Summary

Date: March 2, 2026
Time: 12:00–1:30 PM
Location: KGH Murray Ramsden Boardroom

Attendees

Leader: Brent Weiss, Regional Advocate Advisor, Doctors of BC

Facilitators / Wellness Officers: Dr. Deema Jassi

Attendees: Paymaneh Ritchie, Drs. Jack Loken, Jeff Wong, Alysha MacKenzie-Feder, Pablo Amigo, Marius Aucamp, Janno de Wet, Ann Marie McKenna
Guests: Recorder: Sarika de Wet

Methods

a. Advertisement

- Posters and email invitations distributed via KGH medical staff email lists.
- Invitations shared on WhatsApp (KGH Wellness Community group)
- Personal invitations and messages
- Paper posters placed throughout the hospital

b. Selection of Leader / Guest

c. Record Keeping

- Electronic minutes maintained
- AI minute-taker used with permission
- Written notes recorded

d. Information Sharing

- Summary information to be shared with attending groups

e. Follow-up on Action Items

- As outlined below
- *Items in Blue Font indicate Pending Action Items. These actions are under the direct management of another IHA leader. The Wellness Officer will have the responsibility to find the leader under whose portfolio this matter falls and will follow-up, either by inviting the responsible leader to lead a Brown Bag Lunch, or via another communication channel.*
- *Items in Green Font are under the management and portfolio of today's leaders*

f. Feedback from Attendees

- Informal feedback received via hallway conversations and text messages.

g. Miscellaneous

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Summary of Pebbles & Asks

1) Presentation

Brent Weiss (regional advocate advisor with Doctors of BC) gave an overview of his portfolio (inform, advocate, connect) and presented the 2025 Physician Engagement Survey results.

2) Overview

Brent Weiss, a regional advocate advisor with Doctors of BC, presented the 2025 engagement survey results, highlighting a 28% satisfaction rate with the health authority, down from 33% last year. Key issues included decreased resource requirements, inadequate opportunities for

patient care improvement, and poor communication. Interior Health had the lowest scores, with KGH and Royal Inland performing poorly. Participants emphasized the need for better communication, transparency, and resource allocation.

3) Survey summary & trends

- Engagement scores fell provincially and in Interior Health; overall satisfaction that the health authority is a good place to practice dropped sharply (e.g., KGH ~68% in 2021 to ~29%).

- Response rate declined since COVID (now ~16–17%).

- Key negative trends: reduced satisfaction with resources and opportunities to improve patient care; poorer communication, transparency, and physician input into decisions; increased physical and psychological safety incidents (patient violence, verbal abuse, bullying).

- Facility-level: tertiary sites (KGH, Royal Inland) scored near bottom among similar-sized hospitals; rural sites show different patterns but resource/staffing shortages are widespread.

- Drivers: staffing shortages (physicians, nurses, hospitalists), capital constraints (beds, imaging, long-term care), management turnover, heavy middle management or misaligned management incentives, and moral distress/burnout.

4) Pebble: Physician Engagement and Leadership Challenges

- Attendees shared their experience and the challenges of engaging physicians in leadership positions.

-Physicians commented on their perception of high turnover in administration/management and its impact on sustainable changes/effective leadership and decision-making.

- Physicians feel retention needs to be more of a priority than recruitment. Ensures certainty, consistency and ownership of issues, from start to end.

- A combination of high turnover of leadership/admin and low retention (tendency to decrease FTE) results in no ownership and decreased engagement and a sense of detachment.

5) Pebble: Physical and Physiological Safety

- Increased patient violence, verbal abuse, substance-related and mental-health presentations.

- Bullying/intimidation from colleagues and leadership; toxic workplace culture. Some MDs feel this bullying is related to a) junior vs senior staff b) resource availability and pressures to provide service within limitations c) call shifts.

- Physicians feel de-escalation is not enough, prevention is key.

6) Pebble: Contributing concerns from attendees

- Lack of clear, timely two-way communication from senior leadership and health authority.

- Confusing organizational structure (LMAC/HAMAC/MSA processes) and unclear pathways for physicians to raise issues or escalate (high cognitive/emotional load to engage). Administrative burden and unclear onboarding - physicians unsure how to engage/escalate.

- Poor access to operational data/metrics (wait times, imaging delays, bed flow, resourcing) to assess performance and priorities as it relates to IHA and the province.

- Insufficient on-site presence by senior leaders; many decisions in the hands of few people.

- Decisions made without visible consultation or transparent rationale (e.g. recent decision to stop NSQIP, opening of 6E, pediatrics business proposal).

- Capital/resource shortfalls (beds, CT/imaging access, long-term care, diagnostic capacity).

- Perceived unequal resource allocation (rural incentivization vs. tertiary site needs).

- There is a need for clear communication about ongoing projects, including long-term care facilities and community clinic expansions and visible timelines for projects.

- Physicians experience moral distress from their inability to provide timely care (imaging, biopsies, follow-up).

7) Solutions/Asks proposed by attendees (specific to increasing transparency and communication)

- Increase of senior leadership presence on-site (personal connection/building trust) and regular face-to-face engagement with clinical teams, OR decentralization of “power”.

- Regular, topic-focused town halls with senior leadership (e.g., hallway medicine, physical safety, OR wait times, Leadership training opportunities) to enable dialogue and vulnerability; ensure relevant leaders attend.

- Use interactive tools in meetings & town halls (e.g., Slido) to surface themes and safer questions.

- Make operational data public/transparent (wait times, imaging turnaround, bed metrics, project timelines and budgets) so clinicians can see status, trends, and rationale for decisions.

- Provide clear, concise onboarding and a simple engagement pathway for physicians (who to contact, how to escalate, concise orientation to IH structure, LMAC/HAMAC/MSA roles). Once

an issue has been escalated, come back to that physician and their “one up” with some response.

- Regular, scheduled reporting back on escalations and plans (timelines, budget status) so clinicians know what to expect and can track progress.

- Leaders who can create change need highly qualified administrative support (i.e. Chief of Staff, division heads) to decrease their burden and increase their potential.

- Create transparent forums (monthly blog/video updates or Q&A), summarizing themes, actions taken, and accountable owners - not just memos.

- Showcase potentials for bottom-up initiatives (peer support, civility rounds, violence prevention training) to build trust while system changes proceed.

- Relationship building initiatives.

8) Pebble: Additional community medicine factors/limitations that contribute to over capacity in hospitals

- Limited primary care access / loss of walk-in clinics = EDs used for primary care (Discussion around the overflow impact of college rules on walk-in clinics, leading to increased emergency visits and strain on primary care). Suggestion: call for the reopening of walk-in clinics and the removal of mandatory patient ownership by GPs after multiple visits.

- Offer an NP spot in the ER for rx refills, ear syringing, cough and cold assessment in the meantime.

- Shortage of long-term care, hospice and supported residential beds = delayed discharges.

- Insufficient home-care and community supports (nursing, PSWs, respite) = longer inpatient stays.

- Long waits for diagnostics and outpatient procedures (CT, MRI, biopsies) = admissions/bed-blocking.

- Inadequate outpatient specialty access and long clinic waitlists = more acute presentations.

- Limited rehab / step-down and subacute capacity = patients remain in acute beds.

- Insufficient community mental-health and addiction services = frequent ED/acute admissions and safety concerns.

- Inadequate after-hours/community urgent care coverage = overnight/weekday ED surges.

- Social determinants (housing instability, transportation, caregiver shortages) preventing safe discharge.

9) Upcoming meetings and action items

- Present the 2025 engagement survey results and highlight key areas (broken process/escalation, safety, resourcing) to Health Authority senior leadership in the scheduled meeting with Sylvia Weir, Dr. Mark Masterson, Dr. Devin Harris, and Drs of BC senior leadership.

- Encourage physician attendance at the upcoming brown bag event on April 20 (with Health Authority leadership, Dr. Devin Harris and Jennifer Miller) to gather feedback and foster dialogue.

- Engage with the physical and psychological safety Working Group to discuss scaling pilots (violence prevention training, peer support, wellness initiatives) and follow up on potential rollouts across the Health Authority.