

SOUTH ISLAND MEDICAL STAFF ASSOCIATION

September 24, 2025

General Meeting Minutes – 6:00-7:30pm

1. **Call to Order at 6:00 pm** – Welcome & Territorial Acknowledgement by MSA Co-President Dr. Catherine Jenkins
 - Approval of Agenda; Approval of Minutes from General Meeting on January 21, 2025
 - Acknowledge the loss of community member in August, Dr. Sylvie Argouarch, Geriatric Psychiatry

2. **South Island MSA Announcements**
 - **South Island MSA Executive**
 - Welcome to new executive members, Dr. Gaby Yang and Dr. Shavaun MacDonald
 - Currently have 1 executive seat opening
 - Cannot hold an Island Health leadership position
 - Experience needed is the experience of being a clinical medical staff member – being the eyes and ears of front line physicians, hearing and bringing forward concerns
 - Looking for people interested in advocacy and being part of committees
 - Reach out to Executive or info@southislandmsa.ca if you are interested in learning more

3. **South Island MSA Updates**
 - **Island MSA Presidents/Health Authority MSA (HAMSA)**
 - Reviewing MRP, needs more time to discuss and get feedback
 - Hoping to have something coming in the fall that will involve Medical Staff

 - **IHealth**
 - Special funding for iHealth has ended, any future funding will come out of general revenue meaning that the funding for future activations or improvements is much less
 - Particularly an issue for sites which have not been fully activated.

 - **South Island FEI Society Working Group**
 - Next meeting is October 15th
 - Strategic Planning Funding has been announced for this year only
www.southislandmsa.ca/news/introducing-strategic-planning-funding
 - Intake for SIFEI project applications has closed for Fall, next intake will be January 2026

 - **Physician Wellness and Social Committee**
 - Well Doc Canada Physician Wellbeing Survey - 35% response rate; results will be presented at department-specific meetings, prioritizing QI opportunities
 - Supports concrete improvement work
 - Still time to join your department specific meetings to get results, [Register Here:](#)
 - Oct 7 – Anaesthesia and Surgery
 - Oct 14 – Critical Care and Emergency Medicine
 - Oct 21 – Medicine
 - Oct 28 – Imaging, lab, Psychiatry
 - Nov 4 – Maternity, Pediatrics, Primary Care
 - Had good turnout for the BBQ in September and positive feedback
 - Next event is the Welcome & Thank You in Spring

- **Annual General Meeting Evening (SIMSA/SIFEI/VMS)**
 - Thursday, November 18, 2025 at the Delta Ocean Pointe Resort
 - Doors @17:15, guest speaker @18:00
 - [RSVP here](#)

4. SIMSA Celebrations

- Gold Star Awards recognize those who go the extra mile to care for a patient, who put in extra effort to help a colleague, or who are working in their own way to contribute to a positive work environment
- Recent recipients:
 - Dr. Lesley Silver by Dr. Chris Harper
 - Cheryl Burke by Dr. Rebecca Morley
 - Dr. Brian Farrell by Dr. Elizabeth Ward
 - Izzy Morrissey by Dr. Paul Winston
- Email nominations to info@southislandmsa.ca

5. South Island ICU Bed Crisis – Dr. Gordon Wood

- Lack of ICU capacity in the South Island has been a longstanding issue; first formally raised in 2009 during the H1N1 pandemic
- Despite repeated reviews and growing demand, critical care capacity has not kept pace with population growth or service needs
- Critical care beds include ICU and High Acuity Unit (HAU) beds used by critical care physicians and nurses, but exclude CCU and CVU beds
- Critical care capacity in Victoria is less than one-third of that found in other tertiary hospitals in BC and Canada, measured by: critical care beds per 100 acute care beds, critical care beds per 100,000 population
- Only 2.9% of acute care beds at VGH and 2.2% at RJH are critical care beds
- Critical care beds on Vancouver Island are poorly distributed:
 - Half of the Island's population and most tertiary services are located south of the Malahat
 - Only 31% (11 of 67) of Island Health critical care beds are located south of the Malahat
 - All other BC health authorities have over 70% of critical care beds located in tertiary hospitals
- South Island has 4.7 critical care beds per 100,000 population, compared with 11.5 per 100,000 north of the Malahat
- One-third of ICU admissions to VGH and RJH (2020–2023) were from patients living north of the Malahat
- Victoria residents effectively have access to only 3.1 ICU beds per 100,000 population
- Canada had approximately 13 ICU beds per 100,000 population in 2014; OECD average ranges from 12–14 ICU beds per 100,000
- A 2013 External Review of ICU Capacity in VIHA concluded that:
 - Island Health was woefully under-resourced in critical care
 - Tertiary hospitals required more ICU beds
 - Nanaimo's ICU physical plan was among the worst in the country
 - High Acuity Beds and Critical Care Outreach Teams were required
- Following the review NRGH received a new ICU and a step-down unit at RJH, which has since closed
- Despite recommendations, higher-level care beds remain approximately 2% of total beds
- NRGH now has more critical care beds than RJH and VGH combined
- VGH opened in 1983 with 11 ICU beds and currently has 10 physical beds; since opening Greater Victoria's population has increased by 60%
- Over the past 15 years, VGH ICU admissions increased by 75% and ICU patient days by 80%
- Three ICU beds were temporarily added at VGH in 2015/16

- RJH ICU admissions increased by 135% (350 to 822) over 15 years, bed #s increased only minimally; drug and alcohol overdose–related admissions have placed additional strain on ICU capacity
- Patients requiring higher levels of care are frequently managed on inpatient wards due to insufficient ICU and HAU beds; contributes to inability to decant sick patients from Emergency Departments and use of overflow, contingency, or inappropriate care areas for critically ill patients
- Routinely caring for patients in settings not designed for their acuity
- ICU patient outcomes in Victoria are worse than those in other BC tertiary hospitals
- All BC tertiary ICUs participate in a provincial database using standardized measures, including the Standardized Hospital Mortality Ratio (SHMR)
- SHMR compares actual hospital mortality to predicted mortality based on APACHE IV scores and admission diagnosis
- Island Health’s elevated SHMR may be influenced by:
 - Late ICU admissions and early discharges due to bed shortages
 - Management of high-acuity patients outside the ICU
 - High nursing turnover related to workload, morale, and inadequate physical environments
- Victoria has insufficient critical care capacity
- Existing beds are poorly located relative to population distribution and tertiary service demand
- Patients who would receive higher-level care in other Canadian jurisdictions are routinely managed on general wards, this places significant strain on staff, compromises patient care, and is associated with worse-than-expected patient outcomes

Location of Island Health Critical Care Beds:

Hospital	ICU Beds	HAU Beds	Total C.C. Beds
VGH	10	0	10
RJH	11	0	11
CDH	7	0	7
NRGH	11	11	22
WCGH	3	0	3
CVH	8	0	8
CRH	6	0	6
Total	56	11	67

ICU Beds in BC – beds per 100 acute care beds (Numbers from Critical Care BC)

Hospital Name	# of ICU/HAU base beds	# of acute base beds	ICU/HAU beds per 100 acute beds
St Paul’s	20	437	4.6
Kelowna General	27	497	5.4
Royal Inland	17	297	5.7
Vancouver General	54	843	6.4
Surrey Memorial	46	640	7.2
Royal Columbian	30	450	6.7
University Hospital Northern BC	18	268	6.7
Royal Jubilee Hospital	11	512	2.2
Victoria General Hospital	10	337	2.9
Nanaimo Regional General Hospital	22	365	6.0

6. Discussion – ICU bed crisis

- Recognize the pressure on the resources with the cutbacks
- What is causing the delays getting the capital funding for rebuilding ICU in Victoria?
 - Complex expansion, hindered by the physical space
 - When D&T was first being built, plans included a 16 bed ICU on the 5th floor
- Surrey engaged their community to raise awareness and drive public support; had MLAs and media involved, coming onsite every day
- Story of success – new Renal Unit was created and still has capacity to grow; building it was driven by a dialysis patient approaching their MLA and brought them onsite for a tour
- Nothing is stronger than patient advocacy, need to encourage patients to go to MLA offices and to make their voices heard
- Numbers and statistics alone won't make a difference, need to have the human impact
- There are high performance Canadian hospitals we can learn from, sometimes need outside opinions
- Lost HAU because of staffing and location; HAU needs to be near the ICU not just on a ward
- Could not provide good care in the location HAU was in; couldn't see patients and do monitoring
- During COVID HAU turned into ICU without the right equipment or set up
- HAU and ICU need to have a relationship between units
- Gillian Kozinka update for VGH – have seen a shift in the workforce, able to recruit and retain nurses
- Nursing seats are now being filled, vacancy rates are lowering
- Everything on deck for capital planning at RJH was sent back to Ministry for review and approval, it is all on hold now
- Strategic growth has halted, projects being planned went back for review
- Expanding critical care beds, not just created a HAU; all nurses will have CC training
- During Pediatric Respiratory Crisis had to use HAU space at VGH to care for patients; PICU is also not up to standard
- PICU moving back to 4th floor, will lead to 16 CC beds at VGH
- Need a new build to be able to accommodate growth in Western Communities
- Reliance on Travel Nurses is reducing, getting more sustainable workforce
- Understand the limitations HA has at MoH table; reducing budget, not increasing
- Patient voice and getting politically savvy is where we need to focus
- Ministry wants us to do more with what we've had and be creative
- Politicians listen to the community
- MSA has advantage because are not bound by same privacy requirements, gives us cover to speak out that other administrators do not have
- The MSA has been guarded about going to press as the outcome of press attention is unpredictable
- Want the message to get to the public because these are their hospitals and their voices are needed to make change, need to approach MLAs
- Need to focus on partnership between HA and MSA, phased or multiprong, need to activate as medical staff and share with administration so they have an awareness
- We have more freedom as physicians as the HA employees do
- If we can work in partnership could help prevent ISLH having to go on the defensive
- Data speaks for itself, can back it up
- Victoria Hospitals Foundation (VHF) may be able to help with raising funds for infrastructure and equipment, need HA to cover operating costs; Foundation is confident can get money to build a hospital but need funding to support operating costs
- Expanding the ICU will have downstream benefits for both the PCC wards and Emergency by ensuring that critically ill patients are more promptly transferred out to ICU

7. Island Health Finances & Staffing

- 2024-2025 Budget– \$4.6 billion, \$43.6 million overrun
- 2025-6 Budget
 - 2% cut – \$96 million
 - Over-run \$43.6 million not forgiven
 - IHealth expenses now coming out of general budget
- Coming off a tough time, no one wanted to be in this position
- 40% of provincial budget
- It is very difficult to get specific information about the cuts – some of this is secondary to limitation in what ISLH is able to share
- Recognize that the cutbacks are inherently painful but believe that there are some things that can be done to lessen the pain
- Very painful to have people leaving suddenly and disappearing without saying goodbye
- Disconcerting when people we've worked with are suddenly gone and don't know who to connect with instead
- Being told the cuts are part of "Better Care, Better Value" feels awful
- What have people noticed:
 - Big problems in outpatient neurology; clinics not getting scheduled
 - Have SLPs working with them, have a speech aide spent months training to just have them get let go
 - Pediatrics struggling as a service, had to close Urgent Clinic
 - Don't have the workload or support by staffing
 - Have been too quiet of a voice and are now in a dire spot, hasn't reflected growth or acuity
 - Island Health website still shares services we can't provide
 - Has seemed a lot tighter, less casual staff to cover summer holidays
 - One whole rehab wing had no OT, delaying discharges
 - Large vacancy in Therapy services, not enough people to get the work done that is needed
 - Vacancy rates at RJH and VGH are being addressed locally
 - PT/OT/SW all are understaffed, need to push recruitment in these groups
 - Having contract issues with community, can't bring someone external in
 - There has been an effort to reduce the need for overtime as nursing staffing resources have increased slightly.
 - Significant recruitment done from US, will start in next few months
- LTC has lots of nursing shortages, has been going on for many years; Glengarry has 40+ patients who are unattached
- Can't get physicians to take LTC patients which impacts the hospital
- Have tried to do a lot of SIFEI projects that focus on flow and access
- Meeting soon to discuss letter written to Kathy MacNeil
- What was sent to CEO is being taken seriously and will be working with Dr. Jenkins, Dr. Voon, Dr. McArdle and Dr. Lemire-Elmore, to advance some of the ideas
- Plea to start being more transparent, helpful when engaging medical staff if we know what is happening and why so we can learn and commiserate together
- 15% growth we have seen is being looked at as an administrative bloat; 120 positions that have been deleted strategically moved in the governance structure
- Need to funnel more money back to frontline
- People are not being let go because of performance, but because of how programs are merging and changing
- Focus shift to strategic plans and achieving goals
- Need to focus on being innovative to create a path forward

- Focus on next 10 years, not just here and now
- Different definitions of what “Administrative” means; this is impacting Clinical Informatics, Coordinators, Quality Consultants
- There is space to optimize and innovate, but in terms of what “Administrative” means it is also including those roles that support Clinical change
- Want Unit Clerks roles to be increased again, too much admin burden has moved to physicians

8. Other:

- DOBC HA Engagement Survey – October 1-30; most important survey to do every two years, gets eyes on from Ministry of Health, DoBC and all the HAs
- Letter to CEO was fantastic, disappointed by the response
- We’ll continue to do our part

Adjourn at 7:30pm