HWC HARBOUR WEST CONSULTING

Final Report

Kelowna General Hospital Pediatric Services Interior Health Authority

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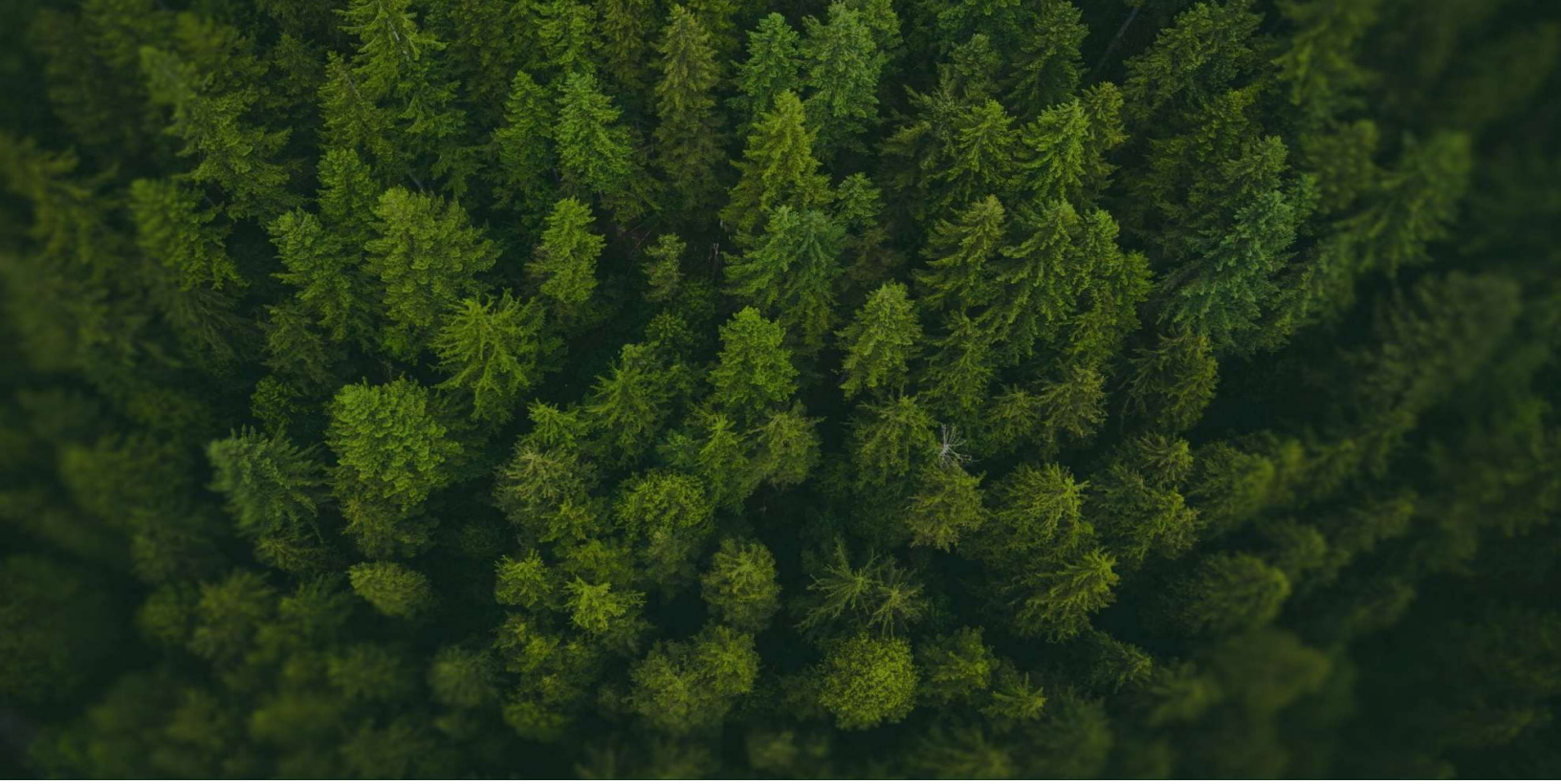

Table of Contents

Introduction 3

Background 4

Methods + Approach 8

Findings 10

Analysis 12

Recommendations 16

Introduction

In 2025, the Interior Health Authority (IHA) experienced major disruptions to continuous pediatric coverage at the Kelowna General Hospital (KGH), resulting in patient diversions, temporary service closures, and reputational impacts for IHA, KGH, and the KGH pediatric unit. While the causes of these disruptions are multi-factorial, IHA leadership sought to understand whether workplace culture dynamics were contributing to challenges affecting the sustainability of pediatric services at KGH.

In response, IHA engaged Harbour West Consulting (HWC), in partnership with Dr. Jana Davidson, to conduct a Workplace Culture Assessment. The purpose of this engagement was to examine the cultural, relational, and structural dynamics influencing pediatric service delivery and to identify opportunities to improve collaboration and system stability. This report summarizes the findings of that assessment and sets out recommendations aimed at strengthening working relationships across clinical teams, leadership levels, and interdependent departments.

The specific objectives of the Workplace Culture Assessment included:

- Identifying current barriers and challenges to sustainable pediatric service delivery at KGH
- Providing prioritized, actionable recommendations to support improved collaboration, organizational effectiveness, and individual workplace satisfaction
- Establishing the groundwork for respectful and productive culture mediation to address any identified workplace concerns

HWC's engagement revealed structural challenges in the health care setting that result in a dependence on physician goodwill and shared objectives to ensure sustainable health care services. With a physician compensation structure that disincentivizes hospital-based care and a pediatric call coverage system that depends on voluntary participation rather than employer-directed scheduling, pediatrician participation in hospital-based care is often driven by professional commitment, intrinsic motivation, and collegiality.

When this goodwill and sense of shared purpose became strained between KGH pediatricians and IHA senior leadership, several pediatricians elected to leave their hospital practice in pursuit of more clinical and personal autonomy and work-life balance. These departures destabilized call coverage and contributed to a seven-week pediatric unit service disruption starting in May 2025. This highly visible service closure exacerbated already tenuous working relationships between local pediatricians and IHA and brought underlying trust and dissatisfaction into the public domain.

Although this assessment focuses on pediatric services at KGH, several findings and recommendations – particularly those related to escalation pathways, transparent decision-making, and relationship repair within a independent contractor physician environment – may have broader applicability across the Health Authority.

This report summarizes the findings, analysis, and recommendations from the Workplace Culture Assessment.

Background

HWC and Dr. Davidson were engaged following a seven-week pediatric unit service disruption at KGH starting in May 2025. The closure generated significant public attention and commentary from community members, elected officials, medical colleagues, former hospital pediatricians, and IHA leadership. The closure and subsequent public discussion amplified pre-existing tensions between physician groups and the Health Authority regarding the sustainability of pediatric services, decision-making processes, and accountability for timely resolution of concerns.

In this context, IHA engaged HWC and Dr. Davidson to assess workplace culture and relationship dynamics to identify barriers to sustainable service delivery and effective collaboration among clinical, operational, and governance bodies.

Pediatric Care at KGH

Participants described an evolving pediatric practice at KGH shaped by hospital renovations, a growing pediatric population, increased patient acuity, expanded NICU practice, and a challenged transport system. Despite these changes, the model of pediatric care has, until fall 2025, remained relatively static.

Between 2010 and 2015, KGH underwent major renovations to open the new Centennial Building in May 2012. With this renovation, the single on-call pediatrician at KGH was required to provide coverage between two buildings and multiple floors to support patients in the pediatric unit, NICU, Labour and Delivery, adult ICU, and the Emergency Department. This update increased the travel distance pediatricians were required to cover, decreasing their efficiency and effectiveness. As such, since 2019, KGH pediatricians have lobbied for a full-time equivalent (FTE) increase from 1.0 FTE to 2.0 FTE per shift to ensure adequate coverage between all five services.

The perceived urgency of this clinician request increased as pediatric volumes and acuity rose. Kelowna's rapid population growth, coupled with evolving regional planning decisions, resulted in KGH accepting younger and higher-acuity patients in the NICU. These shifts increased the number of cases and risk levels pediatricians were required to cover, while decreasing their ability to ensure timely support between the different hospital locations. To exacerbate matters, increased pressure from BC Children's Hospital for KGH to treat more patients locally and a strained medical transport system in BC meant KGH was often asked to keep and treat sick children and babies for extended periods of time.

Sustainability Concerns

Concerns related to the safety and sustainability of pediatric services had been raised formally since at least 2019.

Many pediatricians identified the 2019 LMAC presentation by the KGH Pediatric Department Head on "Code Pinks" as the first time significant concerns were formally raised regarding the sustainability of pediatric services. Based on data the Department Head had personally collected between 2014 and 2019, they outlined risks to quality and continuity of care. The presentation concluded with a number of recommended actions, including a request for increased pediatric ICU nursing support and training and the splitting of the current scope of pediatric care into two call-shifts to cover the PEDIATRIC UNIT and the NICU.

Then, tragically in 2022, there was a sentinel event which deeply impacted the pediatrics care team at KGH. Since that time, further reports have been done including:

- A Post-Mortem Quality Review (2022)
- Engauge Reports (April 2023 and May 2024)
- KGH Pediatric Review - Medical Staff Views (September 2025) prepared by Dr. Sam Azzam, EMD, Clinical Operations, IH South

Both the Engauge Reports (2023 and 2024) and the KGH Pediatric Review (2025), like this report, were commissioned by IHA with the objective of informing recommendations to improve services.

The Engauge Reports involved interviews and surveys with KGH pediatricians over a one-year period to understand what improvements needed to be made and to track progress to support sustainable pediatric care. While a number of changes were made in response to the recommendations that came out of the Engauge Report (2023), the lack of follow-up and action plan to address consistently poor relational scores between physicians and senior IHA leadership was perceived as a significant omission by pediatricians.

Then more recently, Dr. Azzam interviewed 17 KGH pediatricians to inform the KGH Pediatrics Review - Medical Staff Views report (Sept 2025). In this report, Dr. Azzam highlights key themes that came from his engagement including the need for additional resourcing, reconsideration of the NICU/PEDIATRIC UNIT call structure, reliance on other KGH clinicians to support pediatric patients, and the absence of a comprehensive pediatric strategic plan. The recommendations included improving communication between medical staff at KGH and IHA leadership and developing a long-term pediatric strategy.

For many pediatricians, despite the number of presentations and reports prepared, change has perceived to be slow and only reactive to significant events or acute crises. They noted that increased pediatric ICU nursing and training followed the sentinel event, and that temporary MOCAP coverage was made available December 2024.

By contrast, for senior IHA administrators, their commitment to support pediatric services has been on-going and is demonstrated by the funding of the Engauge Reports and more recent work led by Dr. Azzam. They noted that IHA's ability to respond to physician requests is impacted by a number of factors and physician expectations may be misaligned with the reality of what can be reasonably expected from a Health Authority.

Workforce Instability + Pediatric Resignations

As the above reports were being prepared, KGH pediatricians described the morale and sustainability of pediatric services as getting increasingly tenuous. In 2022, the sentinel event, along with other near-miss events, had a profound emotional impact on pediatricians and the broader clinical community.

Between 2023 and 2025, seven pediatricians resigned from their hospital-based practice at KGH, reducing the number of pediatricians from 12 to 4.5 FTEs. While some of these resignations were the result of retirement or family choices, a number cited continued sustainability concerns in letters of resignation sent to IHA administrators.

While it was hoped that mass staff resignations and the depletion of the KGH pediatrics team from 12 to 4.5 FTEs would result in more of a response from IHA leadership, it was the perception of many that IHA continued to dismiss pediatricians' concerns as local issues to be addressed by the pediatricians and hospital administrators. As such, the remaining pediatricians increased their hours to cover call, while actively recruiting new pediatricians and applying for a Rapid Initiation of Associate Physician program (2025). After months of this, when a significant number of shifts could not be covered by the remaining pediatricians or locums, the Department Head outlined an urgent request for more support to ensure adequate coverage at an LMAC meeting in December 2024. As a result of this meeting, Dr. Masterson, VP Medicine began to work closely with

the Department Head to explore options, eventually settling on the decision to close PEDIATRIC UNIT care for an extended period of time.

IHA Actions + Constraints

For IHA administrators, efforts to support the sustainability of pediatric services at KGH have been on-going. The onset of COVID-19 and the floods and fires following 2020 meant that efforts related to the 2019 LMAC presentation were delayed. A 2023 Briefing Note tasking for clarification regarding the intention and purpose of the Pediatric Tiers of Service document was never tabled at HAMAC for unclear reasons. Despite these setbacks, IHA was able to:

- Increase pediatric nursing FTEs (2022)
- Implement pediatric upskilling education initiatives (2024)
- Increase fee-for-service income guarantees (2024)
- Secure temporary second MOCAP (December 2024)
- Submit and get approval for the Rapid Initiation of Associate Physician program (2025)
- Secure approval of an Alternative Payment Plan (APP) from the Ministry of Health (2025)

These initiatives, as well as the hiring of Engauge to conduct their reports, were important efforts to support the sustainability of KGH's hospital services. To support the relational work required to improve the dynamic between IHA and pediatricians, in 2025, Dr. Azzam met with the KGH pediatricians and offered to meet with community pediatricians, including those that had left their hospital-based practice. Administrators reported that no departed KGH pediatricians agreed to meet with Dr. Azzam.

Post-Announcement Meetings (May + June 2025)

After approximately 17 months of sustained strain on coverage, an extended service disruption of PEDIATRIC UNIT care was announced on May 26, 2025.

Following this announcement, a number of meetings were held between the KGH pediatricians, hospital and community-based physicians and IHA representatives. Of note, a meeting was held three days after the start of the PEDIATRIC UNIT service closure, involving senior IHA leadership (including Susan Brown, the former IHA CEO and others) along with KGH and community-based pediatricians, other hospital-based physicians, and hospital administrators. The purpose of the meeting was to discuss the plan to support services during the service interruption. The meeting, however, became very heated and tense. Some physician participants felt that scheduling a problem-solving meeting after the services were forced to close was "too little, too late." Other physicians felt that IHA was not taking responsibility for the crisis after it had been warned about the service instability for years. For some IHA administrators, the level of anger expressed by some of the physicians felt inappropriate, threatening, and counterproductive given the urgency of the situation. Attendees reported that the meeting did not meet its purpose and, in several respects, intensified existing strains between physicians and IHA leadership.

A second meeting was held on June 9, 2025. This meeting was hosted by the KGH Medical Staff Association, with the purpose of fostering a collective understanding of the issues impacting pediatric services at KGH. Dr. Robert Halpenny, IHA Board Chair and Susan Brown, the IHA CEO at the time, were invited to attend. To facilitate a respectful dialogue, the MSA collected questions from the physicians in advance and shared them with IHA leadership prior to the meeting.

At the meeting, a presentation was shared by the IHA Board Chair outlining IHA processes for issue escalation, leaving little time to answer the pre-screened questions. For some physicians, this approach was indicative of a leadership system that could not hear their concerns and they felt disrespected and unheard. For some administrators, this response was indicative of a physician culture which externalizes its frustrations and responsibilities onto others. Across perspectives, participants agreed the meeting highlighted and further strained a misalignment between physician groups and senior IHA leadership.

Communications in the Public Domain

These tensions between physicians and senior IHA leadership continued in the public domain. Community-based pediatricians and other KGH physician leadership went to the media to voice their frustration with IHA related to the pediatric service disruption and what they felt were its causes. This approach with the media was not uniformly supported by the entire physician community, and participants reported that it caused tensions within the frontline healthcare community.

For some IHA administrators, being cast as bad actors in the public and not considering the wider communication needs at play was challenging. Tensions peaked when Susan Brown, former CEO of IHA issued a two-page OpEd in the local Castanet referencing workplace culture:

> "I have heard some concerns about culture in the Emergency and Pediatrics Departments [at KGH] and I share those concerns. I've also seen behaviour that is unproductive and not in alignment with the values of IH – quality, integrity, compassion and safety." (Interior Health, June 16, 2025)

It is within this context that HWC and Dr. Davidson conducted this Workplace Culture Assessment.

Methods + Approach

To support the design and delivery of this assessment, HWC and Dr. Davidson established a Project Steering Committee to provide local context, ensure appropriate participation, and guide key decisions throughout the assessment. The Project Steering Committee informed the Project Engagement Framework, including the:

- Project scope
- Engagement approach and methodology
- Guiding questions
- Initial participant list

The following people formed the Project Steering Committee:

- Dr. Sam Azzam, Executive Medical Director, IH South
- Dr. Cara Wall, Chief of Staff, KGH
- Diane Shendruk, Vice President, Clinical Operations, IH

Additional key stakeholders were consulted on a case-by-case basis to support the Project Steering Committee's work, including the Vice President, Communications and Engagement and Vice President, Medicine at IHA.

To assess workplace culture within KGH's pediatric services, HWC and Dr. Davidson conducted semi-structured interviews with participants identified by the Project Steering Committee. An interview guide was developed to support consistency across consultations and to ensure core topics were explored across participant groups. Participants were invited to participate via email.

In total, 82 individuals were invited for participation, including:

- Hospital-based pediatricians
- Former hospital-based pediatricians who have left their positions at KGH
- Other hospital medical leadership
- Hospital administrators
- Senior IHA administrators
- Nurses
- Community and locum pediatricians

Interviews were conducted in person and virtually throughout November 2025. In total, 45 participants met with HWC and Dr. Davidson representing a 55% participation rate. Some participants met with HWC more than once. Table 1 summarizes the participation rate of each peer group:

Table 1: Participant Description

Peer Group	# of Participants	#of Invitees	Participation Rate (%)
Hospital Pediatricians	9	16	56%
Former Hospital Pediatricians	5	8	62%
Other Hospital Leadership	7	11	63%
Hospital Administrators	5	5	100%
Senior IHA Administrators	6	9	67%
Nurses	3	9	33%
Locums + Community Pediatricians	6	22	29%
Other	4	5	80%
Total	**45**	**82**	**55%**

Upon completion of the interviews, HWC conducted a qualitative thematic analysis to identify recurring themes within and across participant groups. Data was reported in aggregated form to protect participant confidentiality.

The assessment identified eight distinct peer groups; participants who shared similar roles and broadly similar experiences. While individual perspectives varied within each group, priorities and narratives were more consistent within groups than across them. The peer groups identified were:

- Pediatricians
- Former hospital-based pediatricians
- Other hospital medical leadership
- Hospital administrators
- Senior IHA administrators
- Pediatric Department Heads
- Nurses
- Community and locum pediatricians

Preliminary findings were then shared with each peer group in “Reporting Back” sessions to test accuracy, invite clarification, and validate interpretation. In total, seven Reporting Back sessions were convened and input from these sessions was incorporated into the final findings and analysis.

Findings

Across interviews, participants spoke with deep emotion about the impact of the events over the past several years and the deteriorating working relations within and across physician groups and between physicians and senior IHA leadership. While perspectives differed on causes and accountability, participants consistently conveyed high emotional impact, reduced trust, and a growing sense that the system was not reliably able to resolve issues early, clearly, and collaboratively.

Pediatricians

HWC and Dr. Davidson interviewed nine pediatricians who are currently working at KGH and five pediatricians who left their KGH hospital privileges. These interviews were often very emotional and poignant. Pediatricians expressed deep commitment to their community and patients and high-degree of dissatisfaction with their relationship with the Interior Health Authority and concern for the future. The challenging working relations and perceived inability to affectively ensure safe and sustainable pediatric care has been very personally and professional difficult for many, traumatic for some.

Across this group, pediatricians expressed a shared perception that pediatric care – and women and children's issues more generally – has not been prioritized by the Ministry of Health or IHA. As such, they believe that their concerns regarding the quality and sustainability of pediatric services were dismissed for years, as priority was placed on other health service offerings. The result was that health services resourcing did not keep up with increased demand for pediatric services, requiring clinicians to assume higher levels of risk without the support required. This perceived lack of attention and priority was felt to be made at the expense of pediatricians and their ability to provide sustainable care.

Pediatricians described the sentinel event and additional near-miss events as deeply affecting, clinically, personally, and reputationally, both for individual physicians and for the Department's standing in the community. The responsibility of trying to recover the community's trust and lobby for better and safer support and services has had a significant impact on physician morale. While some improvements were made post 2022, it was not enough to establish confidence that the KGH pediatricians had IHA's support and that their concerns were taken seriously. This impact ultimately resulted in a number of pediatricians electing to leave their hospital practice, further jeopardizing the sustainability of pediatric care at KGH.

Many pediatricians described a perception that IHA and local pediatricians were not working towards shared objectives. KGH pediatricians spoke of the perceived lack of pediatric data being collected and analyzed to inform health systems planning and improvements to pediatric care. The majority of participants felt that key pediatric data is not being collected and that what data is collected is inaccessible to most healthcare professionals, with several participants saying that IHA and the Pediatric Network/Program often cite privacy concerns in rejecting access to data. In the absence of visible data and a shared planning framework, pediatricians described resourcing and planning decisions as opaque and potentially biased towards service-level parity between Kelowna and Kamloops despite differences in service delivery. Although both are "no refusal" sites, pediatricians reported that pediatric patients were often diverted to Kelowna, including at times when Kamloops was closer.

For the pediatricians, as the situation at KGH became increasingly precarious and untenable, they felt their concerns were dismissed at the expense of both themselves and the community they were expected to serve.

Senior IHA Administrators

HWC and Dr. Davidson spoke to six senior IHA administrators. Administrators provided varied perspectives on the drivers of service fragility and conflict.

Some framed the sustainability challenge in the context of broader workforce changes, including shifts in physician expectations regarding work-life balance and availability for hospital-based call. Several described that the number of physicians required to cover services has increased over time and that the independent contractor model can make accountability for coverage feel negotiable or unstable. Some expressed frustration that physicians can step back from hospital-based coverage even when system needs remain high.

Other administrators directed their attention internally and described organizational dynamics they believed contributed to slow issue escalation, limited transparency, and constrained problem solving. Some described that under the previous CEO, communication and issue management was siloed and tended to occur vertically or with individuals. Several pointed to the process for a Briefing Note to be approved for submission to HAMAC or SET as a concrete example. They described it as highly time-intensive, requiring multiple layers of approval that made it poorly suited to emergent or high-risk issues and, over time, discouraged escalation because of the effort and delay involved. Even when a Briefing Note was approved, there was limited confidence it would reach the Senior Executive Team's agenda. Relatedly, some perceived that what was ultimately tabled for discussion at SET, HAMAC, and the Board was tightly managed, with decision-making authority concentrated among a small group of positions rather than broadly distributed. In this environment, participants described transparent communication as more difficult and urgent problem resolution as stressful and constrained.

Finally, some administrators emphasized governance complexity and external constraints. They described that physician contracts and compensation are negotiated through structures that sit outside operational leadership and oversight, and that decisions by the Ministry of Health and Doctors of BC can significantly shape the Health Authority's ability to achieve its mandate. Within that framing, some administrators believed physicians may overestimate the Health Authority's ability to change key conditions and may attribute responsibility to the Health Authority for outcomes influenced by levers beyond IHA's control.

Other Participants

Other KGH physician leaders expressed perspectives similar to those of pediatricians, describing a perception that senior IHA leadership is reluctant to hear physician concerns, slow to engage in collaborative problem-solving, and more reactive than proactive in addressing emerging risks. These negative perceptions became further entrenched during the pediatric service disruption.

Several participants noted that media coverage of the PEDIATRIC UNIT closure preceded formal internal communication to KGH clinicians. Although administrators characterized this as an error, physicians reported that the sequence reinforced a perception that reputational management was prioritized over transparent engagement with frontline staff.

During the extended service disruption, emergency physicians proposed a compensation model intended to support pediatric back-up coverage. Participants reported that the IHA CEO's response was interpreted as dismissive, which further strained confidence in leadership's openness to clinician-generated solutions.

Beyond pediatrics, other clinicians emphasized that the sustainability of pediatric services is a system-wide concern. The strain of supporting pediatric patients during the service disruption was highly stressful and untenable over long term. Many expressed on-going concern that, without structural and relational improvements, future service disruptions remain a significant risk.

Analysis

Our engagement revealed that both KGH and IHA possess many of the foundational elements required for a positive workplace culture and a sustainable pediatric service. All participants expressed a strong commitment to delivering high-quality care within the scope of their roles. The Kelowna community includes a number of pediatricians; while not all wish to practice at KGH, many have and chose to resign their hospital privileges due to challenges in establishing effective working partnerships with IHA.

Kelowna remains a highly desirable location to practice. If pediatricians are able to establish mutually satisfying working arrangements, there should be no significant concerns regarding the long-term sustainability of pediatric services. At present, sustainability is constrained by relational challenges, influenced by existing health service governance structures and a reliance on goodwill to ensure service delivery.

Structural Reliance on Goodwill

The current medical structure, which relies on independently contracted physicians to deliver care, requires alignment of values and goodwill between IHA and physicians to function effectively. While the Health Authority is accountable for the delivery and oversight of services, it does not control key levers that influence physician behaviour – most notably physician compensation and many aspects of physician scheduling. In this context, sustained service delivery depends heavily on shared expectations, mutual confidence, and goodwill between physicians and IHA.

Updates to the Physician Master Agreement altered financial incentives in ways that reduced the attractiveness of hospital-based pediatric care. Under this revised Agreement, physicians are better compensated for their community-based work and are not financially incentivized to maintain their hospital privileges. Community-based pediatrics also offers more predictable daytime hours, supporting work-life balance. In a system where physicians can choose among practice settings without financial or professional consequence, hospital-based work becomes largely dependent on non-monetary motivators.

As a result, KGH and IHA administrators must rely significantly on physician goodwill and cooperation to meet basic service needs and its shared mandate. At KGH, participants reported that once goodwill and shared purpose became strained, departures from hospital practice accelerated, shift coverage became increasingly fragile, and the risk of service interruption grew.

This reliance on goodwill extends beyond the Health Authority. Responsibility for determining the physician FTE complement and for building and maintaining the call schedule typically rests with the Department Head. However, like the Health Authority, the Department Head has limited formal authority to direct peers or enforce coverage expectations. Department Heads described the cumulative stress of attempting to maintain coverage as successive departures reduced the roster of available pediatricians. With few practical levers to incentivize participation, they reported relying heavily on relationships and personal influence. Particularly when locums were unavailable, Department Heads described a significant moral burden – feeling caught between pushing colleagues beyond sustainable limits and risking service disruption for patients and the community.

Absent strong monetary incentives, pediatricians who continue hospital-based practice often do so for non-monetary reasons such as workplace satisfaction, collegiality, and kind-heartedness. When these relational and cultural factors deteriorate, the ties sustaining hospital participation weaken, and the system becomes increasingly fragile.

Governance + Decision-Making Ambiguity

The fragility of the system is further exacerbated by the complex, shared leadership structure common in healthcare, in which responsibility for service delivery is distributed across clinical and operational roles. Accountability is shared among many parties and ultimate decision rights are not always clearly defined, allowing for the passing of responsibility and blame with little resolution.

Health services planning and physician recruitment illustrate this dynamic. While both are core system functions, many participants were unclear about how responsibility is distributed. When pediatric service planning lacked clarity or recruitment efforts fell short, physicians perceived the Health Authority as failing to meet its obligations. Conversely, senior IHA administrators perceived physicians as unwilling to adjust their practices or contribute additional effort to maintain services.

At KGH, pediatricians expressed frustration that the Health Authority did not prioritize requests to separate NICU and the pediatric unit services or strengthen recruitment efforts to support sustainability. In turn, the Health Authority expressed frustration with pediatricians who reduced hospital participation or implemented service disruptions.

In this environment, appreciation for the constraints facing the other party diminished and was replaced with resentment and blame. As goodwill eroded, motivations were increasingly questioned and actions were interpreted as driven by self-interest or indifference rather than systemic constraints.

Erosion of Trust + Attributions of Intent

Where governance clarity is limited – particularly around decision rights for planning, recruitment, service configuration, and escalation – ambiguity tends to be filled with inference. Over time, uncertainty about “who owns what” fosters blame and the attribution of intent.

From the physician perspective, the absence of a clearly articulated regional vision for pediatric services, combined with limited access to relevant data, and opaque issue escalation practices contributed to a perception that pediatric services, data informed decision-making and physician wellness were not system priorities. Institutional responses were experienced as reactive – occurring after major events or acute disruption – rather than proactive course corrections.

From the IHA perspective, physician frustration was often interpreted as reflecting limited appreciation of governance constraints and competing system demands. Physicians’ decisions to step back from hospital-based practice or implement disruptions were seen as further destabilizing service continuity. When invitations to engage in proposed solutions were not accepted, this reinforced perceptions of reluctance to partner in problem-solving.

The resulting dynamic created an escalation loop: role ambiguity and limited transparency increased misattribution of intentions, which eroded trust. As trust declined, collaboration weakened. As collaboration weakened, both sides experienced the other as less reasonable or less committed, further entrenching conflict and service fragility.

Personalization of Systemic Strain

As system pressures intensified and decision-making remained contested, the sustainability challenge at KGH shifted from being primarily operational to becoming deeply relational. Operational constraints were

increasingly interpreted through the lens of perceived intent. Frustrations that were once focused on systems and structures became attached to individuals and personal values.

Pediatricians expressed frustration with individual senior leaders, citing perceived lack of empathy and understanding. Senior IHA administrators communicated frustration with what they perceived as physician entitlement, judgement, and culture. As concerns became personalized, opportunities for constructive problem-solving narrowed.

Media involvement further intensified this personalization. Public attention introduced reputational risk for both physicians and administrators, shifting communication from interpersonal dialogue toward more performative statements. This heightened defensiveness made relationship repair more difficult at a time when collaboration was most needed to restore service stability.

Fragility of the Governance Structure

Our engagement reveals a governing structure characterized by separation of compensation negotiations from operational leadership, reliance on independent contractors, and dyad leadership models that depend heavily on goodwill and shared values. These elements can function effectively when relationships are strong. However, under conditions of strain, fiscal constraint, and interpersonal conflict, goodwill can erode.

In such a system, people leadership becomes paramount. Strong, empathic, and strategic leadership can foster the trust and alignment required to sustain service delivery across structural divides.

To that end, at KGH, the leadership of the Chief of Staff, Dr. Cara Wall, the KGH Director for Women's and Children's, Megan Helgason, and the Executive Director, Lindsay Thomson was cited as critical for working with pediatricians to address concerns, solve problems, and boost morale following significant events and during service disruption. Their efforts mitigated further departures and preserved a degree of service continuity.

More broadly, the effectiveness of IHA administrators depends not only on the technical strength of proposed solutions, but also on their ability to foster physician cooperation and shared understanding. Without relational credibility, even well-designed strategies may fail to gain traction. Prioritizing emotionally intelligent, collaborative leadership will be essential to rebuilding cooperative relationships with physicians and navigating complex challenges in a resource-constrained environment.

Nimble, Transparent Resolution Mechanisms

In addition to strong, people leaders who can listen, support and partner with physicians to address complex health services challenges, participants emphasized the need for mechanisms capable of rapidly prioritizing urgent issues, fast-tracking decision-making, clearly documenting decisions and rationale, and tracking actions to completion with consistent communication back to affected clinical groups.

The recent creation of the Pediatrics Action Plan Working Group – an ad-hoc committee formed outside of the standard LMAC/RMAC/ HAMAC structure – was identified by most participants as highly successful at resolving emergent issues related to pediatric care. Its perceived success reflects the value of focused mandates, defined accountability, and transparent communication loops.

Data-Informed Health Services Planning

Sustainable pediatric services will require data-informed health services planning that enables departments to recruit physicians aligned to the future vision of service delivery. Transparent access to relevant data and shared understanding of regional needs will be critical to restoring trust.

Trust and buy-in to the activities of the new Maternal Newborn Child and Youth Program will be critical to aligning the efforts of pediatricians across the region and informing the vision that will guide pediatric health services planning. The current model at KGH which relies on pediatric generalists may not longer be feasible to address the growing level of pediatric patients and their acuity. Ensuring sustainable, safe care may require appropriate specialty/subspecialty coverage to match acuity, reduce burnout risk, and maintain quality. Without this plan, KGH has been recruiting pediatricians who are willing to work as generalists. Many of them do have specialities which they hope will be relevant in the future. Without a credible plan addressing these issues, recruits may not stay and service fragility will persist.

Effective Communication

Finally, effective communication strategies – embedded within a broader people strategy that fosters goodwill and cooperation – will be critical. When relations between physicians and IHA became strained and the discourse became public, negative perceptions hardened and discontent intensified.

Re-establishing shared decision-making forums, strengthening two-way communication, and reinforcing a commitment to joint problem-solving will be critical to rebuilding trust. This change will be required at all levels of leadership to foster the collective understanding of problems and opportunities impacting health service delivery. Leadership that encourages active listening, curiosity, and openness to solutions will be required to support the organizational and cultural transformation necessary for sustainable service delivery. Shifting the focus of communication from blame to accountability and investing in the relational work to build trust will foster the type of partnership between clinicians and administrators required to ensure effective, efficient and safe service delivery.

Recommendations

To support the long-term sustainability of pediatrics at KGH and to foster effective working relationships and a positive workplace culture within IHA, we recommend the following:

1 Facilitated session(s) with participants to identify:

   i. Learnings from the past that prevented effective working relationships and the nimble resolution of issues
   ii. Shared commitments to support and foster productive workplace relationships and dynamics between levels of leadership moving forward
   iii. Behavioural expectations for meetings and public communication
   iv. Opportunities for humility to identify where systems and/or behaviours may have impacted the achievement of shared objectives

2 Commitment and support for data-driven service planning to inform and guide the development of pediatric services in the Interior Health region that is agreed on by both regional hospitals

3 Review of LMAC, RMAC and HAMAC structures and operations to facilitate the development of issue prioritization, escalation, and tracking procedures

4 Review of communication strategies, approaches, and messaging to support effective partnerships with IHA leadership and physicians

5 Prioritization of people-centred, relational, trauma-informed leadership