Trillium Health Partners
Better Together

General Counsel's Report

To: Karli Farrow, President & CEO, Trillium Health Partners
Author: Nicole Vaz, VP General Counsel & Chief Compliance Officer, Trillium Health Partners
Date: January 28, 2022
RE: THP Review of Complaint

Introduction

I have been appointed by Karli Farrow, President & Chief Executive Officer ("**CEO**"), to act as executive lead in reviewing the complaints in the December 22, 2021 letter from Tracey Tremayne-Lloyd (the "**Letter**") on behalf of an unknown number of unidentified Concerned Physicians ("**Concerned Physicians**") and to prepare this report for submission to her. The Concerned Physicians identify themselves as members of the Emergency Medicine (or "**ED**") Program at Trillium Health Partners (the "**Hospital**" or "**THP**").

THP is a large community academic hospital, with over 10,750 staff and 1,375 professional staff, i.e. the Medical Staff, Dental Staff, Midwifery Staff and members of the Extended Class Nursing Staff who are not employees of the Corporation ("**members**" or "**professional staff**"), but rather are independent contractors who annually apply for and receive privileges at the Hospital in accordance with the *Public Hospitals Act* ("**PHA**"). These staff and professional staff serve over 1.7M patient visits annually in the Mississauga and West Toronto community, across three hospital sites and several satellite facilities and operate a number of regional programs including Cancer, Cardiac, Renal, Stroke, Neurosurgery, Thoracic, Vascular and Women's & Children's. With 1,379 budgeted beds, THP's annual inpatient admissions exceed 66,000 and, inpatient discharges and births, in any given year, are the highest in the province, and emergency and urgent care visits exceed the volumes experienced by downtown Toronto hospitals, collectively.

THP's Emergency Medicine Program operates across two main sites, with Emergency Departments located at the Mississauga Hospital site and the Credit Valley Hospital site. The THP Emergency Medicine Program also includes an Urgent Care Centre ("**UCC**") based at the Queensway Health Centre site. The UCC was closed early in the COVID-19 pandemic in order to support pandemic response through staff redeployment and consolidated physical capacity and footprint. THP's Emergency Medicine Program includes 450 staff and 95 physicians and, across sites, sees over 277,000 emergency and urgent care visits annually.

Summary of Complaints Addressed in this Report

This report will:

i. set out my review process;
ii. briefly outline THP's existing standards and complaint policies and processes; and
iii. address the following concerns and/or complaints raised in the Letter, based on the headings in the Letter, and, where there are no headings, based on my interpretation of the issues being raised:

1. Ministry Conflict of Interest
2. Abuse of Administrative Power
    a) Non-speaking role of legal counsel in meetings with professional staff
    b) Bias with Dr. Coke's review
3. Threatening to Suspend, Suspending or Revoking Privileges
    s.21
    b) Other Departments
4. Threats of Reporting to the College
5. Publicly Shaming Physicians
6. Altering or Misrepresenting Meeting Minutes
7. Manipulating Hospital Bylaws to Circumvent Fair Process
8. Availability of Financial Resources for the Management of the Health Care System
9. Endangering the Public
10. THP's Board of Directors condoning the Conduct Complained of in the Letter

This report references THP authorizing documents, which are numbered and enclosed in the attached zip drive ("**ZD**") for reference.

Review Process

THP has several policies and processes to address complaints, which are set out in the next section. An anonymized complaint of this nature that is addressed to a third-party, and specifically to the Minister of Health, is unique in THP's experience. To address the complaint within THP's existing framework and to provide the appropriate level of integrity and governance, I have applied principles and processes from THP's *Whistleblower Policy* **[ZD #1].** These include: (i) my role's accountability with the CEO in evaluating the complaint and determining the appropriate level of response; and (ii) notifying and reporting to the Chair of the THP Board of Directors ("**Board**").

Given the anonymized nature of the complaints, and the resulting inability to review any individual circumstances and concerns, my review and responses in this report to the concerns raised in the Letter are based upon the following, or otherwise noted:

- Information held in THP's Legal Services Department, within the Office of General Counsel, based upon Legal Services' involvement in selected matters referenced in the Letter.
- Information that I obtained from Medical Affairs, which is THP's human resources department specifically for professional staff. Specifically, I made inquiries of Dr. Amir Ginzburg, SVP, Quality and Patient Experience, Practice and Medical Affairs and Alicia Lozon, Director, Medical Affairs and Education.
- Applicable legislative and Hospital authorities, including our Professional Staff By-Law (the "**By-Law**") **[ZD #2]**, and various policies cited throughout. These Hospital authorities are enclosed as **ZD # 1- 14**.

I am mindful of my obligations around the privacy of individual members and the impact of those obligations on my ability to include particulars in this report in consideration of the anonymized collective concerns. Should you require further information or documentation beyond what has been included in the report, I would appreciate Ontario Health's ("**OH**") guidance on what authority THP has to provide the requested particulars.

THP Standards and Complaint Processes

As stated above, a complaint of this nature is unique in THP's experience. However, THP is very familiar with its governing legislation and internal policies and has standardized processes for monitoring and enforcing them while also responding to and addressing complaints within these frameworks. Among its numerous legislative standards and duties, the Hospital oversees the quality of care and treatment of its patients in accordance with the PHA. This includes ensuring exceptional quality of care and sustainable operations. The Hospital equally oversees and protects the safety of its workforce – and addresses prescribed complaints from its workforce – in accordance with the *Occupational Health and Safety Act*.

In order to deliver on THP patient, workforce, and public safety, the Hospital has set out clear standards of behaviour and conduct which apply to all individuals, including Hospital leaders, and which prohibit the types of behaviour that the Letter accuses specific leaders of engaging in (including intimidation, threats, harassment, and retribution). These standards and entitlements are set out in several policies, including THP's *Code of Conduct* **[ZD# 3]**, *Professional Staff Code of Conduct Policy and Procedure* **[ZD# 4]**, *Professional Staff Conflict Resolution Policy* **[ZD# 5]**, *Respectful Workplace Policy* **[ZD# 6]**, and *Workplace Violence Prevention Policy* **[ZD# 7]**. These policies also set out the Hospital's escalation processes to raise and to resolve complaints of behaviours that fall below Hospital standards.

Some of these policies are specific to professional staff. These are policies with which, as a condition of their appointment at THP and in accordance with the *Professional Staff Credentialing Policy* **[ZD #8]**, all members, including leaders, are expected to be familiar and govern themselves in accordance.

Additionally, the Hospital has policies and processes which the CEO and I, as General Counsel, oversee and which specifically enable members and others to raise complaints on a confidential basis with the option to raise the complaints through an external service provider (*Whistleblower Policy* **[ZD #1]**). The Board receives annual, and in certain circumstances more immediate, reports from me on the complaints and investigation findings that come forward in this manner.

Further, in accordance with the PHA and By-Law **[ZD #2]**, members elect officers of the Professional Staff Association ("**PSA**") and may raise concerns to these officers. The PSA President and Vice-President are *ex-officio* members of the Board, and can bring forward to the Board matters raised to them by members. The PSA officers also meet with the CEO and Chief of Staff ("**COS**") and can bring forward concerns directly to them.

In my assessment, there are numerous avenues available to the Concerned Physicians to raise their complaints directly with the Hospital on either an identified or anonymized bases. These avenues are encouraged by the Hospital in order to effectively consider and resolve reported concerns; and retribution for raising such complaints is specifically prohibited.

Concerns and/or Complaints Raised in the Letter

1. **Ministry Conflict of Interest** *(p. 2 of the Letter)*

The Letter raises concerns about engaging or informing Michelle DiEmanuele. The Hospital has not engaged and will not engage or inform Ms. DiEmanuele on the subject matter of the Letter. Respecting the potential conflict of interest emanating from Ms. DiEmanuele's spouse's role with Mohawk Medbuy Corporation, between 2017 and 2019, various due diligence steps were taken s.19

which culminated in a framework approved by the Board to actively monitor and oversee any matters that might create a real, potential, or perceived conflict of interest. This is a process that I, as General Counsel, supported and continue to oversee, and I can confirm remains in place.

2. **Abuse of Administrative Power** *(pp. 3 and 4 of Letter)*

(a) Non-speaking role of legal counsel in meetings with professional staff *(p. 3 of the Letter)*

The Letter raises concerns that the non-speaking role of counsel in meetings with the Hospital obstructs the course of justice. THP has a standard process that speaking roles at meetings between the Hospital leadership and its professional staff are intended for the Hospital leader and the member at the meeting, and not for the Hospital's or member's legal counsel. This process is intended to support a constructive environment wherein the individuals directly involved in a matter have an opportunity to

hear from each other and together resolve issues, and is aligned with best practices in employment (or, here, professional staff) relations.

As detailed in the *Professional Staff Code of Conduct Policy and Procedure* ("***Professional Staff Code of Conduct***") **[ZD #4]**, when concerns are raised respecting a member, depending on the nature and severity of the concerns, it is the practice of a Program Chief or delegate to meet with the member, at times together with Medical Affairs, to discuss, understand, and try to resolve the concern.

Depending on the nature of the issue(s), members may be invited to bring a support person to the meeting, such as a member of the PSA executive or the member's legal counsel. These meetings between the Hospital and the member are typically to discuss and better understand allegations or events, including through reviewing the Hospital's understanding of the circumstances to date and asking the member for their own perspective, offer the member support, and reset expectations going forward.

These are meetings directly between the member themselves and the Hospital – typically represented by a hospital leader such as a Program Chief, a Medical Affairs leader, or, where applicable, the COS – intended to resolve issues constructively and directly between the two parties. As such, members are advised at the outset that, should they choose to bring a support person, that person will not have a speaking role at the meeting. Similarly, if Hospital legal counsel attends at the meeting, Hospital counsel also does not have a speaking role. The member is offered the opportunity to break and speak privately with their counsel upon their request.

These are not statutory proceedings for which members are entitled to counsel. If a member makes a special request that their support person or legal advisor be permitted to participate actively in the meeting, the requests are considered on a case-by-case basis.

It is my assessment that the non-speaking role of legal counsel in meetings between members and the Hospital is not an obstruction of justice.

(b) Bias with Dr. Coke's review *(pp. 3 and 4 of the Letter)*

The Letter references a review conducted by Dr. William (Bill) Coke as an example of the Hospital interfering with investigations. Dr. Ginzburg has advised me that Dr. Coke was asked to interview ED physicians in the course and as one component of a practice review initiated by Professional Practice, which is the Hospital's program that oversees non-member regulated health professionals (such as nurses). This review assessed the interprofessional care provided to pediatric patients in the ED, and involved interviews with several disciplines. Dr. Coke was not investigating any particular individual or group within the professional staff of the Mississauga Hospital site ED; rather, he was interviewing physicians to assess items relevant to the practice review, i.e. pediatric quality of care. The practice

review was discussed at an ED Department meeting in July 2020 and shared in a slide deck that reviewed the key issues, the review process, and the recommendations.

It is my assessment that there may have been misinterpretation or misunderstanding among the ED members interviewed by Dr. Coke as to the context and purpose of these interviews. However, there is no evidence of inappropriate influence, bias and/or obstruction of his review.

3. **Threatening to Suspend, Suspending or Revoking Privileges** *(pp. 4 and 5 of the Letter)*

The Letter raises the concern that the Hospital abuses its power by threatening member's privileges. It is the Hospital's practice to transparently advise members when matters may affect their privileges.

At times, concerns respecting conduct of a member or their clinical abilities may be escalated to the COS or CEO to assess whether immediate or non-immediate action must be taken in accordance 34 of the PHA, the By-Law **[ZD #2]**, the *Professional Staff Immediate Mid-Term Suspension of Privileges Policy* **[ZD #9]**, the *Professional Staff Non-Immediate Mid-Term Suspension of Privileges Policy* **[ZD #10]**, and the *Professional Staff Code of Conduct* **[ZD #4]**. In exceptional circumstances, these actions may include assuming care for a patient on behalf of the member or otherwise restricting or suspending the member's privileges until the matter is reviewed by the MAC and decided by the Board, who take into consideration the MAC's recommendation. When such action is taken, the member is accorded procedural rights as set out in the PHA, By-Law **[ZD #2]**, and applicable policies **[ZD #9 and 10]**.

From a review of professional staff meeting processes with Dr. Ginzburg and Ms. Lozon, and, at times, the attendance of members of Legal Services at these meetings, it is my assessment that the Hospital does not threaten suspension, restriction or revocation of privileges. There are circumstances where the Hospital identifies that a member may be in breach of statutory and/or Hospital authorities that govern the member's care or conduct, and that it is appropriate to inform a member of the resulting potential implications as contemplated by and articulated in the relevant policies, with which they are expected to be familiar.

It is my assessment that these disclosures are articulated to ensure that, where relevant and proportionate to the issue or potential escalation of the issue, the Hospital has been clear and transparent with the member about the standard processes that it must follow. Notice to the member of these processes, as set out in the Hospital's authorities, is a matter of best practice in employment and professional staff relations.

(a) s.21 *(pp. 4 and 5 of the Letter)*

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As stated at the outset of this report, I am mindful of my obligations around the privacy of individual members and the impact of those obligations on my ability to include particulars in this report in consideration of the anonymized concerns. Should you require further information or documentation beyond what has been included above, I would appreciate OH's guidance on what authority THP has to provide further particulars.

(b) Respecting "Other Departments" *(p. 5 of the Letter)*

The Letter raises that the Concerned Physicians have heard from colleagues in other departments outside of the ED on threatening the suspension of privileges. Please see above within this section the assessment respecting Hospital leaders transparently articulating the potential for the suspension, restriction or revocation of privileges.

4. Threats of Reporting to the College *(p. 6 of the Letter)*

The Letter raises concerns that the Hospital threatens to report members to the College thereby perpetuating a toxic culture of harassment and intimidation. The Hospital has a duty to report to a member's regulatory college under circumstances set out in both the PHA (which applies only to physicians) and the *Regulated Health Professions Act*. These reporting obligations are mandatory. Medical Affairs must determine, based upon the member's particular circumstances and the legislation, whether there is a duty to report. Similarly, Professional Practice must engage in this same process when assessing the duty to report non-privileged regulated health professionals to their respective Colleges.

The Hospital may advise the regulated health professional that it is assessing or may need to assess its reporting obligations, including in discussing potential restrictions or suspensions, as set out above. The Hospital may also relay this information to members in other circumstances affecting privileges, including member-initiated practice reductions, leaves of absence, or resignations, discussed further below.

Should a report be required, it is the Hospital's process to notify the member of this requirement and to provide the member a copy of the letter that was sent to their College.

It is my assessment that the Hospital's practice of proactive disclosure is for the member's benefit and is in the interest of transparency and ensuring the member appreciates when the Hospital's statutory reporting duty may be engaged.

5. **Publicly Shaming Physicians** *(p. 6 of the Letter)*

The Letter raises a concern of publicly shaming physicians through physically removing them from the Hospital in front of their colleagues. Where a member's privileges have been suspended or revoked including by the Hospital or by the member themselves, they cannot practice or otherwise exercise any privileges at the Hospital. As such, it is the Hospital's expectation that the member is not on the Hospital premises unless they are there to obtain Hospital care (as would be the case where an individual was no longer employed at THP).

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It is my assessment that the Hospital's practice of escorting a member, who no longer holds active privileges and is otherwise on the Hospital premises, is not intended to publicly shame physicians and is aligned to the Hospital's need to maintain a secure premises for our staff, members and patients.

6. **Altering or Misrepresenting Meeting Minutes** *(p. 6 of the Letter)*

The Letter states that the Hospital "frequently alters or misrepresents meeting minutes" but does not specify what meetings this concern is in reference to.

There are regular meetings of the Emergency Medicine Program's professional staff from their respective Hospital sites. I have been advised by Dr. Ginzburg and Ms. Lozon that minutes from these meetings are circulated to the members. On occasion, there may be disagreement over the captured minutes. To my knowledge, there has been one such instance which was raised by a member, and which I have assessed as being appropriately managed by the Hospital.

In accordance with the *Professional Staff Code of Conduct* **[ZD #4]**, meetings may also be held between professional staff and Hospital leadership. As noted in this Policy, such meetings may be informal, in which cased they may not be documented, or they may be formal meetings that are documented in the

form of a summary letter. These letters are shared with the member and saved in their Medical Affairs file. In my assessment, they are not minutes and not misrepresentations of minutes.

It is my assessment that meeting minutes are not altered or misrepresented.

7. **Manipulating Hospital Bylaws to Circumvent Fair Process** *(p. 7 of the Letter)*

The Letter raises a concern that the By-Law does not provide any limitation of the appointment terms of medical leadership (specifically Chief of Department and/or Head of Division) and that this is an example of these leaders' "reign of power". The copy of the By-Law appended to the Letter is an older 2013 version. The current By-Law **[ZD #2]** is from 2014 and is based upon the Ontario Hospital Association/Ontario Medical Association prototype from that time. The By-Law and the *Chief of Staff Selection and Succession Planning Policy* **[ZD# 12]** set out the appointment terms for the Chief of Staff. Appointment terms for other Professional Staff leadership, including Program Chiefs (i.e. Chief of Department) and Heads of Division are reflected in the *Selection of Professional Staff for Leadership Positions Policy* **[ZD# 11]**.

It is my assessment that medical leadership have terms specified in the By-Law and/or Hospital policies, which are founded on best practices.

8. **Availability of Financial Resources for the Management of the Health Care System** *(p. 7 of the Letter)*

The Letter references repeated requests to review the "Governance fund management". I have inquired with Dr. Ginzburg and Ms. Lozon and do not have sufficient information to confirm which fund is being referenced. There are various sources of funding across THP's clinical programs, including the ED. Dr. Ginzburg and Ms. Lozon believe that this may be in reference to the "Emergency Department Contract Administration and Support Funding Program", which, to their knowledge, is a fund offered by the Ministry of Health directly to the members and not to the Hospital. The Hospital is not aware of any previous complaints regarding this particular fund. Once the Hospital has confirmation of the specific fund being raised by the Concerned Physicians, I will oversee further investigation into this matter.

9. **Endangering the Public** *(p. 7 of the Letter)*

The Letter raises a concern that the Hospital is endangering the public by refusing or obstructing physicians from taking leaves of absence and scheduling physicians who intend to take a leave or to resign.

Physicians may request medical or non-medical leaves of absence, as reflected in the *Professional Staff Leave of Absence Policy* **[ZD #13]**.

Non-Medical Leave of Absence: I am advised by Dr. Ginzburg and Ms. Lozon that, unlike vacation requests, which are managed and scheduled through individual programs and their members, leaves of absence are typically requested for extended lengths of time (i.e. months rather than weeks) and result in the temporary cessation of Hospital privileges. In accordance with the Policy, the request for a Leave of Absence must be first be endorsed by the Program Chief, based on the ability of the program to support the clinical service. This standard process with professional staff is aligned with THP's process when employees seek leaves that are not medical or otherwise statutorily protected (such as parental leaves). The Hospital must assess the operational feasibility of the leave. In assessing whether to grant a Leave of Absence, the Hospital and the member's program must consider factors including the reason for the leave, the duration, the number of requests during the same period, existing human resourcing and the impact on those human resources of the potential additional work created by another member's prolonged absence, and patient needs, in order to ensure that, at all times, the Hospital is staffed to continue its operations and provide quality patient care.

Throughout the COVID-19 pandemic, the Hospital has received increased and multiple requests for leaves from its professional staff across its many clinical programs, including the ED. In this same period, the Hospital has experienced unprecedented surges in patient volumes, health care worker unplanned absences, and need for its health care workers who are clinically able to provide their services to continue to do so. As such, there have been circumstances where the Hospital, including the ED Program, wants to support multiple individuals and their requests for personal, non-medical leaves, but has not been in a position to support the period of leave sought without jeopardizing Hospital operations and patient care.

I am advised by Dr. Ginzburg and Ms. Lozon that, in the context of personal leaves requested during the pandemic that the Hospital may be unable to sustain for the duration sought, the Hospital makes inquiries to better understand the nature of the request and help identify appropriate supports for the member as well as potential alternatives to the leave, such as a temporary reduction in practice or a longer vacation.

Medical Leave of Absence: If a member is clinically unable to provide services, they may request a medical Leave of Absence. Should a medical leave be sought, the Hospital may, in some circumstances, require medical documentation from the member's care provider in order for the Hospital to assess the impact of the member's medical condition on their ability to provide clinical services, the timing (i.e. whether immediate or non-immediate) and the anticipated duration of the leave. This assessment may also inform the Hospital's reporting duties to the member's College, discussed above.

The Hospital may also explore with the member and their clinician whether there are workplace accommodations that could address the member's clinical needs while enabling the member to continue to practice. This would then be managed through an accommodation rather than Leave of Absence process.

As set out in the Policy, if a medical leave is granted, the Hospital may also require medical documentation prior to the member's resumption of Hospital services to assure the Hospital that the member is clinically able to return and provide safe, quality patient care.

Resignation: Where members are seeking to resign their privileges, the resignation process is reflected in the *Professional Staff Retirement Resignation and Reduction in Hospital Practice Policy* **[ZD #14]**, which requires 6 months' notice. Exemptions to this policy are considered on a case-by-case basis.

It is the practice in Medical Affairs that when members are seeking leaves or resignations, Medical Affairs typically offers or recommends supports through the Hospital (such as the PSA, Medical Affairs themselves, and the Hospital's Employee & Family Assistance Program) or third parties (such as the Ontario Medical Association's Physician's Health Program and ePhysicianHealth). Medical Affairs provides a hand-out with the contact details for these and other supports **[ZD #15]**.

Where a member expresses an intention to resign or requests a non-medical and non-immediate leave of absence, it is the Hospital's expectation that the member will be responsible for their shift commitment until the effective date of their leave or their resignation, unless they have reached a different agreement with the Hospital. It is my assessment that the Hospital is not endangering the public by scheduling members who have active privileges and professional duties to attend for their scheduled shifts.

s.21

It is my assessment that these requests have been addressed in accordance with the aforementioned policies and practices, and with a goal to balance the professional staff members' requests and well-being with the operational needs of the Hospital.

10. THP's Board Condoning the Conduct Complained of in the Letter (*p. 9 of the Letter*)

The Letter requests a change in the Board, which it states "has condoned this abusive conduct for years." Based on the nature of issues that come before the Board, which are not member-specific, the Board would not have known of – and could thereby not have condoned – the concerns expressed in the Letter prior to receiving the Letter.

The Board is updated through a number of regular as well as periodic reports which include bi-monthly COS Reports delivered at Board meetings, periodic People Reports which are presented to the Board's Governance and Human Resources subcommittee, and Professional Staff Human Resources Forecasts on matters affecting clinical programs, including staff and professional staff retention, departure, and recruitment. Through these reporting sources, the Board is aware of the departure of staff and professional staff from the ED, among other programs. As above, the Board is also updated through reports from the PSA President, who, with the PSA Vice-President, sit as *ex-officio* Board members.

The Board has not been and would not be provided specific reasons for the departure of individual professional staff. In order to ensure that the Board retain the impartiality and independence required of them under s. 39(4) of the PHA – which prohibits Board members who have participated in an investigation or who are familiar with the subject matter from participating in credentialing hearings on that subject – the Board is not provided particulars respecting a member's circumstances unless they are engaged in a process respecting that member's privileges.

As above, the Board also receives updates from me on the complaints and findings that come forward through Whistleblower complaints. I have not received a Whistleblower complaint respecting the allegations contained in the Letter. As such, these complaints have not, prior to now, come forward to the Board through a Hospital complaint process. As above, to my knowledge, the complaints have also not come forward to the Board through the PSA.

Based on my review of the various processes through which the complaints could have and, to my knowledge, did not come to the Board's attention, it is my assessment that the Board has not been notified of the complaints as articulated in the Letter and has not condoned the described behaviour.

Summary

As is the case where we receive anonymized complaints, and the complaints are not tied to specific events or individual circumstances, the review is limited to more generalized information gathering, which I have done here.

Based on my review:

- It is my assessment that the non-speaking role of legal counsel in meetings between members and the Hospital is not an obstruction of justice.

- It is my assessment that there may have been misinterpretation or misunderstanding among the ED members interviewed by Dr. Coke as to the context and purpose of these interviews.

- It is my assessment that the Hospital does not threaten suspension, restriction, or revocation of privileges or reports to the College, but rather proactively informs members, where appropriate, of the potential for the Hospital's legislative, By-Law, or policy duties to be engaged.

- It is my assessment that, s.21 , escorting members whose privileges have been suspended or revoked and who are on Hospital premises is not intended to publicly shame the physicians, but rather to maintain a secure premises for the Hospital's staff, members and patients.

- s.21

- It is my assessment that meeting minutes are not altered or misrepresented.

- The Hospital specifies appointment terms for its medical leadership in the By-Law and policies.

- Once the "Governance fund" is confirmed, I will oversee further investigation into this matter.

- It is my assessment that leaves of absence and resignations are addressed in accordance with Hospital policies and practices, and with a goal to balancing the professional staff members' requests and well-being with the Hospital's operational needs.

- It is my assessment that the Hospital is not endangering the public by scheduling members who have active privileges and professional duties to attend for their scheduled shifts.

- It is my assessment that, prior to receiving the Letter, the allegations contained therein did not come forward to our Board through existing Hospital processes.

- It is my assessment that the concerns raised in the Letter do not found concerns for the quality of care provided to Hospital patients.

- Based on my understanding of sections 9 and 9.1 of the PHA, it is my assessment that the concerns do not engage and are not legislatively intended to be addressed through these public interest provisions.

Although I have engaged in a review of the concerns in the Letter, as referenced above and outlined in detail in the attached policies, there are numerous avenues available to the Concerned Physicians to raise their complaints with the Hospital on either an identified or anonymized bases. The Hospital encourages the Concerned Physicians to utilize these existing processes to raise these or any additional concerns or questions directly, should they feel comfortable to do so, to enable the Hospital to address and resolve the complaints with the appropriate parties and in the procedurally appropriate venue.

ENCLOSURES
(via zip drive)

1. Whistleblower Policy
2. Professional Staff By-Law
3. Code of Conduct
4. Professional Staff Code of Conduct Policy and Procedure
5. Professional Staff Conflict Resolution Policy
6. Respectful Workplace Policy
7. Workplace Violence Prevention Policy
8. Professional Staff Credentialing Policy
9. (Professional Staff) Immediate Mid-Term Suspension of Privileges Policy
10. (Professional Staff) Non-Immediate Mid-Term Suspension of Privileges Policy
11. Selection of Professional Staff Leadership Positions Policy
12. Chief of Staff Selection and Succession Planning Policy
13. (Professional Staff) Leave of Absence Policy
14. Professional Staff Retirement Resignation and Reduction in Hospital Practice Policy
15. Physician Supports document