SOUTH ISLAND MEDICAL STAFF ASSOCIATION
Minutes
General Meeting – September 25, 2023
In-person (RJH Woodward)/Virtual (WebEx)
Meeting 6:00-7:30pm

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1. **Call to Order at 6:00 pm** - Welcome by MSA Co-President Dr. Fred Voon
   a. Welcome to special guests:
      - Annebeth Leurs – Engagement Partner, Doctors of BC (DoBC)
      - Dr. Pooya Kazemi (IHealth Site Lead, RJH)
      - Dr. Kellie Whitehill (IHealth Site Lead, VGH)
      - Dr. Eric Shafonsky (IHealth Physician Lead)
      - Alanna Black, Director, Partnerships and Communications, Medical and Academic Affairs
      - Amber Addley, Communications Advisor, Medical and Academic Affairs

   b. Approval and adoption of agenda and April 2023 minutes

2. **Remembering Jennifer Oates**
   - Acknowledge the sudden passing of Geriatric Psychiatrist, Dr. Jennifer Oates
   - She was a passionate advocate for patient centered care and ensuring the vulnerable elderly patients entering our system are properly cared for
   - Worked to ensure accuracy of patient records
   - Physician Faculty member of Physician Quality Improvement team, focusing on Patient Engagement
   - This has a different impact on our community than the loss of patients

3. **Update from IHealth**
   - Have Pooya Kazemi (RJH Lead, Anesthesiology) and Kellie Whitehill (VGH Lead, OBGYN) here, both full time physicians who bring their expertise at the bedside to the IHealth planning
   - Have been in roles since before ClinDoc and are there for you to reach out to re: questions, help navigating
   - Education emails going out soon (late September); Zoom sessions followed by in-person sessions
   - Personalization Fairs in January and February 2024
   - February 18th – VGH go live
   - March 17th – RJH go live
   - Ongoing engagement labs, still opportunities to engage (Wednesdays 1:00-3:00pm)
   - Will have Go-Live support elbow to elbow at each site
   - 6 hour remuneration for CPOE plus CME credits
     - Questions re: Education
       - Circle back for further education (month 1, month 3, etc.) – there will be Personalization Fairs before Go-Live to customize your settings, answer questions
       - After will have Skill Sharpening sessions
       - Plan for ongoing opportunities for professional development and training
       - ClinDoc had opportunity for connecting with Peer Mentors in Nanaimo
       - Plan for supernumerary support
   - Objective to have many people around for support (physicians who've used the system, professional technicians, computer support, possible support from residents from Vancouver); elbow to elbow support

- Basic training followed by personalized training
- Supernumerary physician support – need to apply for additional funding
    - Process is currently being targeted
    - If a group decides they have need and can fill a supernumerary line, there is some funding to support time, but the onus is on Divisions and Departments to arrange for the shifts to be filled
    - Contact Eric or Mary Lyn
    - Still time to arrange the support and reach out to Eric and Mary Lyn re: what can be funded, how much for how long
- Education modeling came from elsewhere – used lessons learned from Vancouver and Nanaimo, and other sites across the country to see what the Human Resourcing needs would be; site walkthroughs complimentary
- Care during STAT emergencies
    - Verbal orders allowed, back entry will be needed
    - NUAs cannot place any orders (i.e. stat lab orders); need to ensure a nurse is available to enter the orders into a computer
    - Major Hemorrhage Protocol orders will be done electronically, more efficient and safer than paper
    - Take care of the patient first, chart things later, like we do now
    - Mount St Joseph's hospital – when they launched CPOE, they lost NUA lines. Want guarantee they are not going to lose their jobs and be replaced by physicians and nurses answering the phone
    - There is a significant amount of work the NUAs do; can connect with NUAs in NRGH, they can reassure that there is a lot of work they still do
    - In workflow validations, NUAs in Nanaimo still feel their work is valuable and important
    - There is a team looking at their new roles and no plan to eliminate
    - Also concerned about nursing staff being taken away for order entry and away from patient care
    - Similar with nursing scribing orders now
    - There are shortages in all positions (physicians, nurses, NUAs, pharm techs, etc.)
    - Simulations are very important

- Working with MSA for other engagement opportunities (trivia nights, quiz nights); make the learning fun
- BPMH Pharmacy Tech hiring – work is ongoing, probably won't all be in place by Go-Live
- Goal is to be done within 4 hours of admission (organizational target); useful prior to admission, not after
- Lots of new devices being deployed (RJH: 70 in PCC, 10 in OR, 10 in ED); advocated for more in ER, moving some office space to make room for them
- New computers in OR; increasing from 1 to 6
- PCC – paper form cubbies will be removed and have computers; plus in some sitting areas/storage alcoves
- VGH getting additional devices but less of them; not as much space and lack of electrical plug available
- Call/text/email Pooya and Kellie – Island Health contacts are the easiest or grab them in the hallway

4. Medical Staff input on Chief of Staff (CoS) appointments

- Island wide initiative - received unanimous support from the MSA presidents on the Island at the HAMSA meeting in August
- Want transparency for CoS removals
- Historically, appointee of Chief Medical Officer (CMO) to convey information and carry out directives
- 2018-2020 Medical Staff Rules revision – transition to have some balance between physicians and the Health Authority (HA); build in some protections, but they were then removed by the CMO
- CMO needs to "consult" with medical staff but no obligation to act on results of consultation
- Result of VECTOR document/IHealth struggles, Nanaimo given the right to have meaningful input into CoS
- Port Alberni – removal of Sam Williams as CoS with no information

- Introducing Joe Foster, MSA president in Nanaimo
    - Chief of Staff used to be a position that was elected or nominated by medical staff
    - Throughout entirety of western world, it is the standard to have the CoS as an elected position, not appointed by CMO
    - After years of negotiations, finally got the ability to elect their own CoS; nominated in Nanaimo by "Voices" process
    - Currently funded at one day a week, but likely takes more time
    - Benefits of selected by and elected by:
        - Provides significant voice for medical staff when have difficulty getting heard by administration
        - Still felt the rank and file physicians have little to no influence on decisions making
        - Valuable to have someone you can go to who has the ear of administration
        - Helps with disciplinary process; entirely different process if done by Nanaimo CoS, not EMSS
        - Sit in on Respectful Workplace group
        - Deals with respect and bridges gap between physicians and administrators
        - Process can become polarized but less so with elected CoS
        - Conflict resolution
        - NRGH is currently in crisis; Hospitalists still have no contract, have had to cap services and it causes impacts in the ER
        - Losing staff in Hospitalists and ER
        - Dr Rudston Brown got enough people to diffuse the problem until they can get some help from administration and an actual contract in place
        - No one else in Admin structure could have done what he did
        - Not sure why this doesn't get move leverage with administration; advantage to them to have someone with more credibility to medical staff
        - Engagement survey shows poor scores on engagement, this can help with that
    - Marc Lambiotte MSA president for WCGH; Sam Williams removed from CoS with no notice
        - Haven't gotten a CSO to replace Sam
        - Sam was well respected
        - Not warned or given any time to get replacement
        - Dismissed with no warning, no reason
        - No one wants to step into role after how Sam was treated after a long time in the role
        - Hard to trust administration after what they have done, shows they do not care about Medical Staff in WCGH
        - Looking for leadership worth following; want to support COS currently in place, having voices of medical staff supporting them will give greater strength to role
        - Shows we have their back and they are protected

- **Proposed Resolution:**
    - Recognizing that the Chief of Staff acts as the intermediary between the site Medical Staff and Senior administration, we believe that the following is essential:
        - Support of the medical staff whom they serve
        - Security to allow for autonomy in advocating for patient care and staff wellbeing
    - We are therefore requesting that mechanisms be developed to ensure that Chiefs of Staff have the approval of their Medical Staff prior to appointment
    - We further request that processes be developed to fairly evaluate the Chief of Staff. In particular, removal of a Chief of Staff before the end of their term should follow a clear and transparent process with input from their medical staff

- Envision SIMAC involved in appointment, HAMAC with dissolution
- Dr. Ian Thompson (Executive Medical Director, Medical and Academic Affairs)
    - Asked to talk a bit about this, discussions have been going on
    - Invite to consider:
        - CoS used to be an advocate for Medical Staff and the role has changed over the years and the advocacy has been transferred more to the MSAs
        - 1 – If you are being elected, feel an accountability to those who elected you; CoS is an Island Health leadership contract (between physician and organization). Quite conflictual to feel accountable to those who elected you and those who hold your contract
        - 2 – Fairness or reciprocity if electing someone for an Island Health contract
        - 3 – Legal issue – challenges in place, principle of contract (can't impose obligations or extend rights to those not involved in the contract)

- Reminder "we are Island Health", not just people in offices, everyone working here together for the benefit of patients
- Need people who are acceptable to both administration and physicians
- What is the role of the MSA vs the COS
    - MSA is purely an advocacy group and are looking at the interest in the Medical Staff
    - CoS is an intermediary
    - Quite different roles, looking at different details within organization

- Formal role for CoS is someone on site – appointed by CMO, consultation with medical staff
- One struggle CoS has is actual engagement
    - Physicians having say and getting involved is also a responsibility
    - Most people wouldn't know how to find Hayley Bos and Brian McArdle

- MSA has mandated role in BC Hospital Act to act in an advisory capacity to the Island Health Board
    - Voices at HAMAC – unevenly weighted towards administrators and away from physicians

- Discipline problem/larger issues, MSA can support physicians
- CoS is linking the people together, conversing dept. to dept. to work towards common goal; when moving patients between areas, doing it with civility, integrity and equity
- Really important brokers of good will and collaboration; easy when it is easy, hard when it is not
- Visible, present, active leadership is pivotal to bringing issues forward and building trust
- CoS is who you call in the middle of the night for the unsolvable problem that isn't strictly operational
- Sometimes there are things behind the scenes that CoS will have to decide upon
- A lot of misunderstanding of roles and decisions making (i.e. Island Health is working hard for us and trying to make things better but MoH restricts us)
- May be a conflict of interest if an employee is trying to advocate for physicians
- Possible opportunity for MSA to pay the stipend for the CoS so there is someone funded by the MSA to be CoS so there is no conflict of interest – haven't looked at this option yet
- Think about ourselves as working for the patient, being paid by the province
- Need ability to be able to advocate regardless of who is paying them
- Even if you don't vote for someone, there is legitimacy with people who are elected

Motion – Unanimous carried the motion (will move forward with this)

5. Update on meeting with Minister of Health

- Marko, Manjeet, Chris Hall, CEO, Leah Hollins, representation from some groups (ER, Hospitalists, Surgeons)
- Minister commendably wanted to talk to physicians on the ground, not a press tour
- What happened as a result of the day:
  - Overwhelming Health Human Resources shortage – difficult to solve
  - Advocated for improving physicians voice, planted the seed for two way communication
  - Marko (VP) – Minister requested to meet with ER, Hospitalists (only had a few hours to target who to talk to); invited surgeons due to recent struggles with OR closures
  - Have had several meetings from that to get earlier opening of ORs; looking at same day arthroplasties at SPH, opportunities at Surgical centre
  - Heard from surgeons re: complexity of care journey
  - Essentially committed to how we hear from medical staff; have leaders help identify what the response is to the MSA to help address some of the challenges
  - Minister intends to come back again (hopefully VGH), over the next 12-13 months leading to next election
  - Experience – why was this engagement more successful than the usual way, why was the minister coming to the site more valuable, how do we do more of it
    - All know we are under immense pressure we've never dealt with before
    - Recognition of complexity and HHR strategy
    - Need to hear from experts to drive meaningful change
    - Will be in a better place if we do things collaboratively – work with Administrations, MoH, Physicians
    - Communities are not getting the care they deserve and we need to do better with engagement and partnerships; it is bad right now and won't get better anytime soon
    - Need to decide what to do

  - MoH doesn't always get it right, sometimes focus on things we won't not pick, i.e. intense focus on SPH; can allow us to pilot stuff we wouldn't be able to before
  - Can trial things to move to greater Victoria; UPCCs have a role but not the only area for focus
  - If they are laser focusing on one area, leverage it and see what we can try in another area
  - Can prove concept on a smaller scale
  - Tour across province came as ER closures were happening
  - Same with Covid, saw how things can be moved quickly and money gets shared

6. DoBC HA Engagement Survey – Due October 11th

- This is your chance to have a voice, the results are important and changes happen as a result
- Ben William's team committed to publishing survey results next year; will connect with us re: survey results, will get feedback and we can check in on work being done
- Want to move in the right direction
- If you do one survey the whole year, it is one of the most valuable you can do
- Seen by MoH, DoBC, Board
- Compares HAs, try to encourage everyone to fill it out
- Links are individualized – search your email for surveys@doctorsofbc.ca
- The response rate for South Island has been low; want higher sample size for South Island site
- Taking new approach seriously (questions reach out to Alanna)

7. Other Business:

- **2024 Compassionate Leadership Workshops**
  - June 11 and 12 – Current leaders
  - Oct 28 and 29 – New and emerging leaders

- **South Island MSA Recognition Awards -** Nominations open now!

- **Upcoming Events** – details on South Island MSA website :
  - Mindful Monday – Online tonight
  - South Island FEI Society Working Group Dinner – Monday, Oct 2 (Includes overview of sources of funding for QI and engagement work)
  - South Island Physicians' Walking Group – Sunday, Oct 15
  - Lunch in the Lounge – RJH and VGH – Thursday, Oct 19
  - AGM Evening – Tuesday, Nov 21
    - South Island MSA Recognition Awards
    - Guest Speaker Dr. Heather Patterson

Adjourned at 19:45