ACKNOWLEDGEMENTS

This Manual was prepared by the Ontario Hospital Association with the assistance of KPMG and Borden Ladner Gervais LLP.

The principal authors of the Manual are:

Patrick J. Hawkins is a Partner in the Health Law Group at the law firm of Borden Ladner Gervais LLP. He is a civil litigator, specializing in health law and personal injury defence. He has a LL.B. degree from Queen’s University (1989) and a LL.M. from the University of Cambridge (1990). He was called to the bar in 1992. For the past 21 years, he has devoted much of his practice to representing hospitals and other healthcare facilities in professional malpractice litigation and a wide variety of other litigation and policy matters. He acts as general counsel and provides situational advice to health care providers on a wide range of issues including physician credentialing and relationship management, privacy, freedom of information, quality of care reviews, and adverse event management and disclosure. He is a regular speaker and writer on health law issues.

Heather Pessione is a Partner in the Health Sector Services Group at the law firm of Borden Ladner Gervais LLP. She graduated from the University of Toronto Faculty of Law in 2005 and was admitted to the Ontario Bar in 2006. Prior to her law degree, Heather studied Bioethics, earning an Honours B.A. (with Distinction) in Philosophy from the University of Toronto in 2000, and an M.A. in Philosophy (Bioethics) from Dalhousie University in 2001. In addition to practicing in the areas of commercial and medical malpractice litigation, she routinely assists in providing advice to hospitals and other health care organizations on a wide range of topics, including corporate governance, privacy, health insurance, risk management, physician issues, and interpretation of applicable legislation.
Joshua Lawson is the Public Sector Industry Leader for the Greater Toronto Market and a Partner in KPMG Canada's Advisory Group with over 15 years of consulting experience. He has an undergraduate degree from Cornell University and an MBA from the Haas School of Business at the University of California, Berkeley where he was a Haas Fellow. He has worked on client engagements involving the highest levels of system leadership (payer and provider) as well as across the continuum of health care settings including primary care, large and small community hospitals, academic health science centers and emergency departments. He has worked with clients to develop and deploy strategies to optimize the use of health human resources, design and implement eHealth solutions, manage and reduce wait times for critical services, develop long-term capital investment strategies and negotiate and implement complex, multi-party agreements.

Dusan Lovren is a Senior Manager with over five years of healthcare consulting experience. He holds a Masters in Business Administration from the Rotman School of Management at the University of Toronto, as well as an undergraduate degree in Applied Science also from the University of Toronto. He has extensive Ontario public sector experience encompassing work with multiple ministries, agencies and several hospitals. His experiences span health system planning, program and health service evaluation, business and financial modeling, business case development and managing large multi-stakeholder engagements. He has also worked on First Nations and rural health system design issues.
The Ontario Hospital Association would like to recognize the members of the Advisory Panel that provided expertise and guidance and throughout the development of this Manual.

### ADVISORY PANEL MEMBERS

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Position</th>
<th>Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Nancy Merrow</td>
<td>Chair</td>
<td>Southlake Regional Health Centre</td>
</tr>
<tr>
<td>Dr. Jennifer Blake</td>
<td>President</td>
<td>Society of Obstetricians and Gynecologists of Ontario</td>
</tr>
<tr>
<td>Dr. Chris Carruthers</td>
<td>Former Chief of Staff</td>
<td>The Ottawa Hospital</td>
</tr>
<tr>
<td>Dr. David Cameron</td>
<td>Director, Medical Affairs</td>
<td>Brant Community Healthcare System</td>
</tr>
<tr>
<td>Dr. Gillian Kernaghan</td>
<td>President &amp; CEO</td>
<td>St. Joseph’s Health Care, London</td>
</tr>
<tr>
<td>Dr. Martin Lees</td>
<td>VP, Medical Affairs &amp; Chief of Staff</td>
<td>Chatham-Kent Health Alliance</td>
</tr>
<tr>
<td>Mitra Nadjmi</td>
<td>Senior Healthcare Risk Management Specialist</td>
<td>Healthcare Insurance Reciprocal of Canada</td>
</tr>
<tr>
<td>Dr. Peeter Poldre</td>
<td>Former VP, Education &amp; Medical Affairs</td>
<td>Sunnybrook Health Sciences Centre</td>
</tr>
<tr>
<td>Dr. Maureen Shandling</td>
<td>Senior VP, Medical Affairs</td>
<td>Mount Sinai Hospital</td>
</tr>
<tr>
<td>Dr. Ashok Sharma</td>
<td>Joint Chief of Staff</td>
<td>Grant River &amp; St. Mary’s Hospitals</td>
</tr>
<tr>
<td>Dr. Nancy Whitmore</td>
<td>VP, Medical Affairs &amp; Chief of Staff</td>
<td>St. Thomas Elgin General Hospital</td>
</tr>
</tbody>
</table>

### ONTARIO HOSPITAL ASSOCIATION STAFF

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Position</th>
<th>Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laurie Cabanas</td>
<td>Consultant</td>
<td>Physician &amp; Professional Issues</td>
</tr>
<tr>
<td>Sudha Kutty</td>
<td>Director</td>
<td>Patient Safety, Physician &amp; Professional Issues</td>
</tr>
<tr>
<td>Dr. Bob Lester</td>
<td>Physician Advisor</td>
<td>Physician &amp; Professional Issues</td>
</tr>
<tr>
<td>Navin Malik</td>
<td>Consultant</td>
<td>Physician &amp; Professional Issues</td>
</tr>
<tr>
<td>Melissa Prokopy</td>
<td>Senior Legislative Advisor</td>
<td>Policy, Legislative &amp; Legal Affairs</td>
</tr>
<tr>
<td>Sundeep Sodhi</td>
<td>Consultant</td>
<td>Health System Governance</td>
</tr>
</tbody>
</table>

### ONTARIO MEDICAL ASSOCIATION STAFF

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Position</th>
<th>Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jessica Katul</td>
<td>Senior Policy Analyst</td>
<td>Health Policy</td>
</tr>
<tr>
<td>Barb Leblanc</td>
<td>Executive Director</td>
<td>Health Policy</td>
</tr>
<tr>
<td>Dr. Shawn Whatley</td>
<td>Physician Advisor</td>
<td></td>
</tr>
</tbody>
</table>

### COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO STAFF

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Position</th>
<th>Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maureen Boon</td>
<td>Senior Advisor</td>
<td>Executive Office</td>
</tr>
</tbody>
</table>
INTRODUCTION

Many people tackle their first, official leadership post without significant training or experience as leaders. Much of what physicians bring to leadership comes from their training as clinicians caring for individual patients, and there is a lack of resources to prepare physicians for leadership roles.

To address this gap, the Ontario Hospital Association, with guidance from its Advisory Panel and other experts, developed this manual to support physicians during their transition into a leadership role. The manual will also serve as an important reference guide for physicians already in leadership positions.

While clinical experience builds many essential skills for effective leadership, physicians must develop new skills and acquire new knowledge in order to effectively execute their leadership responsibilities. Becoming a physician leader requires a change in mindset – from a focus on the individual patient within the context of the doctor-patient relationship, to a focus on broader system issues impacting large cohorts of patients.

As members on their hospital board, physicians will need to focus on how to improve and strengthen the system. This will involve the careful management of stakeholder relationships within and outside the hospital, oversight of key initiatives, particularly in the areas of patient safety and quality of care, and a better grasp of personal leadership and communications styles. It will also require a fundamental understanding of hospital governance and legislation that impacts hospitals and their operations.

As leaders, physicians will have a unique opportunity to shape the way care is delivered within their own organization, and perhaps their region and the system as a whole. It is an opportunity for physicians to contribute to system-wide initiatives aimed at addressing gaps and health system challenges, through strategic partnerships, innovation, guidance and support.

This manual is intended to help physicians with their important transition to leadership and to act as an ongoing reference source for them in their leadership role. Physicians will be introduced to basic concepts and information important for new physician leaders working in Ontario’s hospitals. The guide also provides links to other valuable resources which will be useful in helping physicians become more effective leaders.
HOW TO USE THIS GUIDE

This manual is targeted primarily at physician leaders: Chiefs of Staff/Chairs of the Medical Advisory Committee, Chiefs of Medical Departments and other clinical leaders. It was developed as an online resource with printable sections, and contains links to a range of resources found in the appendices at the end of each module. The online format enables readers to tailor their use of the manual to their own needs and priorities.

There are a total of six modules within this resource manual, covering various aspects of the physician leadership role. They include:

Module 1: Health Care in Ontario

This module is intended to provide physician leaders with an overview of Ontario’s health care system. Physician leaders will learn about key stakeholder relationships that need to be considered, the federal and provincial legislation under which hospitals operate, how hospitals are funded and a summary of issues regarding hospital and physician liability for malpractice.

Module 2: Hospital Governance

Module 2 focuses its discussion on the hospital governance structure and the role of the physician leader within it. Physician leaders will also learn about hospital management models, the typical leadership positions held by physicians, and the responsibilities of the physician leader in managing hospital-physician relationships (e.g., the privileges vs. the contractual model, the role of the Regulated Health Colleges, etc.)

Module 3: Leadership Basics: Knowing and Managing Yourself

Various aspects of the leadership role are covered in this module. These include tools and resources that provide physicians with a foundation for effective leadership, with a focus on the skills and qualities of effective leaders. Topics include, “Transitioning into a leadership role”, “Self-awareness principles and tools” (e.g., leadership styles), “Wellness and work-life balance”, and career advancement. A host of additional resources are provided in the appendices.
Module 4: Leading High-Performing Teams

At the core of a high-performing team – one that is focused on its goals and able to successfully attain them – is a leader who knows how to inspire others and effectively manage a team. This module provides physicians with useful tools and information on how to be a better teammate, manager, advocate, and ultimately, a better leader. Also included are resources to help physician leaders manage physician performance, recruitment, retention and transitions.

Module 5: Basics of Hospital Finance

This module provides physician leaders with resources to understand the basics of hospital management, finance, and change management. It builds on the topics covered in Modules 1 and 2, particularly those pertaining to hospital management models, reporting structures and hospital funding. Readers may want to revisit these topics before proceeding with this section. The knowledge in this module may be especially useful for physician leaders working in rural communities or in organizations where physicians take on more senior leadership positions.

Module 6: Quality, Safety and Risk Management

Quality and patient safety are key priorities for Ontario, and essential characteristics of a high-performing system. This module begins with a detailed discussion of the legislative context for quality, safety and risk management (readers may want to review relevant topics in Modules 1 and 2, in particular, the sections on the Excellent Care for All Act and the Quality Care Information Protection Act). Physicians are also provided with the framework, recommendations and tools needed to build an organization focused on quality improvement and patient safety, with the appropriate controls for assessing and managing risk.
DISCLAIMER

The tools and other materials in this resource guide are for general information only and should be utilized by each health care organization in a manner that is tailored to its circumstances. This resource reflects the interpretations and recommendations regarded as valid at the time of publication based on available research, and is not intended as, nor should it be construed as, professional advice or opinion. Health care organizations and individuals concerned about the applicability of the materials are advised to seek legal or professional counsel. The Ontario Hospital Association will not be held responsible or liable for any harm, damage, or other losses resulting from reliance on, or the use or misuse of the general information contained in this resource guide.
OVERVIEW

This section provides an overview of the roles and responsibilities of key stakeholders impacting hospitals. The detailed description of stakeholders can assist physician leaders in understanding the relationship between their hospital and the Ontario health system.

Hospital Stakeholders

Public hospitals must take into account the interests of multiple stakeholders. These include:

- Patients and local community;
- Staff (Employees and Professional Staff);
- Volunteers;
- Community members;
- Local Health Integration Networks (LHINs);
- Ministry of Health and Long-Term Care (Ministry);
- Canadian Institute for Health Information (CIHI);
- Donors and hospital foundations;
- Academic partners;
- Donors;
- Contracting parties;
- Other health providers; and
- The health system as a whole.
Figure 1. A Hospital and its Relationships
Source: OHA Guide to Good Governance
Other important external stakeholders for Ontario hospitals include:

- **Ontario Hospital Association** (OHA);
- **Ontario Medical Association** (OMA);
- **Ontario Nurses’ Association** (ONA);
- **Canadian Blood Services** (CBS);
- **Trillium Gift of Life Network** (TGLN);
- **Cancer Care Ontario** (CCO);
- **Health Quality Ontario** (HQO).

It is the role of the hospital’s board of directors and all of its leaders (including physician leaders) to act in the interests of the hospital corporation, and therefore, hospital leaders are not solely accountable to any stakeholder in particular. Hospital leaders will face challenges when they are choosing between competing demands for limited resources. However, when acting in the interests of the hospital, its leaders must ensure that they act not only in furtherance of the mission and vision of the hospital, but in a way that allows the hospital to discharge its accountability to its stakeholders.

This and other corporate governance concepts are discussed further in Module 2. This module provides further information regarding some of the key hospital-stakeholder relationships relevant to physician leaders. A more detailed discussion of hospital stakeholder relationships can be found in Chapter 2 of the OHA’s *Guide to Good Governance*.

**Patients and Local Community**

The interests of patients and families and the needs of the community being served are of utmost importance. Hospitals provide a vital service to the community with taxpayers’ dollars. Hospital leaders, including physician leaders, must therefore take into account the public interest when determining what is in the best interests of the corporation. The standard to which the hospital will be held accountable with respect to the scope and quality of services it provides, is that which would be expected of a similarly situated hospital (a “community standard”).
Hospital Staff

The physician leader’s relationship with hospital staff will be explored throughout this Manual. At this stage, it is important to understand that hospital staff are comprised of employees (union and non-union) as well as credentialed Professional Staff (many of the hospital’s physicians, midwives, dentists, extended class nurses), and that there are differences in the legal relationship with each group.

Community Members

Public hospitals are not-for-profit corporations, and therefore, have members instead of shareholders. Some public hospitals have community members, and others do not. For example, faith-based hospitals are governed by the religious community and, as such, they do not have community members. The role of community members in the corporate governance of hospitals is discussed in Module 2. It is important to note here that hospital members have a limited role in the corporate governance (most notably, the election of directors) and do not have the rights of a shareholder of a for-profit corporation.

Local Health Integration Network (the “LHIN”)

Ontario has implemented a model for local management of health care services based on LHINs constituted under the Local Health System Integration Act. Each LHIN is a not-for-profit corporation and agent of the government which oversees and represents health service providers in a particular geographic area. The Board of Directors of each LHIN is appointed by the government, and the Directors receive remuneration for their role (i.e., compensation for expenses and payment for time spent on authorized LHIN business).

The LHINs oversee and fund health service providers (as defined in the legislation), including public hospitals. The LHINs also engage in health system planning, system integration (including transferring, merging, amalgamating, or ceasing provision of services) and coordination, and oversee health service provider performance pursuant to service accountability agreements and performance agreements.
Each LHIN has its own website which is accessible from the general site and which contains region-specific information regarding processes and procedures employed by the particular LHINs. More information on LHINs is available here.

Ministry of Health and Long-Term Care (the Ministry)

The Local Health System Integration Act has resulted in the delegation of a number of funding functions to the LHINs, including the legislative power and authority to plan, coordinate and fund local health systems. The Ministry develops policy and provides funding to the LHINs for Ontario’s public hospitals. The Ministry retains ultimate responsibility for the health care system. In addition, pursuant to the Public Hospitals Act, the Minister has the power to intervene in the governance of a hospital through the appointment of a supervisor or an investigator in cases where the Ministry determines it is in the public interest to do so.
Academic Partners

Academic hospitals are formally affiliated with colleges and universities that have medical and other clinical programs, through written affiliation agreements. The agreement creates a contractual relationship between the hospital and the academic institution. University affiliation agreements typically outline each organization’s obligations as they relate to student placement. It may also address Professional Staff appointments at the university, adherence to university and hospital policies and procedures, placement of undergraduate and postgraduate students, and research relationships. College affiliation agreements typically govern the placement of the school's students in a clinical setting at the hospital.

Community hospitals may also have academic affiliations with a university medical school (e.g. North York General Hospital – University of Toronto), to provide clinical rotations for medical students and residents; and with universities and community colleges to provide clinical rotations for students in other health professions.

Further information regarding academic partnerships appears in Module 2.

Canadian Institute for Health Information (CIHI)

CIHI, a national, independent, not-for-profit organization, plays an important role in Canada’s health care sector. CIHI collects, analyzes, and publishes health care data provided by hospitals and other providers in a standardized fashion. This publicly available information supports leaders across the system – health providers, policy-makers, provincial governments – by providing data and information to enable more effective decision-making, and in turn, better health for Canadians.
For example, the public reporting of various patient safety indicators through CIHI, continues to help Ontario’s hospitals implement strategies to improve quality and safety within their organizations, inspire improved performance, and strengthen the public’s confidence in Ontario’s hospitals.

Since 1994, CIHI has worked with system partners to:

- Help improve the depth and breadth of Canada’s health data.
- Build and maintain 27 critical pan-Canadian databases that enable jurisdictions to compare data (e.g., the National Ambulatory Care Reporting System (“NCARS”), National Rehabilitation Reporting System (“NRSS”), National System for Incident Reporting (“NSIR”), among others).
- Produce analyses on health and health care in Canada that are relevant, timely and actionable.
- Increase the understanding and use of data through education, reporting tools and strategies.

Donors and Hospital Foundations

Many hospitals rely, to a significant extent, on charitable donations for equipment and special projects. Foundations generally do not fundraise for ongoing operations. While hospitals may fundraise directly, the most common fundraising model is the hospital foundation: a separately incorporated charitable corporation governed by an independent board of directors. Typically, there is a formalized relationship between the hospital board and the foundation board, and physician leaders will generally not deal directly with donors or the foundation as part of their day-to-day duties. Some physician leaders may hold positions on the foundation board. Physician leaders may also be asked to speak to donors to support the work of the foundation.

While hospital donors and foundations are important hospital stakeholders, as with other hospital stakeholders, it is important for physician leaders and hospital directors to always act in the best interests of the organization, which involves consideration of all stakeholders and accountabilities.
LEADERSHIP QUOTE

Our donors are key partners in the hospital strategic directions. I do my best to attend events and lend my presence as requested by the Foundation.

Dr. Nancy Merrow
Chief of Staff, Southlake Regional Health Centre
OVERVIEW

Physician leaders need to be familiar with the legal context of hospital operations as it relates to their administrative role and responsibilities within the organization.

This section provides an overview of the key legislation governing the Ontario health system and their implications for hospitals and physician leaders.

There are many different pieces of legislation which are relevant to the operation of Ontario hospitals. Copies of current Ontario legislation can be accessed here.

FEDERAL ROLE

The establishment, maintenance and management of hospitals is a provincial responsibility under the Federal Constitution Act, and therefore, the majority of the relevant legislation is provincial.

The few pieces of Federal legislation which impact day-to-day hospital operations include:

- The Canada Health Act, under which the Federal government contributes to provincial health funding and sets out the five principles (“pillars”) which provinces must meet in order to receive full funding from the Federal Government: public administration, comprehensiveness, universality, portability, and accessibility (funding flows are discussed in further detail later in this module);

- The Food and Drugs Act, under which the Federal government regulates pharmaceuticals and medical devices and provides narcotic control.

Health Canada is a department of the Federal government which administers funding for health care funded directly by the Federal government, such as health care for First Nations.

The Public Health Agency of Canada (PHAC) is another department of the Federal government which assists the Federal Minister of Health in exercising and performing his or her powers, duties and functions in relation to public health. PHAC works closely with provincial, territorial and municipal governments given their shared responsibility for public health. PHAC is managed by the Chief Public Health Officer of Canada, who also acts as a Deputy to the Minister of Health.
A hospital corporation is a not-for-profit corporation incorporated under the Ontario Corporations Act and approved as a public hospital under the Public Hospitals Act. Hospitals are not agents or divisions of the government, but are autonomous organizations governed by independent boards of directors.

There are many pieces of provincial legislation which impact on a hospital’s day-to-day operations. This section provides a brief overview of the legislation that is most relevant to the physician leader role. In some cases, more detailed information will be provided in upcoming Modules.

**Public Hospitals Act**

The Public Hospitals Act (PHA) and its regulations provide the framework within which Ontario’s public hospitals operate.

The PHA is administered and enforced by the Minister of Health and Long-Term Care. The PHA sets out the role of the Minister and Ministry with respect to oversight of public hospitals. The Minister’s approval is required with respect to a number of more significant administrative matters, including the incorporation and amalgamation of public hospitals, and with respect to the acquisition and disposal of land.

The PHA governs a number of different areas, including:

- **Corporate Governance:** In conjunction with the Corporations Act, the PHA and Regulation 965 (the Hospital Management Regulation, or HMR) made under the PHA, provide the framework for hospital governance. Pursuant to the HMR, the hospital is governed and managed by board of directors. The PHA and HMR provide for the establishment of corporate by-laws, Professional Staff by-laws, the Medical Advisory Committee (MAC) and Fiscal Advisory Committee, and impose requirements with respect to the composition of hospital boards of directors and the timing of annual meetings. The PHA also empowers the Ministry to appoint an investigator and/or recommend the appointment of a supervisor to manage public hospitals in certain circumstances.

---

1 The Not-for-Profit Corporations Act will replace the Corporations Act when it is proclaimed in force (targeted for July 1, 2013). See discussion on governance below and Module 2 for further details.
• **Physician Appointments and Privileges:** The PHA contains a process describing how members of the Professional Staff are to be appointed and re-appointed, and how board hearings are used to resolve disputes between hospitals and members of the Professional Staff. Hospital privileges will be discussed in more detail in Module 2. For more information, refer to the OHA’s *Professional Staff Credentialing Toolkit*.

• **Reporting:** Under the HMR, the board is responsible for ensuring that the CEO establishes a system to ensure disclosure of every critical incident to the MAC, CEO and patient or patient representative. The board is also responsible for ensuring that the CEO provides aggregated critical incident data to the hospital’s quality committee established under the *Excellent Care for All Act* (ECFAA) at least two times per year. It is important to note that ECFAA imposes further reporting requirements (as set out in more detail later in this Module, and in Modules 2 and 6).

For additional information on quality oversight, see the *Quality and Patient Safety Governance Toolkit* and the *Ontario Guide to Disclosure*.

The CEO is also responsible for reporting to the College of Physicians and Surgeons of Ontario pursuant to the PHA with respect to any disciplinary action taken with respect to physicians.

• **Funding:** There is a general provision in the PHA which enables the Minister to fund public hospitals when it is in the public interest for it to do so. Hospital funding is discussed in detail later in this Module.

• **Patient admissions, discharge and records:** The HMR sets out in detail the requirements for admission and discharge of hospital in-patients and out-patients, and the requirements for patient records.

• **Classification of hospitals:** Under a regulation made under the PHA, public hospitals are classified as general hospitals, convalescent hospitals, hospitals for chronic patients, active treatment teaching psychiatric hospitals, active treatment hospitals for alcoholism and drug addiction and regional rehabilitation hospitals, and are designated into a number of Groups.

• **Communicable disease protocols:** Under the HMR, hospitals are required to provide for the operation of an employee health surveillance program, following the recommendations in the Communicable Disease Surveillance Protocols published jointly by the OHA and the OMA and approved by the Minister. Information regarding the Protocols is available [here](#).
Governance

Hospital corporations are not-for-profit corporations incorporated under the Ontario Corporations Act or, in some cases, incorporated by special legislation.

In October 2010, the Ontario Government passed the Not-for-Profit Corporations Act which, at the time of this Manual’s publication, has not yet been proclaimed in force. When the Not-for-Profit Corporations Act is proclaimed in force (targeted for July 1, 2013), it will replace the Corporations Act with respect to the corporate governance of hospitals.

For more information on the Not-for-Profit Corporations Act, visit the OHA’s Governance Centre of Excellence.

The corporate governance structure of public hospitals will be explored in more detail in Module 2. For more information, refer to the OHA’s Guide to Good Governance.

Charity Law

Hospitals are also charitable corporations. Charity law is outside the scope of this Manual. However, it is important for physician leaders to know that legislation such as the Federal Income Tax Act and the Ontario Charities Accounting Act may limit the business activities that may be carried on by hospitals.

Quality, Transparency, Accountability and Engagement

A number of pieces of legislation have been enacted in recent years which impose new obligations on Ontario public hospitals with respect to quality, transparency, accountability and community engagement. This section summarizes these obligations. A more detailed discussion of many of these issues can be found in Module 6.

(a) Excellent Care for All Act (ECFAA)

ECFAA was enacted in 2010 with the purpose of improving patient care and enhancing the patient experience. Under ECFAA, hospitals are mandated to conduct employee/care provider and patient satisfaction surveys, and to have in place a patient relations process. ECFAA also
requires hospitals to establish a Quality Committee that reports to the board, and to complete annual Quality Improvement Plans. ECFAA links executive compensation to performance improvement targets in the Quality Improvement Plan. For more information, see the OHA’s ECFAA page.

(b) **Broader Public Sector Accountability Act** (BPSAA)

BPSAA was enacted in response to issues raised in the Special Report from the Office of the Auditor General of Ontario in 2010, to enhance transparency and accountability with respect to public funds. BPSAA imposes a number of accountability requirements on public hospitals, including:

- Not using public funds to engage lobbyists
- Reporting on use of consultants
- Managing expense claim reporting
- Setting expense claim rules
- Setting procurement standards
- Establishing allowable perquisite rules
- Creating compliance reports
- Parameters around executive compensation

Detailed information and resources with respect to the implementation of BPSAA is available from the MOHLTC.

(c) **Local Health System Integration Act** (LHSIA)

Under LHSIA, hospitals are required to conduct community engagement “when developing plans and setting priorities for the delivery of health services”. For more information on stakeholder engagement, refer to **EPIC – Engaging People, Improving Care**.
(d) **Public Sector Salary Disclosure Act (PSSDA)**

Under PSSDA, hospitals are required to publicly disclose employee salaries which exceed $100,000. The list of public salaries is commonly referred to as the “Sunshine List”.

(e) **Quality of Care Information Protection Act (QCIPA)**

QCIPA addresses the public interest in facilities engaging in quality of care and peer review activities by prohibiting disclosure of quality of care information generated for the purposes of a designated “quality of care committee”. For more information, consult the OHA’s [QCIPA Toolkit](#).

There are also a number of voluntary processes not prescribed by legislation which contribute to or demonstrate hospital accountability, transparency and engagement. Typical forums for engagement include community advisory committees or councils, “town hall” style meetings and other presentations to community groups and stakeholder entities, patient feedback and surveys, and the hospital website.
HOSPITAL RECORDS AND PRIVACY

Physician leaders should be familiar with the system of patient record-keeping in their institutions from experience with their clinical practices.

Minimum requirements for patient record-keeping by hospitals are contained in the HMR – e.g., all orders for treatment must be dated, in writing, and signed by the Professional Staff member giving the order.

There are also requirements with respect to patient record-keeping in the statutes which govern self-governing health professions, as well as in their policies and procedures and in the policies and procedures of the hospital. For example, rules made under the General Regulation of the Medicine Act set out minimum requirements for patient record-keeping by physicians.

In 2004, the Ontario government enacted the Health Information Protection Act, which introduced two significant new pieces of legislation governing health information in the province: the Personal Health Information Protection Act (PHIPA) and the Quality of Care Information Protection Act (discussed in the previous section).

PHIPA governs the collection, use and disclosure of individuals' personal health information by health information custodians such as public hospitals. PHIPA also addresses the right of patients to access their own personal health information.

For more information, consult the OHA’s Hospital Privacy Toolkit.

As of January 1, 2012, the Freedom of Information and Protection of Privacy Act (FIPPA) applies to public hospitals in Ontario. Under FIPPA, members of the general public have a right of access to all records in the custody or under the control of a hospital from on or after January 1, 2007, unless the records are excluded from the right of access or subject to an exemption. The application of FIPPA represents a significant change for hospitals. Whereas previously, the only right of access to information was by individuals to their own personal health information under PHIPA, many other hospital records are now accessible by the general public under FIPPA. Most hospitals have assigned administrative responsibilities for FIPPA to a Freedom of Information Office or Co-ordinator, and have implemented an administrative, reporting and decision-making structure to ensure compliance with FIPPA. For more information, consult the OHA’s Hospital Freedom of Information Toolkit.

Retention of hospital records, including patient records, is a complex issue which requires reference to a large number of relevant pieces of legislation. The OHA’s Records Retention Toolkit provides a summary of and guidance on this issue.
Inquests and Inquiries

It is important that physician leaders be aware of recommendations with respect to inquiries and inquests as they relate to the provision of care at their hospital.

Under the **Coroner’s Act**, it is mandatory to report unusual or unexplained deaths to the coroner, who is then required to investigate. In some cases, the coroner’s investigation leads to recommendations, and in other cases, the coroner may decide that an inquest is necessary in order to complete an investigation.

An inquest is a public hearing into an unexplained or suspicious death, presided over by the coroner. Inquests are not intended to adjudicate liability or make any findings of fault; the main function is to determine the facts and circumstances of the death and to make recommendations aimed at avoiding or reducing the risk of a death occurring in similar circumstances in the future. The coroner has broad powers to regulate the proceedings.

Under the **Public Inquiries Act**, the Lieutenant-Governor-in-Council has the authority to appoint a commissioner to conduct a public inquiry concerning any matter connected with the good government of the province. On a number of occasions, inquiries in the province have been given terms of reference that relate directly to health care. These typically involve high-profile, system-wide issues or concerns.
For example:

- The **Inquiry into Pediatric Forensic Pathology in Ontario** (the Goudge Inquiry) was created to address serious concerns over the way criminally suspicious deaths involving children are handled by the Province.

- The **Commission to Investigate the Introduction and Spread of SARS in Ontario** (SARS Commission) was struck to investigate the SARS virus that killed 44 people in Ontario in 2003.

In February 2012, the Drummond Commission on the Reform of Ontario’s Public Services released its report, which contains a number of recommendations with respect to health care reform in the province, including a focus on patient-centered care, non-acute care, home-based care, and spending reform. The executive summary can be accessed on the Ministry of Finance’s website.

Reports sent to the OHA from the Office of the Chief Coroner contain details of the investigation and a review of deaths that occurred in hospitals. They include recommendations to hospitals and other related organizations made by either a specialized Committee of the Coroner’s office, or by the coroner’s jury serving on the inquest of the case. These recommendations are intended to prevent deaths in the future that are of a similar nature. An archive of reports can be found on the OHA’s website.

**LEADERSHIP QUOTE**

“Coroner’s reports are reviewed by the Quality Council, a subcommittee of the MAC and the Senior Leadership Team, to understand the application to the care provided within the organization.”

Dr. Gillian Kernaghan

*President and CEO, St. Joseph’s Health Care London*
Consent to Treatment

All physician leaders should be familiar with consent to treatment from their clinical practice. Physician leaders should also be aware of the legal requirements with respect to consent.

The principle of informed consent to medical treatment is codified in Ontario’s *Health Care Consent Act* (HCCA). The HCCA provides that consent to treatment is informed if the individual receives the information that a reasonable person in the same circumstances would require to make the treatment decision. The information provided must include the following:

- The nature of the treatment;
- The expected benefits of the treatment;
- The material risks of the treatment;
- The material side effects of the treatment;
- Alternative courses of action; and
- The likely consequences of not undergoing the treatment.

The extent of disclosure will depend on the particular circumstances of each patient’s case and needs to be related to the patient’s own situation and the nature of the proposed treatment.

Where there is an urgent need for treatment, and obtaining consent is not possible, a provider may be exempt from the requirement to obtain it. The HCCA stipulates that an emergency exists only “if the person for whom the treatment is proposed is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm”.

Both the HCCA and the *Substitute Decisions Act* provide a mechanism for obtaining consent from substitute decision-makers in circumstances where the patient is incapable of providing informed consent for a specific treatment (see below). The HCCA also provides for the review of findings of incapacity by a provincial administrative tribunal, the Consent and Capacity Board (CCB).
Mental Health Law

Physician leaders should be aware of the legislative scheme governing mental health issues, as the treatment of patients with severe mental disorders raises legal issues that often do not arise in the treatment of other illnesses, and all clinical decisions will be subject to a high degree of scrutiny from review tribunals, particularly with respect to whether treatment was authorized. In brief:

- **Mental Health Act (MHA)**: governs hospitalization and provides authority for detention in a “psychiatric facility”. Many large public hospitals with a psychiatric department are classified as “psychiatric facilities” pursuant to the MHA. There are approximately 70 Schedule 1 facilities which provide comprehensive general psychiatric services. Psychiatric facilities designated under Schedules 2 through 6 provide more limited or specialized services.

- **Health Care Consent Act**: Governs patient/clinician relations, informed consent, and assessment of capacity and substitute decisions, and provides for the review of findings of incapacity by a provincial administrative tribunal, the Consent and Capacity Board (CCB).

- **Substitute Decisions Act**: Defines and governs Powers of Attorney for personal care and property.

More information on Mental Health Law is available in the OHA's Mental Health Toolkit.
Workplace Issues

Issues relating to Professional Staff will be dealt with elsewhere in this Manual. This section provides a summary of some of the key legislation relating to workplace issues.

There are two types of hospital employees:

- **Non-Unionized Employees** - Non-unionized employees have traditional employment contracts, subject to minimum employment standards set out in the *Employment Standards Act* (ESA) (e.g., minimum age requirement, maximum hours for full-time employment, entitlement to overtime). Insofar as these standard employment contracts contain benefits which exceed the minimum standards, they will be governed by the common law (judge-made case law) with respect to matters such as wrongful dismissal.

- **Unionized Employees** - The hospital’s employment relationship with unionized employees will be governed by the applicable collective bargaining agreement.

  Collective agreements are negotiated between an employer and a union representing the interests of a particular group of employees. In Ontario, collective bargaining is regulated by the *Labour Relations Act*, which contains a code of rights and procedures, including how employees become unionized, guidelines for collective agreement negotiations, and procedures for arbitration when differences arise. In the hospital sector, labour relations are also governed by the *Hospital Labour Disputes Arbitration Act* (HLDAA). HLDAA removes the right of hospital employees to strike and the right of hospitals to lock out their employees in situations where the parties cannot conclude a collective agreement. The right to strike and the right to lock out are replaced with mandatory binding arbitration. The most common unions in the hospital sector are the Ontario Nurses’ Association (ONA), the Canadian Union of Public Employees (CUPE), the Service Employees’ International Union (SEIU), and the Ontario Public Service Employees’ Union (OPSEU).
The biggest difference between non-unionized and unionized employees is that unionized employees have access to a grievance arbitration process, to challenge employer decisions made in the employment relationship. Generally, unionized employees cannot have their employment terminated without the use of progressive discipline and demonstrated just cause. In contrast, non-unionized employees can have their employment terminated by providing ESA notice of termination or payment in lieu of notice and, if applicable, severance pay under the ESA and notice at common law.

The following pieces of legislation are applicable to both unionized and non-unionized employees:

- The ESA provides minimum standards of employment. This legislation deals with such issues as maximum hours of work, vacation entitlements, public holidays, overtime, and minimum wages. Employment contracts and collective agreements cannot contract out of any of the minimum standards, but can, and often do, provide for more than the minimum requirements.

- Under Ontario’s Human Rights Code, hospitals may not discriminate on the basis of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability, in the context of employment or provision of health care services.

- The Accessibility for Ontarians with Disabilities Act (AODA), and the regulations thereunder, provide for the development and implementation of accessibility standards to assist in breaking down barriers for people with disabilities. These accessibility standards, established by regulations to the AODA, cover five areas of daily living: customer service, information and communications, employment, transportation and built environment. There are a number of detailed standards with which hospitals have an obligation to comply, and new standards will continue to be developed through 2025.
For assistance in meeting obligations under the AODA, refer to the OHA’s online accessibility resource.

- The *Workplace Safety and Insurance Act*, offers through the Workplace Safety and Insurance Board (WSIB), a no-fault insurance system to provide compensation to employees injured in the course of employment. Physicians, who are not typically employees of the hospital, are usually not eligible for compensation through the WSIB. As employers, hospitals are required to pay an insurance premium to the WSIB. The hospital is also required to facilitate and cooperate with the WSIB in the safe and early return to work of injured employees. Injured employees may be entitled for compensation during a period of disablement, and re-employment on rehabilitation, if their claim is accepted by the WSIB.

- Ontario regulates occupational health and safety under the *Occupational Health and Safety Act* (OHSA). Under OHSA, employers must take “every precaution reasonable in the circumstances for the protection of a worker.” Directors and officers (which may include physician leaders) have a duty to take all reasonable care to ensure compliance with the OHSA and any orders made thereunder. Employees (workers) must work in compliance with OHSA and employers must also maintain workplaces that meet the health and safety standards established by OHSA. Physician leaders may fall within the definition of “supervisor” under the OHSA, and if so, they will owe the duties set out within s. 27 of the OHSA. Hospitals have additional prescribed requirements (e.g., reporting requirements) pursuant to the *Health Care and Residential Facilities Regulation* made under OHSA.
  - With recent amendments to OHSA, employers have a duty to address workplace violence and harassment, as well as domestic violence, when it intrudes into the workplace. OHSA requires a written policy, a workplace risk assessment and training in the measures and procedures for mitigation or prevention of workplace violence and harassment. This will be discussed in further detail in Module 4. For more information on OHSA, please consult the Ministry of Labour website.

It is important to note that hospitals may be required to report a health care worker’s exposure to communicable diseases, pursuant to OHSA and/or WSIB policy. Physician leaders should consult the hospital’s human resources department and/or the occupational health and safety department for more details.

There are also occasions when physicians will employ staff in their offices who are based within the hospital. It is the obligation of the employing physician to ensure that applicable labour legislation is adhered to in the context of this employment relationship, and that their employees conduct themselves in accordance with relevant hospital policies and codes of conduct.
PROFESSIONAL REGULATION

Legislation governing the conduct of health professionals is a matter of provincial jurisdiction.

The *Regulated Health Professions Act* (RHPA) is “umbrella legislation” in Ontario which contains general provisions pertaining to all regulated health professions in the province.

Additionally, accompanying legislation relating to each profession details their scope of practice, controlled acts and issues relating to delegation. Examples of regulated health professions in Ontario include physicians, nurses, midwives, dentists, and optometrists. A list of the regulated health professions and their associated legislation is contained in Appendix 3 of this Module.

Once designated, the health profession is bound by the provisions of RHPA which require that a “College” be established which, in turn, passes by-laws that outlines requirements for registration and standards, limits or conditions of practice, among other things. Matters of professional discipline are handled by individual colleges according to the *Health Professions Procedural Code*, a Schedule to RHPA. The Code also creates obligations for public hospitals with respect to matters such as reporting (e.g., revocation of hospital privileges, sexual assault).

RHPA designates a number of treatments as “controlled acts” which can only be performed by certain specified professionals. However, RHPA does allow for a health professional who is authorized to perform a controlled act to delegate the performance of some of the controlled acts to a specified individual who is not otherwise authorized to perform the act. RHPA contains detailed regulations setting out the circumstances under which a controlled act can be delegated.

Another form of delegation is by way of medical directives, which are orders that may be performed for a range of patients whose condition meets the specific conditions set out in the order. For more information on delegation, please see the online toolkit from the *Federation of Health Regulatory Colleges of Ontario*. More information on the Regulated Health Colleges is contained in Module 2.
An example of non-regulated staff is physician assistants. In recent years, a number of physician assistants have begun working in Ontario hospitals, in some cases, pursuant to a pilot project of the Ministry of Health and Long-term Care. Physician assistants are non-regulated health professionals who practice under the supervision of qualified physicians and who receive their authority to perform controlled acts by delegation. More information is available in this Scope of Practice Statement released by HealthForceOntario.
OVERVIEW

It is important for physician leaders to understand the sources of hospital funding, the applicable legislation, and the key players in the funding relationship.

LEADERSHIP QUOTE

“Physicians generally have little knowledge of the legal processes that bind how hospitals acquire goods and services. There are pitfalls to be aware of.”

Dr. Nancy Merrow
Chief of Staff, Southlake Regional Health Centre

The manner by which Ontario hospitals receive funding is complicated and, at the time of publication of this Manual, is in a state of transformation.

Physician leaders are advised to meet with the CFO in their organization to understand the specifics of the funding streams for their organization.
The public funding of health care in Ontario is depicted in the following diagram:

**Figure 2. The Structure of Healthcare Funding in Ontario and Relevant Legislation**
LEGISLATION

The *Canada Health Act* sets out five principles (“pillars”) which the provinces must meet as a condition of receiving full health care funding from the Federal government: public administration, comprehensiveness, universality, portability, and accessibility.

Under the *Health Insurance Act* (HIA) physicians receive funding for insured, medically necessary services directly from the Ontario Health Insurance Plan (OHIP), on a “fee-for-service” basis. This is the standard manner in which physicians are paid, both for their private office practice and for the hospital component of their practice. There are also other physician funding flows which are becoming more common; for example, some hospitals receive funding for physician services under various alternative funding arrangements with the Ministry, and the Hospital On-Call Coverage (HOCC) Program, administered by the Ministry, provides funding for hospital on-call coverage to offset coverage expenditures previously borne by hospital operating budgets. In some cases, physicians are employed and remunerated by the hospital, for example, through arrangements whereby the hospital bills OHIP on their behalf, using the alternative funding referred to above, or out of the hospital’s global budget.

The HIA also defines the scope of insured hospital services. The hospital services to which Ontario residents are entitled without charge is very broad, and includes all laboratory, radiological and other diagnostic procedures, together with the necessary interpretations.

Under the *Commitment to the Future of Medicare Act* (CFMA), it is prohibited to charge or receive payment for insured services or for preferential access to insured services.

Hospital services are funded by the Ministry, and funding is administered by the LHINs.
ACCOUNTABILITY AGREEMENTS

Hospital funding flows from the Ministry to the LHIN under Ministry-LHIN Accountability Agreements (MLAA). More recently, MLAAs have been replaced by Ministry-LHIN Performance Agreements (MLPA). MLPAs for each LHIN are posted on the [LHIN website](#).

Hospitals are accountable for funding through agreements with the LHIN – Hospital Service Accountability Agreements (HSAA) – which require hospitals to be accountable for explicit performance outcomes (e.g., a minimum number of admissions per year). CFMA establishes a process for HSAAAs to be negotiated with the LHIN. The HSAA is then executed by the Hospital and the LHIN. The HSAA contains financial performance obligations based on data from the Hospital Accountability Planning Submissions (HAPS, formerly known as Hospital Annual Planning Submissions).

The HSAA may also require that a performance agreement be entered into between a hospital and its CEO. The content of and process for entering into service accountability agreements and performance agreements is governed by CFMA. Refer to the [LHIN Collaborative](#) for more information about service accountability agreements.

Sources of Hospital Funding

The Ministry, through the LHIN, is the major source of hospital revenue, accounting for about 85-100% of operating revenues for most hospitals. Other sources of revenue include revenue-generating activities (e.g., cafeteria and parking income), funding from other government sources (e.g., Federal funding for veterans’ health care, provincial funding for workplace accidents through WSIB), grants, donations and charitable giving. As set out above, donors are a vital source of hospital funding and important hospital stakeholders.
Hospitals receive funding in a variety of ways. The most significant source of government funding is the hospital’s global budget, which flows from the Ministry through the LHIN and covers the majority of in-patient and out-patient funding. Hospitals have flexibility in allocating their global budget within the terms of their service accountability agreements. Global funding is earned based on formulas – historically, global funding has been based on past funding.
requirements rather than patient volumes or performance (see the next section for a discussion of the Ministry’s new patient-centered approach).

Other Ministry/LHIN funding includes priority services funding for designated programs (e.g., chronic kidney disease), funding to support expansion of services following expansion of hospital facilities, and hospital on-call (HOCC) funding.

Capital Projects may be funded in part by the Ministry, which requires that a significant portion be funded by the hospital through a “local share” (local community giving). Hospitals may also fund capital projects fully from their own revenue-generating activities (e.g., parking revenues). A copy of the Ministry-LHIN toolkit on capital planning is available [here](#).

### Potential Changes to Funding Formula

Hospital funding is a complex area which continues to be subject to change. The underlying legislation, policies of the Ministry and the LHINs, local implementation and hospital-specific issues are in a constant state of transformation.

### LEADERSHIP QUOTE

“Funding drives behaviour. Changes in funding models offer opportunities to innovate.”

Dr. Nancy Merrow  
*Chief of Staff, Southlake Regional Health Centre*

In 2012, the Ministry announced a change in the funding formula which underlies Hospital-LHIN Accountability Agreements (referred to as Health System Funding Reform, HSFR), shifting from global, provider-based funding to patient-focused funding (referred to as Patient-Based Funding, PBF). A Health-Based Allocation Model (HBAM) now distributes funding based on the volume and type of patients, and, in addition, hospitals will receive funding for the number of patients treated for certain procedures (e.g., hip and knee replacements) via Quality-Based Procedures (QBP) funding. HBAM and QBP will be phased in over a number of years. The Ministry’s intention is that, for most hospitals, the global budget will eventually account for approximately 30% of funding, while HBAM will account for 40%, and QBP for 30%.
DECISION-MAKING AT THE MINISTRY

The Ministry’s responsibilities are divided into a number of different divisions which deal with the development, implementation and oversight of different pieces of policy and legislation. For example, at the time of publication, the Deputy Minister’s office is responsible for various branches and initiatives, such as the Public Health Division, the Health System Accountability and Performance Division, and the Health System Strategy Division. The Ministry provides an overview and an organization chart for future reference.
HOSPITAL LIABILITY

Hospital liability is governed by the common law (“judge-made law”) rather than by legislation.

Negligence in the course of administering care and treatment to a patient constitutes malpractice. In order to succeed in such a claim, the patient must demonstrate (1) a relationship that gave rise to a “duty of care”, (2) the duty of care was breached, (3) the breach caused damage to the patient, and (4) through proof, that damages were suffered.

Ordinarily, in a malpractice case, the patient’s direct relationship is with a health care professional for whose conduct the facility may or may not have a direct legal responsibility (discussed in more detail below). The standard to which the hospital and medical professionals will be held is the “reasonable standard” in the particular circumstances of the case.

A hospital has direct liability for its equipment, premises and facilities, patient safety and protection, safe operation of hospital systems, processes and protocols, staff appointments (credentialing), and the monitoring of staff competence. A hospital is also vicariously liable for the negligence of its employees, which may include some physicians who are employees. The majority of physicians are not employees but are independent contractors with privileges at the hospital. Hospitals are not generally vicariously liable for clinical care provided by credentialed physicians, but are responsible for due diligence in the credentialing process. For more information, refer to the OHA’s Professional Staff Credentialing Toolkit.

Physician leaders will typically be provided with liability coverage by the hospital in respect of their leadership role. Physicians are required to maintain individual malpractice insurance in respect of their clinical care.

Hospital liability is addressed in more detail in Module 2. Risk management is discussed in Module 5. For more information on hospital liability, see Morris and Clarke, Law for Canadian Health Care Administrators.
Module 1: Health Care in Ontario
Section 1.4 – Hospital Liability

LEADERSHIP QUOTE

“Get to know your risk manager and use them as a resource.”

Dr. Nancy Merrow
Chief of Staff, Southlake Regional Health Centre
APPENDIX 1

Key Sources

OHA Resources

- OHA Guide to Good Governance
- OHA Professional Staff Credentialing Toolkit
- OHA Quality and Patient Safety Governance Toolkit
- OHA Personal Health Information Protection Act Toolkit
- OHA Quality of Care Information Protection Act Toolkit
- OHA Freedom of Information and Protection of Privacy Act Toolkit
- OHA Records Retention Toolkit

Additional Resources

- EPIC – Engaging People, Improving Care
- Information and Privacy Commissioner
- Drummond Commission on the Reform of Ontario’s Public Services
- Ontario LHINS
- Ministry-LHIN Toolkit on Capital Planning
- Ministry Organization
- Law for Canadian Health Care Administrators
APPENDIX 2

Key Legislation

- Constitution Act
- Canada Health Act
- Food and Drugs Act
- Public Hospitals Act
- Corporations Act
- Not-for-Profit Corporations Act
- Income Tax Act
- Charities Accounting Act
- Excellent Care for All Act
- Broader Public Sector Accountability Act
- Local Health System Integration Act
- Personal Health Information Protection Act
- Freedom of Information and Protection of Privacy Act
- Quality of Care Information Protection Act
- Public Inquiries Act
- Coroner’s Act
- Mental Health Act
- Health Care Consent Act
- Substitute Decisions Act
- Ontario Human Rights Code
- Employment Standards Act
- Labour Relations Act
- Workplace Safety and Insurance Act
- Occupational Health and Safety Act
- Accessibility for Ontarians with Disabilities Act
- Regulated Health Professions Act
- Health Insurance Act
- Commitment to the Future of Medicare Act
- Local Health System Integration Act
APPENDIX 3

Regulated Health Professions Legislation

- Audiology and Speech-Language Pathology Act, 1991
- Chiropody Act, 1991
- Chiropractic Act, 1991
- Dental Hygiene Act, 1991
- Dental Technology Act, 1991
- Dentistry Act, 1991
- Denturism Act, 1991
- Dietetics Act, 1991
- Drugless Practitioners Act, 1991
- Homeopathy Act, 2007
- Kinesiology Act, 2007
- Massage Therapy Act, 1991
- Medical Laboratory Technology Act, 1991
- Medical Radiation Technology Act, 1991
- Medicine Act, 1991
- Midwifery Act, 1991
- Naturopathy Act, 2007
- Nursing Act, 1991
- Occupational Therapy Act, 1991
- Opticianry Act, 1991
- Optometry Act, 1991
- Pharmacy Act, 1991
- Physiotherapy Act, 1991
- Psychology Act, 1991
- Psychotherapy Act, 1991
- Regulated Health Professions Act, 1991
- Respiratory Therapy Act, 1991
- Social Work and Social Services Work Act, 1998
- Traditional Chinese Medicine Act, 2006
OVERVIEW

As discussed in Module 1, hospitals are non-share capital corporations incorporated under the Ontario Corporations Act or, in some cases, incorporated under special legislation\(^1\). Hospitals are governed by many different statutes, the most important of which is the Public Hospitals Act ("PHA").

This section reviews the governance structure of hospitals, as required by the legislative framework, tailored by each hospital through its incorporating documents, by-laws, rules, regulations and agreements.

---

\(^1\) Certain hospitals are incorporated (created) under a special act of the Ontario legislature, as opposed to under the Corporations Act – for example, University Health Network Act, 1997, S.O. 1997, c.45.
CORPORATE FRAMEWORK

The essentials of hospital corporate governance are summarized in this chart and then discussed in more detail below.

### HOSPITAL GOVERNANCE STRUCTURES
- **Hospital established as corporation – Incorporating Documents**
  - Members - elect directors
  - Board of Directors - appoint CEO & some medical leaders (eg. Chief of Staff/Chair of MAC)
  - CEO and Chief of Staff/Chair of MAC - responsible for management of hospital and report to Board

### EXTERNAL AUTHORITIES
- MOHLTC - powers under PHA
- LHIN - powers under LHSIA

### INTERNAL AUTHORITIES
- Incorporating Documents - Letters Patent
- By-Laws, Rules & Regulations, Policies, Procedures
- Structural Hospital Agreements

MOHLTC = Ministry of Health & Long Term Care  
PHA = Public Hospitals Act  
LHIN = Local Health Integration Network  
LHSIA = Local Health System Integration Act  
MAC = Medical Advisory Committee

(a) **Incorporating Documents**

Each hospital will have an incorporating document which establishes the hospital as a corporation – in most cases, “Letters Patent” under the Corporations Act\(^2\) or, in some cases, special legislation establishing the hospital.\(^3\)

The hospital’s objects and purposes are set out in this incorporating document. These objects and purposes are usually very broadly framed, to allow the corporation to establish, maintain and operate a public hospital and related programs and facilities. Overall, the business or

---

\(^2\) As noted above, the Corporations Act will be replaced when the Not-for-Profit Corporations Act is proclaimed into force (targeted for July 1, 2013). At that time, “Letters Patent” will become “Articles of Incorporation”.

\(^3\) See footnote 1 above.
affairs of the hospital need to fit within the objects and purposes as defined in the incorporating document.

Each hospital then has by-laws which set out in more detail how the hospital is structured.

While Letters Patent are important and will need to be reviewed in some circumstances (e.g. if major changes are contemplated to a hospital’s structure), they do not typically effect the day to day operations or impact on the work of the physician leader.

(b) Members of the Corporation

Unlike for-profit or business corporations, hospitals do not have shareholders. As a non-share capital corporation, a hospital has “members”.

Members are appointed according to criteria contained in the Letters Patent or special legislation, hospital by-laws and the Corporations Act. Various different membership models exist, with some hospitals having only the directors as members and other hospitals having broader community-based membership structures. Membership in denominational hospitals is typically limited to representatives of the founding religious organization.

Unlike shareholders of for-profit corporations, hospital members are not “owners” of the hospital. Hospital assets are “owned” for charitable health care purposes.

Members of hospital corporations have limited but significant rights which include:

- Electing directors;
- Receiving financial statements and appointing auditors;
- Approving fundamental changes (such as by-law amendments); and
- Attending annual or special general meetings (including the right to requisition a members’ meeting).

Members typically meet once a year. The Hospital Management Regulation (HMR) under the PHA requires that “Every hospital shall hold its annual meeting between the 1st day of April and the 31st day of July in each year on a day fixed by the board”. The specific business of the annual meeting will be set out in the hospital by-laws, but typically includes only the items listed above. Special general meetings are more infrequent.
Members are not directly involved in the governance of the corporation. They have no role outside of the annual or special general meetings. The governance of the corporation is the responsibility of the directors.

A significant power of the members is the right to elect directors. Typically, this is done through a nominating process that is set out in the by-laws and then confirmed at the annual meeting.

However, subject to the hospital’s by-laws, members may have certain rights to elect directors outside of the nomination process and to remove directors.

Members must also approve fundamental changes to the hospital’s corporate structure, for example, by-law amendments. The members are an important stakeholder to consider whenever major changes are contemplated to the hospital, such as mergers and consolidation of services with other hospitals.

(c) Board of Directors

Corporations are governed by a board of directors. The HMR specifically requires that “every hospital shall be governed and managed by a board”. The board of directors has the ultimate authority and responsibility for the administration of the hospital.

For a detailed discussion of the role of the board of directors, please see Chapter 4: Role and Functions of a Board in the OHA Guide to Good Governance (“the Guide”). See also Law for Canadian Health Care Administrators (2nd edition), by John J. Morris and Cynthia D. Clarke (LexisNexis Canada, 2011), page 6-11.

As set out in the Guide, the hospital board’s primary functions include:

1. Approving goals and strategic direction for the hospital
2. Establishing a framework for performance oversight
3. Overseeing quality of care within the hospital

There are specific statutory responsibilities regarding quality set out in the Excellent Care for All Act and the PHA/HMR – see Module 1, section 1.2 for further detail.
4. Overseeing financial condition and resources  
5. Overseeing enterprise risk management  
6. Supervising leadership  
7. Overseeing stakeholder relationships  
8. Managing the board’s own governance  

Directors are elected by the members based on the requirements set out in the hospital’s incorporating documents and by-laws. The PHA also contains certain requirements for directors:  

- **Rotation of Directors** – Directors may be elected and retired in rotation, but in that event, no person shall be elected for a term of more than five years and at least four directors shall retire from office each year.  

- **Special Directors** – a hospital may appoint life, term or honorary directors, but with some restrictions on their number and voting rights in comparison to the elected directors.  

The HMR mandates that certain people shall be members of the board:  

1. the Administrator (CEO) of the hospital;  
2. the President of the hospital’s medical staff;  
3. the Chief of Staff (or Chair of the Medical Advisory Committee, if the hospital does not have a Chief of Staff);  
4. the Chief Nursing Executive of the hospital.
These directors are often referred to as *ex-officio* directors, or people who are directors by virtue of the office/position that they hold. Unlike other directors who are appointed by the members for defined terms, *ex-officio* directors remain as directors only for as long as they hold that office.

The HMR also provides that any member of the hospital’s professional staff or any employee of the hospital who is on the board shall be a non-voting member of the board. Therefore, these *ex-officio* directors are all non-voting positions.

(d) Physician Leaders as Directors

In some cases, physician leaders will be directors by virtue of their position – i.e., the Chief of Staff (or Chair of the MAC, where there is no Chief of Staff); and the President of the Medical Staff.

All directors owe a duty of care to the corporation. The law establishes that directors owe a “fiduciary duty” to the corporation of which they are a director.

The directors’ duty of care is discussed in detail in *Chapter 6: Duties and Obligations of Individual Directors* in the OHA *Guide to Good Governance*. In general terms, directors are required to act honestly, in good faith and in the best interests of the corporation. Directors must be loyal to the interests of the corporation, and not any particular party or interest that they may represent; they must respect the confidentiality of matters that are discussed in confidence by the board; and, they must support the will of the majority by respecting and adhering to decisions of the board even if they disagree with them. Finally, directors must avoid conflicts of interest between their own interests and the interests of the corporation.

The Chief of Staff (or Chair of the MAC, where there is no Chief of Staff) and the President of the Medical Staff are on the board as non-voting directors. The question that arises is whether they owe the same duties to the hospital as voting directors or if there is some lower standard for non-voting directors. While it is not clear that non-voting directors will be held to precisely the same legal standards as voting directors, the OHA *Guide to Good Governance* states that it is good and prudent practice for non-voting directors to exercise that same degree of diligence and use the same standards as a guide for behaviour as apply to voting directors.
In particular, the challenge for the President of the Medical Staff is how to balance his/her duties and responsibilities as a director (to act in the best interests of the corporation) with responsibility to the medical staff (who elected him/her to the position). The President as a director, like all other directors, should not solely advocate for only one interest; but must recognize that his or her duty is owed to the corporation’s interests as a whole. Where different interests conflict, these must be carefully considered and balanced, to advocate a position that the director believes is in the best interests of the corporation.\(^5\)

For additional information, see the OHA’s Frequently Asked Questions: Amendments to Regulation 965 under the Public Hospitals Act Re: Hospital Board Composition and Duties of Non Voting Directors.

(e) Structural Hospital Agreements

In addition to the accountability and other agreements discussed in Module 1, many hospitals will have other significant agreements that impact on their overall corporate structure and operations. Whereas the approval of most corporate agreements is the responsibility of management, these structural agreements often come under the authority of the board.

These agreements include, but are not limited to, the following:

---

\(^5\) This is not the same as a “conflict of interest”, where the director’s personal interests conflict with the corporation’s interest, in which case the director would exclude him/herself from the particular decision. Where different corporate interests or accountabilities conflict, the director must balance these to arrive at a decision that is in the overall bests interests of the corporation.
• **Partnership, alliance, merger and amalgamation agreements with other hospitals** – These can be agreements from the time that the present hospital corporation was formed or underwent restructuring to combine with other area hospitals. They can also be more recent agreements with other area hospitals to combine administrative functions or other programs or services. These agreements may impact on the overall structure of the hospital and how it operates.

• **Denominational agreements** – Denominational hospitals will have agreements with the founding or supporting religious organization. These may provide special rights to certain sponsors/members.

• **University affiliation agreements** – There are agreements between the teaching hospitals and universities which establish and govern the medical education programs at the hospital and the university. These agreements will affect corporate structure, and particularly the Professional Staff By-Laws, as physicians will be cross-appointed between the hospital and the university, and have responsibilities to each organization. In addition, for most hospitals, there will be operational agreements with universities and colleges for the education of health professionals other than physicians (e.g., nurses, physiotherapists, social workers, etc.), although these agreements do not typically impact on hospital governance structures.

(f) **Public Hospitals Act**

The Minister of Health and Long-Term Care (the “Minister”) is given a number of important oversight responsibilities for the governance and operations of public hospitals in the PHA:

• Certain actions by hospitals require the Minister's approval before they can be taken (section 4): incorporation or amalgamation of hospitals; operation of an institution, building or other premises as a hospital; adding buildings or facilities to an existing hospital; and,: selling, leasing, mortgaging land, buildings or facilities used as a hospital.

• Appointment of investigators, supervisors or inspectors (sections 8, 9 and 18): The Minister may appoint an investigator, supervisor or inspector to a public hospital where the Minister determines that it is in the public interest to do so. Typically, investigators or inspectors are appointed where there is a particular issue in a hospital that has given rise to substantial concern. A supervisor will be appointed where there is a broader concern about a hospital’s operations or administration, with the supervisor assuming the role of the hospital board during the term of the supervision.
HOSPITAL BY-LAWS

The framework for hospital governance and management is set out in the hospital’s by-laws. By-laws are typically developed and approved by the board of directors and then ratified by the members. The by-laws need to comply with requirements set out in legislation and with the hospital’s own incorporating documents as discussed above.  

Each hospital will typically have two by-laws: one for the overall corporate structure, and one dealing with the professional staff of the hospital. This section will review the purpose and components of each of these by-laws.

The OHA has developed two prototype by-laws: Hospital Prototype Corporate By-Law (2010); and the OHA/OMA Prototype Board-Appointed Professional Staff By-Law (2011).

(a) Corporate By-Law

The Hospital’s Corporate By-Law establishes the hospital’s administrative structure. Each hospital’s Corporate By-Law will be somewhat different, but will cover most of the same topics or subject-matter.

The OHA updated the OHA Prototype Corporate By-Law in 2010 to reflect current governance practices. Hospitals are recommended to review this prototype as changes are made to existing corporate by-laws – see OHA Hospital Prototype By-laws Frequently Asked Questions (February 2010).

The key provisions of the Corporate By-Law are as follows:

---

6 As noted in Module 1 and above, the Corporations Act is to be replaced by the Not-For-Profit Corporations Act. Hospitals will need to review their by-laws for compliance with the new legislation when it is proclaimed into force by the Provincial government (targeted for July 1, 2013).

7 The OHA’s Prototype Corporate By-Law (2010) will be updated in 2013, to ensure consistency with the Not-for-Profit Corporations Act when it is proclaimed into force.
Members

The Corporate By-Law sets out how members of the hospital corporation are chosen or elected.

Ontario hospitals have many different membership models, with only directors being members in some hospitals versus other hospitals where there is broad community-based membership. There is no “one-size-fits-all” approach to hospital membership structure. A hospital’s membership structure will have been established when the hospital was first created and might have remained the same thereafter or been modified only at a time of corporate restructuring. The recommendation in the by-law based on modern governance practice, is to have a limited membership model composed only of the directors of the hospital.

The by-law establishes the procedure for members’ meetings, including the annual meeting, which under the HMR, must be held between April 1st and July 31st each year.

Board of Directors

The Corporate By-Law sets out the number of directors and the process by which they are appointed and removed from office. Directors are usually elected annually by the members for a specified term, with a process for the board itself to fill vacancies occurring in between annual members’ meetings. The by-law describes the process for directors’ meetings, which are held monthly in most hospitals. It is recommended that the by-law also deal with conflicts of interest and indemnification of directors and officers who are acting on behalf of the corporation.

An important element of hospital governance is the composition and recruitment of board members. The by-law recommends a transparent recruitment process, with the goal of having a board that is comprised of individuals with the necessary skills and competencies to fulfill the roles and responsibilities of the board.

In addition, as noted previously, the administrator (CEO), Chief of Staff/Chair of the MAC, Chief Nursing Executive and President of the Medical Staff are non-voting directors.

Some hospitals, by virtue of alliance or partnership agreements, will have joint boards of directors for the hospitals within the alliance or partnership group. This will occur where hospitals have agreed to work together, but have remained as separate corporations. In these situations, depending on the particular terms of the agreement, typically some powers will be granted to the joint board and other powers will be reserved for each individual hospital board.
Board Committees

The by-law establishes committees of the board, which assist the board in fulfilling its role. The by-law provides for the creation of the committees that are required by statute, as well as for other standing committees (for continuing issues) and special committees (for specific one-time duties or tasks).

These committees report to the board and may be composed of both board and non-board members, depending on the mandate of the particular committee. Physician leaders will be members of some board committees.

Certain committees are required by statute: a Fiscal Advisory Committee and Medical Advisory Committee are required by the HMR; and a Quality Committee is required by the Excellent Care for All Act (ECFAA). The HMR also sets out the membership and duties for a Nursing Advisory Committee, if the hospital by-laws provide for a Nursing Advisory Committee (but does not require that hospitals have a Nursing Advisory Committee).

No other board committees are required by statute. While the number and composition of other committees will vary between hospitals, common board committees include governance, finance, audit, community liaison and executive. The functions and purposes of each committee

Figure 3. Committees reporting to the Board of Directors
Source: OHA Guide to Good Governance
will be outlined in the hospital’s by-laws, often with more detailed terms of reference developed by the committee and approved by the board.

The OHA’s *Guide to Good Governance* contains a full discussion of the various board committees and their roles.

**Officers**

The Corporate By-Law provides for the appointment of the Officers of the hospital – the Chair and Vice-Chair of the Board; the Chief Executive Officer (CEO); the Secretary; and any other Officers of the Board. Except for the CEO, the officers of the board are not paid employees of the corporation.

The Chief of Staff or, where there is no Chief of Staff, the Chair of the MAC, is appointed under the *Professional Staff by-law* and reports to the board. Other physician leaders are either appointed under the Professional Staff by-law and report to the Chief of Staff and board (e.g., Chiefs of Department), or by the Chief Executive Officer and report to him/her (e.g., Vice-President – Medical and Medical Program Directors). See section 2.2 below for a more detailed discussion of the roles and reporting relationships of physician leaders.

While the HMR provides for the appointment of a Chief Nursing Executive (CNE), the CNE is an employee of the hospital who is hired under the authority of and reports to the CEO. The CNE is not usually appointed by the Board.

*(b) Board-Appointed Professional Staff By-Law*

Most physicians should be familiar with the professional staff appointment process from their own personal experience as a member of the professional staff. However, in their new role as a hospital leader, they will play an important part in professional staff appointments, by leading the peer review system that is the foundation for all professional staff appointments.
Board-appointed professional staff (commonly referred to simply as the “professional staff”) refers to the health care professionals who are appointed by the board of the hospital to work in the hospital, rather than being hired as an employee of the hospital. The professional staff includes all physicians who provide clinical care in the hospital, as well as dentists, midwives and extended class nursing staff.

Under the PHA, the hospital board is responsible for appointing the medical staff and determining their privileges. Similarly, the board is also responsible for revoking, suspending or refusing the re-appointment of medical staff members where necessary. The HMR then permits the hospital to pass by-laws for the appointment of dental, midwifery and/or extended nursing class staff. Hospitals with dental, midwifery or extended class nursing staff, through their by-laws, will treat all professional staff in the same manner and give them the same process rights.

The credentialing process is only required for board-appointed professional staff -- physicians, dentists, midwives and extended class nurses – and not for the other regulated health professionals working in the hospital. From a regulatory perspective, the board-appointed professional staff have independent practice rights (i.e., they are not dependent within their scope of independent practice on the orders of another health care professional to provide treatment). The other health care professionals working in the hospital (e.g., nurses, occupational therapists, social workers, etc.) are all employees of the hospital, hired under the authority of the CEO and provide care according to the orders of the board-appointed professional staff (See further discussion in section 2.3 below).

The hospital’s responsibility with respect to professional staff appointments was summarised by the Ontario Court of Appeal in the 1980 case of Yepremian v. Scarborough General Hospital:

… a member of the public who knows the facts is entitled to expect that the hospital has picked its medical staff with great care, has checked out the credentials of every applicant, has caused the existing staff to make a recommendation in every individual case, makes no appointment for longer than one year at a time, and reviews the performance of its staff at regular intervals. Putting it in layman’s language, a prospective patient or his family who knew none of the facts, would think: “If I go to Scarborough General, I’ll get a good doctor.”

The process by which the board’s responsibilities under the PHA are discharged is set out in the Board-Appointed Professional Staff By-Law. This section provides a brief overview of these by-laws. This process is discussed in detail in the OHA’s Professional Staff Credentialing Toolkit and summarised in the OHA’s Guide to Good Governance – Chapter 5: The Board’s Role in the Credentialing Process.

The Board-Appointed Professional Staff By-Law establishes the framework for the organization and the process for monitoring professional staff who work at the hospital. The important parts of this by-law are as follows:
Categories of Professional Staff

All hospitals will have medical staff appointed under the PHA and the Board-Appointed Professional Staff By-Law.

In addition, most hospitals include in the by-law appointment process some or all of dentists, midwives and extended class nurses. While the PHA requires that the hospital have by-laws for the appointment of the medical staff, the hospital can, but is not required, to have these by-laws apply to dental, midwifery or extended class nursing staff. For hospitals that have dental, midwifery or extended class nursing staff, the Board-Appointed Professional Staff By-Law typically applies the same appointment processes to all groups.

Various categories are established for the professional staff:

- **Active Staff** – professional staff whose primary appointment/practice is with the hospital. This category typically comes with admitting privileges and on-call responsibilities.

- **Associate Staff** – new members of professional staff, intended for the initial 1-2 years of their privileges at the hospital, before being appointed to the Active Staff. This is similar to the probationary period for new hospital employees. This category would usually have admitting privileges and on-call responsibilities.

- **Courtesy or Consulting Staff** – professional staff whose primary appointment is not with the hospital, but attend to patients for a specific service required by the hospital. Professional staff in this category would not usually have admitting privileges or on-call responsibilities.

- **Locum Tenens or Temporary Staff** – professional staff appointed to fill a temporary need; for example, to replace a physician on leave or to cover an unexpected absence or staffing shortage. Depending on the appointment, these professional staff may or may not have admitting privileges and on-call responsibilities for the period of their appointment.

- **Honorary Staff** – a retired member of the professional staff or other person who has made an outstanding contribution to the hospital. This category does not typically come with any patient or clinical care responsibilities, but allows the person to participate in the other activities of the professional staff and hospital.

These categories apply to the medical, dental and midwifery staff. Extended class nurses are often in a separate category.
The **Professional Staff By-Law** sets out the specific qualifications and requirements for each professional staff category and also contains the process by which professional staff can apply for a change in category or privileges. Most hospital by-laws also set out the responsibilities of professional staff members.

**Organization of the Professional Staff**

In most hospitals, except for the smaller community or rural hospitals, the professional staff is divided into departments that are set out in the **Professional Staff By-Law** or as approved by the board. In larger hospitals, the professional staff departments will then be further sub-divided into sections, services or divisions. In hospitals with program management structures, the organization of the professional staff will include groupings by program or service area. See section 2.2 below for a discussion of hospital management models.

Depending on their individual organizational structure, most hospitals will have a Chief of Staff as well as Chiefs of the professional staff departments of the hospital. The hospital will also have a Chair of the Medical Advisory Committee (MAC), who is the Chief of Staff where the hospital has a Chief of Staff or another physician where there is no Chief of Staff. These leaders are appointed by the board, usually based on the recommendation of the MAC and consultations with professional staff members. The Chief of Staff/Chair of the MAC reports directly to the board of directors, with the Department Chiefs reporting through the Chief of Staff. The duties and responsibilities of these physician leaders are discussed further in section 2.2 below.

The PHA also requires the hospital by-laws to set the procedures for the annual election of a President, Vice-President and Secretary of the Medical Staff as well as the duties of these officers. The duties of these physician leaders are discussed in section 2.2 below.

---

8 The HMR requires the board to appoint the Chief of Staff as the Chair of the MAC where the hospital has a Chief of Staff, or to appoint another member of the MAC as Chair where there is no Chief of Staff – s.2(3)(c) and (d).
APPOINTMENT AND REAPPOINTMENT

The PHA sets out the basic process for appointment of the medical staff – see sections 35-43. The Board-Appointed Professional Staff By-Law supplements the PHA requirements.

For a detailed discussion of the appointment and re-appointment process, refer to Chapters 5 and 6 of the OHA’s Professional Staff Credentialing Toolkit.

It should be noted that the PHA sets out the rights for physicians under the appointment process, which are then supplemented by the Board-Appointed Professional Staff By-Law. The other board-appointed professional staff members (dentists, midwives, extended class nurses) do not have rights under the PHA, but only under hospital by-laws. Hospital by-laws typically grant the same rights to other board-appointed professional staff members when the by-laws establish these other types of professional staff. However, the right of appeal under the PHA only applies to the medical staff.

In summary, the appointment process under the PHA and the Professional Staff By-Law is as follows:

1. **The professional staff member submits initial application or annual re-appointment application:**
   - New application – hospital will follow a selection process.
   - Re-application – performance review completed by department Chief.

2. **Credentials Committee reviews & reports to MAC.**

3. **MAC considers application and makes a recommendation to Board:**
   - Required within 60 days of application/re-application (PHA, s.37).
   - If professional staff member requests, reasons must be prepared by MAC.

4. **Board considers MAC recommendation and decides on appointment or re-appointment:**
   - If professional staff member asks for hearing (e.g., where MAC recommends not to appoint or reappoint the individual), hospital board holds a formal legal hearing.

5. **Only physicians can appeal a hospital board decision to the Health Professions Appeal and Review Board (HPARB).**

6. **Physician and hospital have right of appeal to court from HPARB decision.**
Monitoring, Suspension and Revocation

Under the PHA, the Chief of Staff (or Chair of the MAC, where there is no Chief of Staff) and the Chiefs of Departments are responsible for advising the MAC “with respect to the quality of medical diagnosis, care and treatment provided to patients”. The MAC, in turn, is responsible for making recommendations to the board respecting the quality of care provided and the dismissal, suspension or restrictions on the hospital privileges of board-appointed professional staff members.

For a detailed discussion of the process for monitoring, suspending or revoking privileges, refer to Chapter 9 of the OHA's Professional Staff Credentialing Toolkit.

The Professional Staff By-Law describes the process by which such action is taken, usually referred to as “midterm action”. Midterm action is then divided into “immediate action” (if the professional staff member is suspended immediately pending completion of the process) or “non-immediate action” (if the professional staff member continues to work as the process is undertaken). Immediate action is reserved for more serious situations where the professional staff member’s conduct exposes, or is reasonably likely to expose, a patient or other person (e.g., another staff member) to harm or injury, is or is reasonably likely to be detrimental to patient safety, and immediate action needs to be taken to prevent harm or injury to patients or others.9

---

9 Where a professional staff member’s privileges are restricted, suspended or revoked as a result of midterm action, there is a reporting obligation to the professional’s regulatory college – see section 2.3.3 below.
The process for immediate and non-immediate midterm action is essentially the same, except that the timelines for steps in the former are much shorter:

1. **Initiation of midterm action:**
   - Midterm action will have various initiating events – the occurrence of a serious incident or the accumulation, over time, of a series of smaller incidents (although the accumulation of smaller incidents could also be dealt with in the re-appointment process).
   - The event will be documented and reviewed by the Chief of Staff, Chief of Department and/or CEO as appropriate to the event.

2. **Formal Investigation:**
   - Prior to proceeding with midterm action, an investigation will be conducted.
   - This will include providing the professional staff member with an opportunity to participate in the investigation and respond to the event(s).
   - It may also include a review by external expert(s).
   - If issues are not substantiated by investigation, then the matter will end; otherwise, the matter will proceed with further steps below.

3. **MAC Meeting to consider midterm action:**
   - A formal meeting of the MAC during which the results of the investigation are considered, and the MAC determines what recommendation to make to the Board.
   - The professional staff member is usually given the opportunity to attend the MAC meeting and present his/her response to the event(s).
   - The professional staff member is entitled to request reasons for the MAC’s recommendations and to request a hearing before the hospital board.
4. Hearing before the board of directors:

- If the professional staff member asks for a hearing, the hospital board will hold a formal legal hearing.

5. Physician right of appeal to Health Professions Appeal and Review Board (HPARB):

- If the physician disagrees with the decision of hospital board.

6. Physician and hospital have right of appeal to courts:

- If the physician or the hospital disagrees with the decision of HPARB.

Formal midterm action is a relatively infrequent process in hospitals, with most issues being dealt with in the annual re-appointment process. Where midterm action is taken, the Chief of Department and the Chief of Staff will be key participants in the process.

Amendment of the Professional Staff By-Law

As with the Corporate By-Law, it is the responsibility of the board of directors to develop and approve changes to the Board-Appointed Professional Staff By-Law, to be ratified by the hospital members.

For the Board-Appointed Professional Staff By-Law, this is typically supplemented with an additional consultation process involving the members of the professional staff followed by a recommendation by the MAC to the board of directors.

(c) Rules, Regulations, Policies and Procedures

In addition to the Corporate and Board-Appointed Professional Staff By-Laws, hospitals will have a variety of rules, regulations, policies and procedures that govern both administrative and clinical practice within the hospital.
Rules and Regulations

Rules and regulations are adopted by the board as subordinate directives under the by-laws to provide further standard procedures for dealing with certain routine or standing issues.

Hospitals will adopt in the by-law standard *Rules of Order* for how meetings are to be conducted within the corporation. These rules of order would apply to all member, board and committee meetings within the hospital, governing in particular how the meeting chair is to conduct the meeting and how votes are to be held. Commonly used rules of order in hospitals include:

- [Kerr and King: Procedures for Meetings and Organizations](#)
- [Robert’s Rules of Order](#)
- [Wainberg's Society Meetings](#)

Hospitals will also have *Professional Staff Rules and Regulations*, which are adopted under the Board-Appointed Professional Staff by-law. The precise format and content of these rules differs between hospitals, but they typically set out some basic standards or requirements for the clinical and professional practice within the hospital, including, for example:

- Responsibilities of professional staff in each category, in addition to what is stated in the by-laws (e.g., active staff, associate staff, etc.)
- Responsibilities of professional staff that are specific to each department
- Health records requirements for professional staff
- On-call responsibilities of professional staff
- Leaves of absence of professional staff
- Conflicts of Interest
- Code of Conduct
- Mission, Vision and Values of the hospital and the professional staff

Policies and Procedures

Many different names are used to describe the written documents that are created to guide work and conduct within a hospital (e.g., policies, procedures, clinical guidelines, directives, standing orders, etc.). Hospitals have a great number of these policy-type documents in manuals or binders (or more recently online) in every department or service area in the hospital.

Legally, all of these policy-type documents are equally binding regardless of what they are called – they are written descriptions intended to guide work or practice on a particular issue. From a legal standpoint, the focus is what the document says and whether it has been appropriately followed in the circumstances of an individual situation.
For purposes of this manual, a distinction is drawn between governance policies and procedures, which are adopted by the board, and operational policies, which are adopted by some other committee or officer within the hospital.

At a governance level, the board will adopt policies and procedures setting out the standard approach for the hospital on certain matters that are under the authority of the board. The types of policies and procedures relevant to physician leaders may include processes for professional staff recruitment and selection/election of medical staff leaders, conflicts of interest, board confidentiality and codes of conduct. This is a fairly defined set of policies that is usually contained in a board policy manual and discussed during the orientation of new board members. It is often the responsibility of the board’s governance committee, which may include physician members, to review and update these policies.

It is at the operational level that the majority of policies, procedures, etc. are created in hospitals. These are approved by a committee (such as the MAC, if the policy relates to professional staff practice) or by the relevant program or service leader (such as the vice-president responsible for a particular area). Such policies may be provided to the board for reference or information, but are not typically adopted or approved by the board.

Medical Advisory Committee

The Medical Advisory Committee (MAC) is a committee required by hospitals under the PHA. As its name suggests, it is an “advisory” committee to the board on medical matters within the hospital.

Most physician leaders are members of the MAC - it will be one of their main committee responsibilities.
The role and responsibilities of the MAC are discussed in detail in the OHA’s Professional Staff Credentialing Toolkit and summarised in the OHA’s Guide to Good Governance – Chapter 5: The Board’s Role in the Credentialing Process. This section is intended to provide a brief overview of the MAC.

The MAC has two main statutory functions, to make recommendations to the board of directors:

- respecting the privileges of members of the medical/dental/midwifery/extended class nursing staff of the hospital; and,
- respecting the quality of care provided by the medical/dental/midwifery/extended class nursing staff of the hospital.

The HMR further requires that the President, Vice-President, and Secretary of the Medical Staff Association, and the Chief of Staff are members of the MAC, along with such other members of the medical staff as are appointed or elected in accordance with the hospital’s by-laws. The Chair of the MAC is the Chief of Staff, if the hospital has a Chief of Staff, or is a separate position appointed by the board if there is no Chief of Staff.

The hospital’s by-laws may expand on the responsibilities of the MAC and further define its membership. In addition to the members required by the HMR, the MAC is usually composed of the Chiefs of Departments, Medical Directors and/or Program Chiefs. While the HMR permits only physicians (and the Chief of Dental Staff, if there is one) to be members of the MAC, some hospitals have broadened their MAC to include *ex officio* non-voting members including the CEO, Head of Midwifery, Chief Nursing Executive and Vice-Presidents of the hospital.

The HMR requires the MAC to hold at least 10 monthly meetings per year, usually from September to June (with summer meetings if necessary). The HMR also requires the MAC to report in writing to the board at each regular board meeting and report to the medical staff at each regular scheduled meeting of the medical staff.

Some hospitals have joint or common credentialing models with other area hospitals. This will happen when hospitals are working together under some alliance or partnership agreement and have agreed to a common credentialing process. In these circumstances, there may be one MAC jointly appointed for more than one hospital or there may be separate MACs that meet together. Medical leaders may also be appointed with responsibility for more than one hospital.10

---

10 For more information, see the OHA Professional Staff Credentialing Toolkit, page 66-68. It should be noted as well that, even if there is a common or joint credentialing model, each individual hospital board has the duty to appoint the professional staff for their own hospital.
OVERVIEW

This section provides an overview of hospital management and includes detailed descriptions for various physician leadership positions.

HOSPITAL MANAGEMENT

Appendix 2 contains basic management organizational charts for a business corporation, a traditional hospital corporation, and a hospital corporation under a program management model. Hospitals will have different organizational structures and physician leaders should consult their own hospital’s organization chart.

(a) Business v. Hospital Corporations

In a business corporation, shareholders elect the board of directors, and the directors then appoint the Chief Executive Officer (CEO). The board only appoints the CEO, and the CEO is the only employee who reports directly to the board. All other employees are hired under the authority of the CEO and report through the corporation’s management structure to the CEO.

A hospital corporation has a different structure than a business corporation.

The hospital has members who elect the board of directors, and then the board appoints the CEO and the Chief of Staff (or Chair of the MAC, where there is no Chief of Staff). The CEO and the Chief of Staff/Chair of the MAC have separate responsibilities and each reports directly to the board. The CEO and Chief of Staff/Chair of the MAC are also non-voting members of the board. All employees of the hospital are hired under the authority of the CEO and report through the management structure to the CEO, as with the business corporation, but
professional staff are appointed to the board and supervised through a separate management structure. The MAC also reports directly to the hospital board, and not through the CEO.

In the traditional organizational structure of the hospital, management of the professional staff and all other employees is done through separate lines of authority – Professional staff are supervised by the Chiefs of Department, who report to the Chief of Staff, who in turn reports to the Board. All other employees report to managers or directors, who report up to the CEO.

Professional staff are typically not employees of the hospital corporation, but rather independent professionals with an appointment by the board. The Chief of Department and Chief of Staff do not have the standard authority of a manager over an employee, which includes authority to hire, monitor, discipline and terminate. While the Chiefs are responsible for monitoring professional staff, other responsibilities such as hiring, disciplining and termination, fall under the authority of the board.

Hospitals with program management models will have parallel management structures for the professional staff – with professional staff reporting on administrative, operational and budgetary issues to a medical director of the program; and reporting to a department chief on professional practice issues – see Appendices 2 to 4.

(b) Program Management

Most hospitals in Ontario have developed program management models, which supplement the traditional structure discussed above.

Under program management, staff -- including professional staff -- are grouped into patient care programs. Depending on the size of the hospital, this will involve two or three different leadership roles within a particular program:

• An administrative or operational director is responsible for all non-physician staff in the program;
• A medical director is responsible for the medical staff in the program; and,
• A department chief is responsible for the medical staff in the department.

In smaller hospitals, the medical director and department chief roles are often combined, whereas in larger hospitals, they may be separate roles. Hospitals may also group programs into broader service areas, with program, medical and administrative directors reporting to a vice-president responsible for the service area.
There are important differences between the medical director and the department chief roles:

- **Medical Director** - The Medical Director may be appointed by the board or hired under the authority of the CEO. The position typically reports to the CEO. The responsibilities of this position are focussed on administrative, operational and budgetary issues within the program. The medical director works collaboratively with the administrative or operational director on these issues.

- **Department Chief** – The Department Chief is appointed by the board and reports to the Chief of Staff and, through the Chief of Staff, to the board. The responsibilities of this position are focussed on the monitoring and supervision of the professional care provided in the department.

Monitoring and improving the quality of care within the hospital is an important element of the job description of all physician leaders. Under a program management model, it is important for all physician leaders to work cooperatively with each other and with other leaders on quality of care initiatives.

See Appendix 3 for a description of the role responsibilities for the Department Chief, Program Chief and Director of Operations at Sunnybrook Health Sciences Centre, a teaching hospital affiliated with the University of Toronto. Note that in the Sunnybrook position description, the “Program Chief” is the “Medical Director” position discussed in this section.

See Appendix 4 or a comparison of and position descriptions for the Chief of Department and Medical Director roles at the Grand River Hospital and St. Mary’s Hospital.
PHYSICIAN LEADERSHIP POSITIONS

Within the hospital governance and management structure, there are generally three types of physician leadership positions: the Chief, the Medical Director, and officers of the Professional Staff Association. Each of these will be discussed below.

The roles and responsibilities of these physician leaders are discussed in Chapter 3 of the OHA’s Professional Staff Credentialing Toolkit. Further information is also provided in Appendix 2 to 4.

Each hospital should have detailed job descriptions for their physician leadership positions, which include how they are appointed, remunerated, reviewed and accountable within the hospital’s management structure. Expected time commitments should also be set out, as the physician leader position is usually a part-time role combined with a continuing clinical practice.

For the new physician leader who is appointed to a position without a sufficient job description, one of their first tasks should be to develop one so that expectations are clearly defined.

The seniority and reporting relationships for each physician leadership position will be defined in the position’s job description. Most hospitals will have one physician leader who is the senior physician leader. Traditionally, this has been the Chief of Staff appointed by the board. However, in hospitals with program management or hospitals which do not have a Chief of Staff, the senior physician leader may be a vice-president (e.g., Vice-President, Medical) or a Chief Medical Executive (CME).

(a) The Chief Role

The Chief role is described in the Hospital Management Regulation (HMR) and usually further defined within the hospital’s by-laws. This may also be supplemented by a position description that is approved by the board.

Chief of Staff

Most hospitals have a Chief of Staff.

However, this is not a required position under the PHA. The PHA requires a President of the Medical Staff and a Chair of the MAC. The PHA sets out certain responsibilities, which may be outlined within the hospital’s by-laws, for the Chief of Staff, if there is one, or one of these two other officers, if the Chief of Staff position does not exist in the hospital’s leadership structure. If
there is a Chief of Staff, the HMR requires him/her be appointed by the board as Chair of the MAC.

Traditionally, the Chief of Staff has been the senior medical leadership position in the hospital. In hospitals where there is a program management structure, the Chief of Staff may also be the Vice-President, Medical or CME. These positions may also be separate roles and seniority will depend on that hospital’s particular structure.

The Chief of Staff has overall responsibility for monitoring and reporting to the board on the quality of the medical diagnosis, care and treatment provided to all patients in the hospital.

As noted above, the Chief of Staff position is a board appointment. The Chief of Staff is not hired by and does not report to the CEO; he or she reports to the Board. This creates a unique relationship between the Chief of Staff and the CEO, as the CEO is responsible to the board for all aspects of hospital administration (which includes the medical care provided in the hospital), and the Chief of Staff is also directly responsible to the board for medical care. It is therefore essential for the Chief of Staff and the CEO to have a close working relationship. Hospital professional staff by-laws and position descriptions for the Chief of Staff position often define the position as requiring the Chief of Staff to work “in consultation with the CEO” and be “responsible to the board through and with the CEO” on many issues. This defines the board’s governance expectation that these two senior positions will work together for the management of the medical staff in the hospital.

The Chief of Staff role is discussed in detail in the OHA’s Professional Staff Credentialing Toolkit, Chapter 3, pp. 37-39 and Appendix II – Sample 27.

Chief of Department (and Chief of Division or Service)

In addition to the Chief of Staff position, most hospitals also divide the professional staff into departments, each of which will have a Chief of Department. Larger hospitals may further subdivide the departments into services or divisions and have Chiefs or Heads of divisions or services.

The Chief of Department is the senior medical leader in the department, a responsibility shared with the Medical Director for the program in hospitals with a program management structure.

Chiefs of Department and Chiefs or Heads of Divisions/Services are typically appointed by the board. They are responsible for the overall medical direction of the department and report to the Chief of Staff and the MAC. The Chief of Department is a member of the MAC, whereas the chiefs/heads of divisions/services are typically not on the MAC.
The Chief of Department has the main responsibility for the standard of medical care within the department (and chiefs/heads of divisions/services have a corresponding role within the divisions and services). They are also the key part of the performance review system for the individual professional staff members within their department and responsible for providing the necessary information and documentation for the credentialing system.

The Chief of Department role is discussed in detail in the OHA’s Professional Staff Credentialing Toolkit, Chapter 3, pp. 42-44 and Appendix II – Sample 27.

(b) The Medical Director

Except in the largest hospitals, the Chief and Medical Director roles are usually combined – with the Chief of Staff often being the Vice-President, Medical, and the Chiefs of Department also serving as the Medical Director of the particular program.

The Medical Director role is often more of an operational position, with responsibilities focussed on strategic planning, budget management and human resource planning. The Medical Director brings medical expertise to the leadership table within the program, providing this perspective on administrative or management issues. The Medical Director’s role in regards to quality focuses more on programs or system indicators and performance, whereas the Department Chief role has a greater direct focus on quality and performance management of individual professional staff members. The Medical Director and the Department Chief need to work closely together within their job descriptions, particularly on issues related to the quality of care provided.

Appointment and reporting relationships for Medical Directors will vary depending on the administrative structure of each hospital. Medical Directors may be appointed by the board (in a combined position with the Chief) or they may be hired by the CEO. They may report through the Chief of Staff and the MAC, or through the CEO. Medical Directors may also be members of the MAC.

The challenge for hospitals under program management is to develop the right number and reporting relationships for their physician leaders, particularly with respect to the responsibilities of the department chiefs and program medical directors. In smaller hospitals, where the positions are combined, the department and program are typically the same, and one person has overall responsibility for all aspects of medical management. Where the positions are separate, typically the medical director will have responsibility for a larger program that includes more than one department (e.g., Maternal/Child program includes departments of obstetrics and gynaecology and pediatrics, and the Surgical Program includes all surgical sub-specialities and anaesthesia).
The Medical Directors may report to a Vice-President, Medical, who is also a physician, or may report to other Vice-Presidents, who are not physicians and are responsible for groupings of programs within the hospital.

(c) The Professional Staff Association

The PHA requires that hospital by-laws provide procedures for the annual election of a President, Vice-President and Secretary of the medical staff, as well as set out the duties of these and any other officers of the medical staff. The medical staff are required to hold at least four meetings every year.

While the PHA sets these requirements for the medical staff only, in many hospitals, the meetings of the medical staff include the non-medical members of the professional staff who are appointed by the board under the PHA. The “Medical Staff Association” has become the “Professional Staff Association” in these hospitals.

There is no statutorily defined role for the Professional or Medical Staff Association. While the PHA requires that hospital by-laws set out the duties of the officers of the medical staff, there is no corresponding requirement to set out the role of the Association apart from the requirement noted above that the members of the medical staff must hold four meetings each year and elect the officers. The MAC is required to provide a report to each medical staff meeting.

The OHA/OMA *Prototype Board-Appointed Professional Staff By-Law* sets out a standard job description for the President, Vice-President and Secretary of the professional staff. The essential role of the professional staff officers is to:

- act as a liaison between the professional staff, the CEO and the Board respecting matters concerning the professional staff; and
- support and promote the values and strategic plan of the corporation.

Typically, all professional staff officers are members of the MAC, and the President is a non-voting member of the board of directors.¹

¹ Previously, the Vice-President of the Medical Staff was also a member of the board of many hospitals, but this was changed with amendments to the HMR in 2010 – see s.2(1.1).
(d) Academic Hospitals

Academic hospitals have an affiliation agreement with a university for health care education and research. The focus of these agreements is on the education of medical students, and the impact on the physician leadership and professional staff structure within academic hospitals.²

In the context of an academic affiliation agreement, the hospital and university each maintain responsibility for their own internal appointment policies and procedures. However, they agree to work together with respect to common professional staff recruitment needs.

Medical and dental staff members are usually appointed jointly to the hospital’s professional staff and to the university’s faculty. While the hospital and the university each follow their own separate appointment processes, it may be a condition of membership for the hospital’s medical or dental staff that the staff member also maintain a university appointment, or vice versa, with the university maintaining a similar condition of membership.

The Chief of Staff position usually remains a hospital appointment and does not come with a corresponding university role, except as a faculty member. The Chiefs of Departments often have a role within the leadership structure of the corresponding department at the university. The hospital and the university may follow a joint appointment process for designating department head leadership positions at the university and within the affiliated hospitals. A hospital’s department heads will often have joint job descriptions, with responsibilities and reporting obligations owed to each of the hospital and the university.

For a sample of a hospital-university affiliation agreement, see the Medical Affairs section of the London Health Sciences website.

² The hospital may also have other agreements with universities and colleges for the education of other health care students. However, these agreements do not affect the management structure of the hospital.
(e) Multi-Site Hospitals

Multi-site hospitals often add an additional layer of management to the hospital’s structure – with the addition of site-level managers, who report globally into the overall hospital management, but who may also report locally to site directors on site-specific issues.

In this model, there will still be a Chief and/or Medical Director with overall corporate responsibility, plus potentially site chiefs or directors who are responsible for the specific site only. The site chief or director will have the same general responsibilities as outlined above for the Medical Director.

The principles of multiple sites within a single hospital corporation may also apply to separate hospitals operating together within an alliance or partnership agreement, which share professional staff through combined departments or programs at the member hospitals. Shared physician leaders may be appointed with overall responsibility for the department or program, with site specific leaders as well.

The challenge for physician leaders in these multi-site arrangements, and particularly for site chiefs or directors, will be the leader’s role as advocate for the professional staff members at the individual sites versus the hospital corporation or alliance/partnership as a whole. This is especially the case for combined hospitals in different communities which were separate institutions for much of their existence, but have recently merged into one organization. The professional staff are often established in one community and can find it challenging to adapt to the changing practice locations and focus that happen as a result of mergers and amalgamations. Medical staff, in particular, have an interest that need to be considered as programs and services are combined and moved between sites. Other stakeholder groups within the local community may also have difficulty in adapting to these changes.

It is the role of the physician leader from a specific site to bring the interests of that site and its professional staff members to the leadership table. However, because the site leader is appointed to the overall leadership, he or she must consider all of the hospital’s interests and stakeholders when decisions are made. While the site leader can therefore act as an advocate for the site’s particular interests to a certain degree, the role requires a broader focus. The site leader will also be responsible for taking the overall corporate decisions back to the site and working on their implementation with the site’s professional staff. The site leader has to become the site champion for the decisions made.
OVERVIEW

This section will discuss the relationships between hospitals and physicians including hospital privileges, role of the regulated health colleges and principles of institutional liability.

A detailed discussion of hospital-physician relationships is contained in the OHA's Professional Staff Credentialing Toolkit. For a discussion of the challenges and strategies for change in hospital-physician relationships see the OHA’s Hospital-Physician Issues Working Group document - Hospital-Physician Relationships: Where Do We Go From Here?

HOSPITAL PRIVILEGES

All professional staff members who provide clinical services in a hospital will have an appointment to the professional staff under the Public Hospitals Act (PHA) and the hospital by-laws. The Hospital Management Regulation (HMR) is clear that no person shall be admitted to the hospital as an in-patient or out-patient except on the authority of a member of the medical, dental, midwifery or extended class nursing staff of the hospital.

For most professional staff members, the only legal relationship with the hospital is through the appointment under the PHA (see below for a discussion of physician-hospital contractual relationships). There is no other agreement or legal connection with the hospital. They are not employees of the hospital. They bill the Ontario Health Insurance Plan (OHIP) independently and are not paid by the hospital. They may have their own private office separate from the hospital and often only a part of their practice is in the hospital. Legally, they are considered to be independent contractors.

All members of the professional staff are appointed for a maximum term of one year and are required to apply annually for re-appointment. The hospital’s professional staff by-law, policies, rules and regulations will set out the rights and responsibilities of professional staff members depending on their category of appointment. The professional staff members’ performance is measured against these criteria. It is typically the responsibility of the Department Chief and/or Program Medical Director to complete an annual performance appraisal as part of the re-appointment process. This responsibility will be set out in the hospital by-laws and the position job descriptions.

The relationship with physicians under the PHA is managed through the appointment and re-appointment (credentialing) process under the PHA.
Contractual Relationships

In addition to their appointment under the PHA, some professional staff members (mostly physicians) may have other contractual relationships with the hospital. These contracts will be between the hospital and a physician or group of physicians. They will also sometimes involve the Ministry of Health and Long-Term Care (MOHLTC) as an additional party.

These agreements include, but are not limited to:

- **Employment Agreements** – physicians in service areas (e.g., laboratory physicians) may be employees of the hospital. They will usually have individual employment contracts.

- **Hospitalist Agreements** – agreements with physicians (usually general practitioners) to provide in-patient care to designated medical patients.

- **Group Practice Agreements** – agreements between the hospital and a group of physicians to provide services to a particular clinical area of the hospital (e.g., diagnostic imaging).

- **Alternate Funding Plans** – agreements between the hospital, a group of physicians and the MOHLTC to provide services in a particular area for which the physicians are paid on a different model than fee-for-service. These agreements stipulate the types of services that the physicians must provide, including hospital services, and how the physicians will be paid for these services, instead of on the usual OHIP billing model. This payment model is used for selected clinical groups and is also an option for physicians who practice in remote areas where recruitment is limited (e.g., northern Ontario). Alternate funding plans are also common in academic health sciences centers as a way to provide payment for clinical, academic, teaching and research commitments.

- **Hiring Agreements** – agreements with new physicians that provide incentives (e.g., relocation payments) as part of the physician’s move to the community. These agreements typically require the physician to agree to practice at the hospital for a specific length of time in return for the incentive payment.
• **Hospital On-Call Coverage (HOCC) Program Agreements** – an agreement for payment of additional funds, above the usual OHIP fee-for-service rate, by the MOHLTC through the hospital to the physician for providing on-call coverage at the hospital. See the [HOCC page](#) on the MOHLTC website for more information.

• **Return of Service Agreements** – an agreement between the MOHLTC and a physician, usually an international medical graduate, to practice in an under-serviced area.

• **Affiliation or Academic Health Sciences Agreements** – agreements between individual physicians, the hospital and the affiliated university which set out the respective obligations of each of the parties within the academic/teaching hospital environment.

Physician leaders will be responsible for negotiating and managing these contractual relationships. Physician leaders will likely have specific contracts with the hospital for their leadership position. They may also be parties to agreements in their clinical practice. Where the agreement relates to the physician leaders own clinical practice, negotiation and management of the agreement should be delegated to another hospital leader as this would be a conflict of interest for the physician leader.

The Excellent Care for All Act imposes requirements for performance-based compensation on hospital executives as defined in the Act and its corresponding Regulations. This includes physician leaders, such as the Chief of Staff, and requires compensation to be linked to the achievement of performance improvement targets set out in the hospital’s annual Quality Improvement Plan. The portion of compensation that is performance-based should be identified in the physician leader’s contract. Additional roles and responsibilities of the physician leader under ECFAA are discussed in Module 6.

Each contract will be different, depending on its scope and purpose. Most hospitals will have templates for particular contracts that are adapted to each individual situation. The MOHLTC and other institutions also have standard contracts, which may or may not be modifiable by individual hospitals to fit particular circumstances.

The following checklist is suggested for physician leaders who are reviewing contracts:
(a) **Scope of Services**

Each contract will define the scope of services to be provided by the physician(s). This should be reviewed to determine that it appropriately states what the hospital requires of the physician – is it sufficiently clear so that the physician’s obligations can be understood? Is it broad enough to include everything that is required of the physician?

(b) **Hospital Obligations**

The contract will set out hospital responsibilities in return for the physician services under the agreement (e.g., hospital privileges, office space, billing support, etc.). As with the scope of services, this should be reviewed to confirm that the hospital’s obligations are clear and understandable.

(c) **Physician Compensation**

The agreement will define how the physician is compensated. Do the payment amounts and terms reflect the agreement that has been made with the physician?

(d) **Hospital Privileges**

The physician will also have an appointment under the PHA for the clinical services provided to patients in the hospital. The relationship between the agreement and the physician’s privileges should be considered in the development of any physician contract.

(e) **Addition/Deletion of members from group agreements**

For agreements with physician groups, there should be a process in the agreement for the addition of new members to the group and for the removal of existing members.

(f) **Term and Termination**

The agreement should have a defined term. Any options for renewal should be set out, including any conditions that apply to renewal. Finally, the agreement should address the potential for early termination by either or both parties, both with and without cause.

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. As a reminder, hospitals cannot contract out of the provisions set out in the *Public Hospitals Act*. 
ROLE OF THE REGULATED HEALTH COLLEGES

As discussed in Module 1, health professionals in Ontario are regulated under the Regulated Health Professions Act ("RHPA") and also under specific legislation for each profession (e.g., Medicine Act, Nursing Act, etc.) Each regulated health profession is governed by a College.

Physicians are regulated under the RHPA by the College of Physicians and Surgeons of Ontario (CPSO). Physicians are members of the CPSO and subject to CPSO regulation. For physician leaders, the CPSO will regulate both physicians’ clinical practice and their administrative role as it relates to the practice of medicine. As members of the college, physicians are expected to adhere to college standards in health care administrative functions.

Physician leaders may interact with the CPSO in a number of ways:

1. Licensing of Physicians

The CPSO is responsible for physician registration and licensing.

Hospitals require confirmation of the licence status of their physicians through a Certificate of Professional Conduct, which is obtained with consent of the physician on the original application for hospital appointment. Hospitals will also want to confirm the physician’s status on the annual re-appointment by obtaining a copy of the CPSO licence renewal from the physician. Physicians should also be required to disclose any changes in their license status to the hospital.

Physicians may also be licensed by the CPSO on restricted or supervised licences. These types of licences are used by the CPSO for new physicians who have not completed all of their training (e.g., pending completion of specialty examinations) or for physicians who have had

---

1 Physician leaders may also interact indirectly with the other regulated health colleges in their leadership roles, but this will primarily be the responsibility of other professional practice leaders in the hospital (e.g., Chief Nursing Executive with College of Nurses, etc.).

2 For new appointments, hospitals will usually require confirmation of license status directly from the CPSO, whereas for re-appointments hospitals most often rely on the physician to provide confirmation of continued status. Hospitals should consider periodic source verification with the CPSO directly (e.g., checking the public register, requesting a further Certificate of Professional Conduct, requesting a data spreadsheet from the CPSO).
discipline or fitness to practice concerns. These licences may require participation of hospital supervisors in the monitoring of the physician’s practice, which will be the responsibility of the physician leader. While it is the CPSO’s responsibility to determine the terms, conditions and restrictions on any physician’s license, where hospitals are asked by the CPSO and physician members of the hospital staff to participate in supervision arrangements, the hospital and the CPSO should work together to determine the nature of the conditions for hospital-based practice. The hospital cannot be required to simply implement what the CPSO has decided without hospital input.

Complaints and Discipline Matters

The CPSO has a statutory mandate to investigate public complaints and conduct other investigations into physician practice. Complaints can be made to the CPSO by patients or family members. There are also mandatory reporting obligations (see discussion below) which may initiate investigations.

Hospitals may be involved in CPSO investigations where the care in question was provided in hospital. The HMR specifically provides for provision of records and interviews of hospital staff in the context of CPSO investigations. Physician leaders are often interviewed or involved in CPSO investigations that involve professional staff members in their departments.

Hospitals also need to know about other pending or completed investigations at the CPSO as they relate to members of the hospital’s professional staff. Most hospital re-appointment forms require the physician to annually disclose this information. Physician leaders will be required, as part of the re-appointment, to consider and review this information.

Some physicians are also licensed in other jurisdictions. Hospital credentialing forms should also ask about changes in licensing status and pending or completed discipline matters in these other jurisdictions.

Mandatory Reporting Obligations

There are mandatory reporting requirements to the CPSO in the PHA and the RHPA. These include obligations to report:

- where applications or re-appointment applications are denied, or privileges are restricted or cancelled for incompetence, negligence or incapacity;
- if a physician resigns while an investigation into incompetence, negligence or incapacity is pending; and,
- where there are reasonable grounds to believe that a member has sexually abused a patient.
According to the statutes, these obligations generally fall on the administrator (CEO) of the hospital. For practical purposes, however, these reports will often be made by the physician leader (Chief of Staff or Chief of Department) responsible for the investigation of the particular issues or concerns. This will involve an initial report, to advise the CPSO of the situation, and then followed by additional reports as the hospital’s investigation proceeds or CPSO requests for information in the course of its own investigation.

**Remedial Plans for Physicians**

As a result of complaints and other investigations, the CPSO will sometimes impose conditions on a physician’s practice and/or require that the physician participate in a specific remediation plan to address a practice deficiency.

Where the issue relates to hospital practice, this will require the hospital’s participation in the plan. Hospitals should be involved in the creation of the remediation plans and determine whether and how these can be implemented in their facility. Hospitals may also develop their own remedial plans for physicians.

---

3 See discussion under “Licensing of Physicians” above. While it is the CPSO’s responsibility to determine the terms, conditions and restrictions on any physician’s license, the hospital has a responsibility to decide whether and how remedial plans are implemented within the hospital.

4 See Module 4: Leading High Performing Teams, for further information on managing performance.
There is a good description of the hospital administrator’s role in the chapter “Malpractice and Institutional Liability”, found in *Law for Canadian Health Care Administrators*:

*Health administrators frequently will have a role in attempting to avoid legal proceedings or, where they cannot be avoided, in providing assistance to legal counsel and support to health professionals where the conduct of the latter is the subject of the lawsuit. Administrators have responsibility for ensuring the implementation of a quality/risk management program that reduces the likelihood of negligence. Where an unfavourable or unanticipated outcome gives rise to patient complaint, a prompt response from administration may avoid a lawsuit. Where a lawsuit is commenced, or is likely to be commenced, health administrators will participate in the necessary investigation. They should have an understanding of the legal consequences and limitations on confidentiality for such investigations. They may be required to swear an affidavit of documents on behalf of the health facility, represent the facility at the examinations for discovery and, possibly testify at trial. Where civil actions are ongoing, auditors, insurers, board members and others may make requests for information about the status and likely outcome of the litigation.* (pages 219-220)

Lawsuits against hospitals and health care providers are brought forth based on the law of negligence. They have four key elements:

1. **A Duty of Care** – The party suing (plaintiff) must demonstrate that there is a relationship which gives rise to a duty of care. In the health care situation, it is the direct health care provider to patient relationship that gives rise to the duty of care. The institution may also be found to owe a duty of care to the patient.

2. **A Breach of the Duty of Care** – The plaintiff must demonstrate that the duty of care was breached. In malpractice situations, this is done through expert evidence about the applicable standards of practice and whether they were or were not met in the care provided.

3. **Causation** – The plaintiff must prove that the breach caused damage.

4. **Damages** - The plaintiff finally proves the damages that were suffered.

For the hospital, there are two kinds of legal liability to be considered: direct and vicarious liability.

**Direct Liability** is the hospital’s liability for the administration and management of the facility. The hospital is responsible for providing a proper place for health care to be provided – premises that have reasonable and appropriate equipment and that are staffed with competent personnel.
Vicarious Liability is the legal principle which establishes that the hospital is responsible for the conduct of its employees. The hospital is therefore responsible for the actions or omissions of all employee health care providers in the care that they provide to patients.

For physician leaders, under the vicarious liability principle, the hospital is responsible for their actions in the leadership role. This is separate and apart from their clinical role. Physician leaders should be covered under the hospital’s insurance policy for their leadership role.

Physicians who are appointed under the PHA are generally considered to be independent contractors for whom the hospital is not vicariously liable. The vicarious liability principle does not apply to independent contractors. In *Yepremian v. Scarborough General Hospital*, the Ontario Court of Appeal held that, while hospitals have a duty through the PHA appointment process to appoint qualified and competent physicians, hospitals are not vicariously liable to compensate an injured patient when a credentialed physician provides negligent care. Hospitals are not generally vicariously liable for negligent care provided by credentialed physicians, but are responsible for due diligence in the credentialing process.
APPENDIX 1

Key Sources

OHA Resources

- *Guide to Good Governance* – Chapters 4, 5 and 6
- *Professional Staff Credentialing Toolkit*
- *Hospital Prototype Corporate By-Law*
- *OHA/OMA Prototype Board-Appointed Professional Staff By-Law*
- *Frequently Asked Questions: Amendments to Regulation 965 under the Public Hospitals Act Re: Hospital Board Composition and Duties of Non-Voting Directors*

Key Legislation/ Regulations

- *Corporations Act*
- *Excellent Care for All Act*
- *Not-for-Profit Corporations Act*
- *Public Hospitals Act*
- *Hospital Management Regulation*
- *Regulated Health Professions Act*
- *Medicine Act*

Additional Resources

- *Law for Canadian Health Care Administrators*
- *Kerr and King: Procedures for Meetings and Organizations*
- *Robert's Rules of Order*
- *Wainberg's Society Meetings*
APPENDIX 2

Management Models

Business Corporation

1. Board of Directors
2. CEO
3. Vice-Presidents
4. Directors/Managers
5. Employees
Traditional Hospital Corporation

BOARD OF DIRECTORS

CEO

Chief of Staff/Chair of MAC

Vice-Presidents

Chief of Department

Directors/Managers

Chiefs/Heads of Division or Services (in larger hospitals)

Employees

Physicians

_____ Reporting relationships  _ _ _ _ Consulting/Cooperative relationships
Reporting relationships

Consulting/Cooperative relationships
APPENDIX 3

*Denotes primary responsibility

Responsibility Profile for Department Chiefs, Program Medical Chiefs and Directors of Operations

Sunnybrook Health Sciences Centre has a program management model in place that requires effective matrix relationships among key Medical and Administrative Leaders in the organization. This chart provides an overview of the relative responsibilities of Department Chiefs, Program Chiefs, and Director of Operations roles. The roles are co-dependent and it is an expectation that there will be cooperation and collaboration on issues of mutual concern and interest. Although there is an expectation of collaboration, in some areas leaders will assume primary responsibilities with the other members of the leadership team acting in a supportive or secondary role.

Performance reviews for Program Chief, Department Chief and Director of Operations will include an assessment of each one’s ability to support the effective functioning of the program management model, as well as the academic mission of the hospital where appropriate.

Although the Program is the operational structure designed to monitor finances, overall quality of care and workload, it must also contribute to the academic mission of the hospital and its various Clinical Departments.
<table>
<thead>
<tr>
<th>Topic</th>
<th>Department Chief</th>
<th>Program Chief</th>
<th>Director of Operations</th>
</tr>
</thead>
</table>
| Definitions   |  Department Chief position is part of the academic structure recognized at Hospital Medical Advisory Committee (MAC) and University levels  
 Department Chiefs are appointed by the Board following a search process defined by the Hospital-University Affiliation Agreement. |  Program Chief is an administrative position appointed by the CEO upon joint recommendation of the EVPs. A search process is defined in the Medical-Dental-Midwifery Staff Bylaws. |  Director of Operations is the administrative leader of the Program |
| Reporting Relationship |  Externally reports to University Department Chair  
 Internally reports to EVP, Medical and Academic Affairs (the MAC and ultimately the Board) |  Reports to the EVP for operational responsibilities and overall quality of service  
 Reports to the EVP CME for academic responsibilities and quality of medical care |  Reports to EVP for operational responsibility and overall quality of service |

*Denotes primary responsibility*
<table>
<thead>
<tr>
<th>Topic</th>
<th>Department Chief</th>
<th>Program Chief</th>
<th>Director of Operations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsibilities</td>
<td>Operational Planning and Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>✓ Responsible to the CEO or delegate on matters of planning, management and administration of the Department.</td>
<td>Responsible to the EVP, Programs.</td>
<td>Responsible to the EVP, Programs</td>
</tr>
<tr>
<td></td>
<td>Collaborative role with the Program Chief in monitoring of Program budget and taking steps to correct variances due to individual physician activities</td>
<td>Create an annual operating plan, which is consistent with the organization’s corporate goals and supports the values and mission of the organization.</td>
<td>Create an annual operating plan, which is consistent with the organization’s corporate goals and supports the values and missions of the organization.</td>
</tr>
<tr>
<td></td>
<td>✓ Ensures within the overall context of the Department Chief’s scope of responsibility that decisions made within Department are supportive of the Program and do not have negative impact on effective resource management of Program.</td>
<td>To work with the Director of Operations, managers and Medical Dental Midwifery Staff to manage the financial &amp; activity variances and take appropriate corrective action for resources controlled/influenced by medical staff.</td>
<td>To develop the Program budget consistent with effective utilization of resources and ensure that activities are managed in line with Program/Hospital operating plan.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ Involves appropriate stakeholders – including Department Chiefs and Division Heads in the budget process. Where variances are a result of action by physician groups, will assume primary responsibility for instituting corrective action.</td>
<td>Maintains the monthly financial and activity variances and takes appropriate corrective action.</td>
</tr>
<tr>
<td>Resource Utilization</td>
<td>Supportive and collaborative role with specific focus on issues related to medical care</td>
<td>To monitor resource utilization within portfolio in terms of LOS, RIW’s, bed utilization, OR.</td>
<td>Determines nurse/allied health/support staffing budget.</td>
</tr>
</tbody>
</table>

*Denotes primary responsibility*
<table>
<thead>
<tr>
<th>Topic</th>
<th>Department Chief</th>
<th>Program Chief</th>
<th>Director of Operations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>➢ Supportive and collaborative in the development of care plans and protocols to standardize and optimize utilization of Program resources</td>
<td>➢ Supportive and collaborative of the Program Chief in changing medical practice where such practice is not consistent with agreed upon utilization of resources. ✔️ Develop best practice protocols to standardize and optimize utilization of Program resources. ✔️ Lead changes in medical practice where such practice is not consistent with agreed upon utilization of resources.</td>
<td>➢ Coordinates capital equipment requests for the portfolio, and assign priority ranking of requests. ✔️ To take a leadership role for the portfolio in facility planning activities from a user’s perspective</td>
</tr>
</tbody>
</table>
| Capital Equipment and Facilities | ➢ Collaborative role  
➢ Represents departmental needs for capital equipment through the annual budgeting process | ➢ Collaborative role  
➢ Chairs/Co-Chairs Program Council meetings (these have defined terms of reference) – ensures agendas, minutes etc are completed and distributed to Medical Dental Midwifery Staff who did not attend the meetings.  
➢ Attends hospital-based meetings as assigned  
➢ Establishes appropriate committee structures and leads and participates in Committee and work teams to advance Program activities and to ensure broad stakeholder input where appropriate.  
➢ Attends hospital-based meetings as assigned |                                                                                     |
| Committee Structure & Meetings | ➢ Holds regular meetings with the department to inform and seek input on Hospital & University policies and procedures, rules, goals and objectives, strategic planning activities, and resource allocation decisions  
➢ Attends other committees as assigned | ➢ Ensures appropriate mechanisms in place to keep  
➢ Establish effective communication mechanisms |                                                                                     |
| Communication                 | ➢ Communicates hospital and university issues to the |                                                                                                                                                                                                               |                                                                                     |

*Denotes primary responsibility
### Academic Rounds

- **Responsible for the organization of all dept rounds, conferences and interdepartmental academic rounds**

### Director of Operations

- Ensures that operational matters are supportive of the overall academic focus of the Program.
- Supportive and collaborative with Chief Nursing Executive to ensure that development of an overall academic focus specifically nursing and allied health professionals for their Program.

---

*Denotes primary responsibility*
<table>
<thead>
<tr>
<th>Topic</th>
<th>Department Chief</th>
<th>Program Chief</th>
<th>Director of Operations</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Education Activities (Undergrad)</td>
<td>★ Responsible for all departmental education activities and appropriate distribution among members</td>
<td>Supportive and collaborative role</td>
<td>Facilitates educational activities for undergrad nursing/allied health students</td>
</tr>
<tr>
<td>- Education activities (Postgrad)</td>
<td>★ Organize departmental education activities</td>
<td>Supportive and collaborative role</td>
<td>Supportive and collaborative role</td>
</tr>
<tr>
<td>- Research</td>
<td>Encourage, support and monitor and develop research activities within Department, and in collaboration with other stakeholders in academic with the hospitals strategic priorities</td>
<td>Encourage and support research consistent with Hospital’s Research Strategic Plan in collaboration with the Department Chiefs ★ Develop and lead research agenda for Program</td>
<td>Supports and encourages Practice Based Research initiatives ★ Facilitates participation of nursing/allied health in research activities</td>
</tr>
<tr>
<td>- Academic Resource Needs</td>
<td>★ Develop and administer a budget for academic development in line with the organization’s strategic plan</td>
<td>Supportive and collaborative role</td>
<td>Assists in aligning nursing/allied health resources to support academic strategic plan</td>
</tr>
<tr>
<td>- Promotion of Medical Dental Staff</td>
<td>★ Responsible for working with Medical Dental Midwifery Staff to facilitate their academic development Responsible for proposing staff for promotion</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

*Denotes primary responsibility
## Topic: Quality

<table>
<thead>
<tr>
<th></th>
<th>Department Chief</th>
<th>Program Chief</th>
<th>Director of Operations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>*Responsible to Board for quality of care at a departmental level through the MAC with respect to quality of medical care provided by individual departmental members.</td>
<td>To ensure that an interdisciplinary quality improvement mechanism exists and is regularly reporting through the Program.</td>
<td>To ensure that an interdisciplinary quality improvement mechanism exists and is regularly reporting through the Program.</td>
</tr>
<tr>
<td></td>
<td>Monitors and is responsible for the professional care provided to patients by members of the Department and advises the MAC with respect to the quality of medical care.</td>
<td>Specifically with regards to medical care has a joint responsibility with the Department Chief to ensure high standards of medical care are maintained.</td>
<td>To promote the development of multi-professional teams.</td>
</tr>
<tr>
<td></td>
<td>Responsible for clinical outcomes, to the extent that these outcomes are related to professional performance and competence of individual members of the Medical Dental Midwifery Staff and will collaborate with Program Chief with respect to other clinical quality issues / indicators.</td>
<td>To receive regular updates with respect to the quality process within the Program and give appropriate feedback and direction.</td>
<td>Lead the continued development of quality improvement activities, including the promotion of innovation and creativity in the ongoing review and simplification of processes.</td>
</tr>
<tr>
<td></td>
<td>Ensure that a continuous quality improvement plan is in place with regards to physician professional activity.</td>
<td>In conjunction with the team ensure that the Program is functioning at an acceptable level to provide high quality of care. Review quality reports prior to their submission to Hospital Committees and Board.</td>
<td>Identify and monitor processes and outcome indicators related to quality service, teaching and research.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To collaborate with Department Chief in terms of addressing clinical quality, risk and patient safety issues within portfolio.</td>
<td>To prepare regular updates with respect to quality processes within the Program.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>With the Director of Operations responsible for coordinating the</td>
<td>Collaborate with the Program Chief and Department Chief addressing clinical quality, risk and patient safety issues within the portfolio.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CCHSA accreditation activities.</td>
<td>With the Program Chief responsible for coordinating CCHSA accreditation activities.</td>
</tr>
</tbody>
</table>

*Denotes primary responsibility*
### Strategic Planning

**Department Chief**
- Participate in the ongoing formulation of the mission, strategic direction and goals of the hospital, and ensuring a fit between them and the strategic plans of the academic department
- Develop annual plan for department that includes and supports Program and organizational operating plan(s)
- Leadership in women’s health, aging, patient-focused care and the development of strategic alliances

**Program Chief**
- Participate in the ongoing fulfillment and/or formulation of the mission, strategic direction and goals of the hospital
- Leads the development of short and long term plans to advance strategic directions, and corporate goals for the Program with emphasis on women’s health, aging and patient focused care and development of strategic alliances

**Director of Operations**
- Participate in the ongoing fulfillment and/or formulation of the mission, strategic direction and goals of the hospital
- Responsible for development of annual operating plan which reflects strategic directions
- Evidence of leadership in women’s health, aging, patient focused care and development of strategic alliances

### Human Resources

**Recruitment and Medical Human Resource Planning**
- Develop and maintains an up to date human resource plan for the Department and its divisions that is consistent with the University and Hospitals strategic directions and is scoped to meet the annual operating plan parameters of the hospital

**Program Chief**
- Responsibility for identifying medical resource needs of the Program and ensuring that these are addressed in annual operating plan. Identifies recruitment needs with appropriate Department Chief
- Identifies resource impact in

**Director of Operations**
- Develops and recommends the nursing/allied health/support human resource plans for the Program and is responsible for recruiting, hiring, performance review and discipline of such Program staff.

*Denotes primary responsibility*
### PHYSICIAN LEADERSHIP RESOURCE MANUAL

**Module 2: Hospital Governance**

**Appendices**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Department Chief</th>
<th>Program Chief</th>
<th>Director of Operations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presents and justifies all new medical recruits to Medical Human Resources Analysis Committee (MHRAC).</td>
<td>collaboration with the Department Chief of new physician recruits</td>
<td><strong>★</strong> Responsible for developing an interdisciplinary team approach to patient care education and research.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>★ Ensures in collaboration with the Department Chief that medical human resources supports the strategic, academic and clinical needs of the Program and that adequate resources are in place to support new recruits.</td>
<td>★ Promotes and facilitates education for all non-physician staff and students.</td>
<td></td>
</tr>
<tr>
<td>Staff Development &amp; Retention</td>
<td>★ Maintains an active program for staff development including orientation for new members</td>
<td>★ Supports interdisciplinary team development</td>
<td>★ Ensures an annual performance review is undertaken for nursing/allied health/support staff.</td>
</tr>
<tr>
<td></td>
<td>★ Takes disciplinary action when needed</td>
<td>★ Responsible for creating an environment within the Program that supports retention of physicians and other team members and implementing values based HR practices</td>
<td></td>
</tr>
<tr>
<td></td>
<td>★ Maintains job descriptions for all members of the department, and ensures an annual performance review is undertaken</td>
<td>★ Maintains job descriptions for all physicians within the Program who perform an administrative function and contributes to an annual performance review.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>★ Makes annual recommendations regarding re-appointment of Medical Dental Midwifery Staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>★ Organizes reviews of new staff</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Denotes primary responsibility*
APPENDIX 4

Community Hospital Job Descriptions

Grand River Hospital and St. Mary’s General Hospital

1. Chief of Department vs. Medical Director, Roles and Responsibilities

<table>
<thead>
<tr>
<th>Chief of Department</th>
<th>Medical Director</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointed by Board, accountable to COS</td>
<td>Appointed by CEO, accountable to VP Medical</td>
</tr>
<tr>
<td>Advises Board through MAC</td>
<td>Works with VP Medical and VP Program</td>
</tr>
<tr>
<td>Professional Practice for the discipline</td>
<td>Business practice of the program</td>
</tr>
<tr>
<td>Supervises delivery of Quality of clinical Care by the Medical Staff, works with the Medical Director for Quality Planning and Implementation</td>
<td>Quality planning and implementation</td>
</tr>
<tr>
<td>Physician Credentials/Advise MAC for privileges</td>
<td>Monitor, evaluate and achieve effective medical resource utilization</td>
</tr>
<tr>
<td>Individual MD performance evaluation and discipline</td>
<td>Implement and foster clinical excellence through evidence based best practices</td>
</tr>
<tr>
<td>Presents to MAC reports of M&amp;M rounds, and Risk Management activities</td>
<td>M&amp;M rounds, Risk management</td>
</tr>
<tr>
<td>Review and investigate patient care complaints</td>
<td></td>
</tr>
<tr>
<td>Participate in development of Hospital’s Mission Vision Plan</td>
<td>Participate in Goals, objectives and strategic plans for the program</td>
</tr>
<tr>
<td>Attend required committees – MAC, Credentials, Chair Department meetings &amp; others as mandated by the Board or the COS</td>
<td>Attend required hospital/ program operations meetings – clinical leadership, program strategic planning, Quality, clinical priorities, and any ad-hoc committee prescribed by either VP Medical or VP Program</td>
</tr>
<tr>
<td>Physician HR planning and scheduling</td>
<td></td>
</tr>
<tr>
<td>Works closely and in collaboration with the Medical Director</td>
<td>Works closely and in collaboration with the Chief of Department</td>
</tr>
</tbody>
</table>
2. Sample Job Descriptions

Grand River Hospital and St. Mary’s General Hospital

(a) Chief of Department

Preamble
The Chief of a Department has primary responsibility for physician credentialing and privileges, individual performance evaluation and discipline, while the Medical Director does not have or share this responsibility. Still, the Chief of a Department may seek the advice of the Medical Director regarding these matters.

Conversely, the Medical Director is a physician leader with an administrative role in a specific department. The Director’s role is to organize and manage the physicians and to help develop and maintain a systems approach for operational issues including the efficient use of hospital resources.

Position Summary
This is a senior medical position to be appointed by the Board of Directors of Grand River Hospital and the Board of Trustees of St. Mary’s General Hospital¹. The Chief of the Department, through the Chief of Staff, is responsible to the Board for the quality of medical care provided all patients by members of the Department. The Chief of Department position will be open to any active staff member with the required licensing and qualifications.

The Chief of the Department will:

1. Fulfill the functions and responsibilities in a manner that is consistent with the principles and expectations described within the Government of Ontario Public Hospitals Act.
2. Act in a manner consistent with the mission and values of both Hospitals.
3. Provide leadership to the members of the Department in the establishment of an interdisciplinary approach to patient-centered care;
4. Collaborate with the representatives of other disciplines and other medical departments to create an environment that promotes commitment to evidence based practices and improved patient outcomes;
5. Enhance education and research throughout the organizations.

¹ The Boards of Directors and Trustees, for Departments commonly shared between Grand River Hospital and St. Mary’s General Hospital shall appoint as Chief of Department a physician who is on the active staff of both Hospitals. For those Departments not shared between the Hospitals, the appropriate Board will be charged with the responsibility of appointing an active staff member from that Hospital to the position of Chief of Department.
Accountability
The Chief of the Department is accountable to the Chief of Staff as well as to the Board of Directors of Grand River Hospital and the Board of Trustees of St. Mary's General Hospital. Major responsibilities include:

1. Through and with the Chief of Staff supervising the professional care provided by the professional staff within the Department.
2. Advising the Medical Advisory Committee, through and with the Chief of Staff, with respect to quality of professional care provided to the patients and outpatients of the Department by the professional staff.

An annual performance appraisal of the Chief of Department will be conducted in accordance with a process established by both Boards, and in reappointing the Chief of Department; the Boards may give consideration to the outcome of the annual performance appraisal.

Qualifications
1. Member of, or eligible for appointment to, the Active Medical Staff
2. Possesses demonstrated clinical competence and good judgment and is respected in his/her field of practice.
3. Demonstrates a good understanding of the purpose and functions of the medical staff organization and its structure.
4. Ensures that patient care and safety take precedence over all other concerns.
5. Possesses leadership ability, including objectivity, maturity, self-confidence, and a willingness to approach problems with honesty and integrity.

Duties/Responsibilities adapted from the Professional Staff Bylaws/Public Hospitals Act
- Supervise the professional care provided by the professional staff.
- Participate in the orientation of new professional staff.
- Organize and implement a departmental quality assurance program that includes holding regular morbidity and mortality rounds.
- Along with the Chief of Staff advise the Medical Advisory Committee with respect to quality of care.
- Advise the Chief of Staff and Chief Executive Officer of patient care issues.
- Responsible to the Chief of Staff and Chief Executive Officer for determination and appropriate utilization of departmental resources.
- Report to the MAC and to the Department on activities of the department. Work with the Medical Director and/or Program Medical Director to ensure appropriate utilization of resources and quality assurance.
- Determine and communicate medical human resource needs following consultation with medical staff of the Department, the Chief of Staff, and others as required to the MAC.

2 Professional Staff means a member of the Medical, Dental, Midwifery, Extended Class Nursing Staff and/or Ancillary Staff.
• Participate in the development of the Hospital’s mission, objectives and strategic plan.
• Collaborate with the Hospital regarding physician complaints.
• Participate in review of privileges and performance evaluations for Departmental professional staff.
• Ensure compliance with Hospital policies, objectives and rules.
• Enable continuing education and professional development.
• Recommend to the MAC for approval the service leadership structure (as well as specific individuals within that proposed structure).
• Notify the Chief of Staff and the Chief Executive Officer of his/her absence and suggest an alternate designate from within the Department.

The duties of the Chief will include the responsibility for discipline of departmental members in regard to matters of patient care, cooperation with employees, and documentation of care.

**Services in a Department**

When warranted by the professional resources of the department, the Board, jointly where necessary with either the Board of Directors of Grand River Hospital or the Board of Trustees of St. Mary’s General Hospital on the advice of the MAC, after considering the recommendations of the Chief of Department, may divide the department into services.

- The Chief of Department is responsible for recommending to the MAC for its approval both the service leadership structure and the specific individuals within that proposed structure.
- In arriving at these recommendations, the Chief of Department will demonstrate a process of consultation with the Department, and if appropriate, amongst departments and with programs.

**Term of Office**

The appointment shall be for a term of three years, but the Chief of Department shall hold office until a successor is appointed.

The maximum number of continuous terms shall be two provided however that following a break in continuous service of at least one year the same person may be re-appointed.

The term is subject to annual confirmation by the Board of Directors of Grand River Hospital or the Board of Trustees of St. Mary’s General Hospital, or both in the case of a commonly shared Department.

The Boards may at any time revoke or suspend the appointment of a Chief of a commonly shared Department. Likewise, the Board of Directors of Grand River Hospital or the Board of Trustees of St. Mary’s General Hospital may revoke or suspend the appointment of the Chief of a Department specific to that Hospital.

The appointment is subject to the completion of a Service Agreement between the Chief of Department/Service and the corresponding Hospital(s).
(b) Medical Director

PREAMBLE:
The Medical Director is a physician leader with an administrative role in a specific department. The Director’s role is to organize and manage the physicians and to help develop and maintain a systems approach for operational issues including the efficient use of hospital resources.

While the Chief of a Department has primary responsibility for physician credentialing and privileges, individual performance evaluation and discipline, the Medical Director does not have or share this responsibility. Still, the Chief of a Department may seek the advice of the Medical Director regarding these matters.

POSITION SUMMARY:
The Medical Director is the lead physician who assumes an administrative role in the Department. The Director has primary responsibility to effectively organize and manage the physician resources within the Department.

The Director works in collaboration with the Manager/Director responsible for the Department. Collectively they have responsibility for the overall operation of the Department and are accountable for strategic planning for the Department, budget management, prioritization of capital equipment requests, departmental space planning, education and research. Other important responsibilities include the provision of quality and cost effective care, human resource planning, quality improvement and risk management.

POSITION ACCOUNTABILITY:
The Medical Director will be directly accountable to the Vice President, Medical Affairs (St. Mary's General Hospital) and the Vice President responsible for the program (Grand River Hospital). Lateral relationships include the Chief of the Department, the Manager/Director of the Department, and Program Medical Directors and the Vice President/CMO (GRH).

RESPONSIBILITIES:

Physician Management:
Specific Responsibilities
- Organize, implement and evaluate the management of physician resources within the department including adequate human resources and scheduling of the physicians.
- Participate in the recruitment of new medical staff.
- Conduct orientation of new medical staff.
- Communicate administrative directions to the medical staff.
Planning:

**Shared Responsibilities:**
- Participate in the planning and development of the department’s goals and objectives within the context of the hospitals’ strategic plan, mission and vision. Assist with departmental space planning, redevelopment and renovations.
- Develop new and expanded programs to meet community needs.

Utilization:

**Specific Responsibilities:**
- Monitor, evaluate and achieve effective medical resource utilization.

**Shared Responsibilities:**
- Assist with the planning and management of the departmental operational and capital budget.
- Review monthly budget and statistical variance report.
- Assist with the development of strategies to promote clinical efficiencies and appropriate resource utilization.

Quality:

**Shared Responsibilities:**
- Assist with the development of strategies that promote best practices. Participate in quality measurement and improvement initiatives through monitoring and evaluating departmental indicators.
- Participate in resolving physician/staff conflicts, e.g. scheduling conflicts.
- Assist in the development of job descriptions, recruitment, orientation and evaluation of departmental staff as requested.

Education and Research:

**Shared Responsibilities:**
- Promote an environment that supports and fosters clinical excellence through the use of research, evidence based practices and outcomes evaluation.
- Participate in the exploration of innovative practices, trials and evaluations.

Community and Partnership Development:
- Facilitate and promote partnerships and linkages internal and external to the Department.

Meetings:

Attendance required:
- A: Both Hospitals
  - List relevant committees
B: SMGH

Corporate:
- Clinical Priorities (meets quarterly)
- Quality Monitoring (meets monthly)
- Board Meetings Ad Hoc for issues/presentations related to the Department

Unit or Program Based:
- Program M & M rounds (ad hoc/when relevant cases presented)
- Regular meetings with Departmental Manager/Director (issues of utilization/risk/staffing/practice/budget, etc.)

C: GRH:
- Unit Council, as applicable (monthly)
- Planning and Priorities (monthly)

QUALIFICATIONS:
1. Member of the Active Medical Staff.
2. Possesses demonstrated clinical competence and good judgment and is respected in his/her field of practice.
3. Demonstrates a good understanding of the purpose and functions of the medical staff organization and its structure.
4. Ensures that patient care and safety take precedence over all other concerns.
5. Possess leadership ability, including objectivity, maturity, self-confidence, and a willingness to approach problems with honesty and integrity.

APPOINTMENT:
1. The Medical Director will be appointed by the CEO following consultation with the Vice President, Medical Affairs.
2. The appointee will be eligible to serve two consecutive three-year terms, subject to annual appointment.
3. After successful completion of the initial three-year appointment, an internal review will be conducted with the potential reappointment of the incumbent. After six years, automatic reappointment will not be possible. A more extensive review will be undertaken and the incumbent may reapply for the position.

PERFORMANCE EVALUATION:
The Vice President, Medical Affairs following consultation with the CEO and principal stakeholders who interact with the Medical Director, will complete an annual performance evaluation.
OVERVIEW

Physician leaders must excel in both clinical medicine and team management to effectively deal with the medical, administrative, and ethical complexity of the roles they fill. This section provides a well-known model demonstrating the skills and characteristics required for physician leaders to be successful in their role, followed by five practices of exemplary leadership stemming from those characteristics. It is recommended that physician leaders use these characteristics to diagnose their own strengths and areas of need. Following this model are five learning methodologies that can be executed to assist with growth in those specific areas.

Key Sources

**Supporting New Leaders in Developing Collaborative Teams: A Toolkit**


**NHS Institute Leadership Frameworks**

Two leadership frameworks from The NIH Institute for Innovation and Improvement leadership: The Leadership Qualities Framework and the Medical Leadership Competency Framework

**Medical leadership: why it's important, what is required, and how we develop it**

A review article about why medical leadership is important and how to develop it, including mentoring, coaching, action learning, and networking (Warren & Carnall, 2010).

**The Leadership Challenge**

This bestselling book on leadership has been in print for 20 years and remains a trusted source for individuals transitioning into leadership roles.

The Physician Leader's Roles and Responsibilities

Many see leadership as the limited activity of managing other people. Arguably, the most important element of leadership is getting ready to lead. Physicians in leadership positions have a responsibility to prepare themselves for the demands of leadership – having an appropriate work-life balance, being self-aware, understanding and preparing for the challenges of new roles. They should seek to consistently improve their communication skills and identify the leadership characteristics that they want to emulate in order to equip him or her for this new role.
LEADERSHIP MODELS

Characteristics of Admired Leaders

Effective leaders possess many different personality characteristics. Those that are admired by the people they work with share some commonalities. The following list of characteristics is adapted from The Leadership Challenge:

- Ambitious
- Courageous
- Dependable
- Imaginative
- Straightforward
- Broad-minded
- Caring
- Determined
- Inspiring
- Supportive
- Caring
- Competent
- Fair-minded
- Intelligent
- Competent
- Cooperative
- Forward looking
- Loyal
- Cooperative
- Courageous
- Honest
- Mature

Building on this list of qualities, below are five practices of exemplary leadership that managers can seek to emulate:

1. *Model the Way*: model behaviour you expect to see in others.
2. *Inspire a Shared Vision*: develop a positive and compelling vision of the future and communicate it frequently.
3. *Challenge the process*: Leave the status quo by trying something new and fostering innovation.
4. *Enable Others to Act*: collaborate often and focus on building trusting working relationships.
5. *Encourage the Heart*: offer genuine caring and appreciation.

A personal assessment tool adapted to health professionals from the practices above has been developed by the Winnipeg Regional Health Authority, and can be accessed [here](#).
Developing Leadership Skills

Physician leaders may wish to speak with their hospital human resources (HR) departments to see what leadership competencies have been adopted and what leadership development resources and programs are available to them. By way of example, the following five learning methodologies can be used in a hospital setting to help make physicians better leaders. Leaders may choose to use one or more of these approaches in order to strengthen those areas (Warren & Carnall, 2010):

1. **Mentoring**

Clinical mentoring in medicine has traditionally been an informal process in the medical profession. However, for mentoring to be used as a leadership development tool for doctors, a more formalized process to establish mentorship pairings may be required; both between medical and non-medical leaders. Physicians in new leadership roles should seek mentors to guide them as they develop as leaders, both in and out of the hospital.

2. **Coaching**

Unlike the mentoring relationship, coaching is aimed at performance enhancement in a specific area; it is goal-oriented and can be a short-term process. In a coaching relationship, the coach often takes control of the process. New physician leaders should work to identify key areas of need in their new roles, and seek formal coaching from internal or external providers in those specific areas.

3. **Action learning**

Action learning occurs during real life projects and cases, and through observing and working with others in the workplace. New leaders have the opportunity to gain insight and skills in a safe and facilitated environment. Action learning is often most effective in small groups with similar purpose or interests, accompanied by an experienced facilitator. New leaders should seek opportunities for on-the-job action learning as they transition into their new role.

4. **Networking**

New physician leaders should look to grow their network with both peers and senior leaders through formal channels (e.g. national groups or societies), or informal channels (e.g. interacting with others who share similar issues). Peer networks can provide support, learning, and encouragement as one takes on new challenges. Networks consisting of other senior leaders may provide opportunities to contribute and be involved in decision-making, effectively building a new leader’s profile and establishing a number of advocates who can speak on their behalf.
5. Experiential learning

Experiential learning forces individuals to work outside their comfort zones and learn new skills through ‘stretch assignments’ often outside their clinical expertise. These can take the form of new jobs, secondments to other organizations, or filling new roles internally, and is often separate from clinical work. By contrasting strongly held methods and beliefs, experiential learning helps to bring attention to different ways of solving problems. New physician leaders should seek opportunities for experiential learning once they become comfortable in their new roles.

Additional Resources to Consult

OHA Leadership Competencies
The OHA has a variety of resource materials that provide further information on leadership competencies and talent management. These resources include assessment questionnaires, individual development plans, competency implementation guides, among many others.

Canadian Health Leadership Network
The Canadian Health Leadership Network (CHLNet) is a not-for-profit, value network comprised of over 30 health organizations across the country. CHLNet has worked with its partners to facilitate and broker the development of a pan-Canadian leadership capabilities framework and learning platform: LEADS in a Caring Environment. They also provide leadership tools and recommended curriculum and training.

The LEADS framework identifies five key capabilities in Health Leadership Development: Leading self, Engaging others, Achieving results, Developing coalitions, and System transformation. Further detail and additional resources can be found here.

Key Elements of Clinical Physician Leadership at an Academic Medical Center
This study uncovers the characteristics associated with effective physician leadership at an academic medical centre.

The CanMEDS 2005 Physician Competency Framework
This publication by the Royal College’s Office of Education was created as a resource for all those interested in medical education, physician competence, and quality care

Lessons Learned – Reflections of Canadian Physician Leaders
This book observes physicians who have taken on leadership positions in health care management and change issues, and is intended as a resource for physicians thinking of taking on a leadership role (e.g., department head, chief of staff, health care administrators).
The Power of Appreciative Inquiry: A Practical Guide to Positive Change

A ‘how-to’ book, The Power of Appreciative Inquiry, describes a popular approach to organizational change that dramatically improves performance by encouraging people to study, discuss, learn from, and build on what's working, rather than simply trying to fix what's not. Whitney and Trosten-Bloom use examples from many different types of organizations to illustrate Appreciative Inquiry (AI) in action.

Strength Based Leadership

This book provides a study of great leaders, teams, and the reasons why people follow. The book identifies three key elements to becoming a more effective leader: knowing your strengths, getting the right talents on your team, and meeting the four basic needs of those who look to you for leadership. Includes firsthand accounts from leaders, and a personal ‘Gallup’s StrengthsFinder’ test.
OVERVIEW

In the previous section, admired traits of leaders were identified. Another important character trait of an influential and skillful leader is self-awareness: having an accurate picture of one's own strengths and weaknesses, and managing them appropriately. Self-aware leaders recognize their core values, talents, and passions, and make decisions that align with these values. The following section will help leaders identify their personal character traits across four key elements important to self-awareness: a) personality; b) presence and emotions; c) personal leadership style; and d) perception of others. The principles below are tools for individuals to reflect on while in a leadership role.

Key Sources

**How self-awareness helps a physician become a leader**
This is a publication on the importance of self-awareness in becoming a leader (Martin, 2012; Clinics in Dermatology Vol. 30, Issue 2, Pages 248-250).

**MBTI Manual: A Guide to the Development and Use of the Myers-Briggs Type Indicator**
This is a fully referenced psychology textbook on the Myers Briggs Type Indicator (Consulting Psychologists Press, 3rd Edition, 1998).

**Nonverbal Communication: Information conveyed through the use of body language**
This article is intended to help individuals understand the role non-verbal communication plays in others’ perceptions of an individual’s competence, power, and vulnerability (Dunn, 2004; Missouri Western State University).

**Primal Leadership: Realizing the Power of Emotional Intelligence**
Drawing from decades of research within world-class organizations, the authors show that great leaders excel not just through skill and smarts, but by connecting with others using Emotional Intelligence competencies like empathy and self-awareness (Goleman, Boyatzis, & McKee, 2002; Harvard Business Press, 1st Edition).
SELF-AWARENESS PRINCIPLES

1. Personality type, and what it means for personal strengths, weaknesses, and values.
2. Non-verbal communication style, and how it affects presence and emotions.
3. Personal leadership style, and how it affects the way a person manages others.

Beyond these diagnostic self-awareness tools, growing as a leader depends on effectively exchanging feedback with superiors, peers, and team members. Suggestions are provided to help leaders effectively encourage and receive feedback.

LEADERSHIP QUOTE

“Discovering my innate personality traits and communication style was transformational for me as a leader. I finally understood all the people and processes that used to drive me crazy. Better yet, I learned how they complement my style to produce a better outcome on group efforts.”

Dr. Nancy Merrow
Chief of Staff, Southlake Regional Health Centre
SELF-AWARENESS TOOLS

(a) Understanding Personality Type

LEADERSHIP QUOTE

“I always believed that an effective physician leader was one who “knew himself”. That knowledge allows the leader to best utilize his strengths while surrounding himself with people that compensate for his weaknesses.”

Dr. Bob Lester
Former Executive Vice-President
Medical & Academic Affairs & Chief Medical Executive,
Sunnybrook Health Sciences Centre

1. Myers-Briggs Type Indicator (MBTI)

The MBTI became the standard for personality assessments in the 1950s, and continues to be one of the most widely used tools today. The MBTI provides insight on why individuals view the world in a certain way, and why others may have alternative views or opinions based on their own personality traits. It has applications in leadership, teamwork, managing self, and managing others.

2. Emotional Intelligence (EQ)

Those with high “EQ” can recognize, evaluate, and regulate his/her emotions and those of others. EQ comes to some naturally, but the skill can be developed. Developing EQ (emotional intelligence) can enhance leadership ability, enrich relationships, and extend influence. It is made up of four core skills:

- Self-Awareness
- Self-Management
- Social Awareness
- Relationship Management

Unlike personality, emotional intelligence can be developed by training your brain to effectively communicate between its rational and emotional centres. A model for testing aspects of emotional intelligence can be found in Appendix 1.
(b) Understanding Presence & Emotions

There are three different styles of non-verbal behaviour that influence the way individuals outwardly express emotion, and in turn, how they are perceived by others in communication. Understanding personal style can help individuals understand why they might clash with one another, and how they can adapt their approach to find common ground.

1. Passive / Passive Aggressive

- Behaviour in this style can be defined by:
  - Keeping quiet
  - Not saying what you feel, need or want
  - Frequently putting yourself down
  - Apologizing when you express yourself
  - Denying that you disagree with others or feel differently
  - Omitting personal responsibility for actions.
A passive style may be useful when a decision needs to be made incorporating the opinions of all parties; a collaborative style of communication.

2. Aggressive
- Behaviour in this style can be defined by:
  - Expressing your feelings and wants as though any other view is unreasonable or stupid
  - Dismissing, ignoring or insulting the needs, wants and opinions of others.

A more aggressive style may be necessary when a decision needs to be made quickly, without input from many people.

3. Assertive
- Behaviour in this style can be defined by:
  - Expressing your needs, wants and feelings directly and honestly.
  - Not assuming you are correct or that everyone will feel similarly.
  - Allowing others to hold other views without dismissing or insulting them.

An assertive style has been proven to be most effective for frequent communication, maintaining a balance between efficient decision making and managing the emotions and expectations of all parties.

Refer to Appendix 2 for a test from *The Sage Handbook of Nonverbal Communication* to help understand personal style of nonverbal behavior.

Ultimately, the keys to communicating effectively amongst these different styles are understanding and flexibility. Understanding these different styles will lead to more awareness for how your style might come across to others, and how this could impact the conversation. The next step is becoming more flexible in how you approach communication. If you think a certain style may be causing tension in communication, you may want to consider taking a different approach with that individual or group.
(c) Understanding Personal Leadership Styles

Researchers have identified six key distinct leadership styles that incorporate various degrees of leadership attributes (Goleman, Boyatzis, & McKee, 2002). As a leader, physicians may identify more closely with one of the styles -- their ‘default’ personal style. Highly effective leaders tend to act according to their default style, but can switch fluidly between them depending on what is most effective for the situation or team. The table below can be used to identify the style individuals identify most closely with.

<table>
<thead>
<tr>
<th>Style</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visionary</td>
<td>• Strongly positive, moves people towards shared dreams.</td>
</tr>
<tr>
<td></td>
<td>• Appropriate when clear direction is needed or changes require a new vision.</td>
</tr>
<tr>
<td>Coaching</td>
<td>• Highly positive, connecting individual desires with the firm’s goals.</td>
</tr>
<tr>
<td></td>
<td>• Appropriate when employees need to improve performance by building skills.</td>
</tr>
<tr>
<td>Affiliative</td>
<td>• Positive, creating harmony by connecting people to each other.</td>
</tr>
<tr>
<td></td>
<td>• Appropriate to heal rifts in team, motivate at stressful times and strengthen connections.</td>
</tr>
<tr>
<td>Democratic</td>
<td>• Positive, values people’s input and gets commitment through participation.</td>
</tr>
<tr>
<td></td>
<td>• Appropriate when building buy-in or consensus or to get valuable input.</td>
</tr>
<tr>
<td>Commanding</td>
<td>• Can be negative (and misused), soothes fears by giving clear direction in a crisis.</td>
</tr>
<tr>
<td></td>
<td>• Appropriate in a crisis, to kick-start a turnaround or dealing with problem employees.</td>
</tr>
<tr>
<td>Pacesetting</td>
<td>• Can be negative (and is often poorly executed), meets challenging and exciting goals.</td>
</tr>
<tr>
<td></td>
<td>• Appropriate for achieving high-quality results from a motivated and competent team.</td>
</tr>
</tbody>
</table>

Each of these leadership styles can have different results in team settings. View Appendix 3 for more detail on the competencies of leaders who default to each style, and how the style can affect team results.
(d) Understanding Perception of You (encouraging and receiving feedback)

Encouraging and receiving feedback is rarely second nature for most people. Even though listening is a core skill of the physician, open discussion on the behaviour of the physician does not always occur within hospitals. The ‘no news is good news’ mentality, coupled with the expectation of perfection, can make it that much harder to receive meaningful feedback.

Understanding how we are viewed by others is extremely important for leadership effectiveness. Feedback can come from many sources: patients, staff, administrators, colleagues, students, even friends and family. Creating an environment where feedback is safe and encouraged can be difficult to accomplish, but vital for achieving the necessary self-awareness required for growth. In order to create this environment, feedback needs to be actively solicited by those in leadership positions. It is likely that some feedback will be perceived as negative, and the physician needs to be prepared to assure the sender that their feedback is welcome and will result in improved outcomes. A strong effort must then be made to demonstrate that progress has been made in identified areas of weakness.

The following skills for coping with negative feedback are identified in *The Assertiveness Workbook: How to Express Your Ideas and Stand Up for Yourself at Work and in Relationships* (Paterson, 2000):

Seek understanding:
- Avoid retaliation
- Listen and wait
- Ask for clarification
- Express your understanding of the issue
Provide your response:

- Validate their perception
- Validate their emotions
- Use descriptive language
- Agree in part
- Explain without offering excuses
- Do not try to change their mind
- Maintain focus on the issue at hand

Effective leaders correct their ‘fatal weaknesses’, while remembering to capitalize on their strengths. They turn constructive feedback into action by:

- Creating personal action plans based on their key strengths and development areas.
- Aligning resources to support their development (human and organizational).
- Communicating these action plans to peers and team members.
- Remaining accountable to them by setting measurable goals and reporting on progress on a quarterly or semi-annual basis.
Additional Resources to Consult

_The Assertiveness Workbook: How to Express Your Ideas and Stand Up for Yourself at Work and in Relationships_ (Paterson, 2000)

This is a workbook containing effective, cognitive behavioural techniques to help leaders become more assertive.

_Strengths-Based Leadership_

This book identifies three keys to being a more effective leader: knowing your strengths, getting the right talents on your team, and meeting four basic needs of those whom you lead. Readers are also provided with the ‘Gallup’s StrengthsFinder’ personal leadership assessment.

_The Inner Life of Physicians and Care of the Seriously Ill_ (Meier, Back, & Morrison, 2001)

This is a model for increasing physician self-awareness, and identifying and working with emotions that may affect patient care.

_Introduction to Type and Emotional Intelligence_ (Pearman, 2002)

This booklet explores the connections between personality and EQ (emotional intelligence), and provides specific actions for EQ development for each of the 16 types.
OVERVIEW

To be an effective leader, one needs to be healthy, motivated and focused, all of which depend on an appropriate work-life balance.

Maintaining a healthy work-life balance is one of the many factors that contribute to health and wellness, and consequently, professional effectiveness. To quote the www.eworkplacehealth.com online wellness manual, “The quality and sustainability of our healthcare system in Canada is dependent on you as a healthcare provider. If the system is to remain strong, it is critical that those who provide the services within it are strong and healthy”.

A study by Frank and Segura (2009) showed that only 57% of physicians agreed they have a good work-life balance, and the average workweek included 49 hours of professional work; considerably more than the average employed Canadian’s 36.4 hour workweek.

Attaining a work-life balance can be especially challenging for physicians. The issues that physicians deal with are significant – it is not easy for one to simply “turn work off.” Even though knowledge of mental health, physical health and nutrition within the physician community is extensive, it can be challenging for physicians to achieve work-life balance individually or to foster it within their teams.

Key Sources

ePhysician Health: http://ephysicianhealth.com/

The world’s first comprehensive, online physician health and wellness resource is designed to help physicians and residents become resilient in their profession and personal lives, created and developed by Canadian health leaders.

eWorkplace Health: http://eworkplacehealth.com/

An ecurriculum on Workplace Health, this resource is designed to increase practical awareness and understanding of the many factors that influence health at work, which was created and developed by Canadian health leaders.

OMA Physician Health Program: http://www.phpoma.org/

The Physician Health Program and the Professionals Health Program of the Ontario Medical Association serves the needs of physicians, pharmacists and veterinarians at risk of, or suffering from substance use disorders, and/or psychiatric disorders through prompt intervention, referral to treatment, monitoring and advocacy, as well as education.
KEY ISSUES AFFECTING HEALTH AND MORALE

The following section provides an overview of relevant issues affecting health and morale of physician leaders, and in the physicians they lead.

1. Weight, nutrition, and fitness

Many medical practitioners lead busy lives and many struggle to maintain a healthy lifestyle: a combination of healthy weight, nutrition, and fitness.

- Assessing your ‘Best Weight’ (whatever weight you reach living the healthiest lifestyle you actually enjoy) is a helpful benchmark for personal weight goals.
- The Healthy Eating Pyramid provides a good overview of the healthiest foods.
- The best exercise for weight control is the one enjoyed the most, since it will be most likely maintained during challenging and busy periods.
- For some, being accountable to one’s self is the hardest part – free online tools like http://www.myfitnesspal.com/ or http://www.livestrong.com/ can help you reasonable goals, track progress and encourage accountability.

2. Work-life balance

Work-life balance generally translates to satisfaction with one’s entire life, professionally and personally. Work-life balance is highly personal, and encourages individuals to fill their lives with the resources, time, and energy that aligns with their personal goals. A lack of work-life balance often leads to depression, poor work performance, family discord, and burnout (discussed in the next section). It is important to note that there will always need to be compromise; however, with careful planning, self-reflection, and self-awareness, personal fulfillment can be greatly optimized.

The following are steps physicians can take to help achieve greater balance in their lives (Berry, 2010):

- Take time to assess your values and priorities periodically. Some people do this each year on New Year’s Day, or on their birthdays. When you think about what you want your life to look like, accept the fact that you are going to have to make some tough decisions to find balance and meet your personal and professional goals.
- Try to avoid a cycle of constant "delayed gratification" by thinking "I'll finally be happy when ..." or "I can finally slow down when ..."
- Take short breaks -- anywhere from 1 to 5 minutes a day -- to breathe or stretch between patients. Studies show short breaks actually improve productivity, so you'll more than make up for the time you lose by pausing for a moment.
• When "perfect" balance is unattainable -- for example at exam time, a busy rotation or before a deadline -- make caring for yourself a priority by designating time for sleep, exercise and relaxation.

• Visit your own physician to make sure you are taking care of your own health.

• Talk to a friend or a counselor if you feel powerless to change a situation making you unhappy.

• Find a mentor or role model who can give advice on career development, time management and setting priorities.

• Carefully assess the daily routine at your office in collaboration with support staff to find ways to save time and energy. A well-run practice can mean a shorter work day, more satisfied employees, improved revenue and happier patients.

• Perhaps you are working too hard and not "working smart." Are you spending time on administrative tasks that you could outsource, or hire someone to do while you see patients? Could you eliminate commute time and stress by working on paperwork at home with a remote computer system?

• Ask yourself whether you could be missing the big picture. Is your practice ideally located to attract patients, or are you spending time and energy on marketing across town? Where else are you spending time that could be eliminated by making one large adjustment?

3. Depression, anxiety, and burnout

Depression, anxiety, and burnout are common amongst medical trainees and practitioners. Physician leaders need to be aware of the symptoms and resources available to help themselves or support colleagues and team members in distress. Health leaders with sensitivity and formal training in physician health are more likely to implement wellness programs at work, resulting in lower rates of burnout and better physician health.

Depression

• Depression can be caused by excessive stress, genetic vulnerability, physical health problems, medications and/or substance abuse, or combinations of many events, and there is often a considerable overlap between anxiety and depressive conditions.

• Medical students and physicians are strongly urged not to self-diagnose depression; it is recommended to seek a formal diagnosis assessment with a mental health professional.
**Burnout**

- Burnout is a work-related syndrome characterized by emotional exhaustion, depersonalization, and diminished feelings of professional success. The most effective reduction strategy is education on how to cope with stress.
- Burnout can be especially challenging for physicians to address given their motivated personality styles and their commitment to improve patient well-being.

Often, depression, anxiety, and burnout are a result of stress. Stress not only impacts a person’s individual work behaviour, but also the broader work environment. Sometimes individuals approach leaders or peers to communicate their personal or work-related difficulties, but more frequently, stress can be observed through behaviour and non-verbal communication. The following signs provide a reference guide for leaders and peers on early indicators of stress:

- Increased absenteeism
- Altered performance
- Changes in attitude, mood, or behaviour
- Becoming irritable, volatile, or aggressive
- Conflict with others
- Diminished work relationships
- Tiredness/lethargy/lack of interest
- Difficulty concentrating or making decisions
- Changes in appearance or personal hygiene
- Becoming withdrawn or isolated
- Demonstrating unrealistic standards or expectations for self or others
- Uncharacteristically labile
Approaching an individual to discuss performance or emotional issues with respect to stress is a challenging task. Taking time to prepare – gathering notes, mentally rehearsing, and consulting HR if necessary and appropriate, are often helpful preliminary steps. It is important to approach the individual at the earliest indication of the issue, while ensuring the conversation is during a suitable time and located in a private setting. Additionally, creating an environment that is comfortable and relaxed will be more conducive to creating solutions together and opportunities for follow-up conversations to assess progress in the future (Department of Education, Training and Employment, 2012).

Recognizing stress within oneself is often difficult given compromised objectivity. When stressed, seek advice from trusted friends, family, or colleagues. Identify the triggers that are creating stress within personal and/or work life. Assess what solutions are accessible and realistic, and devise a plan to resolve the stress. Superiors should be consulted if necessary. Ultimately, an individual should consider his/her own personal definition of work-life balance and readjust accordingly.

Substance abuse is another potential challenge, sometimes stemming from stress. Like most people, physicians can experience the same situations and factors contributing to substance abuse and addiction including low social support, low self-esteem, family problems, psychological disorders, and stress. Furthermore, physicians have additional risk factors including easy access to controlled substances, contact with individuals who are seriously ill and dying contributing to stress and emotional difficulty, as well as long hours. Colleagues and leaders can identify potential signs of substance abuse through a change in personal relationships and a decrease in community involvement. In addition, since healthcare providers with substance abuse issues typically source their drug supply from the workplace, they often do not show job performance impairments (e.g. frequent absence, arriving late) until the problem is severe (Council on Drug Abuse, 2009). This means that education and support in the healthcare workplace is very important for identifying individuals struggling with substance abuse early and solving these challenges from the early stages.

Indicators of substance abuse in the healthcare workplace may include evidence of an individual signing out more controlled substances than their co-workers, reporting more medication spills or wastes, excessively administering pain medications to patients, waiting to be alone to open or access narcotics, a defensive nature, or evidence of tampering with medication containers.

Substance abuse among physicians and other healthcare professionals needs to be identified as early as possible because it not only affects the health and well-being of the individual, but also the patients they care for. A supportive atmosphere in which individuals feel confident coming forward with the issue, as well as support for recovered substance abusers in their re-entry to safe professional practice, should be provided.
If any of these issues arise, physician leaders are encouraged to review their hospital policies and consult with their HR departments. Further discussion on this topic is provided in Module 4, under the Bill 168 (*Occupational Health and Safety Amendment Act*) section.

4. **Tensions between professional and personal boundaries**

Healthy boundaries between physicians and their patients facilitate better clinical care and professional behaviour. The CPSO recommends the following strategy for individuals concerned about the risk of crossing a boundary:

i. Document any inappropriate behaviour on the part of the patient.
ii. Focus objectively on the patient’s needs and best interests.
iii. Be clear about your own needs and experiences in the relationship, while trying to understand how the patient is experiencing your behaviour.
iv. Step outside the relationship: try to understand what a neutral observer would see.
v. Encourage patients to take responsibility for their own health; don’t impose your knowledge or authority.
vi. Do not accept inappropriate gifts from patients, and do not imply patients are obligated in some way to repay your help.
vii. Consider why you are acting in a particular way (i.e., stress, burnout, depression, etc.).
viii. Discuss with a colleague, while adhering to patient confidentiality.

More detail about this strategy can be accessed from the CPSO.

**Additional Resources to Consult**

**CPSO/OHA Guidebook to Managing Disruptive Physician Behaviour**

This guidebook offers useful tools to those working in a variety of educational and healthcare delivery settings for dealing with the behavior of healthcare professionals, physicians in particular, and the impact of behavior on patient outcomes.

**CMA Guide to Physician Health and Well-Being**

This guide provides facts, advice, and resources on physician health issues. (Canadian Medical Association).

**A mental health strategy for physicians in Canada**

This strategy proposes a framework for a multi-year, collaborative endeavour that the CMA will pursue to optimize the mental health of physicians, residents and medical students. (Canadian Medical Association)
**OMA Physician Health Program (PHP)**
The PHP offers supportive services and resources to physicians, residents, medical students, veterinarians, pharmacists, and their families for a wide range of problems including, mental, physical, and spiritual health (e.g., substance abuse or psychiatric disorders).

**Achieving work-life balance: More than just a juggling act**
This article in American Medical News details tips on ‘work-life balance’ and also offers other resources.

**Health professionals and substance abuse**
This document authored by the Council on Drug Abuse, is specifically geared towards substance abuse for those in the healthcare field.

**Canadian Council on Substance Abuse**
This organization is focused on substance abuse. Its website lists a number of addiction treatment services in Canada.

**The Resilient Physician**
This resource provides commentary on effective emotional management for doctors and medical organizations across a number of areas.

**The Healer’s Calling**
This resource addresses how to find meaning in clinical work.
OVERVIEW

The best leaders are those who make time for consistent, ongoing learning. They are on high-alert for new ideas, insights, and leading practices to improve the way things are done. Leaders capitalize on their strengths, while focusing time and attention on developing their areas of weakness through coaching, training, and mentoring. This section will provide an overview of the many training programs, conferences, accreditations, and associations available to physician leaders in Ontario.

In addition to these training programs, many physicians also choose to obtain advanced degrees (e.g., masters’ level) to support their learning and career advancement as physician leaders. See Appendix 4 for an overview of available degree programs.

LEADERSHIP TRAINING PROGRAMS AVAILABLE TO PHYSICIANS

Institutes

PMI: Physician Management Institute

PMI is the CMA’s leadership development program designed specifically for physicians working in Canada’s health care system. They offer conferences and in-person courses across Canada, and also can deliver the program to the workplace. Sample topics include, strategic planning, self-awareness, managing people, negotiation and conflict, and financial management.

Universities

1. Physician Leadership Program (University of Toronto)

The Physician Leadership Program is a 6-day program over the course of two months, that focuses on developing the knowledge and skills that are required by today's physician leader, with a focus on leadership and management to effect change. Drawing from the latest research and educational practices, the program explores emerging leadership strategies and applies them to the health context.

2. Advanced Health Leadership Program (University of Toronto)

The Advanced Health Leaders Program is targeted at current and potential members of executive teams in the health system. It is focused on the development of the next generation of health leaders. The program seeks to improve understanding and skills in the areas of leadership, the change management, emotional and political intelligence and integrative thinking. There are three five-day modules in the program, that are scheduled two months apart.
3. **Schulich Hospital Leadership and Healthcare Executives: Resilience, Agility, and Presence** (York University)

   This is a program for C-level executives and senior decision-makers in hospitals and other healthcare delivery settings, designed to develop a deeper personal awareness of leadership styles, skills, and the impact these have on others and organizational initiatives.

**Local Associations**

1. **Ontario Hospital Association Physician Leadership Summit**

   The Physician Leadership Summit is a forum for physician members to provide input on physician leadership issues and learn from colleagues across Ontario and internationally. Promoting a culture in which health professionals engage in a collaborative fashion to enhance the hospital-physician relationship is a key focus of the summit. The conference provides attendees with an opportunity to address hospital-physician related issues, as well as network with colleagues across the province. It is one of the most effective strategies for advancing the professional development of physician leaders.

2. **Physician Leadership Development Program**

   The OMA, in collaboration with the Canadian Medical Association, established the Physician Leadership Development Program in 2010 to address the ongoing physician leadership needs within the OMA, as well as to create a community of leaders who will influence the transformation of Ontario’s healthcare system. The Physician Leadership Development Program is available to OMA members only.

3. **MD Physician Services Canada, Practice Management: the business side of Medicine**

   This is a continuing medical education resource which can help physicians manage their practice, optimize revenues, decrease expenses, and improve office efficiency. Offerings include seminar events, 60-minute telephone consultations, online Practice Management Curriculum, and CME Cruises/Sea Courses for physicians.

4. **Association of Ontario Health Centres**

   This organization provides customized educational programmes and workshops for individual organizations on site. Sample topics include, the Community Health Centre (CHC) Model of Care, Governance Fundamentals, Interprofessional Collaboration, eHealth and Electronic Client Records (ECR) Adoption.
Ontario Hospital Leadership Programs & Institutes

Many hospitals in Ontario have developed their own leadership curriculum and education for physicians and administrators. For example:

1. Sunnybrook Leadership Development Institute
   For the past six years, Sunnybrook has partnered with the University of Toronto, Rotman School of Management and the Department of Health Policy, Management & Evaluation, and the Schulich Executive Education Centre (SEEC) to form a Middle Leaders Development Program. The program delivers annual programming focused on leadership development for middle and senior leaders.

2. Ottawa Hospital Leadership Academy
   The Ottawa Hospital Leadership Academy, in collaboration with academic partners, provides participants with leadership insight and actionable tools to improve their effectiveness in leading. The academic component of the program is spread over seven months and is coupled with a team-based project tied to actual organizational priorities.

Available Accreditations & Professional Associations

1. Canadian Certified Physician Executive (CCPE) Program
   The CCPE credential is designed to recognize and advance physician leadership and excellence through a national, peer-generated, standards-based assessment process. Physicians awarded the CCPE have demonstrated that they have the leadership capabilities, knowledge and skills needed for successful performance and, more importantly, for directing, influencing and orchestrating change within Canada's complex healthcare system.

2. Canadian College of Health Leaders
   The Canadian College of Health Leaders is a national, member-driven, not-for-profit association dedicated to ensuring that the country's health system benefits from capable, competent and effective leadership. It provides networking opportunities at the local, regional, and national level, annual awards, conferences, and professional development opportunities for physician leaders.
3. **Canadian Society of Physician Executives**

   The Canadian Society of Physician Executives provides a support and development network to Canadian physician managers, through networking opportunities, practical tools, and customized professional development programs for physicians pursuing healthcare management activities and/or careers.

---

**Recommended Conferences**

1. **Canadian Conference on Physician Leadership**

   The Canadian Conference on Physician Leadership provides participants with the opportunity to watch well-known speakers, participate in workshops and face-to-face discussions with colleagues and international experts. Participants will have the chance to practice leadership techniques and identify challenges facing physician leaders. The conference takes place over two days, with the option of participating in pre-conference workshops for the two days prior.

2. **Canadian College of Health Leaders / Canadian Healthcare Association: National Health Leadership Conference**

   The National Health Leadership Conferences is the largest national gathering of health system decision-makers in Canada including trustees, chief executive officers, directors, managers and department heads, government, education and research institutions, and industry. The 2012 conference focused on ideas, new thinking, and innovation.

---

**Additional sources for Healthcare Conferences & Events in Canada:**

- Longwoods Publishing Corporation
- Canadian Healthcare Association
- PeopleMenders.com
- Canadian Healthcare Network
RESUME DEVELOPMENT TIPS

There is an important distinction between a resume and curriculum vitae (CV). The CV is a list of vital statistics, including employment, research, education, awards, etc., while an executive resume is a document demonstrating why an applicant’s credentials are well-suited for the new role and organization. The following section provides a sample physician leadership resume structure, sample templates, and tips and suggestions for effective resume writing.

Structuring your Resume

Section 1: Contact Information
Section 2: Professional or Career Objective
Section 3: Career Achievements and/or Qualifications (promotions, celebrations, speaking engagements)
Section 4: Relevant Experience
Section 5: Education & Certifications
Section 6: Publications
Section 7: Honors (awards, competitions)
Section 8: References

Sample Templates

Tips and Suggestions

1. Demonstrate professionalism through proper formatting: omit any spelling or grammatical errors, ensure bullets align, ensure consistent underlining and capitalization of titles.

2. Use appropriate action verbs to demonstrate your accomplishments. Begin sentences with action words to capture the reader’s attention and demonstrate the impact of your efforts on your work/team/organization. See Appendix 5 for a categorized list of Action Verbs created by the Boston College Career Centre.
3. When outlining experiences, try to avoid presenting them as a simple list of your roles; rather, focus on the specific challenges faced /were tasked with, what actions were taken to overcome those challenges, and the results of your efforts (the CAR format):

- **Challenge:** Demonstrate the specific challenge you were tasked to complete in your role.
- **Action/Accomplishment:** Identify the action(s) you took to meet that challenge.
- **Result:** Communicate the results of your actions. This can be measureable success – number of staff receiving promotions – or more qualitative -positive feedback from stakeholders, etc.)

4. Use your experiences to demonstrate specific skills relevant to the organization. Consider making a list of the 3-5 key skills being sought, and ensure that these skills are demonstrated through your highlighted experiences.

5. Avoid vague language. Terms like ‘various’ and ‘numerous’ dilute the impact of your communication. Wherever possible, be specific and precise about your experiences and quantify your outcomes.

6. Consider the reader of your resume, and ask yourself: what are the specific problems that I can solve for this reader? Ensure that your resume demonstrates an understanding of the organizational need.

**Example**

From: I was the Vice President of Development responsible for a team of 10
To: Managed a team of 10 highly-motivated individuals as the Vice President of Development

**Additional Resources to Consult**

- **Health Force Ontario ‘Practice U’ Physician Resources**
  
  This resource provides helpful links related to physician careers and employment, ministry programs, compensation, etc. and CV templates for physicians.

- **Canadian Medical Association Knowledge for Practice (K4P)**
  
  Knowledge for Practice (K4P) currently delivers clinical resources, including point-of-care tools, e-books and e-journals, as well as accredited online learning for CMA members.
APPENDIX 1

My Style of Nonverbal Behaviour

This quick self-test from the *The Sage Handbook of Nonverbal Communication* can be used to gain greater self awareness when engaging with other individuals. This test is included as a sample only – some hospital HR departments may have similar self-assessment tools already in place for their staff and physicians.

Ask yourself, how do others perceive my actions? And more importantly, how do I wish to be perceived? If there are gaps, based on the test below, build awareness about your actions as a first step to resolution.

The main aspects of nonverbal behaviour for each style are outlined in the following pages. Descriptions are given for each style.

1. Place a checkmark beside the description that fits your style the best.

2. For each aspect, identify how you usually behave when you are in a situation involving mild conflict (e.g., returning an undercooked meal in a restaurant, or giving your opinion when others disagree).

   ■ **Posture**

   - **Assertive**: An upright posture with the shoulders back.
   - **Passive**: The body hunched, as though you want to make yourself smaller than you really are.
   - **Aggressive**: The posture may be large and threatening or crouched as though you are a tiger ready to pounce.

   ■ **Movements and Gestures**

   - **Assertive**: Movements are usually relaxed and fluid and there is little muscle tension.
   - **Passive**: This varies from person to person. Some people gesture little, looking depressed and lethargic while others make quick but unfocused gestures such as fidgeting. Some people shrug their shoulders and make helpless gestures with their hands.
   - **Aggressive**: The body tension associated with this style is revealed by physical gestures which are rapid and sharp. This includes pointing with an index finger or a karate-like chop.
Physical Distance
- Assertive: People using the assertive style during conflict usually maintain their normal conversational distance.
- Passive: The interpersonal distance is usually greater than normal, combined with turned-away body posture. This makes passive individuals look as if they want to escape from the interaction.
- Aggressive: The interpersonal distance is often closer than usual, invading the other person’s space.

Eye Contact
- Assertive: Eye contact is frequent but broken by occasional horizontal glances away.
- Passive: Eye contact is usually avoided. The eyes tend to be cast downward. When eye contact is made, it's usually done by looking up rather than by lifting the head.
- Aggressive: Eye contact is usually direct and fixed. Considerable muscle tension is usually held around the eyes, resulting in a squinting or glaring look.

Facial Expression
- Assertive: The face generally communicates openness via direct gaze, a calm expression and little muscle tension.
- Passive: The expression is often anxious or apologetic. Considerable tension is likely to be evident. The person may be flush, smiling nervously or laughing inappropriately.
- Aggressive: The face generally holds significant muscle tension, often most noticeably in the jaw. The expression tends to be fixed and is often recognizably angry.

Physical Contact
- Assertive: The individual will generally touch the other person no more or less than is usual for them in other situations.
- Passive: Touching is usually minimal because passive people retreat into themselves.
- Aggressive: If touching is present it tends to be firm and jabbing.
**Fluency**

- **Assertive**: The flow of words is even and conversational without rushing or hesitating.
- **Passive**: There can be considerable hesitation caused by stress and a search for words that will satisfy the person.
- **Aggressive**: The pace of speech may be slower than usual (through gritted teeth) or faster with increased volume and sharp gestures. Some people become less fluent when angry in a sputtering rage.

**Physical Appearance**

- **Assertive**: The assertive person is able to adapt their clothing, hair, glasses tidiness and so on to the situation. They are conscious of the impact their appearance has on people.
- **Passive**: Appearance is designed to help the person blend with the group.
- **Aggressive**: Appearance may be used to deliberately intimidate others or to communicate power. Some rebel against expectations, choosing styles that provoke people.

1. Go over each of the categories for nonverbal behavior
2. Total the number of checkmarks you placed beside each communication style
3. Enter them below
   - ___ **Assertive**
   - ___ **Passive**
   - ___ **Aggressive**

If the majority of your checkmarks fall in the passive or aggressive categories, then your nonverbal communication style could use some attention.

If this is the case, review the categories again. Which of the categories of nonverbal behaviour (i.e., posture, vocal tone, appearance) causes you the most trouble when you are trying to be assertive?

As you practice assertive nonverbal behaviour, it may be important for you to pay particular attention to this one aspect of your style.
APPENDIX 2

Personal EQ Test

This self-test from the Hay Group can also be used to gain greater self-awareness when engaging with other individuals. This test is included as a sample only – some hospital HR departments may have similar self-assessment tools already in place for their staff and physicians.

This is a high level assessment of emotional intelligence – the ability to identify, assess, and control one’s emotions, and those of others.

1. Complete the survey by checking the box next to the statement that most accurately reflects how you would behave in the given situation.
2. Please do this test independently.
3. Compute your score using the answer key provided.

1. You are on an airplane that suddenly hits extremely bad turbulence and begins rocking from side to side. What do you do?
   [A] Continue to read your book or magazine, or watch the movie, trying to pay little attention to the turbulence.
   [B] Become vigilant for an emergency, carefully monitoring the stewardesses and reading the emergency instructions card.
   [C] A little of both a and b.
   [D] Not sure - never noticed.

2. You are in a meeting when a colleague takes credit for work that you have done. What do you do?
   [A] Immediately and publicly confront the colleague over the ownership of your work.
   [B] After the meeting, take the colleague aside and tell her that you would appreciate in the future that she credits you when speaking about your work.
   [C] Nothing, it's not a good idea to embarrass colleagues in public.
   [D] After the colleague speaks, publicly thank her for referencing your work and give the group more specific detail about what you were trying to accomplish.
3. You are a customer service representative and have just gotten an extremely angry client on the phone. What do you do?
   [A] Hang-up. It doesn't pay to take abuse from anyone.
   [B] Listen to the client and rephrase what you gather he is feeling.
   [C] Explain to the client that he is being unfair, that you are only trying to do your job, and you would appreciate it if he wouldn't get in the way of this.
   [D] Tell the client you understand how frustrating this must be for him, and offer a specific thing you can do to help him get his problem resolved.

4. You are a college student who had hoped to get an A in a course that was important for your future career aspirations. You have just found out you got a C- on the midterm. What do you do?
   [A] Sketch out a specific plan for ways to improve your grade and resolve to follow through.
   [B] Decide you do not have what it takes to make it in that career.
   [C] Tell yourself it really doesn't matter how well you do in the course, concentrate instead on other classes where your grades are higher.
   [D] Go see the professor and try to talk her into giving you a better grade.

5. You are a manager in an organization that is trying to encourage respect for racial and ethnic diversity. You overhear someone telling a racist joke. What do you do?
   [A] Ignore it - the best way to deal with these things is not to react.
   [B] Call the person into your office and explain that their behavior is inappropriate and is grounds for disciplinary action if repeated.
   [C] Speak up on the spot, saying that such jokes are inappropriate and will not be tolerated in your organization.
   [D] Suggest to the person telling the joke he go through a diversity training program.

6. You are an insurance salesman calling on prospective clients. You have left the last 15 clients empty-handed. What do you do?
   [A] Call it a day and go home early to miss rush-hour traffic.
   [B] Try something new in the next call, and keep plugging away.
[C] List your strengths and weaknesses to identify what may be undermining your ability to sell.

[D] Sharpen up your resume.

7. You are trying to calm down a colleague who has worked herself into a fury because the driver of another car has cut dangerously close in front of her. What do you do?

[A] Tell her to forget about it-she's OK now and it is no big deal.

[B] Put on one of her favorite tapes and try to distract her.

[C] Join her in criticizing the other driver.

[D] Tell her about a time something like this happened to you, and how angry you felt, until you saw the other driver was on the way to the hospital.

8. A discussion between you and your partner has escalated into a shouting match. You are both upset and in the heat of the argument, start making personal attacks which neither of you really mean. What is the best thing to do?

[A] Agree to take a 20-minute break before continuing the discussion.

[B] Go silent, regardless of what your partner says.

[C] Say you are sorry, and ask your partner to apologize too.

[D] Stop for a moment, collect your thoughts, then restate your side of the case as precisely as possible.

9. You have been given the task of managing a team that has been unable to come up with a creative solution to a work problem. What is the first thing that you do?

[A] Draw up an agenda, call a meeting and allot a specific period of time to discuss each item.

[B] Organize an off-site meeting aimed specifically at encouraging the team to get to know each other better.

[C] Begin by asking each person individually for ideas about how to solve the problem.

[D] Start out with a brainstorming session, encouraging each person to say whatever comes to mind, no matter how wild.
10. You have recently been assigned a young manager in your team, and have noticed that he appears to be unable to make the simplest of decisions without seeking advice from you. What do you do?

[A] Accept that he "does not have what it take to succeed around here" and find others in your team to take on his tasks.

[B] Get an HR manager to talk to him about where he sees his future in the organization.

[C] Purposely give him lots of complex decisions to make so that he will become more confident in the role.

[D] Engineer an ongoing series of challenging but manageable experiences for him, and make yourself available to act as his mentor.

Scorecard:

ANSWER KEY

The questionnaire you just completed is by no means an exhaustive measure of your Emotional Intelligence, both because of its length and the fact that it is self-scoring.

100 -- Maximum Score

75

50 Your Score:________

25

0 -- Minimum Score

1. The turbulent airplane:

Anything but D - that answer reflects a lack of awareness of your habitual responses under stress. Actively acknowledging your stress and finding ways to calm yourself (i.e. engage in a book or read the emergency card) are healthier responses.

[A] 10 Points - Continue to read your book or magazine, or watch the movie, trying to pay little attention to the turbulence.

[B] 10 Points - Become vigilant for an emergency, carefully monitoring the stewardesses and reading the emergency instructions card.

[C] 10 Points - A little of both A and B.

[D] 0 Points - Not sure - never noticed.
2. The credit stealing colleague:
The most emotionally intelligent answer is D. By demonstrating an awareness of work-place
dynamics, and an ability to control your emotional responses, publicly recognizing your own
accomplishments in a non-threatening manner, will disarm your colleague and puts you in a
better light with your manager and peers. Public confrontations can be ineffective, are likely to
cause your colleague to become defensive, and may look like poor sportsmanship on your part.
Although less threatening, private confrontations are also less effective in that they will not help
your personal reputation.

[A] 0 Points - Immediately and publicly confront the colleague over the ownership of your
work.

[B] 5 Points - After the meeting, take the colleague aside and tell her that you would
appreciate in the future that she credits you when speaking about your work.

[C] 0 Points - Nothing, it's not a good idea to embarrass colleagues in public.

[D] 10 Points - After the colleague speaks, publicly thank her for referencing your work
and give the group more specific detail about what you were trying to accomplish.

3. The angry client:
The most emotionally intelligent answer is D. Empathizing with the customer will help calm him
down and focusing back on a solution will ultimately help the customer attain his needs.
Confronting a customer or becoming defensive tends to anger the customer even more.

[A] 0 Points - Hang-up. It doesn't pay to take abuse from anyone.

[B] 5 Points - Listen to the client and rephrase what you gather he is feeling.

[C] 0 Points - Explain to the client that he is being unfair, that you are only trying to do
your job, and you would appreciate it if he wouldn't get in the way of this.

[D] 10 Points - Tell the client you understand how frustrating this must be for him, and
offer a specific thing you can do to help him get his problem resolved.
4. The ‘C’ Midterm:
The most emotionally intelligent answer is A. A key indicator of self motivation, also known as Achievement motivation, is your ability to form a plan for overcoming obstacles to achieve long-term goals. While focusing efforts on classes where you have a better opportunity may sometimes be productive, if the goal was to learn the content of the course to help your long-term career objectives, you are unlikely to achieve.

[A] 10 Points - Sketch out a specific plan for ways to improve your grade and resolve to follow through.
[B] 0 Points - Decide you do not have what it takes to make it in that career.
[C] 5 Points - Tell yourself it really doesn’t matter how much you do in the course, concentrate instead on other classes where your grades are higher.
[D] 0 Points - Go see the professor and try to talk her into giving you a better grade.

5. The racist joke:
The most emotionally intelligent answer is C. The most effective way to create an atmosphere that welcomes diversity is to make clear in public that the social norms of your organization do not tolerate such expressions. Confronting the behavior privately lets the individual know the behavior is unacceptable, but does not communicate it to the team. Instead of trying to change prejudices (a much harder task), keep people from acting on them.

[A] 0 Points - Ignore it - the best way to deal with these things is not to react.
[B] 5 Points - Call the person into your office and explain that their behavior is inappropriate and is grounds for disciplinary action if repeated.
[C] 10 Points - Speak up on the spot, saying that such jokes are inappropriate and will not be tolerated in your organization.
[D] 5 Points - Suggest to the person telling the joke he go through a diversity training program.

6. The setback of a salesman:
The most emotionally intelligent answer is B. Optimism and taking the initiative, both indicators of emotional intelligence, lead people to see setbacks as challenges they can learn from, and to persist, trying out new approaches rather than giving up, blaming themselves or getting demoralized. Although listing your strengths and weaknesses can be a helpful exercise, without actively plugging away motivation to sell will tend to decrease.
[A] 0 Points - Call it a day and go home early to miss rush-hour traffic.
[B] 10 Points - Try something new in the next call, and keep plugging away.
[C] 5 Points - List your strengths and weaknesses to identify what may be undermining your ability to sell.
[D] 0 Points - Sharpen up your resume.

7. The road-rage colleague:
The most emotionally intelligent answer is D. All research shows that anger and rage seriously affect one’s ability to perform effectively. Daniel Goleman, in his book WWEI, coined the phrase "amygdala hijacking" to describe the process of losing one’s temper in this kind of situation. Your ability to avoid or control this emotional reaction in yourself and others, is a key indicator of emotional intelligence. In the road rage scenario, any attempt to calm down your colleague by distracting him away from the effects of the amygdala hijack will have a positive impact on the situation and his behavior, particularly if you are able to effectively empathize with him.

[A] 0 Points - Tell her to forget about it-she's OK now and it is no big deal.
[B] 0 Points - Put on one of her favorite tapes and try to distract her.
[C] 5 Points - Join her in criticizing the other driver.
[D] 10 Points - Tell her about a time something like this happened to you, and how angry you felt, until you saw the other driver was on the way to the hospital.

8. The shouting match:
The most emotionally intelligent answer is A. In these circumstances, the most appropriate behavior is to take a 20-minute break. As the argument has intensified, so have the physiological responses in your nervous system, to the point at which it will take at least 20 minutes to clear your body of these emotions of anger and arousal. Any other course of action is likely merely to aggravate an already tense and uncontrolled situation.

[A] 10 Points - Agree to take a 20-minute break before continuing the discussion.
[B] 0 Points - Go silent, regardless of what your partner says.
[C] 0 Points - Say you are sorry, and ask your partner to apologize too.
[D] 0 Points - Stop for a moment, collect your thoughts, then restate your side of the case as precisely as possible.
9. The uninspired team:
The most emotionally intelligent answer is B. As a leader of a group of individuals charged with developing a creative solution, your success will depend on the climate that you can create in your project team. Creativity is likely to be stifled by structure and formality; instead, creative groups perform at their peaks when rapport, harmony and comfort levels are most high. In these circumstances, people are most likely to make the most positive contributions to the success of the project.

[A] 0 Points - Draw up an agenda, call a meeting and allot a specific period of time to discuss each item.
[B] 10 Points - Organize an off-site meeting aimed specifically at encouraging the team to get to know each other better.
[C] 0 Points - Begin by asking each person individually for ideas about how to solve the problem.
[D] 5 Points - Start out with a brainstorming session, encouraging each person to say whatever comes to mind, no matter how wild.

10. The indecisive young manager:
The most emotionally intelligent answer is D. Managing others requires high levels of emotional intelligence, particularly if you are going to be successful in maximizing the performance of your team. Often, this means that you need to tailor your approach to meets the specific needs of the individual, and provide them with support and feedback to help them grow in confidence and capability.

[A] 0 Points - Accept that he 'does not have what it takes to succeed around here' and find others in your team to take on his tasks.
[B] 5 Points - Get an HR manager to talk to him about where he sees his future in the organization.
[C] 0 Points - Purposely give him lots of complex decisions to make so that he will become more confident in the role.
[D] 10 Points - Engineer an ongoing series of challenging but manageable experiences for him, and make yourself available to act as his mentor.
APPENDIX 3

Leadership Styles

This reference guide from *Primal Leadership: Learning to Lead with Emotional Intelligence* can be used to identify leadership styles. It is important to note that preferred leadership styles often do not match with the optimal leadership styles. The below table provides a guide to identifying the strengths and weaknesses of each style so that leaders can adapt according to varying situations.

<table>
<thead>
<tr>
<th>Style</th>
<th>When to Use</th>
<th>EI Dimensions &amp; Competencies</th>
<th>Team Results</th>
</tr>
</thead>
</table>
| Visionary   | The visionary style does not work well in situations where a leader is working with a team that is more experienced than they are or when the vision becomes overbearing | • Self-confidence  
• Self-awareness  
• Empathy to articulate purpose  
• Transparency (the removal of barriers)  
• Honesty and information sharing | • Inspired work and clear sense of purpose among team  
• Increased team pride and belonging while working towards a common goal  
• Increased innovation as people experiment and take calculated risks  
• Retention of best talent through resonance of the firm’s values, goals and missions |
| Coaching          | Coaching works best with people who show initiative and want more professional development. If it is executed poorly, this approach looks more like micromanaging which can undermine someone's self-confidence | • Emotional self-awareness creates authenticity  
• Empathy to listen before reacting | • Creation of long-term development goals and execution plans for employees  
• Increased motivation from believing that the leader cares  
• Delegated challenging assignments provide stretch goals  
• Increased loyalty to the firm because of nourishing development experiences |
|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| Affiliative       | The affiliative style should be used in conjunction with another leadership style because the style’s focus can allow poor performance to go uncorrected since it rarely offers constructive advice | • Collaboration  
• Empathy  
• Conflict management | • Heightened team harmony and trust  
• Increased loyalty and connectedness  
• Improved communication |
| Democratic        | Not to be used in times of crisis; a leader who puts off crucial decisions in the hopes of developing a consensual decision, risks confusion and lack of direction | • Teamwork and collaboration  
• Conflict management  
• Influence  
• Good listening skills  
• Empathy | • Team ideas and feedback are considered  
• Creation of consensus |
### Commanding: Use with Caution

The commanding style holds an important place in the EI leader's repertoire when used judiciously – in times of crisis or when dealing with a problem person.

- Influence
- Achievement
- Initiative
- Self-awareness, emotional self-control and empathy are crucial to using this style to create resonance

When this style is used poorly:
- Overall team climate decreases
- Decrease in client experience and satisfaction as team attitudes decrease
- Erosion of the pride and satisfaction in work – the things that motivate high-performers
- Decreased commitment and understanding of the collective mission

### Pacesetting: Use with Caution

When leaders use the pacesetting style exclusively or poorly they lack not just vision, but also resonance.

- Initiative
- Achievement
- Empathy
- Self-awareness
- Collaboration
- Emotional self-management

When this style is used poorly:
- People feel pushed too hard without clear guidelines on how to improve performance
- Decreased morale
- Feelings of a lack of trust from the leader
- Short–term results that are not sustainable in the long-term
**APPENDIX 4**

*Advanced Degree Programs*

<table>
<thead>
<tr>
<th>Degree Program (Masters and/or PhD)</th>
<th>Description</th>
<th>Examples in Ontario</th>
</tr>
</thead>
</table>
| Health Policy & Public Health Policy | - Theory and empirical methods for investigating questions about health policy  
- Combination of health economics, politics, social studies  
- **Career paths in government, non-profits, private sector** | - McMaster University  
- University of Toronto  
- York University |
| Health Administration | - Educational and professional foundations for leadership in health care field  
- **Career paths include management of hospitals or health care organizations, provincial or federal ministries, academic health sectors, and private sector** | - McMaster University  
- Carleton University  
- York University  
- University of Ottawa |
| Business Administration (MBA or EMBA) | - Offers students an overview of business: accounting, finance, marketing, human resources, operations, management, leadership, etc.  
- Often one or two year programs with shorter ‘executive’ offerings  
- Accreditation bodies exist to ensure consistency with MBA designation globally  
- **Multitude of career paths in management roles** | - Richard Ivey School of Business at Western University  
- Rotman Business School at the University of Toronto  
- Queen’s University |
| MBA with Health Focus & Joint MD/MBA Programs | - Often a jointly offered program between Faculty of Medicine and Faculty of Business  
- Joint MD/MBA programs train clinicians for a diverse career from academic medical research to design, management, and evaluation of healthcare delivery systems  
- **Career path examples include** | - Rotman Business School at the University of Toronto (MBA in Health Sector Management)  
- Richard Ivey School of Business at Western University (MBA Health Sector stream)  
- York University Health |
<table>
<thead>
<tr>
<th>Management Positions</th>
<th>Industry Management MBA</th>
</tr>
</thead>
<tbody>
<tr>
<td>management positions in hospitals, government, medical devices, pharma, insurance, and financial institutions</td>
<td>- Richard Ivey School of Business at Western University (MSc in Management)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Masters in Management (MSc)</th>
<th>Multitude of career paths in management roles</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Offering an alternative to the MBA; applies research and theory to methods to existing and emerging business practices</td>
<td>- University of Toronto (Dalla Lana School of Public Health)</td>
</tr>
<tr>
<td>- Multitude of career paths in management roles</td>
<td>- Brock University</td>
</tr>
<tr>
<td>- University of Waterloo</td>
<td>- York University</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Promotion</th>
<th>Career path examples include government, quasi-government and community health agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Social science perspective in addressing issues related to health of individuals, communities, and population</td>
<td>- York University</td>
</tr>
<tr>
<td>- Career path examples include government, quasi-government and community health agencies</td>
<td>- University of Waterloo</td>
</tr>
<tr>
<td>- University of Waterloo</td>
<td>- York University</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Informatics</th>
<th>Career path examples include health sector planning and development</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Specialized knowledge in the acquisition and application of research, analysis, and system design; the use of electronic information as a tool for modern healthcare administration</td>
<td>- York University</td>
</tr>
<tr>
<td>- Career path examples include health sector planning and development</td>
<td>- University of Waterloo</td>
</tr>
<tr>
<td>- McMaster University (Masters in eHealth)</td>
<td>- York University</td>
</tr>
<tr>
<td>- University of Toronto</td>
<td>- York University</td>
</tr>
</tbody>
</table>
The following list of action verbs is adapted from the Boston College Career Centre.

<table>
<thead>
<tr>
<th>Management skills</th>
<th>Communication skills</th>
<th>Clerical or detailed skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>administered</td>
<td>addressed</td>
<td>approved</td>
</tr>
<tr>
<td>analyzed</td>
<td>arbitrated</td>
<td>arranged</td>
</tr>
<tr>
<td>assigned</td>
<td>arranged</td>
<td>classified</td>
</tr>
<tr>
<td>attained</td>
<td>corresponded</td>
<td>collected</td>
</tr>
<tr>
<td>chaired</td>
<td>developed</td>
<td>compiled</td>
</tr>
<tr>
<td>contracted</td>
<td>direct</td>
<td>dispatched</td>
</tr>
<tr>
<td>consolidated</td>
<td>drafted</td>
<td>executed</td>
</tr>
<tr>
<td>coordinated</td>
<td>edited</td>
<td>generated</td>
</tr>
<tr>
<td>delegated</td>
<td>formulated</td>
<td>implemented</td>
</tr>
<tr>
<td>developed</td>
<td>influenced</td>
<td>inspected</td>
</tr>
<tr>
<td>directed</td>
<td>interpreted</td>
<td>monitored</td>
</tr>
<tr>
<td>evaluated</td>
<td>lectured</td>
<td>operated</td>
</tr>
<tr>
<td>improved</td>
<td>moderated</td>
<td>organized</td>
</tr>
<tr>
<td>increased</td>
<td>motivated</td>
<td>prepared</td>
</tr>
<tr>
<td>organized</td>
<td>negotiated</td>
<td>processed</td>
</tr>
<tr>
<td>oversaw</td>
<td>promoted</td>
<td>purchased</td>
</tr>
<tr>
<td>planned</td>
<td>persuaded</td>
<td>recorded</td>
</tr>
<tr>
<td>prioritized</td>
<td>publicized</td>
<td>retrieved</td>
</tr>
<tr>
<td>produced</td>
<td>reconciled</td>
<td>screened</td>
</tr>
<tr>
<td>recommended</td>
<td>recruited</td>
<td>specified</td>
</tr>
<tr>
<td>reviewed</td>
<td>spoke</td>
<td>systematized</td>
</tr>
<tr>
<td>scheduled</td>
<td>translated</td>
<td>tabulated</td>
</tr>
<tr>
<td>strengthened</td>
<td>wrote</td>
<td>validated</td>
</tr>
<tr>
<td>supervised</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Research skills</th>
<th>Technical skills</th>
<th>Teaching skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>clarified</td>
<td>assembled</td>
<td>adapted</td>
</tr>
<tr>
<td>collected</td>
<td>built</td>
<td>advised</td>
</tr>
<tr>
<td>critiqued</td>
<td>calculated</td>
<td>clarified</td>
</tr>
<tr>
<td>diagnosed</td>
<td>computed</td>
<td>coached</td>
</tr>
<tr>
<td>evaluated</td>
<td>designed</td>
<td>communicated</td>
</tr>
<tr>
<td>examined</td>
<td>devised</td>
<td>coordinated</td>
</tr>
<tr>
<td>interpreted</td>
<td>engineered</td>
<td>developed</td>
</tr>
<tr>
<td>interviewed</td>
<td>fabricated</td>
<td>established</td>
</tr>
<tr>
<td>investigated</td>
<td>maintained</td>
<td>fashion</td>
</tr>
<tr>
<td>organized</td>
<td>operated</td>
<td>founded</td>
</tr>
<tr>
<td>reviewed</td>
<td>overhauled</td>
<td>illustrated</td>
</tr>
<tr>
<td>summarized</td>
<td>repaired</td>
<td>integrated</td>
</tr>
<tr>
<td>systematized</td>
<td>solved</td>
<td>introduced</td>
</tr>
<tr>
<td>reviewed</td>
<td>trained</td>
<td>originated</td>
</tr>
<tr>
<td>systematized</td>
<td>upgraded</td>
<td>performed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>revitalized</td>
</tr>
<tr>
<td></td>
<td></td>
<td>shaped</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Financial skills</th>
<th>Creative skills</th>
<th>Helping skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>administered</td>
<td>acted</td>
<td>assessed</td>
</tr>
<tr>
<td>allocated</td>
<td>conceptualized</td>
<td>assisted</td>
</tr>
<tr>
<td>analyzed</td>
<td>designed</td>
<td>clarified</td>
</tr>
<tr>
<td>appraised</td>
<td>developed</td>
<td>coached</td>
</tr>
<tr>
<td>audited</td>
<td>direct</td>
<td>counseled</td>
</tr>
<tr>
<td>balanced</td>
<td>established</td>
<td>demonstrated</td>
</tr>
<tr>
<td>budgeted</td>
<td>fashioned</td>
<td>diagnosed</td>
</tr>
<tr>
<td>calculated</td>
<td>founded</td>
<td>educated</td>
</tr>
<tr>
<td>computed</td>
<td>illustrated</td>
<td>expedited</td>
</tr>
<tr>
<td>developed</td>
<td>integrated</td>
<td>facilitated</td>
</tr>
<tr>
<td>forecasted</td>
<td>introduced</td>
<td>guided</td>
</tr>
<tr>
<td>managed</td>
<td>invented</td>
<td>referred</td>
</tr>
<tr>
<td>marketed</td>
<td>originated</td>
<td>rehabilitated</td>
</tr>
<tr>
<td>planned</td>
<td>originated</td>
<td>represented</td>
</tr>
<tr>
<td>projected</td>
<td>performed</td>
<td></td>
</tr>
<tr>
<td>researched</td>
<td>planned</td>
<td></td>
</tr>
<tr>
<td></td>
<td>revitalized</td>
<td></td>
</tr>
<tr>
<td></td>
<td>shaped</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


OVERVIEW

Teamwork and interprofessional collaboration are of high importance to effective healthcare delivery resulting in better patient care, patient safety, and even provider and staff satisfaction. Physicians taking on leadership roles may have varying levels of comfort working in teams based on their past experience, practice areas, and personality types. The following section will identify some of the key challenges related to leading interprofessional teams, and provide a brief overview on ways to effectively overcome these challenges.

The Physician Leader’s Roles and Responsibilities

Effective leaders understand the broader scope of leadership -- to manage oneself, plan for a desired future state, and tap into resources that can help attain that future state. The responsibilities of the physician leader are high. When in positions of leadership, physicians are responsible for working effectively with others, motivating individuals from different backgrounds and viewpoints, and using the various levers available to them to promote high performance within their team. Some physicians may also have administrative responsibilities related to HR planning, recruiting, onboarding, managing transitions, and other aspects of physician resource management.

The content herein provides physicians with the tools and insight to fulfill these demanding responsibilities. Physicians are also encouraged to consult their HR department for policies, procedures, guidelines, and existing documents (e.g., forms, checklists) pertaining to any of the topics discussed in this module.
LEADING HIGH PERFORMANCE INTERPROFESSIONAL TEAMS

For a physician to bring about positive change, they need to do more than motivate other physicians. They need to galvanize the many professions that work together within a hospital. Successful interprofessional teams have a number of characteristics:

- A common vision: A desired end-state to which all members feel they have contributed to.
- An understanding of competencies: An appreciation of the skills and viewpoints that different participants and professions can bring.
- Clear roles: The distinct and interdependent responsibilities that different individuals have in attaining the vision.
- A medium for knowledge sharing: A process and system for individuals to share ideas and understand how the vision is progressing.
- Stakeholder validation and consultation: Internal and external involvement to ensure different viewpoints are considered in the proposed solution.

These characteristics are common to many functioning teams, but they can be especially challenging to instill in an interprofessional environment. One may assume that viewpoints are much more divergent than they are in reality. Listening is critical to bridging gaps, and helps to separate perceptions from reality with respect to the cohesion of viewpoints among team members.

Key Sources

**Supporting New Leaders in Developing Collaborative Teams: A Toolkit**
This resource guide and toolkit supports new leaders in healthcare organizations to build and maintain effective teams. Topics covered include communication styles, active listening skills, conflict, gender/culture and communications, and conducting effective meetings.

**Negotiation Skills for Physicians**
This guide from the American Journal of Surgery helps physicians become better negotiators, offering multiple tools and models to consider.

**Guidebook for Managing Disruptive Physician Behaviour**
This guidebook from the College of Physicians and Surgeons of Ontario and the Ontario Hospital Association offers tools for physicians working in educational and healthcare delivery settings to help them identify, define, and manage disruptive professional behavior and its effects.

**Implementing Interprofessional Care in Ontario**
Healthforce Ontario developed this effective framework for implementing interprofessional care, such as building the foundation, sharing the responsibility, implementing systemic enablers, and leading sustainable change.
Key Success Factors for Leading Effective Teams

1. Effective communications: team leaders must effectively manage open communication, including individual interactions, team communication and group facilitation, and upward communication between team members and leaders.

2. Working within an interprofessional team: what motivates a physician on a team may be quite different than what motivates a lab technician on a team. It is important to recognize such differences and identify a way to motivate all team members.

3. Negotiation and conflict resolution/difficult conversations: Disagreement is not necessarily negative, but it can be destructive when individuals are hurt by personal attacks. For disagreement to be healthy, a safe and constructive environment needs to be established. Participating in such an environment can be challenging for individuals who are prone to negative behaviour. The role of the leader is to help individuals understand points of tension, rise above individual negative labelling, and identify ways to reach constructive conclusions.

Enhancing Physician Engagement in Hospital Priorities

Engaging physicians in strategic decision-making, clinical service planning, development and prioritization of new initiatives, and other leadership tasks requires strong leadership. The first step is to ensure that physicians understand the rationale for engagement, and the benefits of being engaged. It is important for physician leaders to clearly communicate this rationale to their teams; for example:

1. They can advocate for issues that are important to them.

2. If physicians become involved in decision-making, they can contribute to the solution with respect to the issues they are facing.

3. Engagement will ensure that the physician perspective is considered in strategic decisions and in the implementation of decisions.
In the 2011 OHA publication *Hospitals Voice Their Opinions: Core Recommendations for the 2012 Physician Services Agreement*, four key recommendations were outlined which aimed to increase physician engagement with hospital management. This document highlights two key principles can enhance physician engagement in hospital administration (adapted from report):

1. Hospital leaders can involve physicians in the development of new initiatives, rather than solely during implementation, by appointing them to leadership roles and providing incentives for involvement (e.g., quality improvement (QI) initiatives).

2. Hospital leaders and the Ministry of Health and Long-Term Care (MOHLTC) can support physicians in these roles by providing relevant training to support the initiatives (e.g., QI methodologies and leadership skills).

Additional Resources Regarding Enhancement of Physician Engagement in Hospitals

- [OHA Quality and Patient Safety Governance Toolkit](#)
- [Institute for Healthcare Improvement; Physician Engagement in Quality and Safety](#)
- [Institute for Healthcare Improvement White Paper: Engaging Physicians in a Shared Quality Agenda](#)
- [OHA Webinar on Physician Engagement in the Hospital Setting](#)
- [OHA Advisory Board Human Resources Investment Centre](#)
EFFECTIVE COMMUNICATION

Many physicians communicate frequently in their roles by working with a wide range of patients to explain complicated information, and demonstrate empathy while delivering difficult messages. As physicians become leaders in hospital settings, communication often takes on a new and different purpose: not only to solicit and deliver patient information, but also to foster collaboration and solicit input for decision-making in order to address broader organizational issues. In section 3.2, an exercise was provided to help determine personal communication and leadership styles. In this section, the focus is on the specific skills that help leaders of all styles communicate effectively within their organizations.

LEADERSHIP QUOTE

“Leadership and learning are indispensable to each other.”

John F. Kennedy

1. Utilizing active listening skills

Active Listening is a communication technique through which the listener feeds back what he or she hears from the speaker (often in the form of a clarifying question or re-statement/summary). This technique is effective for validating the thoughts and feelings of the speaker.

There are many benefits to active listening. It motivates the sender, who feels that their opinion is validated. It also ensures the listener is listening to more than words, but also understands what the speaker’s body language and tone are conveying, both vital aspects of face-to-face communication (Shouse, 2008). Some of the basic skills for active listening include: asking open-ended questions, providing encouraging statements, asking clarifying questions, summarizing, reflecting the speaker’s feelings (also called echoing or mirroring), using silence, validating the speaker’s thoughts, and asking focused questions (Ivey & Ivey, 2008).

2. Recognizing the impact of gender, generation, and culture on communication

Significant research has focused on how gender, generation, and culture affect the way people communicate. While stereotyping itself can be a barrier to effective communication, it is important to recognize the predispositions individuals may bring to communication. For example, women may be more comfortable building consensus and communicating openly, whereas men may be more comfortable communicating decisions directly. Communication patterns vary by individual, and such patterns can be influenced by both gender and culture.
Generational communication styles have recently garnered significant attention, as this is the first time in history that four generations with unique characteristics are interacting in the workplace (Sherman, 2006). Generational differences can present unique challenges to communication. For example, older generations (born pre-1964) tend to value respect for authority and discipline more highly than younger generations (born in the 1980s and afterwards). While older generations tend to communicate more formally and in person, younger generations tend to be more direct, immediate, and are very comfortable with digital methods of communication. Learning how to communicate with different generations and accommodating multiple styles can eliminate many major confrontations and misunderstandings in organizations.

The following articles provide interesting viewpoints on the challenges of managing multiple generations:

- How to Manage Different Generations (The Wall Street Journal)
- Gen Y v. Boomers: Generational Differences in Communication (FastCompany)
- The Differences between Generations (Society, The Individual, and Medicine)
SOCIAL MEDIA IN HOSPITAL SETTINGS

According to a National Research Corporation survey of 23,000 people in the United States, 41% use social media tools, including Facebook and YouTube, to research their healthcare decisions (The Advisory Board Company, 2012). When used effectively, social media can be an excellent tool for communication, marketing, and sharing information. However, disorganized social media approaches represent a significant risk to an organization’s credibility and reputation. An effective social media plan:

- Outlines the organization’s level of social media engagement, its audience, and the employees responsible for managing social media platforms
- Requires appropriate consents and authorizations, as well as compliance with provincial and federal privacy regulations
- Has flexible policies to accommodate the ever-changing landscape of social media tools

The Change Foundation recently released a social media toolkit for healthcare organizations entitled, Using Social Media to Improve Healthcare Quality: A Guide to Current Practices and Future Promise. The report discusses the link between QI and social media, and identifies the emerging issues and leading practices, including privacy and ethical implications.

The following articles and reports also highlight information and best practices for hospitals engaging in social media platforms, including some world-class examples:

- Social Media Savvy: How Hospitals Use Facebook, Twitter (The Advisory Board Company)
- 20 Hospitals with Inspiring Social Media Strategies (PR Daily)
- Just How Clear is Your Social Media Policy? (Fierce Healthcare)
- Health Canada Social Media Tools

Many Human Resources departments have created social media policies for staff to comply with. Please consult with your organization’s HR department to determine appropriate use and application of social media.
PRESENTATIONS AND PUBLIC SPEAKING

Effective presentations have three important elements: preparation, structuring, and delivery. The following section provides an overview of tips and tricks for each of these three elements.

Preparing Your Presentation

Before beginning to structure the content of a presentation, there are two important considerations to make: outlining the objective and analyzing the audience.

To outline the objective, consider what value the presentation will bring to both the presenter (i.e., what is the main message?), and to the audience (i.e., what is their objective for attending the presentation?). It is important to consider the objective in the greater context of the project or organization.

The following questions can help analyze the audience:

- What do they already know?
- What are their primary concerns? (different from objectives)
- How much do they already know? What views do they already have on these issues?
- What are their expectations?
- How are they likely to receive this information?

Structuring the Content

Once the objective and audience have been considered, the next step is to structure the content. First a presentation ‘type’ should be determined; is this purely an informative presentation with details and facts? Or is a recommendation being made? Should time for discussion be worked in? Once these decisions are made, a complete and compelling story can be created that presents all the important information in a logical manner. Appropriate media should be used for the presentation (e.g., videos, PowerPoint presentation, etc.) to help maintain the audience’s interest.

Delivering the Presentation

The presentation should be well prepared. The speaker should practice running through the presentation and anticipate questions from the audience. Often, the best presentations are told like stories – this not only helps keep the attention of the audience, but also helps maintain a logical and effective structure. Practicing the opening segment is vital, because a strong opening is important for setting the presentation on the right track. During the presentation, it is
important to focus on the audience by talking to individual listeners, watching them reciprocate through body language, and avoid relying too much on the slides or visual materials. Use your physical presence to portray your leadership message and to show that you are committed and engaged.

Additional Tips and Tricks for Effective Presentations

• Get to the point fast, and then be open to discussion.
• Use deep breathing to relax.
• Avoid filling silences by talking; brief silences can be very effective.
• Use visuals as a reference and support only.
• If using PowerPoint, try to include only one message per slide, otherwise the audience may be overwhelmed with information and lose interest.
• Ensure you are the focal point: stand up to present, sit at the head of the table, use the white board.
• Follow up: send an email to the audience, provide copies of slides or links to relevant content

A useful reference for effective presentations is the novel *Presentation Zen*, written by Garr Reynolds, and the accompanying blog.

Conducting Effective Meetings

Conducting effective meetings are important for developing the team, and managing productivity. However, meetings often miss the mark, especially when there is poor preparation or lack of leadership. In 1999, a survey of USA physician leaders identified managing meetings as one of three important skills for emerging leaders in healthcare (Williams, 2001). The following list discusses tools and insight for conducting better, more productive and collaborative meetings.

1. Preparing for the Meeting

It is important to organize meeting details in advance so that participants can confirm attendance and prepare – this includes deciding on participants, meeting location, date, time, dial-in information, homework, and materials to bring along. As a leader, it is important to
respect the time and schedules of meeting participants. In addition, distributing a meeting agenda prior to the event is always helpful for preparing participants for discussion topics, and other meeting activities (e.g., brainstorming sessions, small group work, etc.) Participants should have some guidance to help them develop their thoughts and ideas prior to the meeting. In addition, an agenda provides structure to so that time is used most effectively.

2. **Beginning the Meeting**

When beginning a meeting, it is always helpful to start off by asking participants for an initial contribution. This can be in the form of initial thoughts regarding the topic of discussion, or comments and concerns on other issues. This not only establishes a platform for collaboration later on in the meeting, but also helps create a comfortable environment for individuals who may not be prone to sharing or contributing. At the outset, it is helpful to review ground rules for the meeting to foster an atmosphere of mutual respect. This includes attendance, promptness, participation, interruptions, accountability and responsibility (Pigeon & Khan, 2010). Other important roles to consider are note-taker, meeting facilitator, and time keeper. These tasks help with the meeting’s effectiveness. Furthermore, the attention to these roles sets a positive precedent in and outside of the meeting setting.

3. **Conducting the Meeting**

During the meeting, it is important to cover all of the agenda items. The meeting facilitator should encourage participation, remain on time, and take discussions offline, if necessary. Also, participants responsible for actions as a result of resolutions should be clear with timelines and expectations. Meeting minutes should be distributed after the meeting to ensure clarity.

4. **Adjourning the Meeting**

End the meeting as it began – with feedback from participants. There are some important questions to ask, such as: what is still on their mind? Are there any unresolved issues? Did they find the meeting productive? This will not only strengthen the role of the leader, but will also help gauge the meeting’s success, and if any additional action needs to be taken or any additional issue addressed.

Conducting meetings within the healthcare environment, such as hospitals, is not much different from conducting meetings in other professional settings. Establishing mutual objectives, fostering an open and collaborative environment, and being respectful of participants’ time are all key pillars which form the foundation of a successful meeting. Furthermore, effective meetings – whether in the form of a quick huddle in the hallway or a more formal session, are the primary catalyst to developing a strong, high-performing team.
Additional Resources to Consult:

*Running Effective Meetings: A Primer for Doctors*
This article appears in the Postgraduate Medical Journal, and discusses topics such as types of meetings, how to conduct meetings, and leadership styles.

*Leadership Lesson: Tools for Effective Meetings*
This article, found on the Association of American Medical Colleges website, includes topics such as how to conduct meetings and common challenges.

*Team Development- Section 6: Effective Meetings*
This section within Saskatchewan Health Quality Council’s Quality Improvement Guide describes how to conduct meetings and examples of how to foster an environment that is conducive to participation.
FEEDBACK AND COACHING

Giving constructive feedback to help team members develop and progress in their careers is an essential leadership skill. The Supporting New Leaders in Developing Collaborative Teams toolkit from the Association of Ontario Health Centres, describes seven characteristics of constructive feedback can help physician leaders develop this skill:

1. **Helpful feedback is descriptive, not judgmental.**
   Rather than using evaluative statements like “you don’t listen”, describe the behaviour and the effect it had: “When you and I discuss this issue I am left with the feeling that my views haven’t been heard”.

2. **Helpful feedback is specific, not general.**
   Provide the person with information that is specific enough for them to determine how they might change their behaviour to create a different outcome.

3. **Helpful feedback is relevant to the needs of the receiver.**
   Sometimes feedback does more for the giver than the receiver. Be aware of the needs of the person you are providing feedback to.

4. **Helpful feedback is solicited rather than imposed.**
   People tend to be much less receptive to feedback which they feel is imposed rather than sought out. If feedback must be imposed, it is important to ask the question: “Can I give you some feedback? Is now a good time?” This will ensure the receiver is in the right frame of mind to receive it.

5. **Helpful feedback is timely and in context.**
   If there is an important piece of feedback to provide, schedule a meeting to emphasize its importance and to ensure sufficient preparation.

6. **Helpful feedback is useful and targets behaviour over which the receiver is able to exercise control.**

   Feedback can be viewed across two dimensions:
If the majority of feedback is in quadrant 4 (high desire/high ability), then the feedback exchange is working well. As more feedback falls into the other quadrants, the physician leader may need to re-evaluate the approach. Feedback that cannot be implemented is highly demotivating. Feedback where the receiver has a low desire to implement necessary actions, usually indicates a poor working relationship – either the sender is providing poor feedback or the receiver is unwilling to change.

7. **Feedback can only be helpful when it has been heard and understood.**

Because feedback conversations often put the sender and receiver in uncomfortable positions, some rush through meetings without ensuring a common understanding is reached.

**Effective Coaching: Turning Feedback into Action**

The purpose of feedback and coaching is to help the recipient take personal accountability for his/her own development. Leaders can help individuals turn feedback into action by focusing on three important considerations:

1. **Acceptance**: people will only change if they believe the feedback they are given is valid.
2. **Prioritization**: feedback is best implemented when it is prioritized on a few key areas for short-term development.
3. **Action**: people are more likely to change behaviour when personal accountability plans are created.
Section 3.2 of the toolkit contains recommendations for developing personal accountability plans regarding feedback. As noted there, the steps for turning feedback into action are to:

- Create a personal action plan based on key strengths and development areas.
- Align resources to support personal development (human and organizational).
- Communicate the action plan to peers, managers, and/or team members.
- Remain accountable to the plan by setting measurable goals and scheduling regular progress report meetings.

Section 4.2 also provides an overview of performance management, including tips for reviewing performance and setting objectives.
EFFECTIVE COMMUNICATION FOR AVOIDING CONFLICT

Managing difficult conversations and negotiations are inevitable in the course of a physician’s responsibilities. If managed poorly, they can escalate to a level of conflict that is unhealthy for both the individuals and the organization. For example, avoiding such activities completely, or dealing with them in a passive-aggressive manner, rarely brings resolution to an issue, and generally compounds problems. There are a number of tools that physicians can use to ensure that these necessary conversations are positive for those involved.

1. Effective negotiation tactics

The term “negotiation”, may bring to mind the back-and-forth, zero-sum exchange between two individuals. This viewpoint intimidates some and orients others towards a combative approach, neither of which is constructive. The basic assumption that both sides are competing for some scarce resource derails many negotiations and leads to entrenched positions. There are a number of steps that one can use to ensure negotiations lead to the best possible outcomes (Anastakis, 2003):

- Understand goals and objectives: seek to understand the desired outcomes of all parties.
- Prepare: Do a basic needs assessment, what is needed versus what is wanted. Often, people fall in the trap of believing that wants are needs.
- Determine best alternatives to a negotiated offer (BATNA): While it is best to avoid taking firm positions early on, it is important to know where both parties stand. Who needs...
something more than the other? This also helps determine how far one should move from their starting point.

- **Determine the initial request and the “walk-away” point**: Lay out the ideal outcome, while still being reasonable. This is the initial request. Then determine the point at which the objective could absolutely not be achieved. This is the “walk-away” point – avoid going beyond this.

- **Listen**: The principles of negotiating are very similar to that of effective communications, requiring active listening and a functioning relationship. It is likely that there are other considerations that one’s counterpart will bring about that will not have been anticipated. It is important to hear these issues and adjust accordingly.

- **Negotiate the issues, not the positions**: Stay focused on the issue and the mutually desired outcomes. When a negotiation devolves to a bartering, transactional exchange of positions, the ability to further progress is impeded.

- **Find the zone of agreement**: Focus on where there is agreement and be willing to compromise to reach a conclusion.

### 2. Difficult conversations

Physicians have a great deal of experience with difficult conversations, given the many issues they deal with in the area of patient care. Difficult conversations with colleagues, staff or other healthcare professionals can be more difficult for physicians primarily because they are acting outside of their area of clinical expertise. The principles of difficult conversations are consistent across contexts ([Shouse, 2008](#)). There are a number of key steps for facilitating these conversations:

- Book a meeting to emphasize the importance of the issue and ensure those involved are not driven by “the heat of the moment”.
- Avoid personal issues and focus on behaviours than can be modified.
- Focus on facts and be specific.
- Use descriptive language and avoid a judgmental tone.
- Say what you like that the other individual is doing.
- Bridge to the feedback with the word “and,” not “but”.
- Follow through with questions.
- Forge a collaborative solution.
DEVELOPING AND WORKING WITH CODES OF CONDUCT

Codes of Conduct (often referred to as policies or standards) define expectations for behaviour in the course of the day-to-day life in an organization. Such codes are becoming more and more common in hospital and healthcare group settings, but it should be noted that they are not intended to replace or substitute legal or ethical practice guidelines. Note that these professional Codes of Conduct apply to all members of an organization, not just to physicians. Physicians can check with their HR department regarding their hospital's Code of Conduct. The exact topics covered will vary from hospital to hospital, but some common themes include:

- Respect for opinions, contributions, and individuals
- Protecting privileged information
- The manner in which individuals interact with patients
- Engaging in honest, constructive communication
- Behaviours considered unacceptable
- Management and individual accountabilities

Some sample Codes of Conduct for Ontario hospitals can be viewed through these links:

- Mount Sinai Hospital
- London Health Sciences Centre
- Brockville General Hospital
Physician leaders in hospitals may be responsible for creating or modifying Codes of Conduct for a few different reasons, for example:

- A new facility, group, or team is formed
- An issue occurs that cannot be resolved using the current code
- Structural change to the organization

Most people in an organization do not willfully want to violate policies, standards, and codes of conduct. Often, when issues arise, they are a result of a lack of information or understanding rather than intentional misconduct.

The following steps, adapted from the CPSO/ OHA Guidebook for Managing Disruptive Physician Behaviour, offer recommendations to physician leaders, to help them effectively enable all staff to operate within the Codes of Conduct at their hospitals:

1. When developing or updating the Codes of Conduct, build durable consensus from your organization by ensuring there are opportunities for discussion, input, and agreement. Individuals who feel personal buy-in to guidelines or policies are more likely to adhere to them.

2. Ensure leaders promote the process throughout the organization by communicating the level of accountability expected of managers and team leaders to ensure compliance with the code, and for leading by example by demonstrating the actions they want performed.

3. Encourage individuals to ‘speak up’ about issues, questions, or concerns. Fear of retaliation often acts as a barrier to ‘speaking up’. Ensure team members have a venue to raise issues or concerns in a safe and/or anonymous way, and enforce the code consistently regardless of seniority or clinical discipline.
MANAGING DISRUPTIVE BEHAVIOR

The CPSO/ OHA Guidebook for Managing Disruptive Physician Behaviour states that disruptive behavior is, “...demonstrated when inappropriate conduct, whether in words or action, interferes with, or has the potential to interfere with, quality healthcare delivery.”

It may be a single event or an ongoing pattern of negative behaviour. Such behaviour can have a negative impact on individual psychological well-being, a team’s motivation or a patient’s outcome. It is important to confront such behaviour quickly and professionally.

Recognizing disruptive behaviour

Disruptive behaviour is not always easy to identify. It may occur outside of the view of the physician leader, as with egregious, one-time events. Alternatively, it may occur frequently and openly, but due to a fear of confronting the behaviour, the behaviour becomes viewed as acceptable. It requires courage to recognize disruptive behaviour and willingness to go through with the steps to address it. If unsure as to whether or not an act constitutes disruptive behaviour, please refer to CPSO source above for additional information. Many hospitals use the CPSO Guidebook as a reference on disruptive behaviour. However, to the extent that disruptive behaviour rises to the level of workplace harassment, hospitals and physician leaders must comply with legislative requirements specified in the Occupational Health and Safety Amendment Act.

Addressing disruptive behaviour

Generally, the principles for addressing disruptive behaviour are similar to those for providing feedback, though more involvement may be needed due to the potentially higher consequences associated with disruptive behaviour. Whereas in the communication of feedback, it is important to be descriptive and fact-based, when addressing disruptive behaviour, one must document and corroborate evidence of the behaviour in question. Additionally, when communicating expectations regarding necessary behaviour change, the resulting actions need to be immediate, rather than gradual.

A staged, escalatory approach is the most appropriate way to address the behaviour of the individual. The CPSO delineates three stages of response:

1. First incident (relatively mild): The physician leader should confirm facts to ensure such behaviour constitutes disruptive behaviour. The physician leader should meet with the individual directly and obtain a commitment to change behaviour. Such behaviour and the process to address it should be recorded and filed. The physician leader should then follow-up to ensure the behaviour is no longer occurring.
2. Continued behaviour: The same steps as above should be taken with some additional action. The physician leader should seek to understand the cause and obtain commitment to change in written contract form.

3. Risk of harm to patients or staff: Formal authorities should be notified. It will become necessary to complete an assessment of cause and the physician leader may have an obligation to notify the CPSO. The physician leader may then look to the suspension/revocation of privileges process, if necessary.

Disruptive behaviour needs to be taken seriously. An effective leader confronts an individual’s behaviour directly and promptly, however uncomfortable the discussion can be.

Again, in cases where disruptive behavior rises to the level of violence or harassment, hospitals and physician leaders are encouraged to ensure compliance with legislative requirements specified in the *Occupational Health and Safety Amendment Act*. In response to the tragic workplace murder of Lori Dupont in an Ontario hospital, *Bill 168* was introduced in 2009 to amend the *Occupational Health and Safety Act* and came into force on June 15, 2010.

“Workplace violence” is defined as:
- “The exercise of physical force by a person against a worker in a workplace that causes or could cause physical injury to a worker”
- “An attempt to exercise physical force against a worker in a workplace that could cause physical injury to a worker”
- “A statement or behaviour that is reasonable for a worker to interpret as a threat to exercise physical force against the worker, in a workplace, that could cause physical injury to the worker.”

“Workplace harassment” is defined as:
- “A course of vexatious comment or conduct against a worker in a workplace that is known or ought reasonably to be known to be unwelcome”

The employer must take action when aware of domestic violence that may expose workers to violence in the workplace. The legislation also requires employers to develop:
- Violence* and harassment policies and programs
- Employee reporting and incident investigation procedures
- Emergency response procedure (violence only)
- Process to deal with incidents, complaints and threats of violence
Under Bill 168, obligations fall on employers and supervisors to report and respond to any incidents of workplace violence or harassment. Some of these obligations could apply to physician leaders, especially those who have a supervisory role.

For additional information on reporting responsibilities and procedures under Bill 168, please refer to the OHA Health and Safety Bulletin on Occupational Health and Safety and Violence in the Workplace.
PROFESSIONALISM

Professionalism is at the core of medical practice and at the basis of medicine's contract with society. Physicians and physician leaders are expected to demonstrate their commitment to patients, society, and the profession through ethical practice.

Each year, the Canadian Medical Protective Association (CMPA) assists its members with medico-legal advice and information related to professional behaviour. The CMPA Good Practices Guide, which highlights ways of thinking and acting that the CMPA believes will help future and practising physicians provide safer care and reduce medico-legal risk. This new online learning resource is based on interactive exercises, quizzes, and case examples to illustrate lessons learned. The web-based guide is organized around the six domains of the Canadian Patient Safety Institute/Royal College of Physicians and Surgeons of Canada Patient Safety Competencies framework, and includes an additional domain on professionalism. New physicians and physician leaders can benefit from the insights in the Professionalism domain, which includes the following topics:

- Professionalism in practice
- Being honest
- Being respectful
- Behaviour
- Respecting boundaries
- Supporting colleagues

For more information, please visit the Professionalism domain of the CMPA Good Practices Guide.
Additional Resources to Consult

*The Practice Guide: Medical Professionalism and College Policies*

The Practice Guide articulates the profession’s values and the principles of medical practice; provides assistance to the profession in determining its specific duties and the reasons for those duties; and organizes the existing policies of the College within a principled framework and provides a basis for new policy development.

*What Makes a Successful Interprofessional Care Team*

This study provides an environmental scan of which interprofessional (IP) models are being used across the North West Local Health Integration Network. The outcome identifies themes and determinants associated with successful, collaborative, patient-centred practice.

*Physician Leadership: Essential Skills in a Changing Environment*

This guide helps healthcare executives identify physicians best suited to serve as leaders within the larger healthcare system and to deliberately nurture their growth in these administrative competencies.

*Basic Mediation Training*

This training guide was developed by professors at MIT for trainer(s) leading a Basic Training in Mediation for participants with no prior mediation experience.

*Crucial Conversations Series: Tools for talking when stakes are high; and Tools for resolving broke promises, violated expectations, and bad behaviour*

This resource provide a set of tools for dealing with the most important and difficult conversations with the aim of achieving positive outcomes. The OHA offers crucial conversation workshops for physician leaders and healthcare professionals. Refer to the OHA’s Conference Calendar for upcoming workshops and registration information.

*American College of Physician Executives*

The American College of Physician Executives offers a broad array of CME courses to help physicians become leaders in healthcare organizations.

*VitalSkills*

VitalSkills offers training in interpersonal skills, particularly communication skills, to improve individual and organization effectiveness. Relevant topics include: crucial conversations, solving individual behavioral challenges, and leading organizational change). The OHA partners with VitalSkills to offer four different one-day workshops to individuals working in hospitals and other health care organizations who are looking to significantly change how they work and live.
OVERVIEW

High performance is defined against a set of goals and objectives. Helping the team reach those goals is the responsibility of the leader. The purpose of this section is to provide physician leaders with an overview of common performance management models and tools, with a focus on setting objectives, structuring incentives, building skills, and reviewing and managing performance.

Key Sources

This article from Health Care Management outlines the benefits and challenges of performance, and offers recommendations for successfully implementing performance appraisal programs.

Assessment of the Performance of Practicing Physicians in Canada (Kaigas, 2000)
This report provides an overview of the steps taken in 2000 to develop programs for assessing the practice performance of physicians in Canada. It provides an overview of the MEPP (Monitoring and Enhancement of Physician Performance) Project, and provincial examples of performance management processes.

An Overview of Healthcare Management (Thompson, Buchbinder, Shanks, 2010)
This report defines healthcare management and the role of healthcare manager. It focuses on required competencies, managing performance and talent, and succession planning.

Why Measure Performance? Different purposes require different measures (Behn, 2003)
This article published in the Public Administration Review, focuses on the benefits of measuring performance in public organizations and addressing the complexities of doing so.
REVIEWING PERFORMANCE

The performance review process for physicians in hospitals has historically been varied and informal. Performance reviews should not be viewed as a punitive activity, or as one that imposes an unnecessary administrative burden. Ultimately, it is about setting and tracking objectives towards continued improvement and skill development. Performance reviews aid physicians in setting objectives to appropriately balance their activities to achieve the greatest outcomes.

Often times, an organization will mandate that physicians and other healthcare professionals adhere to a Code of Conduct through a Statement of Commitment or Physician Engagement Agreement. This not only sets the bar for personal performance, but also emphasizes organization-wide priorities for individual performance (e.g., commitment to quality, teamwork, respect). Samples of a Statement of Commitment (Grand River Hospital and St. Mary’s General Hospital) and Physician Engagement Agreement (The Ottawa Hospital) can be found in the Appendix.

In a 2010 article written by Robert D. Behn entitled, *Why measure performance? Different purposes require different measures*, the author identifies eight guidelines that managers can use to measure performance. These guidelines were developed for any public sector organization, and can also be applied to physician leaders in the hospital setting:

1. *Evaluate*: how well is my organization performing?
2. *Control*: how can I ensure that my subordinates are doing the right thing?
3. *Budget*: on what programs, people, or projects should my organization spend the public’s money?
4. *Motivate*: how can I motivate front-line staff, middle managers, stakeholders, and citizens to do the things necessary to improve performance?
5. *Promote*: how can I convince government, legislature, stakeholders, journalists, and citizens that my organization is doing a good job?
6. *Celebrate*: what accomplishments are worthy of the important organizational ritual of celebrating success?
7. *Learn*: what is working or not working?
8. *Improve*: what exactly should we do differently to improve performance?

While the emphasis on each of these eight items will and should vary by context, benefits from reviewing performance are apparent in nearly all environments. In this light, individual performance management is regarded as part of a greater whole. Such an approach assumes that healthcare professionals are motivated to perform well, and that the organization is responsible for removing obstacles to high performance, and enabling individuals to correct any performance issues by providing the appropriate resources and support.
Physician leaders are encouraged to check with their HR departments to determine what performance assessment processes and resources are in place that may be applicable or adaptable to physicians.

Overview of Common Performance Management Models and Tools
The two most common styles of performance management are rating-based (e.g., peer ratings, rating scales, rankings), and outcomes-based (management of objectives and goal-setting). Organizations use many different styles and models of outcomes-based performance management, each built around three main activities:

1. Selection of goals or objectives
2. Measurement of progress against these goals or objectives
3. Interventions in light of this information to improve future performance

Council of Academic Hospitals of Ontario (CAHO) 360-Degree Physician Performance Review
CAHO developed this Toolkit to support the design and implementation of a ‘best practice’ approach for the development of a common framework for 360-degree physician performance assessment. Participation from hospitals is voluntary and non-binding, and the toolkit is publically accessible here:

1. **360-Degree Physician Performance Assessment**
Healthcare Quarterly published a 2010 article offering a 360-degree physician performance assessment for Canadian jurisdictions. The framework assesses performance across three dimensions: knowledge, skills, and behavioural competencies. Within each dimension, competencies are identified along with measures of those competencies. The purpose of the framework is to support physician career planning and to enhance the quality of patient care. The framework is accompanied by a tool kit for implementation.
Figure 4. Performance as the confluence of knowledge, skill and behavioral competence
Source: Healthcare Quarterly (2010)
2. **360° Leadership Competency Assessments**

The 360° Leadership Competency Assessments are multi-rater assessments designed to assess the strengths and areas for development, and are based on the OHA’s leadership competencies. Different from the previous model, the assessments are specifically designed to evaluate individuals in the following leadership roles: Chief Executive Officer, Executive, Director, Manager and Supervisor.

3. **Key Performance Indicators (KPIs)**

KPIs are a commonly used performance measurement tool for evaluating the success of particular activities or individuals. They are quantifiable measures, chosen based on activities that are most important to the organization, department, or individual’s role. The KPIs that are useful to a school (e.g., graduation rates) would be very different from the KPIs of a social service organization (e.g., number of clients assisted). The selection of KPIs is often closely associated with the strategic direction and goals of the organization.

There are three important factors for defining effective KPIs:

- KPIs should be quantifiable; there must be a way to define and measure them.
- The definition of KPIs should not change from year to year (e.g., hospitalization rates per annum).
- Each KPI should have a clear target or goal (e.g., should increase by x%).

Setting such targets can be challenging in public sector environments where desired outputs and outcomes are not always easily measured. KPIs should not be regarded as a panacea; they are part of the leader’s toolkit for tracking progress.

4. **GP/FP Performance Assessment**

The GP/FP Performance Assessment is a five-dimension physician performance management framework developed in 2006 by the College of Physicians and Surgeons of Ontario. This illustrative model offers an example of a competency-based performance assessment that considers physician performance within the broader environmental context. A form similar to this example could be used to assess individual clinical physician performance through a peer or manager assessment.
## Performance dimension | Description
--- | ---
Managing Patient with Acute Conditions and New Presentations (ACUTE) | Physician’s performance in dealing with new patients or patients presenting a new complaint or condition. Conditions are generally non-urgent and will often involve the formulation of a diagnosis for either acute or chronic conditions, and recommendation(s) for treatment.
Managing Patients with Chronic Conditions (CHRONIC) | Physician’s performance in dealing with patients with chronic conditions. Conditions will usually require long-term monitoring and may be present with or without co-morbidities.
Providing Patients with Continuity of Care and Referrals (Continuity Care) | Physician’s performance in dealing with patients who are referred for treatment, surgical procedures, diagnostic procedures or otherwise, to the care of other physicians. Includes the appropriateness of referral (i.e., indications) and follow-up.
Providing Patients with Well Care and Health Maintenance (Well Care) | Physician’s performance in well care visits and preventive health maintenance, including patient visits for annual check-ups, screening, well baby visits, etc.
Managing Patient Records and Recording Skills (Records) | Physician’s performance in records management and recording skills. This reflects the mandatory elements or record format required by legislation and some additional features of the organization and recording tools used.

### Additional Canadian Examples:

5. **Clinical Competence Program** (British Columbia)

The Clinical Competence Program was established in 1993 to present an assessment of competence as a positive process, rather than as a punitive process. A detailed analysis of clinical strengths and weaknesses is provided, and serves as a basis for directing physicians to appropriate remedial medical education. It offers the option of “self-referral”, often used by physicians who have had health problems or are returning to practice after a leave. The program spans two days and utilizes a structured oral examination, patient-management problems, and multiple choice questions. Competencies measured include:

- Knowledge base
- History taking
- Physical examination
- Diagnostic skills
- Management and therapeutics
• Communications
• New items
• Safety

6. Physician Achievement Review (PAR) Program (Alberta)

The Physician Achievement Review Program, developed by the College of Physicians and Surgeons of Alberta, is based on a system of questionnaires distributed to patients and colleagues of the subject physician every five years. Results are sent in confidence to the physician. Questions regarding office management, collegiality, communication skills, psychosocial management, and clinical knowledge and skills are incorporated. Results give physicians a benchmark for good performance and identify opportunities for professional development and practice improvement. The following diagram provides examples of questions asked to the various stakeholders:
PHYSICIAN LEADERSHIP RESOURCE MANUAL

Module 4: Leading High-Performance Teams
Section 4.2 - Managing Performance

<table>
<thead>
<tr>
<th>Questionnaire instrument</th>
<th>Statement content</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-assessment</strong></td>
<td></td>
</tr>
<tr>
<td>Clinical competence</td>
<td>Selects diagnostic tests appropriately</td>
</tr>
<tr>
<td></td>
<td>Selects appropriate treatment</td>
</tr>
<tr>
<td></td>
<td>Manages patients with complex medical problems</td>
</tr>
<tr>
<td>Psychosocial management of patients</td>
<td>Recognizes the psychosocial aspects of an illness</td>
</tr>
<tr>
<td>Humanistic aspects and patient communication</td>
<td>Communicates effectively with patients</td>
</tr>
<tr>
<td>Personal professional management</td>
<td>Respects the rights of patients</td>
</tr>
<tr>
<td><strong>Patient assessment</strong></td>
<td></td>
</tr>
<tr>
<td>Humanistic aspects</td>
<td>My doctor shows interest in my problems</td>
</tr>
<tr>
<td></td>
<td>My doctor treats me with respect</td>
</tr>
<tr>
<td>Office staff</td>
<td>Is helpful and pleasant</td>
</tr>
<tr>
<td></td>
<td>Works well with my doctor</td>
</tr>
<tr>
<td>Technical communication</td>
<td>My doctor provides reports, files or copies of letters</td>
</tr>
<tr>
<td></td>
<td>I am advised of results of tests or radiography</td>
</tr>
<tr>
<td>Physical office</td>
<td>The office has a sufficient waiting area</td>
</tr>
<tr>
<td></td>
<td>The office is in good repair</td>
</tr>
<tr>
<td>Personal communication</td>
<td>My doctor explained my illness or injury to me thoroughly</td>
</tr>
<tr>
<td></td>
<td>I understand the instruction of my health care</td>
</tr>
<tr>
<td>Phone communication</td>
<td>I can reach my doctor by phone after office hours</td>
</tr>
<tr>
<td></td>
<td>I can get an appointment quickly</td>
</tr>
<tr>
<td></td>
<td>I do not wait long for my appointments</td>
</tr>
<tr>
<td><strong>Peer assessment</strong></td>
<td></td>
</tr>
<tr>
<td>Clinical competence</td>
<td>Selects diagnostic tests appropriately</td>
</tr>
<tr>
<td></td>
<td>Selects appropriate treatment</td>
</tr>
<tr>
<td>Psychosocial management of patients</td>
<td>Recognizes the psychosocial aspects of an illness</td>
</tr>
<tr>
<td>Humanistic aspects and patient communication</td>
<td>Communicates effectively with patients</td>
</tr>
<tr>
<td>Personal professional management</td>
<td>Respects the rights of patients</td>
</tr>
<tr>
<td><strong>Consultant assessment</strong></td>
<td></td>
</tr>
<tr>
<td>Professional relationship with consultant</td>
<td>Communicates adequately with consultant physician</td>
</tr>
<tr>
<td>Clinical competence</td>
<td>Refers patients in an appropriate manner</td>
</tr>
<tr>
<td></td>
<td>Critically assesses diagnostic information</td>
</tr>
<tr>
<td></td>
<td>Selects the appropriate treatment</td>
</tr>
<tr>
<td>Humanistic aspects and patient communication</td>
<td>Communicates effectively with patients</td>
</tr>
<tr>
<td>Patient management</td>
<td>Shows compassion to patients and their families</td>
</tr>
<tr>
<td></td>
<td>Communicates adequately with referring physician</td>
</tr>
<tr>
<td></td>
<td>Respects the rights of patients</td>
</tr>
<tr>
<td>Psychosocial management of patients</td>
<td>Accepts responsibility for own professional actions</td>
</tr>
<tr>
<td>Technical skills</td>
<td>Performs technical procedures skillfully</td>
</tr>
<tr>
<td></td>
<td>Demonstrates good judgment in selecting procedures</td>
</tr>
<tr>
<td><strong>Nonmedical coworker assessment</strong></td>
<td>Shows compassion to patients and their families</td>
</tr>
<tr>
<td></td>
<td>Respects the rights of patients to make informed decisions</td>
</tr>
<tr>
<td>Coworker collegiality</td>
<td>Respects the professional knowledge and skills of coworkers</td>
</tr>
<tr>
<td>Communication</td>
<td>Collaborates well with coworkers</td>
</tr>
<tr>
<td></td>
<td>Written communication is effective</td>
</tr>
<tr>
<td></td>
<td>Writes prescriptions clearly</td>
</tr>
</tbody>
</table>

Figure 5. Stakeholder Questions

Source: Assessment of physician performance in Alberta: The Physician Achievement Review (Hall et al., 1999)
Setting Objectives

Setting realistic and measurable objectives for personal and professional development is important in any field, including healthcare. Goals and objectives are desired end points for activity and reflect the strategic and operational direction for the organization (Thompson et al., 2011). These objectives are often linked to the Performance Assessment process to ensure accountability and provide a method for evaluation of success against goals. Many hospital HR departments already have specific forms/templates in place that staff can access and complete as a part of this process. A commonly used framework for goal setting (personal or organizational) is the S.M.A.R.T. Goals framework, first introduced in a 1981 issue of Management Review:

S.M.A.R.T. Goals

The S.M.A.R.T. goal setting framework recommends setting goals which are:

- Specific; consider the five ‘W’ questions for the goal: who is involved, what do I want to accomplish, where will it take place, when is my timeframe, and why is this my objective
- Measurable; establish concrete criteria for measuring progress
- Attainable; goals can be achieved in the timeframe allotted
- Realistic; individual is both willing and able to achieve the goal
- Timely; there is an end date in mind for the individual to be held accountable to

Structuring Incentives

Fundamentally, an incentive seeks to encourage desired behaviour by providing rewards, recognition, or other positive responses that reinforce positive behaviour. Physician leaders will rarely have control over the incentives of their entire team, given various sources of compensation and their team’s involvement in other hospital, academic, and extra-curricular
initiatives. Despite these challenges, the physician leader does have a breadth of tools and techniques that can be used to motivate their teams.

The assumption that money is the only way to motivate individuals greatly limits the incentives that leaders have at their disposal. Some may be motivated more by extrinsic rewards like money but others may be driven more by the intrinsic value of bettering individual or societal outcomes. In his book, Motivation, Agency, and Public Policy: Of Knights and Knaves, Pawns and Queens, Julian le Grand states that extrinsic motivators like money can “crowd out” intrinsic motivation in certain contexts by imposing a transaction value on the behaviour. Well-structured incentives motivate individuals extrinsically and intrinsically without placing a transaction value on the desired behaviour.

There are many non-financial incentives available to physicians, including: career and professional development opportunities, workload management initiatives, flexible working arrangements, positive working environments and access to benefits and supports, among many others.

Successful incentive systems are customized to the particular environment in which they are being implemented. The World Health Organization describes the characteristics of well-structured incentives:

- have clear objectives;
- are realistic and deliverable;
- reflect health professionals’ needs and preferences;
- are well designed, strategic and fit-for-purpose;
- are contextually appropriate;
- are fair, equitable and transparent;
- are measurable; and
- incorporate financial and non-financial elements.

The WHO recommends the following steps in designing an effective incentive package:

1. Scope and define the strategic objective
2. Assemble the evidence: research and consult
3. Construct the alternatives: design packages
4. Select the criteria: how to define success
5. Project the outcomes
6. Confront the trade-offs
7. Decide: consider the stakeholder(s)
8. Tell your story: implement the structure
9. Evaluate and review
BUILDING SKILLS AND TALENT MANAGEMENT

From a strategic perspective, healthcare organizations compete for labour. The highest-performing healthcare organizations are highly dependent on individual performance. As such, human resource functions are often referred to simply as ‘Talent Management’ in healthcare organizations. The focus has shifted to securing and retaining the talent best suited to the job, rather than simply filling a role. This entails training and developing staff who are excellent performers. Understanding Healthcare Management (Jones & Bartlett, 2008) indicate that this can be done through various formal and informal methods:

- Offering training and onboarding programs
- Assisting with hands-on leadership
- Providing continuing education, especially for clinical and technical fields
- Providing job enrichment
- Conducting hospital staff reviews
- Soliciting employee feedback
- Offering staff suggestion programs

The OHA offers a comprehensive range of talent management tools and resources, continuing education, and distance learning courses, available by clicking here.
Dealing with Performance Issues

A study from the CPSO (Kaigas, 2010) assessing performance management systems for practicing physicians in Canada, identified four major physician performance problems:

1. Insufficient competence
2. Inappropriate use of resources
3. Physician impairment (cognitive impairment, mental health, substance abuse issues)
4. Inappropriate behaviour (communicating, ethical/consent issues, boundary issues)

The CPSO then developed a three-step monitoring process that the physician leader can use for mitigating the likelihood of performance issues arising:

Step 1: Screen all physicians (databases, patient/peer questionnaires)
Step 2: Assess physician at risk (Hospital/office audit, structured peer interview)
Step 3: Conduct an individualized needs assessment

When physicians are demonstrating performance problems that require significant information, the study provides the following approach to providing this feedback:

- Delivered immediately
- Remains non-judgemental (focused on the behaviour and outcomes, not the individual)
- Given in person by a peer
- Includes a clear follow-up plan
- Allows the physician to be accompanied by a support person
It is important to note that performance deficiencies cannot always be corrected with educational interventions. In many cases, other issues affect performance (such as mental health, life and family stress, financial crisis) that must be identified and addressed prior to commencing corrective education.

For information on giving feedback and effective coaching and managing disruptive physician behavior, please refer to Section 4.1 of this Module.

Additional Resources to Consult

*Physician Performance Management Tool for Survival and Success* (Medical Group Management Association, 1996)

This text gives insight into the process of physician performance evaluation from both perspectives: the physician leader and the reviewed physician.
OVERVIEW

Human resources is a complex but critical element to healthcare delivery in Canada. Health Force Ontario estimates that 75% of Ontario’s health sector costs are for human resources. To meet the changing needs of the province, the Ontario health sector is moving towards a more interprofessional model, with providers working together to meet population health needs (e.g., Family Health Teams and Community Health Centres). This shift places new and unique pressures on human resource planning to adapt to these new models of care.

Key Sources

Ontario Hospital Association Ultimate HR Manual

This valuable online reference tool for HR professionals offers practical advice and solutions to HR and employment issues. Topics covered include:

- Compensation and Benefits
- Employment Contracts
- Employment Standards and Human Rights
- Health and Safety
- Labour Relations
- Performance Management
- Staffing
- Strategic Human Resources
- Training and Development
- Creating an Employee Handbook

Physician Recruitment and Retention (Health Force Ontario)

A recruitment and retention guide for physicians in Ontario that includes recommended strategies, templates for sample interview questions, needs assessments, Letters of Intent/Understanding, site visit itineraries and feedback forms, and other recruitment and retention support documents.

Physician Retirement in Canada (Pong et al., 2007)

This report observes the potential impact of the aging medical workforce from a broad perspective, seeking to objectively approach the growing concerns of physician shortages.

Professional, personal, and community: 3 domains of physician retention in rural communities (Cameron, 2011)

This report from the Canadian Journal or Rural Medicine explores the professional, personal, and community domains of physician retention in 4 rural communities in Alberta.
DEVELOPING A HUMAN RESOURCES PLAN

The World Health Organization (WHO) defines health human resource planning as “the process of estimating the number of persons and the kinds of knowledge, skills, and attitudes they need to achieve predetermined health targets and ultimately health status objectives”. Human Resource planning is effective in offsetting uncertainty and change to ensure continuity of care in hospital and other healthcare settings. It ensures the individual development needs of employees are met, and personnel costs are accurately incorporated into the overall hospital budget.

Human resource planning at the hospital level typically starts with identifying key system, hospital, and community priorities. These priorities and the current state of the hospital workforce will help identify potential human resource needs and gaps. Typical considerations in human resource planning include:

- Identifying potential skill shortages: Are there sufficient physician resources in each department to avoid risk of potential burn-out?
- Understanding potential changes in the service delivery model: Is the hospital adding a new service, transitioning to a centre of excellence, or becoming a regional centre?
- Forecasting planned retirement and transitions: Which departments will be most impacted by planned retirement in the next planning period?

The gap analysis will form the foundation of the human resource plan. The OHA Professional Staff Credentialing Toolkit outlines the key components that should be included in the human resource plan of each department, including:

- The required number and expertise of staff required, including the number of new staff and rationale for the request;
- Reasonable on-call requirements for staff;
- A process for equitably distributing changes of resources to staff within the department;

OHA Professional Staff Credentialing Toolkit

The Toolkit provides practical guidance to assist hospitals in managing one of their most critical resources: Board-Appointed Professional Staff (physicians, dentists, midwives, and extended class nurses). It explores the relationship between hospitals and the Board-Appointed Professional Staff who are granted “privileges” to practice at a specific hospital.
• A process for making changes to the resource plan and allocation within the department; and
• A dispute resolution process.

For additional information on the human resource planning process for hospitals, please refer to the OHA Professional Staff Credentialing Toolkit. The Toolkit also provides a sample template adapted from Grand River Hospital:

Similar to the above template, many institutions have developed additional templates that can assist in the human resource planning process. For example, London Health Sciences Centre has developed a position request form that helps departments build the case for new positions, and in turn, helps their hospitals prioritize the creation of these positions.

Physicians are encouraged to consult their HR department for any existing policies, procedures, and guidelines for human resource planning, as well as any existing documents (e.g., forms, checklists) that can assist in the process.

Potential barriers to successful human resource planning in hospital settings

By anticipating potential barriers, the physician leader can develop strategies to mitigate any negative impact they present. Examples of these barriers may include:

• **Attitudinal**: Physicians may be resistant to new models – barriers can be broken down through education and experience.

• **Financial**: Incentives in the system do not always encourage interprofessional practice or use of all skills.

• **Integration**: Issues are often addressed independently in the health system (e.g., wait times, emergency preparedness), and a coordinated strategy may be needed.

• **Legislative/regulatory frameworks**: Many are a by-product of collective bargaining agreements and concerns over professional liability.
Recommendations for successful hospital human resource planning

- Consider the broader stakeholder groups in your resource planning. Workplace issues, scope of practice, and changing service delivery impact not only doctors and nurses, but also allied health professionals (pharmacists, dieticians, social workers, case managers, etc.) and even technicians.

- As the scope of practice moves more towards interdisciplinary teams, it will be important for hospital HR managers to look at the unique skills each individual brings to the team and coordinate the deployment of these skills so patients are seeing the care practitioner most appropriate to their case.

- Regular monitoring and evaluation of human resource forecasts is vital to ensure continuity of care.

The above recommendations were adapted from the Human Resources for Health report, *The importance of human resources management in healthcare: a global context*. The report highlights key issues pertaining to human resources in health care, and provides an overview of the healthcare systems in Canada, the United States, Germany, and Developing Countries.

Legal Environment for Human Resource Planning

Modules 1 and 2 of this manual provide additional information on the legal environment for human resource planning. Module 1 provides an overview of the key legislative components (*Employment Standards Act*, *Human Rights Code*, *Labour Relations Act*, among others) that physician leaders should be familiar with for the purposes of HR planning. Unions are also discussed in Module 1. Module 2 provides more information on contractor relationships and contractor-employee differences.

*Recruitment Best Practices and Resources*

Recruitment is the process of identifying the need for a physician, defining the requirements of the position, advertising the position, and choosing the most appropriate candidate. As the effectiveness of the delivery of healthcare services depends largely on the quality of medical staff, recruiting the 'right' person for the job is of vital importance.

HealthForceOntario offers a virtual toolkit for healthcare recruitment, covering topics such as physician recruitment and retention, locum guidelines and frequently asked question, as well as marketing strategies.
The following best practices were identified by HealthForceOntario in their *Physician Recruitment and Retention* guide. The guide also provides sample interview questions, needs assessments, letters of intent/understanding, site visit itineraries and feedback forms, and other recruitment and retention support documents.

1. **Recruitment: First Steps**
   - The community recruiter must be very comfortable with the duties of the role, culture of the organization, and education and experience required.
   - Decisions regarding job description, approximate levels of compensation, etc. should be made well in advance and understood by the recruiter.
   - Once contact has been established with the candidate, the recruiter will establish Ontario licensing eligibility, request a CV, and send a formalized information package (e.g., real estate information, schools, spousal employment support), refer the candidate to the Chief of Staff or Department for follow-up, and schedule a site visit.
   - The recruiter should be prepared to discuss personal/lifestyle questions regarding both the hospital and the surrounding community, specific practice questions regarding responsibilities, training, and incentives.
   - The recruiter ensures topics of professional goals/satisfaction, income, and personal/lifestyle are addressed.
   - The official interview should cover expectations on both sides, ensuring the physician fits the role and culture of the hospital.

2. **Recruitment: The Site Visit and Next Steps**
   - Prepare a well-constructed itinerary for the site visit, which is often coordinated by a team of community members and includes the opportunity to experience both the hospital and surrounding community.
   - The *Physician Recruitment and Retention Guide* provides helpful needs assessment forms to highlight areas the physician is most interested in, as well as itinerary recommendations for the site visit itself.
   - Be sure to send a site visit-follow up, and consider soliciting specific site-visit feedback from the candidate.
   - Hospitals may also consider assigning mentors to the physician to answer additional questions, and even a community mentor for the spouse if interested.
   - Keep communication lines open at all times.
   - If the candidate is interested, a Letter of Intent should be sent by the recruiter and ongoing support for relocation should be provided as required.
3. Reimbursement

- Whenever possible, sites are encouraged to cover expenses for visiting physicians.
- The Ministry of Health and Long-Term Care (MOHLTC) has a [Community Site Visit Program](#) to provide reimbursement for travel and accommodation expenses incurred by healthcare professionals and their spouse within Ontario.

Additional Recruitment Resources


This report provides long-term strategies for five key aspects of physician human resources: education and training; interprofessionalism; recruitment and retention; licensure, regulatory issues and liability; and, infrastructure and technology.

### BEHAVIORAL INTERVIEWING

Interviews play a key role in the recruitment process. Behavioural interviewing, a component of interviewing, is a tried and true method for establishing fit and competency of candidates. The section below discusses a methodology to conduct effective interviews.

1. **Interview Preparation.** Effective interviews require an time investment upfront on the part of the interviewee, and the interviewer. The first thing an interviewer or interview team must decide is the selection criteria. What are the key skills and qualities candidates need to possess to be successful in the role they are applying for? This builds a framework for interviewers to test against through a series of prepared questions.

   Interview questions should be prepared in advance, based on the selection criteria. It is possible to deviate from these questions depending on the candidate, however, the plan will ensure time is spent most effectively and, more importantly, that the interviewer will have enough information to determine whether the candidate will move on in the recruitment process.

2. **Interview Introduction.** Interviews often make interviewees nervous or anxious, which may not be representative of how the candidate would perform in the role. By putting interviewees at ease – for example, engaging in a brief, informal, initial conversation -- there
is a greater probability that the environment will be more conducive to a more fair representation of their fit, personality, intellect, and work ethic.

Furthermore, leading with an initial question which allows the candidate to introduce himself/herself, sets the stage for a comfortable environment. Generally, this in the form of asking why the candidate has applied for the position and what the relevant skills or experiences they have. This question also verifies a candidate’s motivation for applying – did they give a catered answer to the organization? Is the response genuine? These are quick, indicative tests to reaffirm or dispute initial impressions.

3. **Interview Questions.** The best behavioural interviewers are comprised of questions which recount specific examples from their experiences which represent one or more of the selection criteria. This can materialize in describing past accomplishments, specific challenges faced (and how they were overcome), difficult people and/or work conducted in various environments. These questions often begin with “Tell me about a time when” or “Give me an example of”.

Often times, interviewers will ask follow up questions to probe further into the situation and to extract additional insights on the candidates. A helpful framework for evaluating these types of questions is the “STAR” framework (S-“Situation”, T-“Task”, A-“Action”, R-“Result”). This framework is sometimes taken a step further to assess the key learning of the situation and if anything would have been done differently in hindsight.

Seasoned interviewers would agree that establishing a measurement for rating candidates is the most efficient way of keeping track of a candidate’s match versus the selection criteria. This also makes follow-up conversations with other interviewers or the panel much easier, and serves an effective comparative tool versus other candidates.

4. **Interview Close.** Always leave additional time at the end for the interviewee to ask questions. Although interviews are a formal assessment on the company’s or organization’s part to evaluate candidates, it is also an opportune time for candidates to evaluate their potential employers. A candidate’s questions are also a helpful metric for interviewers to reiterate if the candidate is serious about the organization and if they have thought critically about its mission, the role, and their own fit with the organization.

Behavioural interviewing is used under the theory that past behaviours are predictive of future behavior. These interviews, as a result, are a great initial assessment to establish whether a candidate’s personal and professional motivations meet (or exceed) the required threshold for the position, and as a result, are an overall “fit” for the organization.
**Compensation and Benefits**

It is important for physician leaders to understand the compensation and benefit structure at their institution not only for structuring their own contracts, but also for helping structure contracts of physicians who are being recruited.

Physician compensation and benefits will vary significantly from case to case, depending on a number of factors including: the physician’s relationship with the hospital (e.g., independent contractor vs. employee), extent of physician involvement in leadership and administrative functions, the physician’s role in teaching and research activities, clinical workload, on-call requirements, etc.

As such, physicians are encouraged to consult with their hospital’s HR department for more information on their hospital’s compensation policies and procedures.

**Onboarding and Orientation**

Onboarding is a process whereby physicians familiarize themselves with policies, procedures, norms, expectations, and day-to-day responsibilities for all members of the team. Onboarding differs from orientation in a few key ways:

<table>
<thead>
<tr>
<th>Orientation</th>
<th>Onboarding</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Typically a one day event</td>
<td>• Typically extends well beyond first few days</td>
</tr>
<tr>
<td>• Focuses on an organization’s mission, structure, and policies</td>
<td>• Is a systematic process</td>
</tr>
<tr>
<td>• Spends majority of time completing administrative duties: payroll, benefits paperwork, etc.</td>
<td>• Promotes better understanding of culture, mission, and goals</td>
</tr>
<tr>
<td></td>
<td>• Builds access to information</td>
</tr>
</tbody>
</table>
York University’s *New Manager Onboarding Guide* states that the most vulnerable period for employees to leave an organization is the first 18 months after they are hired. As such, effective onboarding is an integral aspect of hospital human resources. Onboarding is also important from a policy perspective, as many hospitals have non-academic onboarding requirements for new physicians (e.g., immunization history, malpractice and liability coverage, confidentiality agreements, etc.).

**Tips for Successful Onboarding**

1. Create an ‘Onboarding Checklist’: a “to-do” list of critical elements, resources, and learning sessions for all new staff.
2. Assign a mentor to new staff to ensure there is a quick outlet for questions.
3. Keep in touch with your new hire as they become familiar with the organization, and consider scheduling regular check-ins to ensure needs are being met.
4. Involve the whole team in the process in order to build relationships early on.

Physicians are encouraged to consult their HR department for any existing policies and procedures on physician onboarding.

**Retention Strategies and Provider Satisfaction**

Retaining qualified, motivated, and satisfied physicians should be a top priority for hospital leaders. Losing physicians can have a significant impact on patient satisfaction and continuity of care. The following list outlines critical retention items identified in Kaiser Permanente’s *Ten Evidence-Based Practices for Successful Physician Retention*:

1. *Effective hiring techniques*: Focus on ‘fit’ and be realistic about what a physician can expect in your organization. State the positives and the challenges. If physicians are surprised by their new environment they may be less likely to stay.

2. *Gracious welcome and start-up resources*: The first few days and weeks of employment are very important for embracing a new environment and securing loyalty of new staff. Focus on providing physicians with the resources required for their jobs, and making them feel instantly welcomed in the community.

3. *Orientation and mentoring*: Ensure orientation is timely and goes beyond basic introduction to the department. Provide an opportunity to ‘enculturate’ a person in the organization and foster feelings of belonging and loyalty through the orientation process. Many physicians also feel a strong need for mentoring.
4. *Role of leadership*: Set expectations, give feedback, provide recognition, and listen. The way a department or physician chief welcomes a new physician and demonstrates leadership is a determining factor for retention. Leadership must make an effort to communicate, listen, and involve their physicians in designing service delivery, leading to less burnout and more satisfied physicians.

In addition to the above items, physician leaders are also encouraged to consider the skills that are needed in their organization. What skills are currently represented on the multi-disciplinary team (both clinical and other)? Physician leaders should recruit appropriately to address expertise and skill gaps within their teams.
RETENTION IN RURAL AREAS

While government strategies have focused a great deal of attention on recruitment strategies to solve physician shortages in rural areas, less attention has been paid to retaining those physicians for the longer term. Many factors influence physician retention in rural areas, including the physician’s background (urban vs. rural), experience, nature of practice, and family considerations.

Professional aspects influencing rural retention:

Adapted from ‘Professional, personal, and community: 3 domains of physician retention in rural communities’ (Canadian Journal of Rural Medicine, 2012)

- Physician supply: an adequate physician supply is necessary to avoid burnout of existing physicians in the community.
- Physician dynamics: the physician complement; a group who works together has a significant influence on retention.
- Scope of practice: a diverse scope is important, allowing physicians to develop skills they may not have the opportunity to undertake in other settings.
- Practice set-up: important factors include physician space, financial, and workload issues to maintain reasonable pace of practice.
- Innovation: rural physicians were identified as having more interest in innovation, and benefited from an improved ability to exert influence and create the work environments they desire.
- Management and support: administrative and staff support can influence a positive culture.

The non-professional aspects of a rural physician’s life can be an important factor in the decision to remain in a rural setting. It is important for hospital leaders to recognize these issues and incorporate them into the organization’s retention strategies.

Non-professional aspects influencing rural retention

While, the professional setting is one of the many factors physicians consider in choosing where to practice, the non-professional aspects are also very important. This may especially be the case when a physician chooses to practice in a rural setting where they lack an existing social network. The physician leader can employ a number of techniques to improve the overall experience of their team:

- Recognize the lack of connections that new physicians and their families may have in the rural areas. Provide opportunities for community building, networking, and social interaction.
- Create opportunities for physicians and their families to have access to cultural or other recreational activities; make them aware of what is available in the community.
• Recognize the different demands that are placed on the physician in this new environment, and provide tailored and appropriate support.

In a recent report written by the Industrial Relations Centre at Queens University regarding rural physicians in Nova Scotia, a recommended set of initiatives were identified to aid in retention efforts. The following considerations may be important to rural physicians in leadership roles:

• Rural physicians feel dissatisfied with their status in the health care field. Physician leaders, regulatory bodies, medical schools, and government should make an effort to make rural physicians feel more valued.

• Using nurse practitioners to provide greater support to rural doctors is recommended.

For more detailed survey results, recommendations, and human resource initiatives, please view the report here:

Additional Sources: Retention of Physicians in Rural Areas

Rural Programs: A Guide for the Rural Physician Programs in British Columbia
This document provides an overview of the various programs offered to rural physicians in British Columbia.

A Situational Analysis of Physician Recruitment and Retention in Rural and Northern Canada: Models, Programs, and Evaluations
This report, created at the request of the Ontario MOHLTC, explores the current Canadian policies and programs pursued to improve recruitment and retention of rural physicians.
MANAGING TRANSITIONS: RETIREMENT, DISABILITY, ILLNESS

This section intends to direct physician leaders to relevant resources regarding the management of transitions within their hospitals, specifically retirement, disability, and illness.

Aging Workforce

As more and more physicians are nearing the traditional retirement age, the health care field is facing significant concerns with physician shortages. This presents a unique challenge for physicians assuming leadership positions in the near future. Workforce planning and recruitment could become significantly more complicated and less predictable. However, two positive trends can help alleviate this concern: physicians tend to stop working later than the average Canadian worker, and many older physicians choose to remain in practice, but limit their activity level as they age.

A 2007 Ontario study (Pong et al., 2007) sought to validate concerns about physician shortages and examine the issue of physician shortage from several angles. The study concludes that strategies should be in place to accommodate and incentivize those in the broad context of the Canadian health workforce who still wish to work. Two specific areas were identified where physician leaders can influence retention strategies for physicians nearing retirement age:

1. Offering possibilities other than full-time clinical practice (e.g., mentorship, administration, teaching); and,

2. For older physicians who wish to continue to do clinical work, but on a part time basis, it is necessary to provide support to ensure capabilities and clinical skills are kept up-to-date (e.g., College of Family Physicians of Canada ‘Sustaining Member’ category for physicians who are involved in medicine but no longer in clinical care, special training or residencies for older physicians).

Disability and Illness

The OHA established the Disability Income Plan in 1976 (updated in 1992) to provide uniform disability income benefits for employees in Ontario. New hospital employees can join the plan after completing the waiting period (six months of service). Physicians are encouraged to contact the HR department in their hospitals to verify whether they are eligible for Hospitals of Ontario Disability Income Program (HOODIP) or not. This plan has information regarding:

For more information regarding the aging physician workforce and relevant resource planning, please refer to the Task Force for A Physician Human Resource Strategy for Canada.
- Joining the Plan as a new employee.
- What steps to take if you become disabled.
- What steps to take if your disability reoccurs after returning to active full-time work.
- Leaves of absence for disability or illness.
- Rehabilitation benefits for employees requiring assistance to return to the workforce.
- Submitting a long-term disability claim.

It is important to note that the employee may require additional considerations as they return to work. The employee will be the best judge of what they are capable of, and what supports they need to be successful, so it is important to ask what they need early on, and identify suitable work consistent with their functional abilities. The Workplace Safety and Insurance Board of Canada prepared a report on *Injury / Illness and Return to Work / Function: A Practical Guide for Physicians*. While its purpose is a guide for physicians to assist their patients returning to work after an injury, the recommendations are also relevant to physicians returning to the workforce.

Physician leaders are also encouraged to familiarize themselves with the *Accessibility for Ontarians with Disabilities Act (AODA).*

Physicians are encouraged to consult their HR department for any existing policies, procedures, guidelines, and existing documents (e.g., forms, checklists) on disability and illness.

**Retirement**

Anticipating local physician supply gaps is an important role for physician leaders. It involves identifying key physicians at, or approaching retirement age, and supporting their successful transition. This might include identifying a new physician to take their place post-retirement, or onboarding an individual to support them as they gradually reduce their service. Successful transition planning will incorporate both the amount of time required for the transition, the financial negotiations and implications of the change, and a clear definition of roles and responsibilities for each stakeholder.

To assist physicians in this process, many hospitals have developed procedures and guidelines for physicians who wish to begin planning their partial or full retirement from their clinical duties at the hospital. Many hospitals also expect their physicians to provide retirement notice well in advance of their planned retirement date. For example, the London Health Sciences Centre (LHSC) *Credentialed Professional Staff By-Laws* states that “retirement dates should be
determined as far in advance as possible, and no later than 12 months in advance of giving up current hospital clinical status.” LHSC also has forms for notifying the Department Chair and Chief of Staff of the physician’s intent to retire. In many cases, physicians are also required to meet with their Department Chair and Chief of Staff to discuss their retirement plans, once the intent form has been submitted.

Physicians are encouraged to consult their HR department for any existing policies, procedures, guidelines, and existing documents (e.g., forms, checklists) on retirement planning.
APPENDIX 1

Sample Physician Engagement Agreement, The Ottawa Hospital

<table>
<thead>
<tr>
<th>The Hospital’s Commitment to Physicians</th>
<th>Values of The Ottawa Hospital</th>
<th>Physicians’ Commitment to The Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commitment to Quality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Foster a culture of excellence in quality of care within an academic environment.</td>
<td>• Champion the development and adoption of organizational processes, practices and policies that drive excellence in quality of care within an academic environment.</td>
<td></td>
</tr>
<tr>
<td>• Strive to develop a culture infused with, and informed by, our organization’s four values.</td>
<td>• Provide quality patient care. Measure progress.</td>
<td></td>
</tr>
<tr>
<td>• Support this commitment to quality by choosing measures that are relevant, content sensitive, meaningful and objective.</td>
<td>• Actively work with the hospital. Acknowledge your key role in improving individual and hospital care processes to boost quality and safety.</td>
<td></td>
</tr>
<tr>
<td>• Cultivate a culture of trust. To that end, evaluations of processes, systems and people must be timely, candid and constructive.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compassion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Create an environment that contributes to physical and emotional health.</td>
<td>• Recognize patients as the primary focus of our collective efforts and advocate on their behalf.</td>
<td></td>
</tr>
<tr>
<td>• Provide care in a manner consistent with patient- and family-centered principles.</td>
<td>• Protect patient privacy and dignity.</td>
<td></td>
</tr>
<tr>
<td>• Promote physician and staff health and well-being.</td>
<td>• Communicate with patients and families in a clear, timely, supportive, engaged and empathetic manner.</td>
<td></td>
</tr>
<tr>
<td>Working Together</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Make decisions and allocate resources in a consultative manner; listen to stakeholders, be transparent and assume accountability for those decisions.</td>
<td>• Engage with others, actively listen to them, communicate respectfully, and consider their ideas.</td>
<td></td>
</tr>
<tr>
<td>• Share information and communicate directly and proactively in an honest, consistent and meaningful way.</td>
<td>• Participate in decision-making. Practice in accordance with group decisions.</td>
<td></td>
</tr>
<tr>
<td>• Ensure that organizational processes and clinical systems are effective; that they recognize and respect the relationship of physicians with the hospital and patients, and align with the hospital’s core values.</td>
<td>• Use resources in an appropriate way and be accountable for utilization.</td>
<td></td>
</tr>
<tr>
<td>• Recognize and celebrate the accomplishments of physicians and staff.</td>
<td>• Work within and respect organizational processes and clinical systems.</td>
<td></td>
</tr>
<tr>
<td>• Demonstrate clear, effective and transparent leadership.</td>
<td>• Treat co-workers as you would like to be treated.</td>
<td></td>
</tr>
<tr>
<td>Respect for the Individual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Treat everyone at The Ottawa Hospital with fairness, equity and respect.</td>
<td>• Treat everyone at The Ottawa Hospital with fairness, equity and respect.</td>
<td></td>
</tr>
<tr>
<td>• Value and respect diversity.</td>
<td>• Value and respect diversity.</td>
<td></td>
</tr>
</tbody>
</table>

Dr. Jack Kitts, TOH President & CEO

The Physician Compact

Physician Name

Physician Signature

Dept/Division Head Signature
g Date
APPENDIX 2

Sample Statement of Commitment, Grand River Hospital & St. Mary’s General Hospital

Grand River Hospital and St. Mary’s General Hospital

COVENANT

We commit to treating patients and staff in a dignified manner that conveys respect for the abilities of each other and a willingness to work as a team of equally valued partners. We promote an atmosphere of collegiality, cooperation and professionalism. We demonstrate empathy, compassion and respect in our interactions with others and are always polite and courteous. We consistently adhere to the rules and regulations of our hospital.

We wish to be held accountable for our commitment and we expect the same dedication from all members of our hospital community.

STATEMENT OF COMMITMENT

I acknowledge that as a member of the Professional Staff of Grand River Hospital and St. Mary’s General Hospital, I have reviewed and am bound to adhere to and respect the Hospitals’ Bylaws, Professional Staff Rules and Regulations and policies applicable to me, including without limitation, the following:

- Professional Staff Conduct and Complaint Management Policy
- Mandatory Reporting Policy
- Comprehensive Appointment and Credentialing Policy
- Health Records Completion Policy
- Confidentiality and Privacy Policies
- Disclosure Policy
- Infection Control Policies (e.g. hand hygiene)
- Consultant On-Call Policy
- Surgical Checklist Policy

All professional staff shall conduct themselves in a professional, collaborative, and cooperative manner and shall adhere to the following general expectations:

- Timely submission of privilege renewal documentation
- Compliance with health record completion requirements and timelines
- Effective use or hospital resources (e.g. timely arrival to the OR)
- Regular attendance at department meetings
- Participation in medical education activities (clinical placements)
- Attendance at meetings called by the Chief of Staff / Department Chief
- Participation in quality of care and QCIPA reviews
- Courteous and respectful communication and interactions with staff, peers and patients
- Continual participation in CME activities

Date: __________________ Signature: __________________

Print Name: __________________

This Commitment shall be signed by every credentialed professional staff member of GRH/SMGH.
OVERVIEW

This section will provide physician leaders with an understanding of the manner in which hospitals are funded, potential changes to the funding formula and information regarding Local Health Integration Network (LHIN) planning cycles.

HOSPITAL FUNDING

The Ministry of Health and Long-Term Care (MOHLTC), through the LHIN, is the major source of hospital revenue, accounting for about 85-100% of operating revenues for most hospitals. Other sources of revenue include revenue-generating activities (e.g., cafeteria and parking income), funding from other government sources (e.g., Federal funding for veterans’ healthcare, provincial funding for workplace accidents through the Workplace Safety and Insurance Board), grants, donations and charitable giving. Donors are also a vital source of hospital funding and important hospital stakeholders.

Hospitals receive funding in a variety of ways. The most significant source of government funding is the hospital’s global budget, which flows from the MOHLTC through the LHIN, and covers the majority of in-patient and out-patient funding. Hospitals have flexibility in allocating their global budget within the terms of their accountability agreements. Global funding is earned based on formulas – historically, global funding has been based on past funding requirements rather than patient volumes or performance (see the next section for a discussion of the MOHLTC’s new patient-centered approach). Other MOHLTC/LHIN funding includes priority services funding for designated programs (e.g., chronic kidney disease), funding to support expansion of services following expansion of hospital facilities, and hospital on-call (HOCC) funding.

Capital Projects may be funded in part by the MOHLTC, which requires that a significant portion be funded by the hospital through a “local share” (local community giving). Hospitals may also fund capital projects fully from their own funding (e.g., parking revenues) or fundraising activities.

For more information, consult the MOHLTC-LHIN Toolkit on Capital Planning.
Potential Changes

Hospital funding is a complex area which continues to be subject to change. The underlying legislation, formal and informal policies of the MOHLTC and the LHINs, local implementation and hospital-specific issues, are in a constant state of transformation.

The Ministry has recently announced a change in the funding formula which underlies Hospital-LHIN Accountability Agreements (referred to as Health System Funding Reform, or HSFR), shifting from global, provider-based funding to patient-focused funding (referred to as Patient-Based Funding, or PBF). A Health-Based Allocation Model (HBAM) now distributes funding based on the volume and type of patients, and, in addition, hospitals will receive funding for the number of patients treated for certain procedures (e.g., hip and knee replacements) via Quality-Based Procedures (QBP) funding. HBAM and QBP will phased in over a number of years. The Ministry’s intention is that, for most hospitals, the global budget will eventually account for approximately 30% of funding, while HBAM will account for 40%, and QBP for 30%.

Annual Budget Cycles

Physician leaders may be involved in supporting their finance team in the annual budgeting process. The budgeting process will be driven in large part by ‘cost centres’ that are defined by the hospital. Physician leaders involved in the budgeting process should have a good understanding of different cost centres, department-level cost segmentation, and different cost categories/drivers (e.g., labour, materials, overhead).

The extent of physician leader involvement will vary considerably across hospitals. Physicians are encouraged to consult with their finance departments to determine their role in this process.

Additional Resources to Consult

*Analysis of Hospital Costs: A Manual for Managers* (World Health Organization)

*This is a practical guide to the principles and methods of cost analysis as a managerial tool for improving the efficiency of hospitals. Targeted at managers and administrators, the manual aims to equip its readers with the knowledge and skills needed to calculate the costs of different activities or departments, analyze their significance, and use this information to manage resources wisely. Throughout, recommendations and advice are specific to the different purposes of cost analysis and the different types of decisions commonly facing managers.*
LHIN PLANNING CYCLES

The organizational priorities and funding levels of individual hospitals will often be impacted by LHIN planning cycles. As described in Module 1, the LHINs oversee and fund health service providers (as defined in the legislation), including public hospitals. The LHINs also engage in health system planning, system integration (including transferring, merging, amalgamating, or ceasing provision of services), co-ordination, and oversee health service provider performance pursuant to service accountability agreements and performance agreements. Physician leaders are encouraged to visit their LHIN’s website, which will have information and resources on the LHIN planning process and priorities. Helpful planning documents published by each LHIN include (among others):

- Strategic plans
- Annual reports
- Business plans
- Community engagement plans
- Health service integration plans
OVERVIEW

Physician leaders must understand how their organizations are managed financially, specifically in regards to budget planning and forecasting. The ability to interpret financial statements, understand performance ratios, and project accurate cost budgets allows physician leaders to share common language with hospital administrators and more effectively communicate decision rationale to their teams. This section will provide basic financial education for new physician leaders, and direct readers to additional resources for further information.

Key Sources

Note: The following resources are US-specific, hence some information may not be accurate and relevant for Canadian hospitals. However, these resources do contain helpful information specific to understanding financial statements and performance.

How to read a financial report
This booklet developed by Merril Lynch guides readers in reading financial & annual reports.

Investopedia Financial Dictionary
This online financial encyclopaedia offers a comprehensive dictionary of financial terms with clear explanations, examples, video explanations, and additional resources including articles of interest related to the term searched.

Health Care Financial Statements
This guide helps physician leaders identify and understand the four basic types of financial statements particular to health care organizations.

A Community Leader’s Guide to Hospital Finance This resource guide provides vocabulary to help understand a hospital’s financial performance, an overview of financial statements, and tools to help evaluate financial performance.
ELEMENTS OF A FINANCIAL STATEMENT

There are three key types of financial statements used in the Ontario hospital system:

1. Statement of Financial Position
2. Statement of Operations and Changes in Net Assets

An example of each of these is provided in the appendices of this module. Each of these sample statements is organized into three major sections: heading, body, and notes. The heading contains the name of the organization, type of financial statement, and date(s). The body of the statement contains the financial data. The notes contain details of the financial information, including descriptions, accounting policies, and additional information relevant to the reader. Often, the notes are grouped together for all three financial statements at the end of a report.

*Note: for the purpose of illustration, example statements were modeled after the financial statements from the 2011 Annual Reports of the *University Health Network, Alexandra Hospital Foundation in Ingersoll*, and the *London Health Sciences Centre*.*

1. The Statement of Financial Position

The Statement of Financial Position is a snapshot of an organization’s financial position at a specific point in time. It shows what the organization owns (assets) and what the organization owes to others (liabilities + net assets) at the report date. For a balance sheet to be properly ‘balanced’, the total assets must equal the total liabilities + net assets. For more information, refer to Appendix 1.

2. The Statement of Operations and Changes in Net Assets

The Statement of Operations and Changes in Net Assets is a two-part statement that shows how an organization performed during a period of time (typically a year), and whether the organization’s operations resulted in a profit or loss. This statement is somewhat similar to the Statement of Cash Flows (see below), but recognizes revenues and expenses when they are earned or owed, not necessarily when “cash” changes hands. For example, supplies may be ordered in December (the last month of a fiscal year), but the invoice is not paid until January (the first month of the following fiscal year). The expense would appear in the Statement of Operations for the current fiscal year, but not on the Statement of Cash Flows until the following year.

The first part is the ‘Statement of Operations’: a measure of whether more money was generated/received or spent, resulting in the ‘Excess of revenue over expenses for the year’ total. The second part is the ‘Changes in Net Assets’ section, which adds the excess of revenue over expenses for the year to the previous year’s ‘Net Assets’ mount, resulting in the ‘Net Assets, end of year’ amount.
It is important to note that there is a difference between the operating and capital budgets. A useful analogy for these budgets is the purchase of a car. The purchase of a car is capital, as the expected life of the motor vehicle is more than one year. The cost of fuel only provides a short-term benefit (less than one year), and therefore is an operating expense. These two budgets are linked, because a person needs to ensure that s/he have enough funds in both his/her capital and operating budgets to support the purchase and ongoing expense before purchasing the car. For more information, refer to Appendix 2.

3. The Statement of Cash Flows

The Statement of Cash Flows shows the amount of cash and cash equivalents entering and leaving an organization. It helps stakeholders understand how the organization’s operations are running -- where the money is coming from, and how it is being spent. It is different from a ‘Statement of Operations’ because it does not include the amount of future incoming and outgoing cash that has been recorded on credit. Because cash is not estimated, the ‘Statement of Cash Flows’ provides a reliable perspective on short-term hospital financial performance. For more information, refer to Appendix 3.
UNDERSTANDING KEY PERFORMANCE RATIOS

Performance ratios can help managers put individual figures in context by comparing several pieces of financial information through one summary measure. They can be used to look at trends over time, understand the full financial story of an organization, and compare financial performance to other organizations. There are two major categories that ratios aim to evaluate which are relevant to Canadian hospitals: (1) Profitability, and (2) Liquidity. Within these categories, there are two main performance ratios that are important to note in terms of hospital financial reporting:

<table>
<thead>
<tr>
<th>Ratio Category</th>
<th>Ratio</th>
<th>Definition</th>
<th>Why it is used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Profitability</td>
<td>Operating Margin or Total Margin</td>
<td>Revenues in excess of expenses / Total Revenues</td>
<td>Shows the percentage of profit kept for every dollar of revenue, and excludes the impact of facility amortization (land, building and building service equipment). This is ultimately a measurement of hospital efficiency. This can be an indication of cost control, as well as revenue growth. Remember that in order to understand trends (cost versus revenue changes), you must look at the actual input numbers versus the percentage the formula generates. It is important to note that “100%” efficiency will never exist. Some baseline of expenses must be present to run the hospital. That being said, there is certainly an optimization model that is possible which maximizes a hospital’s operating margin, while still delivers on other key metrics such as quality of healthcare and ability to meet community demands.</td>
</tr>
</tbody>
</table>
### Liquidity

<table>
<thead>
<tr>
<th>Current Ratio</th>
<th>Current Assets</th>
<th>Current Liabilities</th>
</tr>
</thead>
</table>

Measures how many times the hospital is able to meet its short-term obligations with short-term resources. Short-term obligations are obligations typically due within one year’s time, whereas short-term resources are those resources readily available to equity and debt holders (such as cash, accounts/receivables, inventory, and prepaid expenses) in terms of being able to be liquidated into cash.

The higher the ratio, the more liquid a hospital is. If current liabilities exceed current assets, a hospital may have a difficult time meeting short-term obligations. If the current assets of a company are more than twice the current liabilities, the hospital is generally considered to have good short-term financial strength.

Within each of these ratios, the hospital, LHIN, and province may have different mandates or thresholds that the hospital must or strive to adhere to. In 2010-2011, St. Michael's Hospital reported that the provincial total margin average was 2.1% and current ratio average was 0.85.

In addition to the above ratios, year over year (YOY) trend analyses (specifically for revenues and expenses) and industry/LHIN/provincial average benchmarking can be performed.

**Investopedia provides a great resource for more information about performance ratios, elements of financial statements, and other financial questions.**
UNDERSTANDING THE BALANCED SCORECARD

The Balanced Scorecard (BSC) is a tool which aligns strategic goals with performance indicators. The BSC is “balanced” as it includes both financial (planning and funding), as well as other strategic and operational indicators. It also includes both relevant past history and future objectives, and encompasses both a process to measure as well as an accountability framework. The BSC has historically been used as a business tool, but has been adapted for use in hospitals, as well as other public sector organizations to represent their unique strategy for long-term value creation.

The BSC tells an organization’s strategic story by describing how the organization’s leaders will motivate employees with the right mix of skills, tools, and information in an environment designed for sustaining improvements. This is done in order to drive process improvements that have maximum leverage for delivering value to clients, while simultaneously meeting financial obligations.

Typically, BSCs are represented through four dimensions: a client perspective, a financial perspective, an internal perspective, and a learning and growth perspective. In a few Ontario-based examples, healthcare organizations have interpreted these dimensions in terms of the following four quadrants:

1. Health Determinants and Status – Tracks the rate of disease and health behaviour patterns
2. Resources and Services – Focuses on inputs (finance, HR) and corresponding outputs (key activities, level of service)
3. Community Engagement – Measures client and community satisfaction and participation in program planning and delivery
4. Integration and Responsiveness – Measures health unit responsiveness to issues and evidence

The BSC aims to cross-functionally link business departments and healthcare providers to optimize cost savings along with delivering the best care to patients, providing the best service to the community, and playing a role in health prevention as shown in the quadrants above. Most often, BSC’s are “owned” by the finance team, but many individuals from the organization in other departments have elements they are accountable for, and the performance objectives and measures cascade down the organization to support higher-level objectives.

Some examples of BSC used within hospitals and healthcare organizations in Ontario can be found below:

_Sunnybrook Hospital: Balanced Scorecard_

_York Region Public Health: Balanced Scorecard_
Additional Resources to Consult

*PMI’s Dollars and Sense: Finance and Economics for the Health Care Leader Course*

PMI offers a course to healthcare leaders specifically focusing on finance within the healthcare environment. The course is based on seven key modules over three days:

- **Health economics**: Learning economic concepts as they relate to health care.
- **Applying health economics**: Applying economics to health care challenges.
- **Hospital financial information**: Understanding statements, cash flow, and amortization.
- **Investment evaluation**: Understanding criteria for investment alternatives.
- **Cost/Profit dynamic**: Understanding cost behaviour, contribution margins, and break-even analyses.
- **Cost-benefit analyses**: Understanding different tools to apply economic analyses.
- **Ethics**: Applying knowledge of all modules into different scenarios.

More information about the program, including course offerings, is indicated in the annual PMI catalogue which is posted on the [PMI website](#).
APPENDIX 1

The Statement of Financial Position

1. Assets: the resources of the organization which are used to provide service and generate value
2. Current assets: assets which can be converted to cash or used to pay current liabilities within one year (e.g. cash & cash equivalents, short-term investments, supplies, prepaid expenses)
3. Non-current assets: assets which cannot easily be converted into cash (e.g. long-term investments, property & equipment less amortization)
4. Liabilities and Net Assets: calculated as ‘Assets = Liabilities + Net Assets’
5. Liabilities: the financial obligations of an organization
6. Current liabilities: financial obligations which must be settled in one year (e.g. current portion of long-term debt, accounts payable)
7. Non-current liabilities: financial obligations which must be paid over a time period longer than one year (e.g. long-term debt)
8. Net assets (also known as ‘Fund Balance’, or ‘Shareholders’ Equity’ in investor-owned organizations): = Assets – Liabilities; assets with varying degrees of donor restriction
The following financial statement was modelled after a Statement of Financial Position from the University Health Network Annual Report (2011).

<table>
<thead>
<tr>
<th>Section</th>
<th>Elements</th>
<th>Example</th>
</tr>
</thead>
</table>
| **Title** | Name of Organization  
The Statement of Financial Position  
Date | |
| **Body** | 1. Assets  
2. Current Assets  
   - Cash & cash equivalents 100  
   - Accounts Receivable 75  
   - Inventory 50  
   - Prepaid expenses 10  
Total Current Assets 235  
3. Non-current Assets  
   - Capital assets, net 800  
   - Long-term investments 200  
Total Assets 1235  
4. Liabilities & Net Assets  
5. Liabilities  
6. Current Liabilities  
   - Accounts payable 250  
   - Current portion of long-term debt 5  
Total Current Liabilities 255  
7. Non-current Liabilities  
   - Deferred research contributions 100  
   - Long-term debt 200  
   - Deferred capital contributions 300  
Total Liabilities 855  
8. Net Assets 380  
Total Liabilities & Net Assets 1235  
| **Notes** | Accounting Policies  
Information on Key Numbers |
APPENDIX 2

The Statement of Operations

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Revenue: income of the organization derived from providing patient services, sale of assets, contributions</td>
</tr>
<tr>
<td>2.</td>
<td>Expenses: measure of the resources used to generate revenue (operating expenses include salaries, supplies, insurance, lease, etc.)</td>
</tr>
<tr>
<td>3.</td>
<td>Excess of Revenue over Expenses for year: also known as operating income, or ‘surplus’</td>
</tr>
<tr>
<td>4.</td>
<td>Net assets, beginning of year: taken from previous year Statement of Operations</td>
</tr>
<tr>
<td>5.</td>
<td>Net assets, end of year: sum of Net Assets, beginning of year and excess of revenue over expenses for year</td>
</tr>
</tbody>
</table>
The following financial statement was modelled after a Statement of Operations from the Alexandra Hospital Foundation in Ingersoll annual report (2011).

<table>
<thead>
<tr>
<th>Section</th>
<th>Elements</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Name of Organization</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Statement of Operations and Changes in Net Assets</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>Body</td>
<td>1. Revenue</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ontario Ministry of Long-Term Care / LHIN</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospital Programs</td>
<td>800</td>
</tr>
<tr>
<td></td>
<td>Specially funded programs</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>Other Patient Services</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Grants &amp; donations for research / other purposes</td>
<td>200</td>
</tr>
<tr>
<td></td>
<td>Ancillary services and other</td>
<td>175</td>
</tr>
<tr>
<td></td>
<td>Amortization of deferred capital contributions</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>Total Revenue</td>
<td>1375</td>
</tr>
<tr>
<td></td>
<td>2. Expenses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Compensation</td>
<td>850</td>
</tr>
<tr>
<td></td>
<td>Medical, surgical supplies and drugs</td>
<td>150</td>
</tr>
<tr>
<td></td>
<td>Specially funded programs</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>Plant operations and equipment maintenance</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>Depreciation</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Interest on long-term debt</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Supplies and other</td>
<td>150</td>
</tr>
<tr>
<td></td>
<td>Total Expenses</td>
<td>1350</td>
</tr>
<tr>
<td></td>
<td>3. Excess of Revenue over Expenses for year</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>4. Net Assets, beginning of year</td>
<td>250</td>
</tr>
<tr>
<td></td>
<td>5. Net Assets, end of year</td>
<td>275</td>
</tr>
<tr>
<td>Notes</td>
<td>• Accounting Policies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Information on Key Numbers</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 3

The Statement of Cash Flows

1. Cash from Operating Activities: The changes in cash resulting from normal operating activities of the organization
2. Excess of revenue over expenses for year: taken directly from Statement of Operations
3. Cash Used from Investing Activities: Cash inflows and outflows resulting from investments
4. Cash from Financing Activities: Cash inflows and outflows resulting from financing activities (e.g. obtaining grants, borrowing or paying back long-term debt)
5. Net Increase in Cash and Equivalents during the year: Total cash flows from operating, investing, and financing activities
6. Cash and Equivalents, Beginning of Year: taken from previous year’s statement
7. Cash and Equivalents, End of Year: Total of net change in cash and cash equivalents plus last year’s final amount; same number that appears in the ‘cash’ section of balance sheet
The following financial statement was modelled after a Statement of Cash Flows from the London Health Sciences Centre Annual Report (2011).

<table>
<thead>
<tr>
<th>Section</th>
<th>Elements</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Name of Organization</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Statement of Cash Flows</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>Body</td>
<td>1. Cash from Operating Activities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Excess of revenue over expenses for year</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>Add (deduct) items not involving cash</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Depreciation</td>
<td>75</td>
</tr>
<tr>
<td></td>
<td>Amortization of deferred capital contributions</td>
<td>-50</td>
</tr>
<tr>
<td></td>
<td>Provisions for doubtful accounts</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Net change in non-cash working capital balances</td>
<td>52</td>
</tr>
<tr>
<td></td>
<td>Net increase (decrease) in deferred research contributions</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-2</td>
</tr>
<tr>
<td></td>
<td>Total Cash Provided by Operating Activities</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td>3. Cash Used from Investing Activities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Purchase of capital assets</td>
<td>-50</td>
</tr>
<tr>
<td></td>
<td>Net decrease in loans receivable</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Increase in long-term investments</td>
<td>-5</td>
</tr>
<tr>
<td></td>
<td>Total Cash Used in Investing Activities</td>
<td>-52</td>
</tr>
<tr>
<td></td>
<td>4. Cash from Financing Activities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contributions received for capital purposes</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>Repayment of long-term debt</td>
<td>-8</td>
</tr>
<tr>
<td></td>
<td>Cash Provided by Financing Activities</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>5. Net Increase in Cash and Cash Equivalents during the year</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>6. Cash and cash equivalents, beginning of year</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>7. Cash and cash equivalents, end of year</td>
<td>100</td>
</tr>
<tr>
<td>Notes</td>
<td>• Accounting Policies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Information on Key Numbers</td>
<td></td>
</tr>
</tbody>
</table>
OVERVIEW

As discussed in Module 1, a variety of legislation has been enacted in recent years which impose new obligations on Ontario public hospitals with respect to quality, transparency, accountability and community engagement.

This module provides an in-depth discussion of expectations under the Excellent Care for All Act (ECFAA) which was enacted in 2010 with the purpose of ensuring that Ontarians receive health care of the highest possible quality and value. ECFAA and the complimentary amendments to Regulation 965 (i.e., Hospital Management Regulation, as referred to in Modules 1 and 2) under the Public Hospitals Act (PHA) are the primary legislative vehicles for the province’s “quality agenda.”

Key Sources

High Performing Healthcare Systems: Delivering Quality by Design (Baker, Macintosh-Murray, Porcellato, Dionne, Stelmacovich, and Born, 2008)

This book provides a literature review offering recommendations for executing successful quality improvement (QI) initiatives. It also profiles a number of health systems across the world to provide benchmarking and inspiration.


This case study examines the roles of four physician leaders from hospitals in Ontario and describes their contribution to the design and implementation of hospital quality and patient safety agendas.

Quality Improvement Guide (Health Quality Ontario)

The objective of this guide is to help healthcare organizations start and support quality improvement initiatives, with a recommended process overview, and accompanying tools and support materials.
ECFAA BACKGROUND AND CONTEXT

The diagram below provides an overview of all the key policy components under ECFAA.

ECFAA mandates that every health care organization must establish a Quality Committee that reports to the organization’s Board of Directors. The Quality Committee is responsible for:

- monitoring and reporting on quality issues and overall quality of services;
- making recommendations for quality improvement priorities;
- ensuring best practices are shared with staff; and,
- overseeing the development of Quality Improvement Plans (QIPs).

ECFAA regulation also specifies the membership, composition and governance of Quality Committees.
Further, related regulatory changes under the PHA establish an explicit link between the Quality Committee and the Medical Advisory Committee (MAC). Where the MAC identifies systemic or recurring quality of care issues, the MAC must make recommendations on these to the Quality Committee. The Quality Committee, in turn, must consider these recommendations in making its own recommendations to the Board.

Monitoring the patient experience and analyzing the relevant data is also a key requirement of ECFAA. Under ECFAA, hospitals are required to:

- **Conduct patient surveys** on an annual basis for patients and caregivers who received services from the institution within the past 12 months; the Ministry of Health and Long-Term Care (MOHLTC) provides some guidance and recommendations on how these surveys could be conducted.

- **Conduct surveys of employees and persons providing services (e.g., physicians)** within the organization every two years to measure provider satisfaction with their experience working at the organization, and their views about the quality of care provided by the organization.

- **Develop a patient relations process** that reflects the patient declaration of values. The MOHLTC states that the patient declaration of values will “help organizations continue to put patients first and move toward patient-centred care by clarifying what Ontarians can expect from their healthcare organizations.”

Under the PHA, hospitals are required to:

- **Disclose individual critical incidents** to the MAC, (Critical incidents are discussed in more detail in section 6.2.).

- **Disclose aggregate critical incident data** occurring at the hospital to the hospital’s Quality Committee at least twice a year. The aggregated data includes all critical incidents occurring at the hospital since the previous reporting period. Also, as described in Module 1, pursuant to agreements entered into by hospitals at the direction of the Ministry, public hospitals are required to report critical incidents related to medication/IV fluid occurring after October 1, 2011 to the National System for Incident Reporting (NSIR), a database which is administered by the Canadian Institute of Health Information (CIHI).

The data gathered through critical incident reporting, patient and provider surveys, and the patient relations process must be taken into consideration by the organization in the development of their annual QIPs.

ECFAA requires each institution to submit its annual QIP to Health Quality Ontario (HQO) for the purposes of provincial comparison and reporting on the performance improvement targets. In addition to being submitted to HQO, QIPs must also be made available to the public.
QIPs are also directly linked to executive compensation. ECFAA requires that the compensation of the organization’s CEO and other prescribed executives is linked to the achievement of performance improvement targets as set out in the annual QIPs (MOHLTC, 2011).

With these requirements, ECFAA equips the system with new tools and processes for achieving higher quality care. HQO – whose mandate was expanded through the ECFAA legislation – has been tasked with supporting many of ECFAA’s requirements. Its mandate includes monitoring and reporting of key indicators to the public, supporting quality improvement priorities and initiatives within the healthcare sector, and translating evidence-based recommendations into practice.

For a more comprehensive discussion of each of the ECFAA components, please refer to OHA’s guide on the ECFAA legislation.

Physician Leader’s Roles and Responsibilities

As healthcare organizations increase their focus on quality improvement, patient safety, and risk management, strong leaders are needed to effectively manage change and build organization-wide commitment to high performance and safety.

ECFAA has created numerous opportunities for physicians to play a lead role in their organization’s quality movement. These roles could include, among many others:

- Participating actively in their organization’s Quality Committee and/MAC (Module 2 provides a detailed discussion of the role of the MAC and the responsibilities of physicians on the MAC);
- Developing a process and guidelines for critical incident reporting;
- Ensuring individual critical incidents are reported to the MAC and aggregate critical incident data is reported to the Quality Committee;
- Leading a team in the analysis of critical incidents and development of corresponding mitigation strategies;
- Providing input into the development and improvement of patient and provider surveys;
- Developing a mechanism for monitoring and analyzing patient and provider survey data;
- Identifying potential quality improvement opportunities through daily clinical responsibilities and interactions with other physicians and staff;
- Leading the design and implementation of quality improvement initiatives;
• Providing input into the QIP development process;
• Setting an example for other physicians and staff by continuously promoting a focus on quality through daily activities and interactions;
• Developing excellent professional relationships with the organization’s programs, thereby strengthening the inter-professional/multi-professional team approach to quality improvement, patient safety, and risk management; and,
• Using results from quality indicators to stimulate inter-professional dialogue about quality and safety.

The physician leader’s role within any of these initiatives will depend greatly on the individual’s role and leadership context. Those in senior leadership positions may be tasked with leading these initiatives themselves, or with selecting and overseeing dedicated individuals to manage them. The success of these initiatives often relies not only on local leadership, but also on all other physicians who will contribute to the implementation of the initiative, and continued compliance to procedures and guidelines that are developed.

The Need for Quality Improvement
Consistent with the ECFAA framework, improving the safety and quality of patient care is an increasingly important objective across all health systems. As improvements in science and technology have offered the promise of better healthcare and improved health, they have also increased complexity in the healthcare delivery system. The 2008 article, *High Performing Healthcare Systems: Delivering Quality by Design*, notes “Many healthcare systems have been unable to cope with the acceleration of knowledge growth, thus creating a gap between the care that is possible and the care that is delivered”.

Traditionally, excellence in healthcare has been defined in terms of individual physicians or caregivers. However, experts argue that improving quality and safety can only come from designing structures and processes that “reduce the likelihood of errors, make errors more visible, and provide the means to remediate before harm occurs” (Baker et al., 2008). Strong leadership is vital to all quality improvement and safety initiatives; physician leaders have important roles to play in their local clinics, care groups, and hospitals.

The following section provides an overview of quality improvement concepts, the quality improvement landscape in Ontario, and tools and resources for physician leaders managing and executing quality improvement initiatives.
QUALITY IMPROVEMENT

A high quality healthcare system is defined by HQO as one that is accessible, appropriate, effective, efficient, equitable, integrated, patient-centred, population health-focused, and safe. The table below provides definitions of these attributes as they appear in HQO’s Quality Monitor.

<table>
<thead>
<tr>
<th>Attributes of Quality</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessible</td>
<td>People should be able to get timely and appropriate healthcare services to achieve the best possible health outcomes.</td>
</tr>
<tr>
<td>Effective</td>
<td>People should receive care that works and is based on the best available scientific information.</td>
</tr>
<tr>
<td>Safe</td>
<td>People should not be harmed by an accident or mistakes when they receive care.</td>
</tr>
<tr>
<td>Patient-centred</td>
<td>Healthcare providers should offer services in a way that is sensitive to an individual’s needs and preferences.</td>
</tr>
<tr>
<td>Equitable</td>
<td>People should get the same quality of care regardless of who they are and where they live.</td>
</tr>
<tr>
<td>Efficient</td>
<td>The health system should continually look for ways to reduce waste, including waste of supplies, equipment, time, ideas and information.</td>
</tr>
<tr>
<td>Appropriately Resourced</td>
<td>The health system should have enough qualified providers, funding, information, equipment, supplies and facilities to look after people’s health needs.</td>
</tr>
<tr>
<td>Integrated</td>
<td>All parts of the health system should be organized, connected and work with one another to provide high quality care.</td>
</tr>
<tr>
<td>Focused on Population Health</td>
<td>The health system should work to prevent sickness and improve the health of the people of Ontario.</td>
</tr>
</tbody>
</table>
High-quality care results from effective practices and interactions of caregivers, patients, support staff, as well as the information they need to generate desired outcomes. The 2008 article, *High Performing Healthcare Systems: Delivering Quality by Design*, notes that, “Quality improvement initiatives often include methods to analyze and improve (or design) work processes, techniques to collect and integrate patient information into the design of work, and methods to test and implement improvements.”

In its *Quality Improvement Guide for Long-Term Care*, HQO presents a definition of healthcare quality improvement (QI) from the Hastings Centre in New York; “A broad range of activities of varying degrees of complexity and methodological and statistical rigour through which healthcare providers develop, implement and assess small-scale interventions, identify those that work well and implement them more broadly in order to improve clinical practice.”

A QI initiative is also defined by HQO as having the following features:

- Local interdisciplinary teams empowered and trained to set goals for improvement.
- Teams identifying causes of problems, barriers to quality or flaws in system design that lead to poor quality.
- Teams testing different ideas for improving how care is delivered in multiple brief, small experiments of change.
- Teams conducting frequent, targeted measurement of quality in a way that gives them instant feedback on whether the changes they are testing are heading in the right direction.

The Model for Improvement

The Model for Improvement is a simple and effective tool for accelerating improvement in healthcare organizations. The model, which was developed by Associates in Process Improvement and is endorsed by HQO as well as the Institute for Healthcare Improvement (IHI), aims to improve healthcare processes and outcomes using two basic components:

1. The first addresses fundamental questions about improvement goals, measurement, and possible changes; and

2. The second is a rapid-cycle, four-step process: Plan, Do, Study, and Act (PDSA), which allows organizations to develop, test, and implement changes for improvement.
Leading Quality Improvement Initiatives

It is widely accepted that strong collaboration among physicians, nurses, and all other health professionals within the interdisciplinary team is critical to the success of quality improvement projects (Reinertsen et al., 1998). However, this remains a challenge in many hospitals. Reasons for this may include physician autonomy, administration approaching change from a systematic level without adequately considering service delivery implications, or insufficient formalized training in quality improvement.
To overcome this challenge, healthcare institutions are developing formal physician leadership positions in quality and patient safety. A case study of physician leaders in Ontario hospitals observed the contributions leadership made to quality and patient safety agendas (Hayes et al., 2010): The following benefits were observed from having a physician in a quality improvement (QI) leadership role:

- The ability to incorporate clinical input into corporate initiatives.
- Greater credibility in the eyes of all health disciplines for having a physician in a leadership role.
- Increased involvement from the broader physician group in QI agendas.
- Improved adoption of the change initiative.
- More successful attitudinal and cultural change.

In a 2003 article, *Connections between Quality Improvement and Measurement*, Bewick et al. states that leaders can influence the success of QI initiatives by ensuring that the organizational infrastructure necessary for improvement is in place, including:

- Leadership to guide and inspire improvement:
  - Leaders exemplify organizational values, and
  - Leaders celebrate and even participate in improvement initiatives.
- Alignment of strategic organizational incentives and improvement goals.
- Understanding of time and change management necessary to change core processes.
- Education and training for staff in improvement theory, methods, and techniques.
- Reliable flow of useful information.

Ultimately, the more that the individuals who will be implementing the change initiative are involved in the initial design and definition of the change, the more successful the initiative will be.
Additional Resources to Consult

Tools for QI Teams; Links and Resources; MRP QIP Reference Guide (Health Quality Ontario)

HQO is a government agency tasked with measuring and reporting to the public of Ontario on health system outcomes, in support of continuous quality improvement, and to promote healthcare supported by the best possible scientific evidence. HQO also offers tools for QI teams, and links and resources regarding QI in Ontario.

The Most Responsible Physician Quality Improvement Program Reference Guide provides quality improvement implementation supports that are aligned with the initiatives that ‘Most Responsible Physician’ (MRP) groups are pursuing in their Quality Improvement Programs, and a list of the initiative topics that each MRP has outlined in its program. The reference guide includes supports for a number of QI initiatives, including:

- Admission guidelines and policies,
- Patient flow, and
- Treatment protocols.

Healthcare Quarterly Special Issue on ECFAA

This special issue of Healthcare Quarterly highlights Ontario’s healthcare system transformation with a special focus on ECFAA. The issue includes articles on patient-centred care, successful quality councils, leadership engagement, and perspectives on ECFAA.

Quality and Patient Safety Governance Toolkit (Ontario Hospital Association)

This online toolkit is designed as a set of practice templates and tools for hospital boards in Ontario. Topics covered include:

Module 6: Quality, Safety and Risk Management
Section 6.1: Quality Improvement and Safety

- Quality of the Board and its Practices
- Measurement and Reporting
- Board-Management Working Relationships that Support Quality Improvement
- Empowering Patients and Families
- Ensuring Strong and Effective Relationships with Physicians and Clinical Leadership

Education for Quality and Safety Leaders: A Needs Assessment and Program Review (British Columbia (BC) Patient Safety & Quality Council)

This report describes the education and professional development needs identified by the BC health authority staff responsible for leading QI and patient safety initiatives, approaches to patient safety and quality training from 11 programs in Canada, the US, and the UK.

Organizational Essentials for Quality Improvement Plans (Baker & Baker, 2011)

This presentation from the National Health Care Leadership Conference discusses organizational essentials for high performance, key components of a quality plan, leadership requirements for performance excellence, and tensions between a quality plan and reporting requirements. It also provides a case study of creating and executing a quality plan at St. Joseph’s Healthcare Centre, Toronto.

Engaging Physicians in a Shared Quality Agenda (Institute for Healthcare Improvement, 2007)

This white paper presents a framework on which hospital leaders might build a written plan for physician engagement in quality and safety. The paper includes tools to help hospital leaders assess organizational factors that can inform the degree of difficulty in engaging physicians, as well as to identify and prioritize initiatives for which physician engagement is essential.

High Performing Healthcare Systems: Delivering Quality By Design (Baker et al.)

This book provides a number of case studies of organizations and systems “that have made the pursuit of quality and safety a core element of their strategies, a part of everyone’s work and the way they differentiate themselves from their competitors.”
Hospital Quality Improvement Plans

As part of ECFAA, healthcare organizations are required to prepare annual QIPs for the following fiscal year, and to disclose the plan to the public. As part of the 2013/2014 QIPs, organizations are required to include a report on their progress against targets set out in 2012/2013.

2012/13 Quality Improvement Plans: An Analysis for Improvement (HQO)

For additional guidance on QIP development, physicians can consult HQO’s 2012 QIP: An Analysis for Learning. This document identifies successful examples of plans that have a clear vision and strategy for improvement, with the aim of providing a learning opportunity for other organizations as they develop future QIPs.
UNDERSTANDING PROCESS IMPROVEMENT

Process improvement is one aspect of broader quality improvement that organizations can undertake to help them achieve their priorities. In the healthcare context, process improvement techniques examine patient flow within the hospital or a particular ward/department from end-to-end, with the aim of identifying specific processes that can be redesigned to improve outcomes. These outcomes are often associated with improving efficiencies and/or the quality of care provided to patients.

Similar to their role in quality improvement initiatives, physician leaders can play a role in the identification, design and implementation of process improvement initiatives.

The remainder of this section provides a brief description of some commonly used process improvement techniques.

LEAN

“LEAN” is a management/production process that is essentially centred on increasing efficiency: preserving value with less work. Further, LEAN is a system that is designed to make the improvements work and be sustained. The expense of resources for any goal other than the creation of value for the customer/client is deemed wasteful, and thus a target for elimination. An application of LEAN can be observed in the ThedaCare business improvement system which recommends that standard work for leaders is a critical underpinning of program success.

Additional Resources:

- Healthcare Quarterly provides an overview through a 2009 article entitled [Leading Lean for Canadian Healthcare Leaders](Fine et al., 2009)
- The OHA offers an online certification course for [Lean Healthcare -- Greenbelt](#).
LEADERSHIP QUOTE

In his Harvard Business Review essay on “Why Transformation Efforts Fail”, John Kotter points out that without a vision, transformation efforts can easily dissolve into a list of confusing and incompatible projects that take the organization in the wrong direction or nowhere at all. The tools of LEAN are not enough to deliver higher quality, safe care and improved morale. Sustainable improvement requires a system.

Whereas many organizations will take a project-based approach, North Bay Regional Health Centre plans to use a system that builds and supports a continuous improvement culture. This LEAN management process is designed after the Business Improvement System at ThedaCare. It has 10 elements:

1. Daily Unit Stat Sheet
2. Daily Huddle
3. Unit Leadership team
4. Monthly Scorecard
5. The monthly performance review meeting
6. Front Line Standard Work
7. Leader Standard Work
8. Visual Management
9. Unit waste removal activities including Rapid Improvement Events
10. PDSA (Plan, Do, Study, Act) – also known as the scientific method

One very exciting part of the system is the huddle board. Each of our units/departments will have a huddle board which supports the achievement of breakthrough goals and continuous daily improvement. This system will support frontline workers in solving problems every day and provide a way of translating strategy from the front line to the senior executives and back again.

Paul Heinrich
CEO, North Bay Regional Health Centre
Six Sigma

Originating as a business management strategy, Six Sigma seeks to improve the quality of process outputs by identifying and removing the cause of defects (errors) and minimizing variability in business processes. Six Sigma projects carried out within an organization follow a defined sequence of steps with quantifiable targets. Many organizations also create a special internal infrastructure for organizational experts in these methods (known as “Black Belts”, “Green Belts”, etc.).

An article written in the Journal for Healthcare Quarterly provides an overview of how principles of Lean Thinking and Six Sigma can provide a framework for innovation in Healthcare (de Koning et al., 2006).

Root Cause Analysis/Corrective Action

Root cause analysis is a method for identifying and measuring problems or issues an organization is facing, then finding their root causes and understanding the relationships these root causes share. Steps are then taken to identify multiple potential solutions, test them through simulation, and implement them with control mechanisms to ensure the problem does not recur in the future.

Corrective action programs seek to eliminate the cause of a defect or error, and prevent its recurrence by ensuring its root cause is also eliminated.

Additional Resources to Consult

**Lean Hospitals**

*Building on the success of the Shingo Prize-Winning first edition, Lean Hospitals: Improving Quality, Patient Safety, and Employee Engagement, Second Edition, explains how to use the Lean management system to improve safety, quality, access, and morale while reducing costs. Lean healthcare expert Mark Graban examines the challenges facing today’s health systems, including rising costs, falling reimbursement rates, employee retention, and patient safety.*

**Accreditation Canada**

*Accreditation Canada is a not-for-profit, independent organization accredited by the International Society for Quality in Health Care (ISQua), providing national and international health care organizations with an external peer review process to assess and improve the services they provide to their patients and clients based on standards of excellence.*

**What is Value in Health Care?** (Michael Porter)

*This article from Michael Porter relates the concept of ‘value’ to a healthcare setting, and discusses the ways it can be better understood and measured.*
OVERVIEW

Advances in medicine over the years have substantially increased the complexity of care that many patients receive. This complexity – coupled with other factors such as an aging population, resource shortages, outdated models of training, and many others – has increased the likelihood of adverse events in the care that is provided to patients (National Steering Committee on Patient Safety, 2002). Patient safety continues to be an important topic for healthcare providers across Canada, as a number of media stories and legal cases on unintended adverse events have emerged over the years. Governments have continued to support the patient safety agenda, which has become tightly linked with the broader quality movement. As part of its patient safety strategy, the federal government established the Canadian Patient Safety Institute, which works with governments, health organizations, leaders, and healthcare providers to inspire extraordinary improvement in patient safety and quality.

Physicians must play an integral role in ensuring that the care provided to their patients meets the highest standards in safety and minimizes the potential for unintended adverse events. Physician leaders should take this responsibility further by providing a structure and mechanism to their peers and other health professionals, for reporting, analyzing, and resolving potential errors and adverse events. For example, morbidity and mortality rounds are mechanisms for reporting and discussing patient safety issues.

UNDERSTANDING AdVERSE EVENTS

Adverse events are defined in the Canadian Adverse Events Study (Baker et al., 2004) “unintended injuries or complications that are caused by healthcare management, rather than by the patient’s underlying disease, and that lead to death, disability at the time of discharge or prolonged hospital stays.” While some adverse events are unavoidable (e.g., unanticipated allergic reaction to a drug), estimates show that roughly half of all adverse events are potentially preventable.

The Canadian Adverse Events Study provided a starting point for developing strategies to minimize the incidence of avoidable adverse events. Among the key findings, the study notes that one of the most important factors in improving patient safety is ensuring the work environment of healthcare professionals encourages the development of initiatives for minimizing adverse events and their effects.

In this context, physician leaders must encourage the reporting of adverse events, continued monitoring, and improved communication and coordination among care providers.


Additional Resources to Consult

**Canadian Patient Safety Institute**

The Canadian Patient Safety Institute (CPSI) is a not-for-profit organization that exists to raise awareness and facilitate implementation of ideas and best practices to achieve a transformation in patient safety. They develop evidence-informed products and resources that are customized for the frontline, middle managers, senior leaders, and boards.

**A Guidebook to Patient Safety Leading Practices: 2010** (Ontario Hospital Association)

The aim of this guidebook is to highlight and share innovative patient safety initiatives in Ontario hospitals, focused on four themes: boards and leadership, teamwork and communication, transparency of data and accountability, and patient and family and engagement.

**University of Toronto Centre for Patient Safety**

The Centre for Patient Safety creates, disseminates, and implements new knowledge in the field of patient safety at the University of Toronto and its affiliated hospitals. Examples of initiatives include:

- Quality improvement workshops, including an annual symposium
- Publications on a range of patient safety-related topics
- A researcher database
- A broad range of consulting services
- Learning sessions in Patient Safety and Quality Improvement, including a certificate program course for clinicians and administrators

**Institute for Safe Medication Practices Canada**

The Institute for Safe Medication Practices Canada (ISMP Canada) is an independent, national, not-for-profit organization committed to the advancement of medication safety in all healthcare settings and the promotion of safe medication practices. They offer educational events, publications, and medication safety tools and checklists for healthcare organizations.

**Quality of Care Information and Protection Act**

As described in Module 1, the *Quality of Care Information and Protection Act* (QCIPA) addresses the public interest in facilities engaging in quality of care and peer review activities by prohibiting disclosure of quality of care information generated for the purposes of a designated “quality of care committee”.


Enacted in 2004, QCIPA was developed in response to the growing importance of patient safety. QCIPA promotes the patient safety agenda in Ontario by providing a legislative vehicle for hospitals and other health facilities to review adverse events with the assurance that the information resulting from the review is protected from disclosure. In short, QCIPA promotes increased information sharing and unfiltered collaboration among health providers, with the aim of understanding and resolving avoidable adverse events.

For more information on QCIPA, physicians are encouraged to consult OHA’s QCIPA Toolkits (2004 and 2007).

Disclosure of Harm
Despite best efforts to ensure patient safety, patients may incur harm during the delivery of healthcare. Harm is not always preventable, nor is it necessarily an indicator of substandard care. Disclosure of harm provides patients with the information they need to make autonomous, informed decisions about their healthcare and promotes a culture of safety where openness, transparency and learning from adverse events are encouraged.

Physicians owe a common law legal duty to disclose errors to their patients. This duty arises from the doctrine of informed consent and the fiduciary relationship between a physician and a patient. The duty to disclose has been adopted in the codes of ethics of the majority of professional governing bodies, and is often addressed in institution-specific policies and procedures.

As described previously, hospitals are now also required by the Hospital Management Regulation to disclose all “critical incidents” to patients or family members, the hospital’s administrator and the MAC. The hospital board is required to ensure that the hospital administrator establishes a system for ensuring the disclosure of critical incident as soon as practicable after the incident occurs. Disclosure must include:

- The material facts of what occurred;
- Consequences for the patient as they become known; and
- The actions taken and recommended to be taken to address the consequences to the patient.
The Hospital Management Regulation defines a “critical incident” as any unintended event that occurs when a patient receives treatment in the hospital that results in death or serious disability, injury or harm to the patient, and does not result primarily from the patient’s underlying medical condition or from a known risk inherent in providing treatment. Many hospitals will have different definitions of critical/adverse events and/or errors, but the definition in the PHA will shape the hospital’s statutory disclosure obligations.

The Hospital Management Regulation (HMR) also requires that critical incidents be charted in the patient’s medical record. HMR further requires that the hospital board ensures that the administrator establish a system for analyzing the incident and taking steps to avoid or reduce the risk of further similar incidents occurring, and that there be disclosure of this information to patients or family members at an appropriate time following the initial critical incident disclosure.

In addition, ECFAA requires hospitals to develop QIPs that take into account, among other factors, “aggregate critical incident data as compiled based on disclosures of critical incidents”.

The HMR provides that the requirement to disclose these systemic steps is also subject to the requirements of QCIPA. The relationship between disclosure of critical incidents and QCIPA is complex. Additional guidance is provided in the OHA’s December 2010 Legislative Update.

It is important to note that Ontario has adopted legislation that supports the use of an apology when an adverse event or critical incident occurs. Under the Apology Act, an apology made in connection with any matter will not be considered an express or implied admission or fault or liability in civil and administrative proceedings.

The following resources are also available to physicians for reference regarding policies and guidelines on the disclosure of harm.

**Additional Resources to Consult**

*The Ministry of Health and Long-Term Care Guidelines for Critical Incident Reporting*

This document provides Ministry guidelines for critical incident reporting, and refers to the World Health Organization’s International Classification for Patient Safety (ICPS) framework.

*Canadian Disclosure Guidelines: Being Open with Patients and Families* (Canadian Patient Safety Institute, 2011)

The purpose of these guidelines is to support and guide healthcare providers on communicating when harm occurs in healthcare, and to encourage organizations to develop policies and processes to effectively support communications.


This policy articulates the College’s expectations of physicians for informing patients when harm is sustained in the course of receiving healthcare including, the legal basis for disclosure, what and when to disclose, whom to disclose information to, and who should disclose this information.
Learning from Adverse Events: Fostering a just culture of safety in Canadian hospitals and health care institutions (The Canadian Medical Protective Association, 2009)

This booklet describes the requirements and processes for reporting adverse events and close calls, and the best approach for reviewing these events. It also explains how CMPA members and other healthcare providers can foster a culture of safety within a hospital/institution, whether they are in a leadership/management role or a participant in the reporting and review process.

Communicating with your patient about harm; Disclosure of Adverse Events (The Canadian Medical Protective Association, 2008)

This report offers definitions of the terms harm, adverse event and disclosure, a framework for understanding harm, an explanation of the different stages of disclosure, and a brief synopsis of no-harm events.

Adverse Health Event Management: International and Canadian Practices (Gregory)

This paper aims to facilitate an understanding of the international, national, provincial and organizational “leading practices” in adverse health event management.

Ontario Guide to Disclosure: Implementing the Amendments to Regulation 965 under the Public Hospitals Act (OHA)

Available for purchase via: This guide summarizes existing provincial disclosure legislation and provides resources to support the disclosure process.
OVERVIEW

While patient safety is one significant risk that hospitals must properly manage, there are many other risks that healthcare organizations encounter. For instance, hospitals may encounter financial risks in meeting overall financial budgets/commitments; human resource risks in the ability to attract, develop and retain the talent needed to meet its objectives; or privacy risks with regards to the safeguarding of personal information or data, to name a few.

Healthcare organizations are focusing more attention and effort on risk management, due to both external factors (such as public expectations for greater accountability and governance), and internal factors (such as better resource allocation).

The following section provides an overview of risk management strategies, and provides useful tools for physician leaders tasked with managing risk. Physician involvement in risk management activities will vary greatly from institution to institution and depend on the physician’s role within the leadership structure.

At the very least, all physician leaders can expect to be involved in the patient safety aspect of risk management (as discussed in the previous section). With respect to other risks within the organization such as financial risks, human resource risks, privacy risks, and others, physician leaders may provide input into various aspects of risk management (identification, assessment, mitigation, etc.). Physician leaders are encouraged to consult with hospital administration to understand their hospital’s model for risk management and their potential role in risk management activities.

Key Sources


*The purpose of this resource guide is to review the basic elements of IRM and, without prescribing an exact format or critiquing any particular approach, to offer sensible, efficient, and effective techniques and tips for IRM implementation.*
WHAT IS INTEGRATED RISK MANAGEMENT?

Risk Management is a function of the administration of a hospital or other health care organization that is directed toward the identification, evaluation, and correction of potential risks which could lead to injury for patients, staff members, or visitors, and result in property loss or damage (Mosby's Medical Dictionary, 2009). Many organizations manage large risks independently of one another, often within organizational silos, and this can lead to overlooking major risks. An alternative solution, IRM, provides a common framework for understanding and prioritizing very different types of organizational risks from all areas of the organization (HIROC, 2011).

The Emergency Care Research Institute (ECRI) defines IRM as:

“An approach for identifying critical risks, quantifying their potential impact and likelihood, prioritizing, and identifying risk management strategies to bring risks to acceptable levels”.

HIROC developed a risk management process for IRM that is built on the following eight steps: deciding on a simple framework, ensuring oversight and coordination, confirming organizational context, assessing risks, reporting risks, managing risk, and evaluating and improving the IRM program.

For additional information on this process, and accompanying tips and suggestions, physicians are encouraged to consult the IRM Resource Guide on HIROC’s website.
WHY MANAGE RISK?

A number of internal and external factors may influence healthcare organizations in Canada to implement integrated risk management strategies. The following examples were highlighted in the 2011 HIROC publication, ‘Integrated Risk Management (IRM) for Healthcare Organizations; Risk Management Resource Guide’:

External Drivers

1. Public accountability and reputation: expectations for public accountability in healthcare are increasing, including better fiscal responsibility for public funds. This is also becoming a more important factor for recruitment of competent staff, board members, and donors.

2. Governance: a call for better corporate governance is influencing the health system, as organizations and their boards are moving towards ensuring processes are in place to identify and manage risk.

3. Accreditation: Canada’s new Qmentum standards have articulated the need for leadership teams to implement integrated risk management strategies.

4. Provincial government uptake; IRM has been adopted by the ministries of health in British Columbia, Alberta, and Ontario.

Internal Benefits

1. To reduce the internal impact of surprises in the future.
2. To allocate valuable resources according to risk priorities.
3. To comply with relevant legal and regulatory threats and international norms.
4. To improve stakeholder confidence and trust.

Challenges to IRM

There are considerable challenges and costs associated with an IRM implementation. Coordinating IRM is extremely complex, as leaders need to have the organization- and system-wide view in mind at all times, while coordinating the multitude of stakeholders on the ground.

Among the most significant barriers to successful implementation are overly complicated structures and processes. The, Ten common misconceptions about enterprise risk management, a Morgan Stanley publication, states that “failure to recognize that [IRM] is in fact an easier, simpler, and more logical undertaking than most people realize”. Risk management should follow a simple, well-understood process, with a dedicated coordinator role in place from the beginning.
Another challenge occurs in acting upon the risks that were assessed. Often, a lack of clarity and accountability around objectives will lead to a failure to follow through on risk assessment findings. To overcome this challenge, objectives and action items should be clearly linked to an owner, with a timeline that is clearly defined (PricewaterhouseCoopers, 2008).

**Additional Resources to Consult**

*Healthcare Insurance Reciprocal of Canada* (HIROC)
HIROC is an insurance reciprocal (members insure themselves and each other, sharing the risk) that works in partnership with healthcare organizations across Canada to provide stable and cost-effective medical malpractice liability insurance, claims management expertise, and risk management services.

*A Practical Guide to Risk Assessment* (PricewaterhouseCoopers)
A practical guide defining risk assessment, offering key principles for effective and efficient risk assessments, and outlining essential steps for performing a risk assessment.

*Risk and Insurance Management Society, Inc.*
The RIMS Canada Council (RCC) is a standing committee of RIMS representing the Canadian chapters. The RCC addresses the strategic initiatives of RIMS and risk management issues in Canada.

*Canadian Healthcare Risk Management Network*
The Canadian Healthcare Risk Management Network (formerly Ontario only) is a membership-based forum for healthcare professionals to discuss current issues in risk management, patient safety, and quality, share information, and network.
OVERVIEW

Effective leaders are able to recognize that changing environments provide opportunities to introduce new innovations, improve efficiency, and strengthen the quality of the organization. Successfully managing change often requires concerted coordination of strategy, organizational buy-in, and the adoption of new behaviours. The following section provides leadership strategies and tools for managing change, that are specifically focused on the healthcare service delivery environment.

Key Sources

*Implementing strategic change in a health care system: The importance of leadership and change readiness* (Health Care Management Review, 2008)

This study explores how three variables—agreement with new strategy, leaders’ actions, and groups’ general orientation towards change—can influence members of physician teams to take actions supporting a strategic shift aimed at improving patient satisfaction.

*Strategies and Tools for Managing Change* (MacPhee, 2007)

This article describes major leadership strategies and tools for effectively managing change; observing traits of leaders, followers, and the organization; and offering relevant change management tools.
KEY VARIABLES INFLUENCING EFFECTIVE CHANGE

A 2008 Health Care Management Review article titled, ‘Implementing strategic change in a health care system: The importance of leadership and change readiness’, explored how three key variables influenced physicians to take actions to support a strategic shift aimed at improving patient satisfaction. The results can be applied to healthcare settings more broadly, and offer physician leaders insight into key variables they will face when initiating change:

1. Agreement with new strategy
   When members of a team or organization have consensus about the direction of a strategic change, this has a positive influence on the success of implementing that change.

2. Actions of leaders
   Leaders of a group or organization, specifically middle-level managers, have a strong ability to enhance or undermine the organization’s ability to implement strategic change. Leaders who effectively demonstrate support for a new strategy are likely to see greater or faster improvements resulting from the change initiative, and mid-level managers specifically serve as an important gatekeeper of bottom-up change (Woodbridge and Floyd, 2006).

3. General orientation toward change
   Group/network norms and capabilities can also influence the success of a change initiative, regardless of whether that group is supportive of the initiative or not. For example, norms determine whether people are rewarded or punished for embracing change. When group norms are not consistent with new behaviours, individuals may resist change for fear of informal sanctions. Alternatively, group norms that value innovation may see greater success from the change initiative.

LEADERSHIP QUOTE

“Leadership is Influence, Nothing More, Nothing Less.”
John Maxwell
Author, The 21 Irrefutable Laws of Leadership
Combining variables

The combined effect of these three variables should be considered when implementing a new strategy. Individuals may agree with the new strategy, but lack the group norms or capabilities for successful implementation. Leaders may demonstrate support for the strategy, but may also need to provide direction and resources to ensure a group has the ability to implement the strategy. Ultimately, success of a change initiative hinges on two key factors:

1. The ability to understand the complexities of the change initiative; and
2. The willingness of individuals to change their actions to support the implementation of the new strategy (the aforementioned key factors can influence that willingness).

Change Model: Four Stages of Change in Healthcare Organizations

Healthcare organizations face unique challenges when implementing a change initiative. Often these organizations have multiple missions, such as providing healthcare, employing community members, and remaining financially steady. There are also many autonomous stakeholders to consider when managing the change, such as employees, funders, and patients. A 2006 Healthcare Quarterly article outlined a four-stage change management process for healthcare organizations.

Stage One: Determine Desired End State

1. Identify performance gap or opportunity (e.g., strategic or technical opportunities have emerged);
2. Create specific measurable goals;
3. Consider systems and activities required to measure these goals; and,
4. Discuss required new behaviours, capabilities, organizational structure, and systems.

Stage Two: Assess Readiness for Change

1. Conduct a broad situational analysis, considering:
   a. Who are the key stakeholders, and do they recognize need for change?
   b. Who are the likely supporters or opponents?
   c. Are resources available to implement change?
   d. Will new capabilities need to be developed?
   e. Are there past examples of organizational change to learn from?
2. Enlist appropriate change leader(s); they should be influential, motivated, connected, and skilled leaders:
   a. This may take the form of individual leaders, or a steering committee of individuals who take on different responsibilities in the change initiative.

Stage Three: Broaden Support and Organizational Redesign
1. Develop and execute a communication strategy delivered by a credible source, with tailored messages for target audiences:
   a. Communicate what the change is, why it is occurring and why now, how it will affect individuals in the organization, and why they should support it.

2. Ensure affected staff can appreciate the benefits of change by designing an organizational system that is aligned with the change:
   b. Consider the Star Model when designing this organization. The following subsystems are ‘points’ of the star which must work together (Golden and Martin, 2004):
      ▪ Goals and tasks
      ▪ Structure
      ▪ People and human resource policies
      ▪ Rewards
      ▪ Information and decision support

Stage Four: Reinforce and Sustain Change
1. Initiate performance monitoring efforts to:
   a. Showcase successes and reward supporters;
   b. Recognize and support any losses associated with the change process; and
   c. Reconsider goals in light of new information or opportunities.

2. Reflect on the change process by asking:
   a. What could have been done differently/more quickly/with fewer resources?
   b. Have the right changes occurred?
THE ROLE OF LEADERSHIP IN DRIVING CHANGE

Strategic change derives maximum positive impact when groups support the new direction that the organization is taking.

LEADERSHIP QUOTE

“Informed and engaged physician leaders working with the administration of the hospital is a successful recipe for organizations to remain current, patient-centred, and innovative.”

Dr. Gillian Kernaghan
President, St. Joseph’s Health Care London

Leaders can influence this support by:

1. Focusing on building support for the strategic changes with direct, consistent communication:
   a. Help members of the organization understand both the benefits or outcomes of change, and the risks of continuing with the status quo (e.g., a safer work environment).
   b. Outcomes should be realistic, valued, and manageable.

2. Looking for new ways to involve staff in identifying ways of implementing the strategy:
   a. Allow individuals to take ownership of implementation to improve buy-in.

3. Modeling behaviours to build group norms that value change:
   a. Approach mistakes as opportunities for learning and correction;
   b. Reward team performance;
   c. Be willing to try new things;
   d. Convey energy toward reaching goals; and
   e. Remain visible and positive to counter apathy or low morale.
4. ‘Chunking’ complicated initiatives into more manageable parts that can be implemented locally:
   a. Change happens more quickly when an initiative is simple and where local adaptation is possible.
   b. Asking people to think and act outside their range of local influence can lead to discouragement.

5. Provide appropriate rewards for improved performance:
   a. Rewards should be aligned with the pre-set, measurable goals of the change initiative.
   b. Social recognition should be balanced with financial compensation.
CHANGE MANAGEMENT TOOLS

The following tools from *Strategies and Tools for Managing Change* (MacPhee, 2007) can help facilitate a change management process:

*The Vision / Mission Statement*

A clear vision and mission can unify the values of stakeholders, leading to collaboration. The change process should begin with a vision/mission analysis, and a project plan for bringing the vision and mission to life. The following table offers a template for conducting a mission/vision analysis:

<table>
<thead>
<tr>
<th>Step</th>
<th>Key Question</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>What is the organization’s basic purpose?</td>
<td>• Consider priorities of the hospital, strategic partners, the ministry, and the community.</td>
</tr>
<tr>
<td>2</td>
<td>What is unique or distinct about the organization?</td>
<td>• This is the “selling point” for stakeholders, especially external stakeholders.</td>
</tr>
<tr>
<td>3</td>
<td>What is the future orientation?</td>
<td>• One to two sentences should summarize future strategy or organizational aspirations.</td>
</tr>
<tr>
<td>4</td>
<td>Who are the key stakeholders?</td>
<td>• Some statements include examples of key internal and external stakeholders. This can be a powerful way to get “buy-in” from stakeholder groups -- include them in the vision/mission statement.</td>
</tr>
<tr>
<td>5</td>
<td>What are the key words or phrases?</td>
<td>• Do these words represent the organizational culture’s values, beliefs, and practices?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If they are enduring words, they should serve as a “thread” in departmental philosophy statements, and in project plan descriptions, goals, and objectives.</td>
</tr>
</tbody>
</table>
Team Brainstorming and Pre-planning Exercises

a. Identify the critical success factors of your new strategy, the “must have’s” and desired results.

b. Conduct a stakeholder analysis: consider which groups will be impacted by the change, and their level of commitment to implementing the new strategy.

c. Consider drivers and restraints in the ‘bigger picture’. Consider a SWOT analysis (strengths, weaknesses, opportunities, and threats) that examines the internal strengths and weaknesses, and the external opportunities and threats.

Teamwork and Project Management

Effective teamwork and project management are critical to the success of change projects. See Section 4.1 for recommendations for managing high-performance teams, and Section 5.2 for helpful project management tools.

Environmental Scan Tools

Two tools can be useful in conducting a quick environmental scan during the process of change management. One tool is referred to as the “SWOT” analysis described above, which encourages a leader to consider the “strengths”, “weaknesses”, “opportunities”, and “threats” for various contexts (e.g., an analysis of the organization, department or a particular initiative).

Another helpful preliminary tool is the “PESTEL”, which is often used in strategic planning processes. The “PESTEL” tool employs “political” (P), “economical” (E), “social” (S), “technological” (T), “environmental” (E), and “legal” (L) analyses of an issue. These tools are not meant to be exhaustive in their scan, but rather serve as a starting point for evaluation.

Additional Resources to Consult

Leading Change: Why Transformation Efforts Fail (Kotter, 2007)

In one of Harvard Business Review’s most popular change management articles, John P. Kotter identifies the eight largest errors that organizations can make that can doom their change management efforts (known as the Kotter 8-Step Model for Leading Change).
OVERVIEW

The role that a physician plays in clinical research throughout their career depends greatly on his or her level of interest, and in the nature of the clinical trials conducted in their clinical environment or practice area. Participation in clinical trials can have significant benefits for physicians:

- It gives physicians a publishing opportunity, which brings significant credibility in the academic community.
- It can lead to opportunities for promotion.
- It allows physicians to strengthen their position as a key opinion leader and consultant, regardless of whether they are paid directly for their clinical trial services.

The Physician Leaders Role in Clinical Research

Research is conducted in hospitals by clinicians, but each institution has access to its own approval process (the Research Ethics Board), with which clinician research is required to comply before conducting research on the premises. Again, research and clinical discoveries at hospitals may be subject to an affiliation agreement with a university, and/or research policies and procedures which should be consulted and understood by physician leaders when considering research opportunities.

At the lowest level of participation, a clinician may be involved in a Phase III trial (Health Canada, 2009), where they would see the patient and follow a script. Ultimately, they are responsible only for seeing that nothing goes very wrong for that patient. The patient selection and data collection would only be carried out by a trial coordinator. Participation in Phase I/II research sees clinicians contributing to the development of the research protocol, where skill and speed are important success factors.

Clinicians who are active researchers and who understand the underlying pathophysiology of the conditions in question are invaluable to clinical trials. They are able to lift the performance of both the research and clinical components of the trial.

Hospital leaders improve leadership within the clinical research arena by putting more effort into identifying and nurturing these unique clinician scientists, perhaps through special remuneration and recognition packages.
CLINICAL TRIALS: GOVERNANCE RESOURCES

The following documents provide useful information and policies that guide clinical research governance in Canada.

   A joint policy of Canada’s three federal research agencies – The Canadian Institutes of Health Research (CIHR), the Natural Sciences and Engineering Research Council of Canada (NSERC), and the Social Sciences and Humanities Research Council of Canada (SSHRC), is a benchmark for the ethical conduct of research involving humans in Canada, and compliance with the policy is a requirement of federal funding.

2. **Clinical Trials Manual** (Health Canada)
   This manual provides tools and relevant links to facilitate the successful filing of a Clinical Trial Application (CTA) to Health Canada, for clinical trials that involve the use of Pharmaceutical and/or Biological and Radiopharmaceutical drugs in human subjects. The manual is an administrative instrument, and where information is inconsistent with regulations, the regulations should take precedent. Topics include:

   **Background Information**
   - Publication: e.g., naming of authors, publishing results
   - Intellectual Property: e.g., ownership and use of data, ownership and use of inventions
   - Food and Drug Act, Regulations overview and key links
   - Clinical Trials Application information
   - Roles of Stakeholders (Health Canada, Sponsor, Research & Ethics Board, Qualified Investigators)
   - Compliance to Regulatory Framework
   - Classification of Clinical Trials (Phases I through IV)
Clinical Trials

- Overview of the Application Process (preparation, submission, screening, evaluation, authorization/rejection, submission of amendments, and post-authorization requirements)
- Investigator/Institution Initiated Clinical Trials
- Accountability & Transparency
- Relevant Links
- Abbreviations and Definitions
- Frequently asked Questions
- Contact Info and Useful Links

3. **Statement of Principles to be Considered When Negotiating a Clinical Studies Agreement**
   (Council of Academic Hospitals of Ontario)
   
   This document sets out the recommended minimum standard requirements for Ontario academic hospitals when negotiating a clinical study agreement. It is not meant to be interpreted as contract language, but rather to express the general concepts that should be included in contracts. Principles covered include:
   
   - Publication: e.g., naming of authors, publishing results
   - Intellectual Property: e.g., ownership and use of data, ownership and use of inventions
   - Confidentiality: e.g., nature of confidentiality obligation, permitted disclosures, terms
   - Privacy
   - Indemnification: e.g., indemnitor obligations, exclusions, and conditions
   - Limitation of Liability of Institution/Investigator/No Warranties
   - Disclosure of Existence of Contract and Use of Name
   - Parties’ Rights and Obligations: e.g., compliance, conflict, force majeure
   - Dispute Resolution and Governing Law/Jurisdiction
   - Termination: e.g., termination events, survival of rights/obligations following termination
4. *Law and Ethics in Biomedical Research: Regulation, Conflict of Interest and Liability* (Trudo Lemmens, Duff Waring)

Law and Ethics in Biomedical Research uses the Gelinger case as a touchstone, illustrating how three major aspects of that case -- the flaws in the regulatory system, conflicts of interest, and legal liability -- embody the major challenges in the current medical research environment. Editors Trudo Lemmens and Duff R. Waring, along with a host of top scholars in the field, demonstrate why existing models of research review and human subject protection are in need of improvement, and how more stringent regulatory and legal means can be used to strengthen the protection of research subjects and the integrity of research.
CLINICAL TRIALS: ETHICAL AND LEGAL FRAMEWORKS

The following documents provide useful information and frameworks for conducting clinical trials in Canada, legally and ethically.

1. *Ethical Conduct for Research Involving Humans* (CIHR, NSERC, SSHRC)

   This joint policy of Canada’s three federal research agencies is a benchmark for the ethical conduct of research involving humans, and acts as a condition for individuals and institutions to be eligible to receive and administer funding from the Agencies. The site also offers companion documents, including highlights of the policy, and tables of concordance. Topics covered by the policy include:

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Topic</th>
<th>Sections</th>
</tr>
</thead>
</table>
| 1       | Ethics Framework | a) The Importance of Research and Research Ethics  
b) Core Principles  
c) How to Apply this Policy |
| 2       | Scope and Approach | a) Scope of Research Ethics Review  
b) Approach to Research Ethics Board Review |
| 3       | The Consent Process | a) General Principles  
b) Departures from General Principles of Consent  
c) Capacity  
d) D. Consent Shall Be Documented |
| 4       | Fairness and Equity in Research Participation | a) Appropriate Inclusion  
b) Inappropriate Exclusion |
| 5       | Privacy and Confidentiality | a) Key Concepts  
b) The Ethical Duty of Confidentiality  
c) Safeguarding Information  
d) Consent and Secondary Use of Identifiable Information for Research Purposes  
e) Data Linkage |
| 6       | Governance of Research Ethics Review | a) Establishment of Research Ethics Boards  
b) Procedures for Research Ethics Board Review  
c) Reconsideration and Appeals  
d) Research Ethics Review during Publicly Declared Emergencies |
<table>
<thead>
<tr>
<th>Module</th>
<th>Topic</th>
<th>Subtopics</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Conflicts of Interest</td>
<td>a) Key Concepts</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b) Institutions and Conflicts of Interest</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c) Research Ethics Board Members and Conflicts of Interest</td>
</tr>
<tr>
<td></td>
<td></td>
<td>d) Researchers and Conflicts of Interest</td>
</tr>
<tr>
<td>8</td>
<td>Multi-Jurisdiction Research</td>
<td>a) Review Mechanisms for Research Involving Multiple Institutions and/or Multiple Research Ethics Boards</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b) Review of Research Conducted Outside the Institution</td>
</tr>
<tr>
<td>9</td>
<td>Research Involving the First Nations, Inuit, and Métis Peoples of Canada</td>
<td>a) Key Concepts and Definitions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b) Interpreting the Ethics Framework in Aboriginal Contexts</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c) Applying Provisions of This Policy in Aboriginal Contexts</td>
</tr>
<tr>
<td>10</td>
<td>Qualitative Research</td>
<td>a) Nature of Qualitative Research</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b) B. Research Ethics Review of Qualitative Research</td>
</tr>
<tr>
<td>11</td>
<td>Clinical Trials</td>
<td>a) Key Concepts</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b) Clinical Trial Design and Registration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c) Assessing Safety and Minimizing Risk</td>
</tr>
<tr>
<td></td>
<td></td>
<td>d) Financial Conflicts of Interest</td>
</tr>
<tr>
<td></td>
<td></td>
<td>e) Analysis and Dissemination of Clinical Trial Outcomes</td>
</tr>
<tr>
<td>12</td>
<td>Human Biological Materials Including Materials Related to Human Reproduction</td>
<td>a) Types of Human Biological Materials</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b) Collection of Human Biological Materials</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c) Consent and Secondary Use of Identifiable Human Biological Materials for Research Purposes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>d) Storage and Banking of Human Biological Materials</td>
</tr>
<tr>
<td></td>
<td></td>
<td>e) Research Involving Materials Related to Human Reproduction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>f) Research Involving Pluripotent Stem Cells</td>
</tr>
<tr>
<td>13</td>
<td>Human Genetic Research</td>
<td>a) Application of Core Principles to Genetic Research</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b) Plans for Managing Information Revealed through Genetic Research</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c) Genetic Counselling</td>
</tr>
<tr>
<td></td>
<td></td>
<td>d) Genetic Research Involving Families</td>
</tr>
<tr>
<td></td>
<td></td>
<td>e) Genetic Research Involving Communities and Groups</td>
</tr>
<tr>
<td></td>
<td></td>
<td>f) Genetic Material Banks</td>
</tr>
<tr>
<td></td>
<td></td>
<td>g) Gene Transfer</td>
</tr>
</tbody>
</table>
2. **Canadian Bioethics Companion** - Chapter 8: Research Ethics (Unger, 2011)

   This chapter from the Canadian Bioethics Companion provides a Roadmap of Canadian research ethics regulations and oversight, including grants and funding, and overview of regulations and guidelines, research ethics boards, and legal considerations. Topics covered include:
   - Evolution of Research Ethics Guidelines
   - Roadmap of Canadian Research Ethics Regulations and Oversight:
     - Grants and Funding
     - Overview of Regulations and Guidelines
     - Legal Considerations
   - Research Involving Humans – the Tri-Council Policy Statement
   - Research Involving Animals
   - Responsible Conduct:
     - Conflicting and Competing Interests
     - Authorship and Publication
     - Research Misconduct
     - Liability
   - Summary and References


   This guidance document is an international ethical and scientific quality standard for designing, conducting, recording, and reporting trials that involve the participation of human subjects. The document provides assistance to industry and healthcare professionals on how to comply with the policies and governing regulations. Topics covered include:
   - Principles of Good Clinical Practices – International Conference on Harmonization
   - Institutional Review Board/Independent Ethics Committee
   - Investigator (qualifications and agreements, resources, compliance, reporting, etc.)
   - Sponsor (quality assurance and control, trial design, financing, compensation, monitoring etc.)
   - Clinical Trial Protocol and Protocol Amendment(s)
   - Investigator’s Brochure
   - Essential Documents for the Conduct of a Clinical Trial (before, during, and after)
4. **A Guide to the Personal Health Information Protection Act** (Information and Privacy Commissioner/Ontario)

This guide provides information about how the Personal Health Information Protection Act applies to the course of day-to-day activities and more specific scenarios. It also provides answers to frequently asked questions regarding the act. Topics covered include:

- Guide purpose
- Overview of the Act
- Does the Act apply to you?
- What information does the Act protect?
- Practices to protect personal health information
- Collection, use, and disclosure of personal information
- Access to personal health information records
- Correction
- How will the Act be enforced?
- Definitions

**Additional Resources to Consult**

*Clinical Trials Asset Map: A Showcase of Ontario’s Excellence in Clinical Research* (Ministry of Research and Innovation, 2012)

*This publication provides an overview of Clinical Trial activity in Ontario, demonstrating Ontario’s advantages as they relate to research and innovation, showcasing key clinical trial activities, and spotlighting world renowned researchers in Ontario.*

*Canada’s Strategy for Patient-Oriented Research* (Canadian Institute for Health Research, 2012)

*This document sets out a vision and strategy to improve health outcomes and enhance patient care through the lever of research. It observes and addresses strengths and weaknesses of the Canadian and International landscape, then provides a strategy for Canada.*