Executive Summary

How a system is designed can dramatically affect how well it works. We experience that every day in our professional lives – and the same is true for Doctors of BC.

There are significant issues with our governance structure and these have provoked a number of reviews and proposals for change over the last many years; some initiated by the Board, some by individual members. Recent change proposals have received significant levels of voter participation and, although none received the required 75% majority, all received greater than 50% approval. This indicates an appetite for change.

One problem is the size of our current Board. At 39 members, it is the largest of the provincial medical associations, well past the recommended size of 5-15. This leads to inefficiency, and the cost and logistics of calling the Board together makes it difficult for Doctors of BC to be nimble and respond quickly to situations that arise.

Another problem is the built-in role conflict that Board members face. Each is expected to represent the constituency that elected them. But when it comes to a vote, each has the fiduciary duty to put aside the views of their constituency and vote in the best interests of all members. This duality leads to role confusion and conflict.

Lastly, if the Board is to truly have a representative function, we are missing many voices around the table. The Board has a shortage of specialists, and many other voices are missing: individual sections, students, residents, those new in practice, and those practicing in First Nations communities. The list goes on.

In developing the model before you, the Governance Committee chose to follow a path of consultation. We posted an initial model on our website in September 2015, engaged in multiple consultations with individual members, sections, Societies and Board members, then posted a second iteration for membership input this past summer.

These consultations showed that members embrace the principles of representation, collaboration and engagement with members, as well as cost effectiveness and efficiency.

The model before you reflects those principles. It is a ‘dual’ model, comprised of a larger Representative Assembly that better captures the diversity of voices within our profession, and a smaller Board to govern with more efficiency and nimbleness.

The larger Representative Assembly is comprised of a mixture of delegates from different regions and from all existing Sections. It has delegates from rural, new in practice, students and residents, those providing services to First Nations, the Societies and CMA. And it contains provisions to allow changes in the number and allocation of seats if it can be improved.

The Board is much smaller; only 9 Directors. This allows efficiency in decision-making, and the ability to be quickly responsive to events that arise. Two of the directors are Officers: the President-Elect and President, elected by the membership. The remaining 7 are Directors at

Large, nominated by and from the membership as a whole, and elected by the members of the Representative Assembly from amongst the nominees. The Representative Assembly also has the authority to remove Directors at Large from office. This ensures that the Board remains accountable for its decisions. There are also provisions to ensure a better balance between the number of GPs and the number of Specialists on the Board than currently exists. Although members of the Board govern on behalf of all members, not on behalf of their constituents, having that diversity assures our members that the different experiential skill sets of GPs and Specialists are present and contributing as decisions are made.

The Representative Assembly is advisory to the Board, not directive. This is a legal requirement. The Board has the legal authority to make decisions, but also the legal accountability and liability. So the Board cannot have another body fettering its decisions. At the same time, however, with the RA electing and possibly recalling them, the voice of the Representative Assembly will be very influential. Two other provinces that employ this type of model, Alberta and Saskatchewan, both find it to be effective and constructive.

Questions regarding the proposal? Contact: voting@doctorsofbc.ca

*(**Note**: Doctors of BC will be closed for the holidays December 23 – January 2. All queries sent during this time will be responded to as soon as the offices reopen on January 3.)*

Technical/login questions pertaining to casting your ballot? Contact: helpdesk@everyonecounts.com

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Following are charts summarizing the proposed **Representative Assembly** (pages 3-10 and the **Board of Directors** (pages 11-14).

REPRESENTATIVE ASSEMBLY

The **mandate** of the Representative Assembly (RA) is to represent members' interests, provide a forum for members to come together to discuss issues of importance to the profession, and provide guidance to the Board.

The **objectives** of the RA are:

- To provide a forum for robust discussion of issues relevant to the profession and to so advise the Board in its deliberations;
- To give a voice to a wider range of members so that a healthy diversity of opinion is understood before decisions are made;
- To enhance the accountability between the Board and members;
- To influence the strategic course of the Association;
- To liaise between the Board and various Association constituencies; and
- To facilitate the separation between governance and representation.

The RA will meet a minimum of 3 times per year. Additional meetings may be called by the Board, in consultation with the Speaker of the RA.

There will be 104 voting members on the RA. In addition, there will be a non-voting Speaker and Deputy Speaker. The 9 Board directors will be non-voting participants. There will not be any Vice Delegates.

	Proposal	Explanatory Notes
Functions of RA	**1. Positions Elected by RA Members** The RA will elect the following from amongst individuals nominated by and from the general membership: • Seven Board Directors at Large • Members at Large on each of the Governance and Nominating Committees • Speaker and Deputy Speaker of the RA If a member of the RA or Board is elected as Speaker or Deputy Speaker, their RA or Board position will be vacated and back-filled. The RA will also form a committee to choose one nominee for President-Elect (general membership can also nominate a candidate)	• RA members will be immersed in Association affairs so in a unique positon to elect Board Directors at Large • Board is accountable to the RA so appropriate for the RA to have responsibility for electing Board Directors at Large. • Governance and Nominating Committees are important statutory committees, which include members at large currently appointed by the Board. This process will allow members to choose the member at large representatives. Due to the smaller size of the Board, the number of Director members of the Nominating Committee is decreased from 3 to 2 and the number of Members-at-Large is increased from 2 to 3.

Functions of RA (cont'd)		• The role of the Speaker is vital to ensure due process and facilitate conversation, rather than to represent member interests. The Speaker must remain impartial and so will not have the ability to vote. • The RA will elect a Speaker, in whom they have confidence and trust, choosing from all candidates nominated by and from the membership as a whole. • A person may not be a voting member of the RA and the Board simultaneously. • Members at Large to the Audit & Finance Committee, another important Statutory Committee, will still be elected by members at the Annual General Meeting • There will be no change to the Statutory Negotiating committee or to the negotiations process, apart from a new consultation process with the RA. • The RA is required to rank election ballots by majority rule, but may by special vote establish a different ranking method in advance of an election.
	2. <u>Strategic Direction/Policy/Negotiations</u> The RA will identify issues and make recommendations to the Board on the strategic direction of the Association, major policy, negotiations, or any other issue that the RA feels deserves the attention of the Board.	• RA is a forum where members will take important matters for discussion, advice and planning for moving forward. • Discussions and decisions of the RA will inform the Board, which is accountable to the RA.

<table>
<tr>
<td rowspan="2">Functions of RA (cont'd)</td>
<td>3. Board Accountability

The RA will monitor Board performance and will have the ability to elect board Directors at Large as well as remove Board Directors at Large who are seen to be acting contrary to the best interest of the Association.</td>
<td>• Ultimately, the Board is accountable to the members of Doctors of BC. As the RA is representative of Association members and more immersed in Association affairs than the average member, it will have responsibility for electing Board members from nominees from the general membership, monitoring the Board's performance, and holding Board Directors to account.

• The RA will develop a process for monitoring Board performance and the principles that need to be followed when considering the removal of a Director at Large.</td>
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<td>4. Bylaw Amendment Proposals

The RA will review member-proposed bylaw amendments and determine whether they will be sent to referendum.

Member proposed bylaw amendments accompanied by the signature of 5% or more of the voting membership in good standing will not require a review and determination by the Representative Assembly.</td>
<td>• Currently, any two members can propose changes to the Bylaws, and as long as a proposed amendment meets legal requirements, the Doctors of BC is required to present it to members for voting.

• Having the RA review and approve member-proposed bylaw amendments for referendum not accompanied by the signature of 5% of the voting membership will provide peer review of the proposals, ensuring that the proposals are in the best interests of the Association.</td>
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<td>Composition of RA</td>
<td>1. District Delegates

There will be 20 District Delegates on the RA from ten new Districts.

<table>
<tr><th>New District</th><th>Voting Membership (Approx)</th><th>Delegates</th></tr>
<tr><td>1 South Vancouver Island</td><td>1,496</td><td>2</td></tr>
<tr><td>2 Upper Vancouver Island</td><td>1,070</td><td>2</td></tr>
<tr><td>3 Vancouver Coastal</td><td>4,293</td><td>2</td></tr>
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<td>• Physicians generally trust a representative that they know or that shares their professional characteristics and/or regional concerns.

• District Delegates in particular can assist with liaison between the Association and District constituents.

• Allowing the same number of delegates per district (rather than using proportional representation) will better ensure that the issues and voice of the less-populated Districts are heard.</td>
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Composition of RA (cont'd)

4 North/West Vancouver, Sunshine Coast, Howe Sound, Bella Coola Valley, Central Coast, Powell River	1,041	2
5 North Fraser	2,166	2
6 South Fraser	1,478	2
7 Okanagan Thompson	1,529	2
8 East/West Kootenays	387	2
9 Skeena	98	2
10 Cariboo/Peace River	453	2

There will be a stipulation that the District Delegates must be comprised of 1 GP Delegate and 1 Specialist Delegate per District.

- This District representation supports equity between GPs and Specialists.

2. Area of Practice Delegates

There will be:

- 35 Delegates appointed by the 35 Specialist Sections – one appointed from each Specialist Section see attached list of Sections;
- 2 Delegates appointed by the GP/SP Mixed Sections --1 from Surgical Assist and 1 from Clinical Faculty;
- 35 Delegates appointed by three GP Sections as follows:
  - 1 Delegate appointed by the Section of Sports and Exercise Medicine;
  - 1 Delegate appointed by the Section of Hospital Medicine;
  - 33 Delegates appointed by the Section of General Practice with the first cohort from amongst the following groups:
    - 2 Delegates from each of the 10 geographical Districts;
    - 10 Delegates within their first 10 years of practice post-graduation - geographically determined; one from each District;
    - 1 Delegate who is a Family Practice Resident 1;

- The inclusion of Area of Practice Delegates enhances member confidence that Delegates will understand the professional issues that they face.
- This representation supports equity between GPs and Specialists and gives a voice to rural and those practicing with the First Nations communities.
- There will be no explicit prohibition against an RA Delegate being a member or office holder of another organization.
- Members will be asked the following questions on their Doctors of BC membership renewal form in order to identify which Delegates they are eligible to vote for and to provide better demographic information to aid the RA and the Board in future discussions on RA composition and member services.
  1. *Which Doctors of BC Section do you most affiliate with (regardless of whether you pay their Section dues)?*
  2. *Can we share your contact information with the Section?*

Composition of RA (cont'd)	▪ 1 Delegate who is a Family Practice Resident 2; ▪ 1 additional Delegate; criteria to be determined in consultation with the Section of General Practice; • 4 Rural Delegates (2 GP, 2 SP) nominated and elected by members providing medical services in designated RSA communities; and • 2 Delegates (1 GP, 1 SP) providing medical services to the First Nations Health Authority or in communities under the jurisdiction of the First Nations Health Authority.	3. *Can we share your contact information with the Society of GPs or Specialists of BC?* 4. *Do you provide medical services to the First Nations Health Authority or its communities?* 5. *Do you provide medical services in a rural community within the scope of the Rural Subsidiary Agreement?* • Sections may still be created by the Board on the recommendation of the RA, and existing Sections may have their recognition revoked by the Board after consulting with the RA. Such changes will alter the list of Sections that appoint a Delegate to the RA. The RA will be tasked with developing criteria it recommends the Board consider when looking at the creation or revocation of the recognition of a Section. • The first cohort of the Section of GPs has been described here after discussion with the Section. In the future, the Section of GPs will be tasked with the allocation of its seats based on the following principles: 1. Representation shall be maintained from all geographical areas of the province; 2. Physicians within their early years of practice shall be represented; and 3. The diversity of practice focus and styles shall be recognized.
	3. <u>Society Representatives</u> • One delegate appointed by the Society of General Practitioners (SGP) • One delegate appointed by Specialists of BC (SBC)	• The inclusion of Society Delegates enhances member confidence that Delegates will understand the professional issues they face, and assists in the liaison between the Association and the Societies.

Composition of RA (cont'd)		• Both Societies will continue to have their guaranteed seats on the Statutory Negotiating and Review Committees as entrenched in the Bylaws.
	4. CMA Division Delegates One Delegate from amongst the BC delegates to the CMA Board. The BC delegates will decide amongst themselves who the representative will be.	• The inclusion of a BC CMA Division Delegate on the RA enhances bilateral communication between the Doctors of BC and the CMA.
	5. Student/Resident Representatives • One Delegate appointed by the Medical Undergraduate Society (MUS) and • One Delegate appointed by Resident Doctors of BC (RDoBC)	• Medical students and residents have a stake in the future of the Association and in the future of the delivery of medical services in BC. Having student and resident representation with a vote would provide these important stakeholders with a meaningful voice in the affairs of the Association.
	6. Board Officers/Directors The Immediate Past President will be a voting Delegate of the RA and some statutory committees (Governance, Nominating, and Human Resources committees), but will not be a Board member. Both Officers of the Board (President and President-Elect) and all Directors at Large will attend RA meetings as non-voting participants.	• The inclusion of Board Officers and Directors on the RA will help to ensure that the Board is well informed of all discussion taking place at the RA. • As there is potential for conflict between the role of the RA and the role of the Board (e.g. election of Board Directors by the RA), Board Officers and Directors should be non-voting participants of the RA. This also helps reinforce the separation between governance and representation.
	7. Observers An Association member may attend RA meetings as an observer at any time, with advance notice and agreement of the Speaker. Observers cannot vote and may speak only with permission of the Speaker or Deputy Speaker.	• Allowing observers at RA meetings helps ensure that proceedings are as open and transparent as possible.

Composition of RA (cont'd)	**8. Terms** The terms of the various positions on the RA will be as follows: • District and Area of Practice Delegates: 3 years • SGP and Specialists of BC Representatives: 1 year • RDoBC and MUS Representatives: 1 year • CMA Division Delegates: 1 year • Speaker and Deputy Speaker: 3 years (reaffirmed annually) • Officers and Board Directors: *ex officio*	• Delegates require sufficient time to learn the role and gain experience in order to effectively carry out their duties. It is considered that this can be achieved through 3 year terms for these positions. • Expiry of these positions will be staggered to better ensure continuity of knowledge • 1 year terms for appointed representatives provides the respective organization with autonomy and flexibility. • Terms will be adjusted for first cohort of District and Area of Practice Delegates to prevent complete turnover after the first three years.
	9. Term Limits Term limits for the various positions on the RA will be as follows: • No member may serve more than 6 years within 10 years as a voting member of the RA. • Years on RA as Immediate Past President, RDoBC or MUS Representatives do not count towards the 6 years within 10 years limit. • A member may serve as Speaker for 2 consecutive terms, but this will be a lifetime maximum. A Speaker cannot subsequently become Deputy Speaker. • The Deputy Speaker will also have a 2 consecutive term limit but can still be elected Speaker for another 2 terms.	• Term limits ensure that there will be regular introduction of new Delegates who will bring fresh ideas and perspectives. • Serving 6 years within 10 years provides sufficient time for Delegates to learn the role and contribute to discussions, and is unlikely to be too long as to lead to disengagement. • Term limits also provide more members with an opportunity to serve on the RA. • The RA will be tasked with assessing the term limits for RA Sectional and District Delegates during its first three years. It will then make a recommendation to the Board on how these term limits may be best defined for the future.

Changes to Structure and Composition of the RA	**1. Changes to RA Composition** The number and allocation of seats at the RA can be altered: a. By a special resolution (2/3 of votes cast) of the RA ratified by the Board (excluding Sections); b. By the recognition/revocation of a Section; or c. With a change in the number of Districts.	• New Sections can be recognized by the Board on the recommendation of the RA. • Sections can have their recognition revoked by the Board after consultation with the RA. • The Board can alter the number of Districts and thus the number of District Delegates to the RA would change accordingly.
Other	**1. Attendance/Vacancy** The Speaker will have the discretion to declare an RA position vacant if a Delegate misses 2 or more meetings per year (AGM to AGM).	• As the RA will only meet 3 times per year (unless an extraordinary meeting is called), it is expected that the representatives will attend unless extenuating circumstances exist. • Allowing the Speaker to decide allows a level of discretion for extenuating circumstances.
	2. Rules of Process The Rules of Process will not be embedded in the Bylaws. These will be determined by the RA and be able to be modified by the RA to meet its needs.	• Rather than dictating in advance how the RA should run its meetings, it is considered more constructive to provide the RA with flexibility to determine its own rules.
	3. Quorum The quorum will be greater than 50% of the voting members of the RA. As they are non-voting, the Speaker and Deputy Speaker will not count towards the quorum.	• A simple majority is a typical quorum.
	4. Reporting The Speaker will provide a report to members at the Annual General Meeting and after each meeting of the RA. A report will also be prepared for the annual Doctors of BC White Paper.	• The RA is accountable to Association members. • Providing reports to members helps to ensure transparency and keeps member informed and thus engaged.

BOARD

The Board is legally responsible for the management of the affairs of the Association. Under a revised structure and will maintain its fiduciary and oversight responsibilities and set the Association's strategic direction and policies. The representation interests of practice types, Societies and geographic constituencies will reside with the Representative Assembly.

The Board is accountable to the Representative Assembly and the entire membership.

The Board will meet no less than 4 times per year. Extra meetings may be called by the Chair.

There will be 9 Board members comprised of President, President-Elect and 7 Directors at Large

	Proposal	Explanatory Notes
Composition	**1. Officers** The President and President-Elect will both be *ex officio* voting members of the Board. The Immediate Past President will not be a Board member, but will be an *ex officio* voting member of the RA and some statutory committees (Governance, Nominating and Human Resources Committees) **2. Directors at Large** There will be 7 Directors at Large on the Board. There will be no vice-delegates or alternates. It will be stipulated that there will be no fewer than 3 GP and 3 Specialist Board Directors at Large The seventh Board Director at Large will be elected annually. If the incoming President is a Specialist, this seventh Director at Large will be a GP. If the incoming President is a GP, this seventh Director at Large will be a Specialist. **3. Board Chair/Vice Chair** The Chair and Vice Chair will be voting members of the Board, elected annually by and from the Board. All Board members will be eligible (including Board Officers).	• Governance experts often indicate a range of 5-15 Board members as appropriate for not-for-profit organizations. Research also indicates that the most effective group size for decision-making is 5-7. • The intention is for the Board to be competency-based (with required competencies being determined by the RA from time-to-time). Having said that, it is considered important that the particular skills and competencies of both GPs and Specialists be reflected in the Board. • No Board Director will represent either Specialists or GPs, but rather will use their experience as a skill set to fulfill their fiduciary duty to act in the best interest of the entire membership • There are no designated seats for representatives of other organizations on the Board. The Board is the forum where each member has a legal fiduciary duty to the membership as a whole.

Composition (cont'd)		• A Board member appointed by a specific group would largely be seen as a representative for that group. This contributes to a lack of clarity in their role and blurred lines of accountability between their fiduciary duty to the Association and their duty to their constituents. • Each director has a legal duty to act in the best interest of the entire Association, not for the organization that appointed them. If there are designated representative positions on the Board, the issue of structural conflict of interest and role confusion for directors between their fiduciary duty to the Association and their duty to a constituency remains. • There will be no explicit eligibility prohibition based on a member's position or office in another organization.
Elections	**1. President-Elect and Directors at Large** One President-Elect nominee will be selected by a special committee made up of members of the RA. The name, biographical information and election platform of the committee's nominee will be sent to the membership along with a Call for Nominations inviting any other member who wishes to run to submit their nomination papers. If there are other nominees from the membership, there will be an election by the members from amongst all nominees. Alternatively, if there are no further nominees from the membership, the special committee's nominee will be acclaimed. The Directors at Large will be nominated from the general membership and elected by the RA.	• All members will maintain their right to nominate and elect a candidate for President. • The RA will develop its process for the special committee to follow when selecting its nominee for President Elect. Part of this process will be to develop principles that help ensure that the President-Elect reflects the needs of the Doctors of BC and the diversity of its membership. • As the intention is for the new smaller Board to be competency-based (as determined from time-to-time by the RA), it will be more effective if the RA is tasked with electing Directors at Large from amongst candidates nominated by the membership.

Elections (cont'd)	**2. Terms** Terms of Board positions • President: 1 year • President-Elect: 1 year • Directors at Large: 2 years with the exception of the seventh alternating Director at Large who shall have a term of one year. • Chair/Vice Chair: elected annually by the Board, from within the Board	• Directors at Large need time to learn the role and gain experience in order to effectively carry out their duties. At the same time, it is important to have a healthy turnover to encourage new ideas. This can be achieved through 2-year terms, with the obvious exception of the annual election of the seventh alternating Director at Large. • Taking into account the term limits below, 2-year terms allows for 2, 4 or 6 year total terms which provides more flexibility for members. • Terms for Directors at Large shall be arranged in order to accommodate term limits and so that approximately no more than four Directors at Large end their terms in a given year.
	3. Term Limits Term limits of Board positions • Directors at Large may serve no more than 6 years within 10 years. • A Director at Large who has reached their term limit is not prohibited from running for President-Elect or sitting a term as President.	• Term limits ensure that there will be regular introduction of new Board members who will bring new ideas and a fresh perspective, and also provides more members with an opportunity to serve on the Board. • Serving 6 years within 10 years provides sufficient time for Board members to learn the role and contribute to discussions, and is unlikely to be so long as to lead to disengagement.
Other	**1. Rules of Process** The Rules of Process will not be embedded in the bylaws. These will be determined by the Board and be able to be modified during the course of its business.	• Rather than dictating in advance how the Board should run its meetings, it would be more constructive to provide the Board with flexibility to determine its own rules.

Other (cont'd)	**2. Quorum** The quorum will be six Directors.	• The small size of the Board supports a quorum of more than a mere majority.
	3. Reporting The Chair of the Board will communicate to the membership after each meeting and at the AGM (orally and through the annual Doctors of BC White Paper).	• The Board is accountable to Association members. Providing reports to members helps to ensure transparency.

SECTIONS

SPECIALIST SECTIONS
Anesthesia
Vascular Surgery
Cardiac Surgery
Chest Surgery
Hematology & Oncology
Endocrinology & Metabolism
Infectious Diseases
Neurosurgery
Allergy & Immunology
Geriatric Medicine
Dermatology
Gastroenterology
Physical Medicine & Rehabilitation
Respiratory Medicine
Nephrology
Public Health Physicians
Cardiology
Plastic Surgery
Critical Care
Rheumatology
Otolaryngology
Urology
Palliative Care
Neurology
OBGYN
Ophthalmology
Lab Medicine (BCALP)
Orthopaedics
Internal Medicine (CRIM)
Radiology
Pediatrics
General Surgery
Psychiatry (BCPA)
Emergency Medicine
Pain Medicine

GP SECTIONS
Section of Sports/Exercise Medicine
Section of Hospital Medicine
Section of General Practitioners

MIXED GP/SPECIALIST SECTIONS
Section of Clinical Faculty
Section of Surgical Assistants