Medical and Academic Affairs
Partnerships and Communication

island health

Doctors of BC Survey Response — July 2024

Since the release of the Doctors of BC (DoBC) survey results, the Partnerships and Communication portfolio in Medical and Academic Affairs has attended physician-centred events where the results were presented. The purpose was to openly discuss the survey results, hear feedback, understand specific challenges, and collect suggestions for improving physician engagement at Island Health.

Between January and May 2024, the Partnerships and Communication team has attended, presented at, or obtained feedback from the following forums:

- Medical Staff Townhall (with a special DoBC survey presentation)
- HAMAC
- HAMSA Executive Committee Semi-Annual Meeting
- Transparency & Communication Steering Committee
- Department Head Council
- South Island MSA
- Saanich Peninsula Physician Society
- Cowichan District Hospital MSA
- Physician Engagement Society Courtenay/Comox (PESCCI)
- Nanaimo MSA

Through the conversations, recommendations and feedback emerged within the following themes: *Decision Making; Leadership Visibility; Communications and Transparency; Clinical Practice Improvements; Health & Safety and Culture.* See the table in *Appendix A* for the full list of specific challenges or suggestions provided.

The data collected through this work, together with the DoBC survey results, has had a significant impact in defining the annual workplan for Medical and Academic Affairs.

Goal Setting and Prioritization

After collating and theming the feedback received, under the direction of Dr Keith Menard, the Partnerships and Communications team has developed SMART goals that were based on:

- Alignment with Island Health priorities and current work
- Workable ideas that address long standing issues
- New ideas that address multiple areas of concern

Table 1. Proposed SMART goals to improve engagement with medical staff at Island Health.

Acronym List

LMAC = Local Medical Advisory Committee
HAMAC = Health Authority Medical Advisory Committee
CLHA = Consolidated Local Health Area
HEC = Health Authority Medical Staff Association (HAMSA) Executive Committee
MAA = Medical & Academic Affairs
MSA = Medical Staff Association
SI/CI/NI = South Island/Central Island/North Island
IAP2 = International Association of Public Participation
PSLS = Patient Safety and Learning System
DoBC = Doctors of BC
FTE = Full Time Equivalent
HR = Human Resources

Key Feedback Theme	*SMART Goals*	*Proposed Timeline*	*Measures*
Decision Making			
Allow for more local control and empower local decision making, clarify leadership roles and accountabilities.	1. Support Department Head Council and Chief of Staff Council with structure and agenda to ensure their input on key organizational and medical staff priorities.		
	2. Review and enhance medical leadership structure to ensure clear reporting lines, clearly define accountabilities and responsibilities, and ensure fair FTE allocation and compensation.		
	3. Increase medical leaders' understanding and involvement in the HR planning process and provide regular reports to LMACs and CLHA Acute Councils.		

	4. Establish quarterly meetings led by the Medical Director, Workforce Stabilization & Recruitment with local medical and departmental leaders to review and input on the human resources assessment and planning.		
Provide a way to escalate urgent local issues that require regional involvement. Provide regular updates to medical staff.	5. Create and distribute simple reference documents (general and site-specific) outlining local leaders and relevant governance committees, where to go for which issues. Distribute to MSA and local leaders.		
	6. Enhance and support the Chief of Staff role to achieve resolution for urgent local issues. Enable with strong connections with the network of clinical and operational leaders, ensure Chief of Staff are sitting at the right tables, create a Chief of Staff Council.		
	7. Develop a templated reporting tool and a reporting process to enable fast local communications to medical staff. Promote use among local medical leaders.		
Meaningfully engage medical leaders and medical staff in Island Health projects. Seek representation across the Island Health region.	8. Create positions for medical staff representation from CI, NI and SI on committees. Promote this approach across Island Health.		
	9. Make it easy to find and apply for current vacancies and engagement opportunities (e.g. committee work, focus groups, surveys, etc.). Use IAP2 language to highlight level of decision making in all opportunities for engagement.		
	10. Increase promotion of medical-staff engagement practices to Island Health project teams via the MAA Med Staff Change Management and Engagement Consultant.		
Leadership Visibility			
Improve internal reporting and accountability	11. Post agenda and meeting notes from HAMAC and HAMAC sub-committees on Intranet.		
	12. Allow for medical staff to provide additional documents or speak to agenda items on HAMAC and HAMAC sub-committees (process modeled on the City of Victoria Council Meetings).		
	13. Create and send one page summaries from HAMAC and from Department Head/Chief of Staff tables monthly with key updates for medical staff. Send to LMACs and MSAs as consent agendas for their meetings.		
	14. Share via broad circulation the HAMSA Executive Committee (HEC) report and summary to medical staff after semi-annual meetings.		

	15. Send monthly updates from Island Health project teams that touch on HEC priorities - sent to LMAC and MSA for consent agenda.		
Want to see senior and local operational and medical leaders in meetings with medical staff and on the floor.	16. Align senior leaders with appropriate local meetings. Audit senior leadership attendance of local meetings and implement necessary adjustments.		
	17. Collaborate with MSA to ensure the right senior and local leaders are invited and expected at the MSA meetings.		
	18. Establish regular leadership site visits and reporting on outcomes of visits in partnership with MSA.		
	19. Build an annual rotating schedule of “Coffee in the Lounge” for senior medical and operational leaders to connect with medical staff on site.		
	20. Support relationship building between MSA Executive and administration and local medical and operational leadership. Promote understanding of each others' responsibilities, accountabilities and potential collaboration spaces.		
Retain and support medical and administrative leaders	21. Enhance clarity of medical leader roles and accountabilities in all recruitment documents with clear language to highlight decision making capacity and expectations.		
	22. Support all Department Heads with appropriate administrative assistant coverage to support communication to members.		
	23. Provide up to date distribution lists to Department Heads, Chief of Staff, and MSA to support effective communication to members.		
	Transparency and Communications		
Create more opportunities for two-way communication on key shared priorities that impact patient care.	24. Enable Med Staff Townhalls for two-way communication, move from Inform to Involve. Utilize this forum to facilitate real-time dialogue and to gather input on shared priority topics. Feedback goes back to the relevant project team.		
	25. Offer an anonymous feedback channel for medical staff to provide ongoing and open anonymous feedback. Create a clear policy on the use of this feedback.		
	26. Pilot an online participation space for medical staff to input on key issues. Feedback provided to HAMAC or clinical governance bodies for discussion.		

	27. A Medical & Academic Affairs delegate visits a site each month as a "pop-up" info desk with coffee to engage with medical staff and gather input on key local concerns, issues, and projects.		
Improve online resources to find information easily: org charts, leaders accountabilities, procedures, policies, project information, etc.	28. Include up to date organizational charts and leadership directory on the medical staff website to make it easy to find key contacts.		
	29. Add an 'accountabilities' field for each leader to the new organizational charts.		
	30. Revamp of Medical Staff Website: leverage medical staff feedback via the Transparency in Communication Steering Committee – improve navigation, content and overall user experience.		
Clinical & Practice Improvements			
Provide Dragon dictation	31. Provide regular updates to MSA from the IHealth team about currently enabled sites and expected dates for Dragon Dictation.		
Strengthen PSLS system and processes	32. Strengthen the PSLS system, processes and follow up. Stand up a medical staff-led working group to review the current state and develop recommendations for improvement of the PSLS system.		
Improve financial summaries and education around contracts for med staff	33. Provide education for medical staff about compensation frameworks and financial models negotiated by Doctors of BC – led by DoBC. 34. Provide MAA contacts to MSAs for questions around contracts and compensation. 35. Review and improve financial summaries to make reconciling payments simple for medical staff. 36. Outline in committee terms of reference how medical staff are compensated.		
Post and share clinically relevant facility metrics	37. Make clinically relevant facility metrics available to medical leaders, and medical and clinical staff via the CGII Acute Quality and Ops Council.		
Health and Safety			
Enhance physical and psychological wellness for medical staff	38. Develop a plan to reinvigorate Schwartz Rounds at current pilot sites and expand to other sites, as a forum for clinicians to share and reflect on the emotional and psychological impacts of their work.		
	39. Bolster collaboration with Physician Health Program to ensure that IH physicians have access to medical staff wellness and mental health resources.		
	40. Hire dedicated people to increase focus on medical staff and residents' health and		

	safety.	Active	
Prioritize violence reporting and prevention	41. Implement a consistent workplace incident self-reporting mechanism with responsive follow up support and resources for medical staff.		
	42. Bolster violence prevention training with medical staff co-leads and support from OH&S, increasing relevancy to medical staff.		
	43. Improve data availability and share reporting for sites to assess site-specific issues and action taken to address concerns/mitigate risks.		
Culture			
Improve respectful workplace processes	44. Share finalized Respectful Workplace report with all medical staff. 45. Enhance respectful workplace policies and procedures. Post regular updates from the Respectful Workplace working group on the intranet with agendas/summaries.		
Invest in medical staff wellness and recognition	46. Develop a recognition strategy for medical staff.		
Provide appropriate onboarding, training and mentorship to medical staff and medical leaders	47. Create a robust onboarding process and orientation for new medical staff. 48. Design a comprehensive onboarding, welcoming, orientation and mentorship process for current and new medical leaders. 49. Develop a fulsome recruitment strategy to provide a supported medical staff journey in collaboration with MSA, Divisions of Family Practice and other local and regional partners.		
Look for and emulate best practices on engagement with medical staff.	50. Establish regular touch bases to learn from successes and challenges in medical staff engagement from other health authorities and successful healthcare organizations.		

If you have any questions or comments about this work, please connect directly with Dr. Keith Menard, MAA Medical Director Keith.Menard@islandhealth.ca, or Alanna Black, Director, Partnerships and Communication Alanna.Black@islandhealth.ca.

Appendix A. Raw feedback received from medical staff through verbal and written engagements.

CHALLENGES	SUGGESTIONS
Decision Making	
• There is a disconnect between Ministry, Health Authority policy, and frontline clinician experience**.** Physicians want to have a voice at a Provincial Level but don't know how to get meaningfully involved with provincial decisions or how/when to engage. • Longstanding lack of transparency and accountability in decision making - island wide. • Physicians are brought into the project too late**.** • Physicians are used to seeing a result or change when issues arise, it is hard to trust the Medical Leaders when repeated concerns or issues go unaddressed. • Top down organization not sharing power across the island. Centralized control disenfranchises physicians and communities. Need to allow for more local control. • Physicians don't know which decisions need to be escalated where and who makes the decisions. • Physicians experiencing high moral distress trying to resolve critical resource challenges. • Lack of follow up on significant challenges. • Crisis mode is contributing to the poor DoBC survey scores.	*Allow for more local control and empower local decision making:* • Involve the local Physician Leaders. Physicians will engage with their Physician Leaders if they know that the process will lead to something. • Local leaders need to have enough decision making power to address local issues. Local leaders should build relationships with front-care staff to be aware and address challenges before they become crises. • Conversations with regional leaders should occur at local tables. • Design medical leadership structure to ensure more local representation. • Ensure local sites are involved with HR planning in a wholesome way. • Create a Chief of Staff table to elevate their voice in the decision making. *Health Authority work should be based on data and represent a collaboration between administration and medical staff:* • Regional plans in various care areas need to be based on medical need, population health statistics and improve access to care. • Physician Leads should be invited to important meetings by operational leaders. • Medical staff need to be at the tables where decisions about their care area are made. They need to have an opportunity for meaningful input. • Connect with physicians about decisions that impact day-to-day patient care. • Actively seek Central, North and South Island med staff representation on the committees. The population of Central and North Island needs to be properly represented in management and leadership. • Create continuous connections between Island Health project teams and physicians on large projects. Want to be meeting on a regular basis, not only once a year in response; meetings should be an iterative process, come back with concrete goals, then meet again for update and more feedback – especially around shared HAMSA priorities. • Define how MSA Executive can work with IH leadership to help move common priorities forward. In Vancouver Coastal, MSA Executives are invited to senior leaders meetings twice a month. MSA Executives should have more voice at the Island Health tables. • Turn concerns into dedicated committees or working groups with tangible goals. Empower the committees to make necessary decisions and changes. Create summaries (purpose and actions) for each committee. *Provide a way to escalate urgent local issues that require regional involvement. Provide regular updates to medical staff.* • Promote using existing quality structures to raise issues – your local medical leads can raise issues via LMACs and the new Operation and Quality Councils. • For urgent local issues that require regional involvement, ensure timely updates to the physicians and local leaders: that you are working on

	the issue, what is being done, what mitigation is in place. Offer ways to provide feedback, seek out creative solutions from point of care staff. • Leadership needs to partner with staff to create definitive action plans to prevent nurses and physicians from leaving and to recruit. *Look for and emulate best practices:* • Share good MSA practices about ways of working with local admin leaders. • Review what works well for engagement in: 1) other Health Authorities or in Mayo Clinic, that have better scores and 2) review sites with high engagement scores. Apply continuous quality improvement to engagement.
Leadership Visibility	
• Trust in senior leaders is very low. • There is low visible accountability for leadership mistakes. Accountability and transparency are essential for trust. • Leadership doesn't understand what physicians do and their struggles. • Department Heads are not paid to visit sites in their purview.	*Make it easy to know who to connect with for specific issues:* • Make org charts easy to find, search and navigate. Make contacts on the website up to date. • Help membership understand Senior leadership titles and roles. Share profiles on leaders – who they are, what is their role, what do they actually do, what would we connect with them about. • Executives should be more accessible to the sites. *Commit to visible leadership across all levels of leadership:* • Regular emails from local leadership (eg. Chief of Staff, Site Director) to highlight specific projects and explain decisions. • Want to see CEO, senior medical leaders, and operational executives in the hospitals in the patient care units. • Local operational leaders (eg. Site Director) should walk the floor, understand key challenges to getting patients discharged. • Senior leadership should attend MSA events in person. Attach some of the senior leaders to the MSA meetings as regular attendees. • Invite administrative leaders to attend meetings for each group (Divisions/ Departments), physicians could send in some questions/concerns ahead of time and appropriate person could come to answer/discuss. • Regional and local administrative leaders should have office hours for physicians (and others) to pop in and ask questions *Improve internal reporting and accountability:* • Improve reporting of departments, sites and programs to their membership. • Share the Ministry of Health mandate with members. • Create a process to evaluate medical leaders. *Retain and support medical and admin leaders:* • Pay medical leaders for hotel to visit sites (visible leadership) • Encourage long service in administrative leadership roles.
Clinical Practice Improvements	

• Address inequities in care, access and programs in Central and North Island. • Need better compensation for physician leaders doing multiple roles. • Aspiration for equity. Contracts – access to what other sites have, why is that not transparent? • Less paperwork and less meetings to make things happen. • Need representation for women's health. • Physicians learn about decisions last minute. • Bed block, worsening hospitalist crisis, unfilled shifts. Don't have enough inpatient doctors for unattached, unassigned patients. Years coming. • Physician burnout. • Nursing shortages. • Mid Island is in crisis.	*Financial transparency:* • Need education and transparency about contracts and processes, how they work • Prioritize critical contracts – share and communicate that they are priority. Include reasons for delays/commitments to transparency and timelines. • Medical leader financial summaries need to be clearer to make it possible to reconcile payments for engagement/ HSR funding/committee work. *Clinical practice improvements:* • Need Dragon dictation Island wide. • Complete order sets in a timely manner. Only 2 of 59 order sets are done. • Ensure site operations overnight to help with patient transfer. • Strengthen PSLS system, processes and follow up. • Increase experience at work. • Physician extenders (e.g., Physician Assistants, Associate Physicians, Nurse Practitioners) – we are starting to explore these and could have benefit for the tasks that medical staff take on. *Utilize Data:* • Make data on overcapacity in hospitals available to the public. • Demonstrate effectiveness of the new Access Flow Team. • Share metrics with physicians in transparent ways (e.g., length of stay and OCB). • Need to quantify how bad it is: (e.g., 2X as busy a service, demographics crushed, facility not designed for demand etc.) *Inclusive practices:* • Schedule meetings further in advance – physicians need time to coordinate their schedules. • Meeting agendas should be released a week prior.
Communications and Transparency	
• Communication needs to flow two ways between the senior leaders and medical staff. • We appreciate when not all communication is happy and rosy, would rather hear failures communicated and letting us know things that are not started yet. • There is a disconnect between HAMAC and other governing committees and the front lines. • Medical staff needs to be able to find information they need easily: leadership information, policies, procedures,	*More ways to have a voice:* • Create a place to provide anonymous feedback when med staff want to – not survey. • Increase promotional efforts for vacancies on working groups and advisory committees. Post opportunities to engage in physician lounges, and in MSA newsletters. • Improve the reach and participation at Town Halls: 1) Town halls could expand to involve Island Health, physicians, Ministry of Health and patients. 2) Allow two-way communication during Medical Staff town halls: Move from 'Inform' to 'Involve'. Use Slido to seek med staff input. • Make agendas and minutes from HAMAC and other committee meetings accessible to medical staff. Offer a way to speak to an issue on an agenda to front-line staff without being a part of the committee. *Two-way continuous communication on key priorities:* • For urgent local issues that require regional involvement, ensure timely updates to the physicians and local leaders: that you are working on the issue, what is being done, what mitigation is in place. Offer ways to provide feedback, seek out creative solutions from point of care staff. • Ensure there are feedback and notification mechanisms in place when physicians bring issues/suggestions to attention (committees or

specific project related information, how to get involved, agenda and minutes of major committee meetings.	leadership). Let the physicians know that you took the feedback, what you are doing with it, and the results. Eg. share the Respectful Workplace work: how it was done, who participated, what are the outcomes. Then create effective engagement and work with med staff to implement recommendations. *How to communicate:* • Clearly identify where Ministry and Island Health responsibilities are, and where physicians can have a voice. • Improve medical staff webpages: make it easy to find policies, procedures, leaders, important contacts. Streamline and simplify messaging for medical staff. • Use IAP2 framework to clearly state level of engagement for meetings with physicians. • Need more transparency on what is mandated versus what can be negotiated. *What to communicate:* • Communications and Transparency Committee needs to create an action tracker and show tangible results. • Large projects (e.g., CGII, iHealth) need to be more transparent in communicating work done to date, planned work. • Share HEC impact report/summary with medical staff after each meeting. • Communicate how election 2024 will affect Island Health planning. • Communicate how CGII local tables and CARE Networks make a difference in the communities. Socialize and remind people that we now have a quality structure – and it should be used within each community.
Health and Safety	
• Co-create a culture that encourages reporting, speaking up, and psychological safety. • Address the blaming culture (especially concerning medical/behavioral errors) instead of a just culture approach.	*Physical and psychological wellness:* • Expand Schwartz rounds for sites. • Consider ergonomics in all retrofits, new builds and capital purchases. *Violence prevention and disciplinary process:* • Prioritize violence prevention training, implement a clear violence reporting process. • Improve respectful workplace processes. Respectful Workplace report has been released. Transition to restorative justice approach to improve disciplining process.
Culture	
• Invest into local medical leaders – so they have access to orientation, better skills, understand their role. • Address the culture of gaslighting and marginalization of people who raise concerns. • Operation folk are afraid of physicians – there is a divide. • Us vs Them culture; physicians need to take responsibility too. We hold the leadership/operations	*Recognition:* • Introduce Celebration of Excellence Awards. • Create services for medical staff wellness. *Onboarding:* • Support medical leaders through training, orientation and mentorship. • Improve medical staff onboarding by partnering with MSAs for onsite components. • Provide all medical staff access to Island Health navigating series, in particular the introductory orientation session.

accountable, and they hold us accountable to work together. • Leaders vs. Non-leaders – we need to be united. • It feels like there can be secrecy with the public on how bad things are. • We need to change the narrative – our medical staff is highly engaged but frustrated. • Acknowledge that DoBC results have impacts on all of us, as medical leaders.	