadership in Hamilton.

iv. Unfair allocation of resources

We heard that resources are unfairly allocated between the Niagara Health sites.

v. Exclusion of persons with disabilities

We heard from one participant that they were disappointed that this review process excluded persons with disabilities. We did not hear of any particular concerns regarding physicians with disabilities, but we include the comment here for completeness.

l) Additional process information

For completeness, we confirm that we did speak with individuals at Niagara Health who are either responsible for or involved in certain processes that gave rise to physician concerns (described above) and heard their perspectives on this. In some respects, they confirmed gaps in processes. In

[16] We do not have further details on this and did not pursue it further as it does not pertain to a potential systemic barrier.

other instances what they may have described as the process did not always align with what physicians understood the processes or practices to be and/or did not align with the physicians' experiences or observations. In that regard, there seems to be a gap. Our approach to the review was not to test who was right or wrong in what was shared with us. What is important is that the physicians hold certain beliefs and perceptions based on their experiences and observations at Niagara Health. We do recognize that in some cases, physicians' perspectives may be based on a lack of knowledge or awareness, but as we note below in more detail in the recommendations section, we do see that as being part of the problem.

10. Information Gathered from Document Review

In addition to the information from the interview and surveys, we were also provided with relevant documents for our review. The following is a summary of the documents and the information extracted from them.

a) DEI Memo to staff

In May 2022, the Chief of Staff issued a memo to Niagara Health staff regarding the outcome of a review conducted by the Ryerson (as it then was) Diversity Institute. The memo indicated that there was a difference between medical leadership and non-medical leadership regarding the distribution of leadership roles to equity-deserving groups. It indicated that the physician leadership team reflected a high representation of racialized individuals but not gender diversity, while the opposite was true for the non-medical leadership group. The data revealed that 10% of directors/physician chiefs were female and 40% were from equity-deserving groups; 21% of managers, deputy chiefs, and heads of service were female, while 67% were from equity-deserving groups.

The memo went on to reference steps that have been or are being taken at Niagara Health to close the gaps that were identified. They can be summarized as follows:

- Signing on to the Government of Canada's 50/30 challenge – The challenge encourages organizations to achieve gender parity (50%) and representation of persons from equity-deserving groups (30%).

- Recruitment of medical leaders – Intention to have a comprehensive recruitment and selection process for all medical leadership positions similar to what is in place for physician chiefs; advising external recruitment firms of Niagara Health's DEI strategy; inclusion of a DEI specialist on all physician chief interview panels and other leadership roles as requested; inclusion of DEI-related questions for all leadership roles; recruitment panel members required to watch a training video which highlights keys to interviewing with a diversity and inclusion lens; the Mutual Respectful Workplace and Diversity policies are reviewed with all newly hired physicians and new leaders.

- Leadership development opportunities – A leadership development program called "Extraordinary U." Physician chiefs are eligible to participate and the opportunity will be extended to Heads of Service and Deputy Chiefs for 2022/2023; succession planning program in place since 2016 (plan includes succession planning for physician chief and chief of staff roles). Intention to extend succession planning to head of service roles in 2023; for 2021-2023, DEI goals have been included in leadership performance goals and reviews for non-medical colleagues and chiefs.

- Updating policies and processes – A DEI lens policy checklist is being used to mitigate or reduce the potential for bias and to address systemic barriers. The checklist is designed to validate the inclusion of key statements and processes within Niagara Health's policies and by-law; the DEI lens checklist is being used to review workplace behaviour and related policies and practices.

- IRS reporting issues - the Incident Report System (IRS) has been updated to include a field to specifically report acts of discrimination; all submissions are reviewed by the Chief of Staff and Workplace Relations. Every incident is investigated by Workplace Relations or an external third party; the reporting process is outlined in the annual Mutually Respectful Workplace Diversity LERNH module and training on the process will be offered to physicians.

b) Niagara Health DEI action plan

Niagara Health has been engaged in certain steps geared towards advancing their DEI initiative. One of those steps included the establishment of a DEI committee and a commitment to the government's 50/30 challenge.[17] In May 2022, the Chief of Staff issued a memo to all professional staff at Niagara Health providing an update to them on diversity, equity, and inclusion. The memo referenced the results from an external process conducted by Ryerson University (as it then was) in which they (Ryerson) completed a Diversity Assessment Tool and a DEI staff and physician survey. We received a copy of the survey results that was shared with the physicians. It showed that 98 physicians participated in the survey, which represented 19% of the total number of physicians at Niagara Health. In

[17] A commitment to ensure that the workforce represented 50% female and 30% racialized groups.

furtherance of that commitment, a member of the DEI committee now participates in the recruitment and interview processes at Niagara Health.

c) IRS complaints 2018-2022

We were provided with a summary of the IRS complaints against physicians for the period 2018 to 2022. The data can be summarized as follows:

Year	# of physician-relates IRS
2022	46
2021	24
2020	35
2019	44
2018	33

The complaints were all classified as either level 1 ("near miss/good catch") or level 2 ("no harm") and were primarily categorized as related to either code of conduct or harassment. The incidents occurred in diverse departments at all five sites at Niagara Health. We noted that many of the complaints pertained to disrespectful and offensive communication by physicians. The following is a summary of the main responses or outcomes of the complaints:

- Protocol review and clarification
- Facilitated conversation (sometimes declined despite being offered)
- Coaching
- Training/Re-training – training included training on the Mutual Respectful Workplace Policy
- Chief of department met with physician to review series of concerns (in some cases, follow-up was said to be ongoing)

- Mandatory learning courses

It was explained to us that the outcome of coaching and reviewing the Mutually Respectful Workplace includes policies, strategies, and tools, and the response is tailored to each particular incident. It was further explained to us that the practice, in the event of an IRS complaint, is to follow up with the complainant and/or physician after one to three months to ensure a sustained behaviour change.

We did note reference to an external investigation into a complaint of sexual harassment, which was substantiated, and the physician was subject to discipline (we do not know the nature of the discipline issued). We also noted that some complaints were described as "unsubstantiated," but there is no indication as to what process was conducted or information gathered to arrive at that conclusion.

d) Summary of physician reviews from 2019-2023

The data revealed that there have been 11 physician reviews from 2019-2023. The physicians subject to review were from diverse departments across the Niagara Health system. Of them, nine were male and two were female and three were said to have self-identified as a member of an equity-deserving group on a recent re-appointment form that they had presumably completed (two of those three physicians were female and one was male).

e) Niagara Health DEI training summary

We understand that the following is a list of the DEI training that is taken by physicians at Niagara Health:

- DEI overview, expectations, and training at orientation for new hires

- Annual clinical interprofessional practice training — Cultural Humility approach to DEI
- Annual mandatory LERNH/on-line module — Mutually Respectful Workplace and Diversity
- Inclusive recruitment training video for everyone on interview panels
- New leader onboarding (including physician chief on-boarding) — DEI training
- Updates/training at Medical Advisory Committee
- Annual physician lunch and learn training series (with Chief of Staff) for CME credits
- San'yas Indigenous Cultural Safety Training available to staff, leaders, and physicians
- DEI Essentials for leaders and physicians on the following:
    - Land Acknowledgement, what it is, and how we connect it to action
    - An introduction to Cultural Humility
    - Purpose of Diversity, Equity and Inclusion — systemic racism, historical underrepresentation, equal opportunity, business case-talent, innovation, creativity
    - Systemic racism
    - White privilege
    - Challenges-gap in policy and actual work being done
    - Culture Humility and REAL models
    - Unconscious bias and strategies to manage it
    - Microaggressions

- 7 ways to practice active allyship — deep curiosity, honest introspection, humble acknowledgement, empathetic engagement, authentic conversations, vulnerable interactions
- 6 traits of inclusive organizations — cognizance, courage, commitment, collaboration, curiosity, cultural intelligence
- Applying learning to action

11. Policies

As part of the review, we were also provided with copies of the following relevant Niagara Health policies:

- Niagara Health System Professional By-Law
- Niagara Health System Rules & Regulations
- Professional Staff Code of Conduct
- Disruptive Professional Staff Members
- Mutually Respectful Workplace & Diversity

These are relevant because they inform certain recommendations that we make in this report. We have extracted the relevant sections from these respective policies and included them in **Appendix D** attached.

12. Recommendations

Our mandate is to conduct a systemic review to identify any systemic barriers within Niagara Health's physician group, make findings, if possible, in relation to any specific allegations of systemic discrimination, and make recommendations based on these findings. While we did hear some specific allegations, insofar as individuals were unwilling to come forward due to

their fear of reprisal and asked that we not disclose their identity, we were unable to probe further and make factual findings with respect to those specific allegations. The effect is that we were therefore limited in our ability to make findings with respect to systemic discrimination regarding those specific allegations. However, based on what we were told, as outlined in the information gathered sections above, we have identified areas for potential systemic discrimination. In this section, we discuss those areas for potential systemic discrimination and make recommendations on how to address the potential barriers identified.

For completeness, while we made best effort to capture and note all or most of the concerns that were shared with us so that Niagara Health is aware that those concerns exist, we do not make recommendations regarding all the issues shared with us. This is because they do not all speak to a systemic barrier. The following are some of the topics regarding which we do not make recommendations, but nonetheless note as matters that might very well warrant Niagara Health's attention:

- Uncertainty of the MSA's role
- General disrespectful communication by and against physicians where the communication is not towards any particular marginalized group
- Generally failing to include physicians in a department in decision-making on matters that affects them such as their compensation
- Potential discrimination in long-term patient care

- Adverse treatment of internationally trained physicians[18]

Before turning to our recommendations, we wish to note some of our general observations which inform our recommendations.

a) General observations

Based on the information that we have gathered, we have identified potential systemic barriers within the physician group at Niagara Health. We recognize that systemic discrimination within the healthcare system in Ontario may not be unique to Niagara Health. The issue has been and continues to be widely discussed in the media and other platforms. In fact, as we heard during the review, a contributing factor may be the wider Niagara community in which Niagara Health functions.

Nonetheless, we believe that the barriers that we have identified, if they indeed exist, have been created because of gaps in the policies, practices, and procedures at Niagara Health, as well as what seems to be the organizational culture at Niagara Health.

It is evident that there is a lot of work being done at Niagara Health to further the DEI initiative and that is to be commended. However, it is apparent that while positive steps have been taken, there is still a need for considerable growth and improvement as is indicative from the experiences shared by the physicians in this process.

We appreciate that the adverse experiences shared may not represent the experience of most physicians at Niagara Health. However, what we know about systemic barriers is that they tend to impact a minority or

[18] Although we make no recommendations specific to dealing with the treatment of internally trained physicians, our recommendations to address discrimination and disrespectful communication, if implemented, should aid in addressing some of the concerns raised regarding internationally trained physicians at Niagara Health.

marginalized group. Thus, when assessing barriers and their impact, we do not generally rely on the experience of the majority; rather, we pay close attention to the experience of those who fall into those minority or marginalized groups.

We note that some of our recommendations may overlap with some DEI measures that we have heard Niagara Health intends to take or have taken. Nonetheless, we have included our recommendations and the justifications for each so that they may be considered by Niagara Health when considering if and how to implement the respective measures.

Also, as mentioned above, we noted that there were at times a difference in what physicians described as their observations and experiences and what was shared with us as operating practices and procedures. As noted earlier, our approach to the review was not to test who was right or wrong. Instead, our approach was to look globally at the matters brought to our attention, identify any potential barriers, and make recommendations where we note those barriers. That is the focus of our recommendations. We now turn to the recommendations.

The recommendations have been grouped into categories based on the potential systemic barriers that have been identified. The approach to each category is to first outline the basis of our conclusion that there is a potential systemic barrier and then go on to outline the recommendation to address the particular barrier. A summary of our recommendations and the basis for each recommendation is also attached as **Appendix E.**

b) Recommendations regarding hiring, promotion, and opportunities for advancement

As mentioned as part of our general observations, we noted, based on what we heard, a general lack of standardized processes for hiring, promotion,

and accessing opportunities for career advancement in the physician group. In essence, we heard that while there is a standardized process for the recruitment of department chiefs, there is no standardized process for their reappointment to their department chief position, and they are being reappointed as a matter of course with no regard to their performance or feedback from physicians with whom they work in the department. The effect is that where there are concerns such as discrimination, improper treatment, or poor management by department chiefs, those concerns can be perpetuated for years because it seems like there may not be a real opportunity for those concerns to come to light and be reasonably considered. This represents a potential gap in the system that seems to be having adverse effects on some physicians.

On the other hand, with respect to other (non-chief) department leadership positions (deputy chiefs, site leads, and heads of service), we heard that there is no standardized process either for their recruitment or their reappointment. Instead, their appointment and reappointment are left to the unilateral decision of the department chief who makes a recommendation to the Chief of Staff and MAC. However, there are no established factors to inform the consideration of the recommendation made. As such, what happens is, in essence, a "rubber-stamping" exercise. The effect, we heard, is that such subjective practices have been vulnerable to being influenced by biases, whether conscious or unconscious.

We also heard that there is no established practice or process for succession planning at Niagara Health. We heard from some leaders that they may have some informal succession process in place while others did not necessarily turn their minds to the issue of succession. The result is that there is no concerted effort to identify the most talented, and this, along

with the lack of hiring or reappointment processes, may have the effect of excluding qualified physicians.

We have made the recommendations that follow to address these issues.

i. Work with a DEI expert

To address these potential barriers, and minimize the risk of systemic discrimination, we recommend that Niagara Health work with a consultant and/or DEI expert (whether internal or external) to propose amendments to the by-law and create and implement rules or guidelines to standardize hiring, promotion, and access to opportunities for advancement at Niagara Health. What follows are some of the changes and steps that we recommend can be considered by Niagara Health together with the consultant and/or DEI expert.

ii. Amend the by-law to address the reappointment of department chiefs

We recommend that Niagara Health amend the by-law to clearly outline the process for the reappointment of department chiefs as well as the factors to be considered by the MAC in deciding on reappointment. We further recommend that the factors to be considered could include consideration of the department chief's performance review as well as feedback from the staff and physicians within the department. When seeking the feedback from members of the department, it is best if the members of the department be afforded the opportunity to share that feedback anonymously to avoid any concern of reprisal or job security.

iii. Establish process for performance review – department chiefs

If the recommendation immediately above is adopted, it would also mean that, if the Board has not yet established a process for reviewing the performance of department chiefs, then they would need to do so, and we recommend that they do.

iv. Amend the by-law to address hiring/reappointment of (non-chief) leadership positions[19]

The by-law could be amended to include an established process for the hiring of deputy chiefs, site leads, and heads of service as well as an established process, like that recommended in item (i), for the reappointment of physicians to these positions. It is not clear why site leads were not included in the by-law as a leadership position under Article 9. Thus, to the extent that a site lead is a recognized leadership position, the position could be included in the by-law and included in any established standardized process.

As it pertains to the reappointment to the respective positions, we recommend that this be subject to the performance review of the person who holds the position and feedback from within the department and between departments, where necessary.

v. Develop factors to be considered in hiring and reappointment decisions for (non-chief) leadership positions

For the hiring and/or reappointment for each leadership position, the by-law could perhaps outline the factors to be considered by the MAC and/or

[19] To be clear, our recommendations here do not apply to department chiefs, because the by-law currently includes a standardized hiring process for department chiefs.

the Board when determining whether to accept the department chief's and/or Chief of Staff's recommendation.

vi. Develop standardized recruitment practices for leadership positions

We recommend that Niagara Health work with the consultant and/or DEI expert to establish standardized recruitment practices for leadership positions that are set out in the by-law and/or a separate policy. That standard process should include widespread advertisement of positions and diverse application and interview review panels. To supplement the standardization of the process, we recommend:

(i) That there be guidelines for departmental leaders on best recruitment practices.

(ii) That guidelines be given to the department chief on the manner and nature of obtaining feedback from physicians within the department or between departments.

vii. Establish guidelines regarding succession planning

As it pertains to succession planning, we recommend that guidelines be established to inform succession planning for departmental leaders. The guidelines should emphasize identifying diverse talent to contribute to the effort of diversifying the leadership and providing support to individuals who are intending to take on leadership roles.

c) Recommendations regarding potential negative impact of pregnancy and parental leave

We heard that pregnancy adversely impacts female physicians in their matriculation from Associate Staff to Active Staff and female surgeons who

need operating room time. We have made the following recommendations to address this potential issue.

i. Review physician matriculation process to ensure no impact from *Human Rights Code*--related leaves

In the by-law, when physicians are first appointed as Associate Staff, they undergo a two-year probationary period before being appointed to Active Staff, subject to their performance review. As mentioned above in the information gathered section, we heard that females who take maternity leave may be adversely impacted in the matriculation process. Specifically, we heard that female associate physicians who have taken maternity leave during their two-year probationary period as Associate Staff have been set back in their ability to matriculate to Active Staff because the time taken for maternity leave has not been counted. We also heard that the setback is in fact longer than the time taken for maternity leave, because consideration for their matriculation is deferred until whenever the next performance review is conducted, which is not necessarily immediately upon their return.

The by-law is silent on the impact, if any, that a maternity leave (paternity leave or disability leave)[20] will have on a physician's ability to matriculate to Active Staff. The effect is that there is a potentially discriminatory impact, in violation of the *Human Rights Code*'s, on women who take maternity leave, men who take paternity leave, and physicians who take leave for a disability or extended illness.

[20] The by-law states that a leave of absence includes maternity leave, paternity leave, and leave due to extended illness or disability.

We recommend, therefore, that Niagara Health consider the impact of these leaves on matriculation and ensure that any potential discriminatory impact is addressed in the by-law.

ii. Review allocation of operating room time to ensure no impact from maternity/parental leave

We also heard that female surgeons lose their allotted operating room times when they take maternity and/or parental leave and they do not get it back when they return. We heard that operating room time is a scarce commodity for surgeons, so this result greatly impacts female physicians. We also heard that inadequate operating time may ultimately affect career advancement opportunities, because operating experience is a considered factor for leadership opportunities. This is a potential systemic barrier affecting women who take maternity and parental leave.

Therefore, we recommend that Niagara Health take necessary steps to examine the impact of maternity and/or parental leave on access to operating room time and determine whether there are any adverse impacts tied to these leaves. If there are, Niagara Health needs to put safeguards in place to ensure that women who take maternity and/or parental leave are not adversely impacted.

d) Recommendations regarding reporting and complaint process

As mentioned above, we heard many reasons why physicians at Niagara Health do not report their concerns. Those reasons include – a fear of reprisal, particularly when the concern involves the leaders to whom they would normally have to report their concern, their experience that nothing will be done, the practice of certain physicians (particularly non-racialized and male physicians) not being held accountable, and lack of confidentiality

in the process. We also heard that even if they use the existing IRS, they do not know what happens with their complaint after it is made.

In light of the above, unless a mechanism is put in place to allow physicians to safely report their concerns, very little can be achieved in the way of change. Therefore, we recommend that the following be done to standardize the reporting and complaint process:

i. Appoint an independent physician ombudsman

The physicians at Niagara Health need to be able to report their concerns to someone whom they feel they can trust and will take their concerns seriously. An independent physician ombudsperson, one who is either external or internal to Niagara Health, could give that assurance. The role of the ombudsperson would be to receive physician complaints (whether through IRS, a written complaint, direct communication, interviews, or any other means), assess the complaints, determine the appropriate process for resolution, and arrange for any necessary communication.

If an investigation is required, the investigation could be conducted by the ombudsperson in conjunction and consultation with the Medical Affairs Department (which we understand is currently involved with handling such complaints). If this recommendation is adopted, we further recommend that a policy be established to outline and govern the function of the ombudsperson, or an existing policy be amended to reflect this.

ii. Implement a confidential reporting system

Given the overwhelming fear of reprisal that physicians have, we recommend that Niagara Health implement a confidential reporting system. Online reporting services exist to facilitate this function.

iii. Train physicians on reporting and complaint process

Based on the information that we received, it became apparent to us that many physicians are unfamiliar with the policies at Niagara Health that relate to the reporting and complaint process. Therefore, we recommend that they be trained and educated on them.

iv. Look into the impact of failing to expunge unsubstantiated complaints from record for racialized physicians

We heard that unsubstantiated complaints are not expunged from a physician's record. Specifically, we heard that racialized physicians are disproportionately subject to more complaints than non-racialized physicians because of racism and when these complaints are considered, they are often found to be unsubstantiated. However, despite being unsubstantiated, the complaint remains on their record and contributes to a subsequent decision to review the physician's practice. This, we heard, is part of the problem contributing to racialized physicians being disproportionately subject to review (discussed in more detail under a separate heading below). This is also a potential systemic barrier.

It is not clear whether the complaint remaining on the record is a policy or practice, nor are we aware of Niagara Health's rationale if it is indeed a practice or policy. Nevertheless, insofar as there may be a potential systemic barrier for racialized physicians, we recommend that Niagara Health look into (i) whether there is indeed a failure to expunge unsubstantiated complaints from a physician's record and (ii) if so, whether the failure to do so has a disproportionate impact on racialized physicians. This could be part of the work done by the task force discussed below regarding the physician review process.

e) Recommendations regarding physician reviews

We heard from many participants about the disproportionate experience of racialized physicians with respect to physician reviews. To summarize, we heard about racialized physicians being disproportionately subject to review, being subject to harsher treatment during their reviews, not being given any information about the issues giving rise to their review, no accountability for those who bring vexatious or frivolous complaints, no accountability for non-racialized physicians with problematic patient cases, and being subject to review where they (racialized physicians) are the ones who filed a complaint.

This is potentially discriminatory because what it speaks to is differential treatment of racialized physicians with respect to the review process leading to an overrepresentation of racialized physicians being subject to review.

As outlined in section 10 (d) above, we were provided with the data for the physicians subject to review from 2019-2023. Based on the information received, there have been 11 physician reviews (the physicians were from diverse departments across the Niagara health system). Of them, nine were male and two were female and three were said to have self-identified as a member of an equity-deserving group on a recent re-appointment form that they had presumably completed (two of those three physicians were female and one was male).

We note that certain individuals who have been subject to review have been described to us as being racialized, but they are reflected in the data provided to us as not self-identifying as a member of an equity-deserving group. Therefore, there is potentially a gap in the data that was provided to us and what was actually obtained. We do not know if the explanation is a gap in understanding what was meant by the term “equity-deserving

group," if there is any discrepancy in the data provided, or if there is another explanation for the disconnect. This is not insignificant because, on the face of the data that we have, the individuals who have been subject to review in the last five years have been predominantly non-racialized males, which does not necessarily align with the concern that we heard so much about. The explanation could be a few things. Namely:

- The data that we have been provided is incomplete; or
- The feeling or perception that racialized physicians have been subject to disproportionate treatment based on their race and ethnicity may be wrong because the physicians do not have the benefit of the data that we have.

We also note that what the data provided does not tell us about the concern that non-racialized physicians are not subject to review despite having what is perceived as serious occurrences regarding patient care. Naturally, there would be no data for that.

We are not making a determination on any of this one way or the other because we do not have enough information to make that determination. However, what is clear is that there is a perception that racialized physicians are disproportionately subject to review while non-racialized physicians who are also known to have problematic patient care situations are not subject to review. From our perspective, the perception (valid or not) seems to stem from a lack of established process to govern the review process and a lack of information known to physicians, thereby leading to the concern of a lack of transparency.

To address these potential barriers for racialized physicians, we recommend that a written process (either in a policy or other document) be established

to standardize the review process, training on the process, and a task force be created to look into whether racialized individuals are indeed disproportionately subject to review. We have expanded on these recommendations below.

i. Standardize process for physician reviews

We recommend that Health Niagara standardize, in writing (in a policy or otherwise), the process for deciding when a review will be done, including who be appointed as the decision-makers, factors informing decision for review, notification to the physician under review, and the opportunity for them to respond.

ii. Provide training on review process

Physicians should be trained on any new written processes. However, even if that recommendation is not adopted (i.e., the recommendation to standardize the process in writing), we recommend that physicians be trained on the practice or procedure that currently exist at Niagara Health for reviews. In our opinion, if physicians are educated on the review process, they will know what to expect if they become involved in the review process and will be better able to objectively assess whether they are being treated differently. Their perspective will be based on their knowledge about the process rather than speculation.

iii. Create a task force to examine physician review process

In addition to the establishment of a standardized process to regulate the review process, we recommend that a task force be created to:

(i) Continue to collect data and monitor the identity of the individuals who are subject to review with a view to actively

identifying if there is indeed an overrepresentation of racialized physicians being subject to review.

(ii) Review all the cases of physicians that have been subject to review and determine:

- If the physicians were indeed disproportionately from racialized groups.
- Whether a review of the racialized physicians was warranted in those particular circumstances.
- Whether the processes that were engaged by Niagara Health in relation to racialized physicians were consistent with the process engaged for others.
- Whether racialized physicians have been subject to harsher or unfair treatment in comparison to non-racialized physicians.
- Whether there are similar circumstances that involved non-racialized physicians and, if so, how they were dealt with.

We recommend that the task force comprise of individuals with subject-matter (i.e., medical) expertise, legal knowledge, and a DEI lens. To address the perception of the physicians on this issue and a concern of a lack of transparency, the task force could publish the results/data (without identifying anyone) so that the physicians at Niagara Health can have a better sense of whether there is a problem or not.

f) Recommendations regarding work environment

We heard that the environment at Niagara Health was unfavourable for persons from certain equity-seeking groups, particularly female and

racialized physicians. In essence, we heard that racialized and female physicians feel excluded from decision-making while the perspective of white physicians are considered; racialized and female physicians are subject to disrespect from staff, patients, and other physicians; racialized physicians are stereotyped as aggressive or unprofessional when expressing opinion and objections; and females are unwilling to pursue leadership opportunities because the environment at Niagara Health does not set them up for success or they are perceived as not being able to handle the responsibility along with their family obligations.

We also heard of concerns that certain religious holidays are not considered when events, meetings, and programmes are planned, and the effect is that persons who are part of those religions are excluded. These reveal potential systemic barriers.

Our recommendations regarding the work environment are below.

i. Work with a DEI consultant/expert

Based on the feedback we received, it appears to us that there are some real concerns regarding the work environment and work culture at Niagara Health which adversely impact the work experience for racialized and female physicians. Thus, the response needs to be a deliberate and long-term effort to change the culture at Niagara Health – and how physicians perceive the culture. That effort goes beyond what this review process could achieve because it requires a shift in the "on the ground" day-to-day operations and functioning of Niagara Health through the support and ongoing monitoring of a consultant and/or DEI expert whose focus is to track these issues and respond to them when they arise. That is our recommendation. Specifically, that Niagara Health work with a consultant and/or DEI expert to look into the issues that we have identified, develop

and implement strategies on how to address them, and monitor the efficacy of those strategies. What follows are some of the steps that we think could be taken to start the process of changing the work environment and culture at Niagara Health.

ii. Develop guidelines on departmental decision-making

From our perspective, physicians feeling excluded from decision-making processes, like many of the other concerns we have discussed so far, have to do with a lack of established processes and actions being taken based on the subjective determination of the leader of the day. We do recognize that the role of a leader presupposes that they will have some measure of autonomy and decision-making powers. However, there needs to be clarity on what those decisions are and there should be some guidance on the best practices in exercising decision-making powers because the exercise of decision-making powers ought not to be exclusive or discriminatory.

Therefore, we recommend that guidelines be developed to provide guidance to departmental leaders about the matters over which they have autonomous decision-making powers and those which require consultation with members of the department before a decision is made. The guidelines should speak to inclusive and non-discriminatory decision-making.

iii. Provide training for physicians

We recommend that management training for the departmental leaders be delivered. Such training should include a component on managing diverse groups in a manner that is equitable and inclusive, and on microaggressions. The training should include education on identifying these biases (such as the stereotype that racialized people are aggressive) and how to overcome them.

We also recommend that physicians, particularly those responsible for hiring, be educated on discriminatory practices in hiring, particularly relating to sex and family status-based discrimination that affects women – for example, discouraging females from applying for leadership positions. Regarding internal recruitment, we heard that interviewers are now required to watch a video on recruitment with a DEI lens. This is commendable, but we recommend that they be required to do more than watch a video, because there is no guarantee that physicians actually learn from the video — that is more likely through direct training where interaction with an instructor is possible.

We also recommend that Niagara Health conduct workshops with Niagara Health physicians in which Niagara Health would do the following:

- Outline the concern it has regarding the seeming culture of disrespectful communication by physicians.
- Emphasize Niagara Health's non-tolerance for disrespectful behaviour.
- Indicate the potential repercussions for this type of behaviour.
- Encourage individuals to report adverse experiences.

Also, conduct a workshop with (non-physician) staff in which Niagara Health would do the following:

- Indicate Niagara Health's non-tolerance for disrespectful behaviour from staff or physicians.
- Encourage staff to report concerns or adverse experiences.

- Remind staff that, while reporting is encouraged, the complaint/IRS is not to be used as a weapon against physicians or anyone else.

- Emphasize the non-tolerance for vexatious complaints and outline the potential consequences for vexatious complaints.

The message from the workshops should be reiterated on Niagara Health communication platforms including the website and internal communications.

iv. Address barriers regarding the hiring of women and racialized physicians

Regarding the barrier created for hiring women based on the organizational culture, as well as racialized physicians, Niagara health needs to take steps to 1) actively recruit women and racialized physicians, and 2) change the perception about the environment. We recommend the following, as a start:

- *Advertise vacancies on diverse job boards* – A first step to attracting females and racialized physicians to leadership is to ensure that Niagara Health's recruitment process targets platforms accessed by female and racialized physicians if it does not already do so. For example, advertising vacancies with the Federation of Medical Women of Canada and Canadian Women in Medicine.

- *Publicize Niagara Health's commitment to engaging women and racialized physicians in leadership* – On internal and/or external platforms, issue a public statement expressing Niagara Health's commitment to advancing women and racialized physicians in leadership and invite qualified female physicians to apply for such opportunities when they arise.

- *Celebrate women and racialized physicians in leadership* – When females and racialized physicians at Niagara Health are appointed to leadership positions, issue internal communication across Niagara Health.

- *Invite diverse referrals* – Invite physicians and staff at Niagara Health to refer female and racialized candidates that they know of.

- *Ensure that recruiters are trained in unconscious bias* – One of the concerns that we heard is that the external recruiters used by Niagara Health have historically targeted male physicians. However, we also heard that one of the DEI efforts has been to add two new external recruiters. Whether the recruiters are internal or external, it is important that Niagara Health be satisfied of their training in unconscious bias to lessen the likelihood that they will engage in biased recruitment processes.

v. <u>Provide support to women with families</u>

We recommend that Niagara Health consider and implement supports for women at Niagara Health to pursue leadership positions. One example we heard during our interviews is the possibility of job sharing. We heard that two female physicians were allowed the opportunity to share a role. We are not suggesting that this be an organization-wide implementation; we are simply noting it as an example of support that has been afforded. Other support might be the resources that are made available to them. For example, we heard that female physicians, particularly surgeons, tend to take shorter maternity and parental leave, but that there is nowhere (except a room with a glass window) for them to breast pump. While this is not specific to leadership per se, providing a private safe space for female physicians to use a breast pump would be a step that signals to the females

at Niagara Health that Niagara Health is prepared to provide an environment in which they are set up to succeed without them having to sacrifice their family commitments.

vi. Demonstrate non-tolerance for disrespect and discrimination

As part of the long-term effort to change the culture at Niagara Health and communicate non-tolerance for harassment or discrimination, Niagara Health ought to make it part of its practice to impose appropriate repercussions where discrimination and disrespect occurs. The repercussion is what will function as deterrence and contribute to an ultimate shift in the culture and mindset regarding women in leadership.

vii. Include consideration of religious holidays in DEI efforts

To address the issue of events being scheduled without considering religious holidays or other customs, we recommend that part of the mandate for Niagara Health's DEI specialist could include looking into measures and strategies that may be implemented to ensure that religious holidays and practices are taken into account when events and/or meetings are held at Niagara Health.

13. Conclusion

In this review, we were unable to make any factual findings given that individuals did not wish to disclose their identity so that an investigation into their concerns could be conducted. Nonetheless, based on the information that we received; we identified gaps in the system that could potentially lead to systemic gaps for physicians. We have made recommendations on how to address some of these gaps and we are confident that, should they be implemented, it will go a long way to resolving some of the barriers, either actual or perceived, that exist. That

said, for our recommendations to be effective, it will require the commitment of all physicians at Niagara Health and other leaders as an entire shift in the organizational culture is necessary.

As organizations across the country have been taking steps to combat the growing concern of systemic barriers within their workplace, this is an opportunity for Niagara Health to enhance and bolster its participation in that fight and to position itself as an agent for change within the wider Niagara community.

Date: August 14, 2023

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Per: Dana J. Campbell-Stevens
RUBIN THOMLINSON LLP

Appendix A

THE NIAGARA HEALTH SURVEY

Thank you for taking the time to participate in this voluntary survey, which is intended to inform of any systemic barriers that may exist within the Niagara Health physician group. As you have been told, the review is being conducted independently by us, Rubin Thomlinson LLP.

This survey will take approximately 20 minutes to complete. We ask that you respond to the survey questions thoughtfully and candidly. Your responses are confidential. Rubin Thomlinson will review the surveys as part of the review process, but we will not be submitting the completed surveys to Niagara Health.

The survey asks questions related to your perception and experience regarding systemic barriers within the Niagara Health physician group.

This survey includes questions with specific answer options; however, we also invite you to share the reasons for your responses and any other comments that you may have and would like to share. As such, there is an opportunity at the end of the survey to expand on your answers, if you so choose. You will also be given the option to provide your name and contact information. The reason for this is to allow us (Rubin Thomlinson) the option to follow up with you directly if we require clarification or more information about any of your responses or for us to contact you if you wish to have a one-on-one interview to discuss your thoughts.

The deadline to submit your response is November 25, 2022. Although this survey is optional, your participation is important to Niagara Health. If you have any questions about the survey, please email us at dcampbell@rubinthomlinson.com

Thank you, in advance, for your participation in this process.

1. What is your role or position at Niagara Health? (select all that apply)

- [ ] Physician
- [ ] Medical Advisory Committee member
- [ ] Member of leadership team
- [ ] Other (please specify)

2. What department are you in? (select all that apply)

- [ ] Anesthesia
- [ ] Diagnostic Imaging
- [ ] Emergency Medicine
- [ ] Family Medicine
- [ ] Laboratory Medicine
- [ ] Medicine
- [ ] Obstetrics & Gynecology
- [ ] Oncology
- [ ] Pediatrics
- [ ] Psychiatry/Mental Health
- [ ] Surgery
- [ ] Other (please specify)

- [ ] None of the above

3. Please specify your division (select all that apply).

- [ ] Chronic Pain
- [ ] Interventional Radiology
- [ ] Cardiology
- [ ] Critical Care Medicine
- [ ] Dermatology
- [ ] Endocrinology
- [ ] Gastroenterology
- [ ] General Internal Medicine
- [ ] Geriatrics
- [ ] Hospitalist
- [ ] Infectious Diseases
- [ ] Nephrology
- [ ] Neurology
- [ ] Physical Medicine & Rehabilitation
- [ ] Respirology
- [ ] Rheumatology
- [ ] Midwifery
- [ ] Hematology/Thrombosis
- [ ] Other (please specify)
- [ ] Medical Oncology
- [ ] Palliative Care
- [ ] Radiation Oncology
- [ ] Neonatal ICU
- [ ] General Dentistry
- [ ] General Surgery
- [ ] Ophthalmology
- [ ] Oral Surgery
- [ ] Orthopedic Surgery
- [ ] Otolaryngology
- [ ] Plastic Surgery
- [ ] Surgical Assist
- [ ] Thoracic Surgery
- [ ] Urology
- [ ] Vascular Surgery
- [ ] Prefer not to answer

- [ ] None of the above

4. What is your primary credentialing category with Niagara Health?

- [ ] Associate
- [ ] Active
- [ ] Courtesy
- [ ] Locum/Term
- [ ] Temporary
- [ ] Other (please specify)

5. How long have you been working with Niagara Health?

- [ ] Less than one year
- [ ] More than one year but less than three years
- [ ] More than three years but less than five years
- [ ] More than five years

6. I am treated with respect at Niagara Health.

Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
○	○	○	○	○

7. Interactions at Niagara Health between physicians are respectful and positive.

Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
○	○	○	○	○

8. The Niagara Health workplace environment for physicians is inclusive and accepting of diversity.

Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
○	○	○	○	○

9. There is an atmosphere of trust between physicians at Niagara Health.

Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
○	○	○	○	○

10. I feel that my opinions are respected by my physician colleagues at Niagara Health.

○ Strongly Disagree ○ Disagree ○ Neither Agree nor disagree ○ Agree ○ Strongly Agree

11. I feel comfortable expressing opinions that differ from those who are senior to me.

Strongly Disagree	Disagree	Neither Agree no Disagree	Agree	Strongly Agree
○	○	○	○	○

12. I believe that reprisal for reporting concerns is a problem at Niagara Health for physicians.

Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
○	○	○	○	○

13. I believe that there is discrimination within the physician group at Niagara Health.

Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
○	○	○	○	○

14. I rate the level of discrimination in the physician group at Niagara Health as:

- ☐ Non-existent
- ☐ Mild
- ☐ Extreme
- ☐ Neutral

15. The type of discrimination that exists in the physician group at Niagara Health is on the basis of: (select all that apply)

- [ ] Citizenship
- [ ] Race
- [ ] Place of Origin
- [ ] Ethnic Origin
- [ ] Colour
- [ ] Ancestry
- [ ] Disability
- [ ] Age
- [ ] Creed/Religion
- [ ] Sex/Pregnancy
- [ ] Family Status
- [ ] Marital Status
- [ ] Sexual Orientation
- [ ] Gender Expression
- [ ] Record of offences
- [ ] None of the above
- [ ] Prefer not to answer
- [ ] Other (please specify)

16. I have witnessed or personally experienced discrimination at Niagara Health.

- [ ] Yes
- [ ] No
- [ ] Prefer not to answer

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17. My experience was:

- [ ] Personal
- [ ] As a witness
- [ ] Being told about discrimination
- [ ] Other (please specify)

18. The nature of the discrimination that I experienced, witnessed or heard about was:

- [ ] Systemic discrimination (based on policies, procedures, or practices)
- [ ] Discrimination by another physician
- [ ] Discrimination from a patient
- [ ] Other (please specify)

19. I experienced, witnessed or heard about discrimination in the following areas (select all that apply).

- [ ] Hiring
- [ ] Promotion
- [ ] Salary/Compensation
- [ ] Discipline
- [ ] Performance management
- [ ] Access to training or other opportunities
- [ ] Distribution of work
- [ ] Prefer not to answer
- [ ] Other (please specify)

20. Please briefly explain the discrimination that you witnessed, experienced, or heard about.

21. Was the discrimination reported?

- [ ] Yes
- [ ] No
- [ ] Not known
- [ ] Prefer not to answer

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22. To whom or by what means was the matter reported? (select all that apply)

- [ ] Chief of Staff
- [ ] Chief Executive Officer
- [ ] Division Chief
- [ ] Other (please specify)
- [ ] Site Chief
- [ ] Information Reporting System (IRS)
- [ ] Medical Staffing Association

23. I believe the response to the complaint was adequate.

Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
○	○	○	○	○

24. Why was it not reported?

- [ ] I did not know who to report it to
- [ ] I did not believe there would be any response
- [ ] I feared reprisal for reporting
- [ ] I did not think I would be believed
- [ ] None of the above
- [ ] Prefer not to answer
- [ ] Other (please specify)

THE NIAGARA HEALTH SURVEY

25. I believe that Niagara Health is doing enough to address the issue of discrimination in the physician group.

Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
○	○	○	○	○

26. I would feel comfortable reporting discrimination at Niagara Health.

Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
○	○	○	○	○

27. I am aware of the Niagara Health reporting procedures if a physician needs to report a concern of discrimination.

Yes	No	Somewhat
○	○	○

28. I believe that the reporting procedures for physicians to report concerns at Niagara Health are adequate.

Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
○	○	○	○	○

29. I am satisfied with my career advancement within Niagara Health.

Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
○	○	○	○	○

30. I feel supported by Niagara Health in my career advancement.

Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
○	○	○	○	○

31. I am aware of career advancement opportunities at Niagara Health when they are available.

Yes	No	Somewhat
○	○	○

32. I believe that career advancement opportunities are equally available for all physicians at Niagara Health.

Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
○	○	○	○	○

33. I believe that work opportunities for physicians are distributed equitably at Niagara Health.

Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
○	○	○	○	○

34. I believe that all physicians at Niagara Health have equal leadership opportunities.

Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
○	○	○	○	○

35. I am aware of the hiring process for chief and deputy chief of department positions at Niagara Health.

Yes	No	Somewhat
○	○	○

36. I believe that the process for hiring chiefs of department at Niagara Health is transparent and equitable.

Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
○	○	○	○	○

37. I am aware of the hiring process for all other (non-chief) physician leadership positions at Niagara Health.

Yes	No	Somewhat
○	○	○

38. I believe that the process for filling all other (non-chief) physician leadership positions at Niagara Health is transparent and equitable.

Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
○	○	○	○	○

39. I am aware of the disciplinary procedures for physicians at Niagara Health.

Yes	No	Somewhat
○	○	○

40. I believe that the disciplinary procedures for physicians at Niagara Health are transparent and equitable.

Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
○	○	○	○	○

41. What do you think is a possible solution to any of the concerns that you have identified?

42. Please provide any additional information about, or to further explain, your survey answers. You may also include anything you would like Rubin Thomlinson to know about these topics.

43. What is your current gender identity?

- [ ] Female
- [ ] Male
- [ ] Non-Binary person
- [ ] None of the above
- [ ] Prefer not to answer
- [ ] Other (please specify)

44. Do you identify as an Indigenous person?

- [ ] Yes
- [ ] No
- [ ] Prefer not to answer

45. Do you identify as someone who is racialized, a visible minority, person of colour, or an analogous term?

- [ ] Yes
- [ ] No
- [ ] Prefer not to answer

46. How do you identify your race/ethnicity/ancestry?

- [ ] African/Black (e.g., African, African-American, African-Canadian, Afro-Caribbean, etc.)
- [ ] Arab (e.g., Algerian, Lebanese, Tunisian, etc.)
- [ ] East Asian (e.g., Chinese, including Hong Kong and Macau, Japanese, Korean, etc., and including Asian-Canadian, Asian-American, etc.)
- [ ] European/Non-white (e.g., Roma, etc.)
- [ ] European/White (e.g., Belgian, Croatian, English etc.)
- [ ] Filipina/Filipino
- [ ] Indigenous (outside of North America)
- [ ] Indigenous (within North America)
- [ ] Latin, South or Central American (e.g., Brazilian, Chilean, Colombian, Mexican, etc.)
- [ ] South Asian (e.g., Indian, Pakistani, Sri Lankan, etc., and including Indo-Caribbean, Indo-African, Indo-Fijian, West Indian, etc.)
- [ ] Southeast Asian (e.g., Cambodian, Indonesian, Laotian, Vietnamese, etc.)
- [ ] West Asian (e.g., Afghan, Iranian, etc.)
- [ ] Prefer not to answer
- [ ] If none of the above, please specify:

47. Do you wish to speak directly with us (Rubin Thomlinson) about your survey responses or any of the topics addressed in this survey?

- [ ] Yes
- [ ] No

48. Contact Information

Name

Email Address

Phone Number

Appendix B

Niagara Health Professional Staff Departments and Divisions

Department	Division
Anesthesia	Chronic Pain
Diagnostic Imaging	*Interventional Radiology*
Emergency Medicine	
Family Medicine	
Laboratory Medicine	
Medicine	Cardiology
	Critical Care Medicine
	Dermatology
	Endocrinology
	Gastroenterology
	General Internal Medicine
	Geriatrics
	Hospitalist
	Infectious Diseases
	Nephrology
	Neurology
	Physical Medicine and Rehabilitation
	Respirology
	Rheumatology
Obstetrics & Gynecology	MidWifery
Oncology	Hematology/Thrombosis
	Medical Oncology
	Palliative Care
	Radiation Oncology
Pediatrics	*Neonatal ICU*
Psychiatry/Mental Health	
Surgery	General Dentistry
	General Surgery
	Ophthalmology
	Oral Surgery
	Orthopedic Surgery
	Otolaryngology
	Plastic Surgery
	Surgical Assist
	Thoracic Surgery
	Urology
	Vascular Surgery

Appendix C

NH Professional Staff Demographic Data

	Active/ Associate				Courtesy/Term			
Department - Specialty	**Total Number**	**Percent Male**	**Percent Female**	**Agerage Age**	**Total Number**	**Percent Male**	**Percent Female**	**Average Age**
Anesthesia	29	69%	31%	54	6	50%	50%	44
Diagnostic Imaging	30	87%	13%	47	8	63%	38%	41
Emergency Medicine	60	63%	37%	47	23	61%	39%	49
Family Medicine	17	65%	35%	61	77	52%	48%	54
Laboratory Medicine	12	58%	42%	60	2	100%	0%	62
Medicine - Cardiology	13	62%	38%	45	25	80%	20%	47
Medicine - Critical Care Medicine	9	56%	44%	43	12	75%	25%	39
Medicine - Gastroenterology	6	100%	0%	46	1	100%	0%	33
Medicine - General Internal Medicine	35	63%	37%	45	38	68%	32%	43
Medicine - Geriatrics	3	100%	0%	40	4	50%	50%	64
Medicine - Hospitalist	6	50%	50%	47	12	75%	25%	48
Medicine - Infectious Diseases	4	100%	0%	38	3	33%	67%	47
Medicine - Nephrology	7	86%	14%	53	5	100%	0%	47
Medicine - Neurology	4	50%	50%	49	3	33%	67%	69
Medicine - Respirology	8	88%	13%	49	1	100%	0%	33
Obstetrics & Gynecology	18	33%	67%	46	7	43%	57%	57
Oncology	22	45%	55%	43	9	67%	33%	46
Pediatrics	12	50%	50%	50	15	27%	73%	52
Psychiatry/Mental Health	18	56%	44%	54	13	46%	54%	55
Surgery - ENT	6	67%	33%	49	1	0%	100%	64
Surgery - General Surgery	16	88%	13%	57	1	100%	0%	68
Surgery - Ophthalmology	11	82%	18%	53	1	100%	0%	46
Surgery - Orthopedic Surgery	14	93%	7%	47	12	92%	8%	44
Surgery - Plastic Surgery	5	100%	0%	55	0	N/A	N/A	N/A
Surgery - Urology	9	67%	33%	47	0	N/A	N/A	N/A
Surgery - Vascular Surgery	5	100%	0%	44	0	N/A	N/A	N/A
Surgery - Surgical Assist	0	N/A	N/A	N/A	45	80%	20%	53
Midwifery	27	0%	100%	39	11	0%	100%	37
Dentistry	9	100%	0%	60	1	100%	0%	51
Grand Total	**415**	**64%**	**36%**	**49**	**336**	**62%**	**38%**	**50**

Appendix D

Excerpts of Relevant Niagara Health Policies

Niagara Health System Professional Staff By-Law

5.2 Suspension, Restriction or Revocation of Privileges

(1) The Board may, at any time, in a manner consistent with the *Public Hospitals Act* and this By-Law, revoke or suspend any appointment of a member of the Professional Staff or revoke, suspend, restrict or otherwise deal with the privileges of a member of the Professional Staff.

(2) Any administrative or leadership appointment of the member of the Professional Staff will automatically terminate upon the restriction, revocation or suspension of privileges or, revocation of appointment, unless otherwise determined by the Board.

5.3 Immediate Action

(1) The President or Chief of Staff or Chief of Department may temporarily restrict or suspend the privileges of any member of the Professional Staff, in circumstances where in their opinion the member's conduct, performance or competence:

(a) exposes or is reasonably likely to expose any patient, health care provider, employee or any other person at the Hospital to harm or injury; or
(b) is or is reasonably likely to be, detrimental to patient safety or to the delivery of quality patient care within the Hospital, and immediate action must be taken to protect patients, health care providers, employees and any other person at the Hospital from harm or injury.

(2) Before the President or the Chief of Staff or Chief of Department takes action authorized in subsection 5.3(1), they shall first consult with one of the other of them. If such prior consultation is not possible or practical in the circumstances, the person who takes the action authorized in subsection 5.3(1) shall provide immediate notice to the others. The person who takes the action authorized in subsection 5.3(1) shall forthwith submit a report on the action taken with all relevant materials and/or information to the Medical Advisory Committee.

5.4 Non-Immediate Action

(1) The President, the Chief of Staff, or the Chief of Department, may recommend to the Medical Advisory Committee that the privileges of any member of the Professional Staff be restricted, suspended or revoked in any circumstances where in their opinion the member's conduct, performance or competence:

(a) fails to meet or comply with the criteria for annual reappointment; or
(b) exposes or is reasonably likely to expose any patient, health care provider, employee or any other person at the Hospital to harm or injury; or

(c) is or is reasonably likely to be, detrimental to patient safety or to the delivery of quality patient care within the Hospital or impact negatively on the operations of the Hospital; or

(d) fails to comply with the Hospital's By-Laws, Rules and Regulations, or Policies, the *Public Hospitals Act* or any other relevant law.

(2) Prior to making a recommendation as referred to in subsection 5.4(1), an investigation may be conducted. Where an investigation is conducted, it may be assigned to an individual within the Hospital other than the Medical Advisory Committee or an external consultant.

[...]

ARTICLE 9 LEADERSHIP POSITIONS

9.1 Medical Leadership Positions

(1) The following positions shall be appointed in accordance with this By-Law:

(a) Chief of Staff; and

(b) Chief of Departments.

(2) The following positions may be appointed in accordance with this By-Law:

(a) Deputy Chief of Staff;

(b) Deputy Chief of Department; and

(c) Head of Service.

(3) Notwithstanding any other provision in this By-Law, in the event that the term of office of any person referred to in this section shall expire before a successor is appointed the Board may extend the appointment of the incumbent.

(4) The Board may appoint a person on an acting or interim basis where there is a vacancy in any office referred to in this section or while the person holding any such office is absent or unable to act.

(5) An appointment to any position referred to in this section may be revoked by the Board at any time.

(6) Where this By-Law contemplates a search committee process to identify a candidate for appointment such process may be dispensed with, at the discretion of the Board, where the incumbent or an acting or interim appointee is being considered for appointment or re-appointment provided the Board is satisfied an appropriate selection process was followed in connection with the acting or interim appointment.

9.2 Appointment of Chief of Staff

(1) The Board will appoint a Physician as Chief of Staff.

(2) In the event of a vacancy and in any event before the expiry of a term of the Chief of Staff, the Board will establish a search committee for the position of Chief of Staff and will establish the composition and terms of reference for any such search committee, provided that the search committee will be chaired by a member of the Board and will include at least one (1) other member of the Board, two (2) representatives of the Medical Advisory Committee, the President of the Medical Staff and the President and such other members as the Board shall appoint.

9.3 Term of Office

(1) Subject to annual re-appointment by the Board, and unless the Board otherwise determines, the Chief of Staff will be eligible to serve two (2) consecutive terms of up to five (5) years each provided that a Chief of Staff may hold office until a successor is appointed.

(2) Despite subsection 9.3(1), the Board may appoint the Chief of Staff for one (1) additional term of up to five (5) years.

(3) Prior to making any re-appointment of the Chief of Staff, the Board shall consider the results of the annual performance evaluation of the Chief of Staff.

(4) Notwithstanding any other provisions contained in the By-Laws, the appointment of the Chief of Staff may be revoked at any time by the Board.

[...]

9.5 Performance Evaluation of the Chief of Staff

An annual performance evaluation of the Chief of Staff will be conducted by the Board pursuant to a process established by the Board from time to time.

[...]

9.7 Appointment of Chiefs of Department

(1) The Board will appoint a Chief of each Department upon the recommendation of the Medical Advisory Committee.

(2) In the event of a vacancy or in any event prior to the expiry of the term of a Chief of Department, the Board will direct the Medical Advisory Committee to establish a search committee to undertake a search for the vacant position. The search committee will make a recommendation through the Medical Advisory Committee to the Board.

(3) The search committee will be chaired by the Chief of Staff and shall include the President and the following who shall be appointed by the Board:

(a) at least one member of the Medical Staff of the Department for which the Chief of Department is being sought;

(b) a representative of the Board;

(c) one of the President, Vice President or Secretary-Treasurer of the Medical Staff;

(d) a member of the Medical Advisory Committee recommended by the Medical Advisory Committee; and

(e) such other members of the Medical Staff from Departments which work closely with the Department Chief as recommended by the Chief of Staff.

(4) In exceptional circumstances the Board may, on the recommendation of the Medical Advisory Committee dispense with the search committee process and adopt an alternative process. The Medical Advisory Committee shall consult with the members of the Department before making its recommendation to the Board.

9.8 Term of Office of Chief of Department

(1) Subject to annual confirmation by the Board, and unless the Board otherwise determines, Chiefs of Department will be eligible to serve two (2) consecutive terms of up to five (5) years each provided that a Chief of a Department may hold office until a successor is appointed.

(2) Despite subsection 9.9(1) the Board may appoint a Chief of Department for one (1) additional term of up to five (5) years.

(3) Notwithstanding any other provisions contained in the By-Laws, the office of the Chief of Department may be revoked by the Board at any time.

9.10 Performance Evaluation of Chiefs of Department

An annual performance evaluation of each Chief of Department will be conducted pursuant to a process to be established from time to time by the Board.

9.11Appointment of Deputy Chiefs of Departments

(1) The Medical Advisory Committee, on the recommendation of the Chief of Department, may recommend to the Board Deputy Chiefs of Department for

appointment by the Board. Notwithstanding any other provisions contained in the By-Laws, the office of the Deputy Chief of Department may be revoked at any time by the Board.

(2) The Chief of Department will consult within the Department (and if appropriate, between Departments) and with the President and the Chief of Staff prior to making any recommendation to the Medical Advisory Committee for the appointment of a Deputy Chief of Department.

(3) The appointment of the Deputy Chief of Department will be on an annual basis and subject to annual review by the Chief of Department in accordance with a process approved by the Board.

(4) Subject to annual confirmation by the Board, and unless the Board otherwise determines, a Deputy Chief of Department will be eligible to serve two (2) consecutive terms of up to five (5) years each provided that a Deputy Chief of Department may hold office until a successor is appointed.

[...]

9.13 Appointment of Heads of Service

(1) The Board, on recommendation of the Medical Advisory Committee, after receiving the recommendation of the Chief of Department, may appoint a Head of Service. Notwithstanding any other provisions contained in the By-Laws, the office of the Head of Service may be revoked at any time by the Board.
(2) The Chief of Department will make recommendations to the Medical Advisory Committee for Heads of Service after consultation within the Department (and if appropriate, between Departments) and with the Chief of Staff.
(3) Heads of Service appointments will be on an annual basis and subject to annual review by the Chief of Department in accordance with a process approved by the Board.
(4) Subject to annual confirmation by the Board, and unless the Board otherwise determines, a Head of Service will be eligible to serve two (2) consecutive terms of up to five (5) years each provided that a Head of Service may hold office until a successor is appointed.
(5) Despite the foregoing the Board may delegate to the Medical Advisory Committee the authority to appoint one or more Heads of Service.

[...]

OFFICERS OF THE MEDICAL STAFF

12.1 Officers of the Medical Staff

(1) The officers of the Medical Staff will be:

(a) the President;

(b) the Vice President; and

(c) the Secretary/Treasurer;

[...]

12.5 President of the Medical Staff

(1) The President of the Medical Staff shall:

(a) preside at all meetings of the Medical Staff;

(b) act as a liaison between the Medical Staff, the President, and the Board with respect to matters concerning the Medical Staff; and

(c) support and promote the vision, purpose, core values and strategic plan of the Corporation.

Niagara Health System Rules & Regulations

SECTION 1 – PROFESSIONAL STAFF DUTIES AND PERFORMANCE

1.1 *Duties and Responsibilities*

(a) Each member of the Professional Staff shall:

[...]

(xxii) ensure that any concerns relating to the operations of the Hospital are raised and considered through the proper channels of communication within the Hospital such as the Chief of Staff, Chiefs of Department, Medical Advisory Committee, President and Chief Executive Officer and/or the Board and where appropriate use the incident reporting system (IRS) adopted by the Hospital for such concerns. Such concerns should not be the subject of commentary on social media;

[...]

1.2 *Orientation for New Professional Staff*

(a) All new members of the Professional Staff shall undergo an orientation, including both a general orientation to the Hospital and a more detailed orientation to the Department or Service.

(b) The Chief of Department in cooperation with the Chief of Staff shall be responsible for organizing the orientation and ensuring all new members of Department participate. The orientation shall involve members of the Professional Staff, Hospital management and/or other staff resources and include both clinical and facility orientation.

(c) The orientation shall include but not be limited to:

(i.) Hospital purpose, vision and core values;

(ii.) Hospital By-laws, Rules and Regulations and Policies;

(iii.) Departmental and Service policies;

(iv.) On call coverage requirements and procedures;

(v.) Fire safety;

(vi.) Disaster response plan;

(vii.) Security and emergency numbers;

(viii.) Medical staff facilities and room numbering systems;

(ix.) Cardiac arrest procedures;

(x.) Press releases and media contact;

(xi.) Medical record policies; and

(xii.) Confidentiality of patient information.

1.3 *Annual Performance Review*

Annually, unless an enhanced performance review is being undertaken, the Chief of Department shall review and provide a report in relation to each member of the Department who applies for reappointment to the Professional Staff such review and report to be in accordance with a performance evaluation process approved by the Board from time to time.

1.4 *Enhanced Performance Review*

The Chief of Department or designate may require that a member of the Department undergo an enhanced performance review in circumstances that may include but are not limited to the following:

(a) where concerns have been raised about the quality of care being provided by the Professional Staff member;

(b) where any report related to a criminal, or patient care, or other issue that may impact the reputation of the Corporation or the quality of care provided by the Corporation has been made to a College in respect of a Professional Staff member; and

(c) in circumstances where the Chief of Staff or Chief of Department is of the view such a review is warranted.

1.5 *Enhanced Performance Review Process*

The enhanced performance review shall be conducted through a process determined by the Chief of Staff in consultation with the Chief of Department or as may be approved by the Board from time to time and may include a peer review, use of external reviewers or other appropriate process.

The Member under review may request involvement of the Medical Staff Association in the process if he/she desires.

[...]

SECTION 2 – DEPARTMENT AND SERVICE MEETINGS

2.1 *Department and Service Meetings*

(a) The Professional Staff of each Department and Service shall meet at least four times per year.

(b) The Department Chief or Head of Service, as the case may be, shall be responsible to ensure that an agenda for the meeting is circulated to

Department or Service members at least seventy-two (72) hours in advance of the meeting and that such agenda is aligned with and furthers the objectives of the relevant Clinical Program.

Professional Staff Code of Conduct

1.0 Purpose

1.1 The purpose of this Code of Conduct is to clarify the expectations incumbent upon all professional staff credentialed at NH and provide a definition of Expected Behaviours.

1.2 These expectations apply in relation to any and all interactions with persons within NH, whether such persons are colleagues, other healthcare professionals, trainees, patients and their families or any other individuals, to ensure that the quality of patient care is not adversely affected and the values of NH upheld.

[...]

3.3 Expectations of Professional Staff

a) On being credentialed to NH, professional staff are deemed to accept a common goal, with all other members of the organization, to maintain a high quality of patient care and professional conduct.

b) Interpersonal interactions within NH shall be conducted with courtesy, respect and dignity.

c) It is a violation of this Code of Conduct for any member of the professional staff to engage in behavior that would reasonably and objectively be considered to be discriminatory, offensive, harassing or disruptive to the workplace or that does not meet a high standard of professionalism.

d) Discrimination for the purposes of this Code of Conduct refers to unequal treatment on the basis of an individual's race, ancestry, place of origin, color, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status and disability.

e) Harassment is a form of discrimination and is defined by the Human Rights Code as "engaging in a course of vexatious comment or conduct that is known or ought reasonably to be known to be unwelcome".

f) Discriminatory, offensive or harassing conduct may be written (including electronic communication), oral or behavioural in nature and includes, but is not limited to the use of profanity, sexual comments or images, racial or ethnic slurs and derogatory or demeaning gender-specific comments.

g) NH expects that disagreements will be handled with courtesy, respect, and dignity for one another.

h) These expectations are in addition to any legal standards, standards set by respective professional regulatory bodies, or any standards set for staff with faculty appointments by their respective affiliated academic institutions.

Disruptive Professional Staff Members

3.5 **Stage One Behaviours**
Characteristics of "stage one behaviour" include any or all of:

a) The behaviour represents a single instance rather than repetitive behavior.
b) The severity of the behaviour is not extreme and it is not associated with anger.
c) The behaviour is exhibited by a professional staff member who has generally demonstrated adherence to the By Laws, Rules and Regulations and the Code of Conduct.

3.6 **Stage Two Behaviours Characteristics of "stage two behaviour" include any or all of**:

a) Continuing or a pattern of behaviour, despite a stage one intervention.

b) Increasing intensity and severity of behavior.

c) Multiple complaints.

3.7 **Stage Three Behaviours Characteristics of "stage three behaviour" include any or all of**:

a) Substance abuse.

b) Conditions or disorders (mental or physical) that affect the professional staff member's fitness to practice.

c) Dangerous behaviours.

d) Criminal behaviours.

Response and Resolution

3.8 **Stage One Responses to stage one behaviours may include, but may not be limited to**:

a) Discussion with the professional staff member of the issue(s).

b) An offer of education, coaching or counseling to help resolve the issues.

c) A plan to resolve the issue(s) brought forward by the complainant, the professional staff member of NH.

d) Set expectation for non-recurrence.

3.9 **Stage Two Responses to stage two behaviours may include, but may not be limited to:**

e) a) Discussion with the professional staff member of the issues.

f) b) Follow-up investigation.

g) c) An assessment of the professional staff member through the 360 process.

h) d) Consultation with legal counsel.

i) e) A plan for the management, treatment, education, monitoring and feedback for the professional staff member.

3.10 **Stage Three Responses to stage three behaviours may include, but may not be limited to:**

a) Reporting the behaviour to the appropriate authorities, including the applicable regulatory College.

b) Mandatory intervention and referral to appropriate clinical services.

c) Suspension or termination of privileges, which may trigger a mandatory report (under section 85.5 of the Health Professions Procedural Code and/or section 33 of the Public Hospitals Act), to the applicable regulatory College.

Follow Up

3.11 **Stage one follow-up will include, but may not be limited to:**

a) Discussion with the Chief of Staff 6 months following resolution of the issue(s).

3.12 **Stage two follow-up will include, but may not be limited to:**

a) A review of the results of the implementation of the plan of management, treatment, education, monitoring and feedback referred to in section 3.9 every 3 months for one year.

3.13 **Stage three follow-up will include, but may not be limited to:**

a) The implementation and monitoring, under the direction of the Chief of Staff, of any recommendations made by a clinical treatment unit, regulatory body, assessor, expert (including an assessment of the fitness to practice of the professional staff member).

Mutually Respectful Workplace & Diversity

1.0 Purpose

1.1 To provide overall guidance regarding workplace behaviour at Niagara Health (NH). This policy is based on our Core Values, which guide the standards and expectations we hold ourselves and others accountable to. NH acknowledges its' responsibility to provide an environment which is free from racism, sexism, ableism, homophobia, discrimination and bias, and where all individuals, including members of equity-deserving groups, are treated with respect and dignity. NH is committed to:

a) The principles of equity for all persons inclusive of citizenship, race, place of origin, ethnic origin, colour, ancestry, disability, age, creed, family status, marital status, sexual orientation, gender identity or gender expression reflected in the organization's policies, procedures and relations with staff, physicians, students, volunteers and affiliates;
b) Promoting a safe, respectful and inclusive environment where NH affiliates (see Definitions) see themselves valued and reflected within the organization; and
c) Promoting through all of its processes, practices and structures, an environment which is free of discrimination and bias.

[...]

4.0 Policy

4.1 The NH Code of Conduct and NH Values apply to everyone in the organization at all levels. Interactions involving affiliates, patients, visitors or family members are to be guided by the following:

a) Expectations of behaviour:

i) Conduct that reflects the Values of NH, including promoting diversity and inclusion;

ii) Creating safe and inclusive spaces for everyone.

iii) Treating others equitably, and with respect, dignity, understanding and acceptance;

iv) Promoting teamwork, collaboration and communication;

v) Participating in the creation/maintenance of a positive environment and workplace culture;

vi) Promoting individual responsibility and excellence;

vii) Giving and receiving feedback in a positive and constructive way; and

viii) Providing comments and asking questions that focus on problem solving, not on the individual;

b) Behaviour that does not meet expectations includes, but is not limited to:

i) Acts, attempts, or threats of violence inclusive of domestic violence;

ii) Bullying (physical or psychological);

iii) Harassment, sexual harassment, discrimination, microaggressions, assault, abuse;

iv) Collective Harassment (by a group, program or department of NH);

v) Intimidating comments, remarks or conduct, whether intentional or unintentional;

vi) Derogatory written or verbal communication, gestures, pictures or posters (for example, name calling, use of profanity, slurs, graffiti, jokes, remarks, taunting) that relate to any of the Prohibited Grounds under the Ontario Human Rights Code; and

vii) Creating or perpetuating stereotypes and barriers

Appendix E

SUMMARY OF RECOMMENDATIONS

As part of the systemic review that we conducted, we were asked to make recommendations to Niagara Health, based on the information we gathered, on how to address the areas for potential systemic discrimination within the physician group. Generally, we believe that those barriers (if they do exist) have been created because of gaps in the policies, practices, and procedures at Niagara Health, as well as the apparent organizational culture. We recognize that positive steps have been taken, and there has been considerable growth and improvement; as such, we note that some of our recommendations may overlap with some EDI measures we have heard Niagara Health intends to take, or have already taken. Nonetheless, we have included our recommendations and the justifications for each, so that they can be further considered by Niagara Health.

The table below provides a summary of the recommendations to address the potential systemic barriers that have been identified:

ISSUE	RECOMMENDATION
Hiring, promotion, and opportunities for advancement *Basis for the identified issue:*[1] There appears to be a lack of standardized processes for hiring, promotion, and accessing opportunities for career advancement in the physician group. As a result of this, appointments and/or reappointments (or chief and non-chief positions) appear to be made with no regard for performance, feedback, or established criteria,	1. Work with an EDI expert. • We recommend that Niagara Health work with a consultant and/or DEI expert (whether internal or external) to propose amendments to the by-law and create and implement rules or guidelines to standardize hiring, promotion, and access to opportunities for advancement at Niagara Health. Items 2-6 below are some of the changes

[1] The basis for the identified issue, in all issues identified in this chart, is based on the information that we heard from participants. As outlined in the report, we did not test the truth of the information that we received.

raising concerns of discrimination, biases, and poor management.	and steps that we recommend can be considered by Niagara Health together with the consultant and/or DEI expert. 2. Amend the by-law to address reappointment of department chiefs. • Clearly outline the process for the reappointment of department chiefs as well as factors to be considered by the MAC in deciding on appointment. 3. Establish process for performance review for department chiefs. 4. Amend the by-law to address hiring/reappointment of (non-chief) leadership positions. • Include an established process for the hiring of deputy chiefs, site leads, and heads of services as well as an established process for the reappointment of physicians to these positions. 5. Develop factors to be considered in hiring and reappointment decisions for (non-chief) leadership positions. 6. Develop standardized recruitment practices for leadership positions. • Create guidelines for departmental leaders on best recruitment practices; and • Provide guidelines to department chiefs on obtaining feedback within and/or between departments.

	7. Establish guidelines regarding succession planning. • Emphasize identifying diverse talent so to support diversifying the leadership
<u>Potential negative impact of pregnancy and parental leave</u> *Basis for the identified issue:* Pregnancy may adversely impact physicians in their matriculation from Associate Staff to Active Staff, as well as female surgeons who need operating room time.	1. Review physician matriculation process to ensure no impact from Human Rights *Code*-ground-related leaves. • Consider the impact of maternity leave (or paternity/disability leave) on matriculation to ensure that any potential discriminatory impact is addressed in the by-law (which, as it stands, is silent on this). 2. Review allocation of operating room time to ensure no impact from maternity/parental leave. • Look at the impact of leaves on access to operating room time, determine if there are adverse impacts, and put safeguards in place to protect against this.
<u>Reporting and complaint process</u> *Basis for the identified issue:* Physicians do not report their concerns for fear of reprisal, lack of proper response, lack of accountability, and lack of confidentiality in the process. Where the existing IRS is used, it is not known what happens thereafter.	1. Appoint an independent physician ombudsman (either external or internal to Niagara Health). • This person will receive physician complaints, assess the complaints, determine appropriate process for resolution, and arrange for any necessary communication. • Where an investigation is required, this person could conduct it, together with the Medical Affairs Department. • A Policy should be established to outline and govern the function of the ombudsperson.

	2. Implement a confidential reporting system. 3. Train physicians on reporting and complaint process. 4. Look into the impact of failing to expunge unsubstantiated complaints from record for racialized physicians. • Determine if it is true that unsubstantiated complaints are not expunged from a physician's records, and if so, determine if this has a disproportionate impact on racialized physicians.
<u>Physician Reviews</u> *Basis for the identified issue:* Racialized physicians are disproportionately subject to review (including instances where they file a complaint), harsher treatment during their reviews, and are not provided information about the issues giving rise to their review. Additionally, there is no accountability for those who bring vexatious/frivolous complaints, and no accountability for non-racialized physicians with problematic cases.	1. Standardize process for physician reviews. • Establish in writing the process (in policy or otherwise) for reviews, including when it will be done, who will be appointed as decision-maker(s), criteria for decision for review, notification to physician under review, and opportunity for the physician to respond. 2. Provide training on review process. • Physicians should be trained on any new written policies, as well as existing practice or procedure at Niagara Health. Such training will enable physicians to objectively assess whether they are being treated differently. 3. Create a task force to examine physician review process. The task force should: • Continue to collect data and monitor the identity of those subject to review, with a view to identifying overrepresentation of racialized physicians.

	• Review *all* physician cases subject to review and determine if there is disproportionate representation from racialized groups, and the merits for review of racialized physicians. • Be comprised of individuals with subject-matter expertise, legal knowledge, and a DEI lens. • Publish the results/data, without identifying anyone, for transparency and understanding amongst physicians.
<u>Work environment</u> *Basis for the identified issue:* The environment is unfavourable for persons from certain equity-seeking groups, particularly female and racialized physicians. These groups feel excluded from decision-making, while the perspectives of white physicians are considered; racialized and female physicians are subject to disrespect, and are stereotyped as aggressive or unprofessional when expressing opinions/objections; and females are unwilling to pursue leadership opportunities because the environment at Niagara Health does not set them up for success or they are perceived as not being able to balance the responsibility alongside family obligations. Additionally, there is concern that certain religious holidays are not considered when planning, at the exclusion of those who are a part of those religions.	1. Work with a DEI consultant/expert. • Engage the support and ongoing monitoring of a consultant and/or DEI expert whose focus is to track DEI issues and respond to them when they arise, particularly those issues identified in this table. Together, develop and implement strategies to address those issues, including items 2 to 7 below. 2. Develop guidelines on departmental decision-making. • Provide clarity on decisions made, as well as guidance to department leaders about the matters for which they have autonomous decision-making power and those which require consultation with members of a department before a decision is made. 3. Provide training for physicians. • Management training for department leaders, addressing topics such as managing diverse

	groups in an equitable and inclusive manner, microaggressions, and education on biases. • Physician training, particularly for those responsible for hiring, on discriminatory practices in hiring. • Conduct workshops with Niagara Health physicians and non-physician staff, separately, outlining the concerns regarding disrespectful communication by physicians, Niagara Health's zero-tolerance for such behaviour, repercussions for such behaviour, and encouraging individuals to report adverse experiences, while reminding staff of consequences for vexatious complaints. 4. Address barriers regarding the hiring of women and racialized physicians. • Advertise vacancies on diverse job boards; • Publicize Niagara Health's commitment to engaging women and racialized physicians in leadership – on internal and/or external platforms; • Celebrate women and racialized physicians in leadership; • Invite diverse referrals; and • Ensure that recruiters are trained in unconscious bias. 5. Provide support to women with families. • Examples of support may be allowing job sharing opportunities or providing resources (i.e., a safe space to breast pump) that create an

	environment that facilitates success without having to sacrifice family obligations. 6. Demonstrate non-tolerance for disrespect and discrimination. • Impose appropriate repercussions for such behaviour. 7. Include consideration of religious holidays in DEI efforts.