



Critical Review of the Formal Complaints Process

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It is not the job of First Nations, Inuit, and Métis peoples to teach the work of decolonization and reconciliation to non-Indigenous people, organizations, and institutions, and we thank all those who generously participated in this critical review process.

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Executive summary

The College of Physicians and Surgeons of British Columbia (the College) has several opportunities to become a leader in the province, the country, and the world when it comes to embedding cultural safety and humility into its complaints process, and its organizational structure and policies more generally. British Columbia is home to incredibly diverse populations of First Nations, Inuit and Métis communities, and the College has the chance to learn from the many Nations, communities, and leaders in the province to deliver more culturally safe and accessible health-care services and ensure that its organizational policies and processes are aligned with principles of cultural safety for Indigenous Peoples.

The critical review revealed several key themes which characterize the kinds of gaps that exist within the current complaints process. These include accessibility, cultural safety, formal vs. soft complaints, communication, resolution and accountability, and self-identification and data. Through the analysis of critical review research, a series of eleven recommended actions for change were identified for a future state of the College's complaints process to make it safer and more accessible to First Nation, Inuit, and Métis people.

To improve cultural safety and accessibility for Indigenous Peoples, a future state of the College's complaints process should include:

1. In-person options for patients to share their complaints or experiences with the College.
2. Options for patients to share 'soft' complaints.
3. Soft complaints being reflected within the College's data and annual reporting.
4. Revisions to the College's complaints webpage to include information about different complaints options and how to access them online.
5. Transforming the complaints form to be a fillable online form.
6. Review and revision of the College's communications materials regarding complaints to make them more compassionate and respectful.
7. Formalized partnership with the First Nation Health Authority (FNHA) and/or other Indigenous health organizations.
8. Expanded options for transformative justice and healing.
9. Options for complainants to identify their racial and cultural identity.
10. Demographic data in College's end of year reporting.
11. Use end of year reporting as a means of truth-telling.

Introduction

In March 2017, the College became a signatory to the BC Declaration of Commitment - Cultural Safety and Humility in the Regulation of Health Professionals. The declaration was co-signed by registrars of all colleges in the BC Health Regulators, the Ministry of Health, and the First Nations Health Authority. Since then, the College has been on a journey to learn the truth about the experiences of First Nations, Inuit and Métis people living in the province and to take appropriate action to reconcile past harms. The College recognizes the history of systemic racism against Indigenous Peoples across Canada, and its legacy on health outcomes for Indigenous communities.

In the Fall of 2020, the College's Board added a new pillar to the 2021-2024 Strategic Plan, which addresses Indigenous-specific systemic racism in health care by embedding cultural safety and humility into the College's regulatory processes, operations, governance structures, and practice standards. As one element of this work, the College has undertaken a critical review of its complaints process to identify opportunities for making the process safer and more accessible to First Nations, Inuit, and Métis people.

The College contracted experts from the Castlemain Group who specialize in research, engagement and collaboration with Indigenous people, communities, and organizations to conduct the work of the critical review. Through guidance from the esteemed Indigenous Advisory Panel made up of First Nations and Métis leaders in health care, Castlemain led the primary and secondary research of the critical review. Undertaking this review is a vital step for the College to take as an organization that strives to use knowledge as a tool for creating change. At an organizational level, the critical review sheds light upon the barriers that discourage or prevent First Nations, Inuit, and Métis people from bringing forward concerns about their experiences and identifies opportunities for the process to be better informed by a lens of cultural safety and humility.

Through engaging with College staff, external partners, and experts in Indigenous health care, this critical review examines the extent to which the current complaints process:

- supports the experiences of Indigenous Peoples in their interactions with physicians and surgeons in BC;
- is informed by culturally safe practices; and
- upholds the BC Declaration of Commitment - Cultural Safety and Humility in the Regulation of Health Professionals.

This report summarizes the outcomes and key themes that emerged throughout the critical review, and includes recommendations for a future state of the complaints process that will be safer for Indigenous patients and families to access and participate in.

Recommendations from *In Plain Sight*

First Nation, Inuit and Métis people and communities have been speaking out about systemic racism in health care for decades. This racism is manifested in all aspects of the health-care system through racist stereotyping and assumptions, microaggressions, overt racism and bullying, culturally inappropriate forms of communication, and so much more. *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care* carefully details the various forms of anti-Indigenous racism in health care and their impacts on Indigenous Peoples, communities, and their health outcomes. The report directly references

and details the problems with complaints processes in the health-care system, and the ways that they fail to meet the needs of Indigenous patients and families.

In Plain Sight's Finding #7 states:

Complaints processes in the health care system do not work well for Indigenous peoples. Review evidence demonstrates that complaints processes are not easily accessible to Indigenous peoples, do not include space for Indigenous cultural processes and methods of dispute resolution, and can be re-traumatizing. The end result is that Indigenous people may be left with little recourse for poor treatment, reproducing past harms and trauma that have been part of the experience of colonialism in the health care system. An integrated, accessible, and culturally appropriate Indigenous complaints process is needed. Indigenous people find the complaints process inaccessible, and this is reflected in a low number of complaints filed.¹

While *In Plain Sight* was a wake-up call to many non-Indigenous people, health-care organizations, and institutions in British Columbia, it merely reflects what First Nations, Inuit and Métis people in the province have been voicing for a long time. The report's findings on unsafe and inaccessible complaints processes in health care were foundational to the research undertaken within the College's critical review process and helped to ground the findings of the review in the context of BC health care specifically.

Critical review methodology

Environmental scan and desktop review

The critical review began with an environmental scan of best practices and culturally safe complaints processes currently being implemented by health-related colleges in jurisdictions across Canada, as well as New Zealand and Australia. The Canadian components of the environmental scan included the colleges/licensing bodies within each province and territory, where applicable, for:

- Physicians and surgeons
- Nurses
- Naturopathic doctors
- Chiropractic medicine
- Dentists and dental surgeons
- Registered massage therapists (RMTs)
- Physiotherapists
- Optometrists, and
- Social workers

¹ *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care*, 2020, page 43. <https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Summary-Report.pdf>.

The environmental scan sought to explore any existing and successful practices for culturally safe complaints processes being used by colleges that are similar in function and purpose to the College of Physicians and Surgeons of BC.

While the environmental scan was comprehensive in scope, it uncovered the limited work currently being done to create safer complaints processes for Indigenous Peoples in Canada. While many of the health-related colleges in the country acknowledge on their websites and online communications that they have a role to play in addressing anti-Indigenous racism in health care, the environmental scan revealed that these acknowledgements have not yet been translated into much concrete action.

A comprehensive desktop review was also completed to gather secondary information about the common challenges of medical complaints processes, specifically as they relate to the cultural safety of Indigenous people, families, and communities. The desktop research included reviews of professional and academic reports, public inquiries, news articles, and academic journal articles on the topics of Indigenous health care, anti-Indigenous racism in health care, accessibility of health services and complaints processes for marginalized populations, guidelines on complaints management for health care, and more. The College's library also provided access to its databases and performed searches using the below search terms for academic journal articles:

- Complain* process* OR complain* polic*
- Cultural competenc* OR cultural approach OR Indigenous cultural inclusion OR cultural sensitivity OR culturally sensitive AND/OR adaptations AND/OR accommodations
- Cultural safety OR culturally safe
- Cultural Safety AND Humility
- Culturally inclusive OR inclusion
- Complaint* process* best practices OR recommendations OR guidelines OR suggested practices
- MESH terms: Medical malpractice, health equity, health inequity, healthcare disparities

Key informant interviews

College staff

To augment the secondary desktop research, key informant interviews were held with seven College staff members working across the various stages of the complaints process, including intake, complainant navigation, and complaint investigations. These interviews aimed to build a robust picture of the current complaints process, and a better understanding of the challenges currently facing the College in its capacity to inform and support the public, and specifically Indigenous Peoples, who attempt to use its complaints process.

Key experts

To account for external perspectives on the merits and weaknesses of the current process, 14 key individuals were interviewed for their insights and experiences serving and supporting Indigenous Peoples using the current College complaints process.

Critical review: the current state

The College of Physicians and Surgeons of BC complaints process

Across the primary and desktop research, it is clear that the current complaints process complies with standard best practice in anonymity and procedural transparency. Currently, members of the public wishing to lodge a complaint about service they have received from their physician or surgeon must fill out the official complaint form in writing or online if they have access to the necessary software. Complaints are accepted in all languages, and the College website's complaint information may be translated into nine different languages, however these do not include any Indigenous languages. Complaint navigation is available for individuals who would like additional assistance completing the form, however, at this time complaints cannot be processed over the phone.

Once the College receives the complaint, the individual is notified through the mail of their case file number and provided with contact information of the College staff member responsible for their file's administration and processing. Complaints received by the College are streamed weekly into five panels based on complaint context, severity and investigated accordingly. Case administrators then send out the complainant's official initial complaint correspondence to the subject physician, as well as the complainant for their reference. Case files that are more complex may also include hospital medical records or information from additional other regulated health professionals or witnesses. The subject physician has two weeks to respond, and their response is reviewed by one of three College managers.

Upon receipt, the College sends the physician's response to the complainant for review, and while no response is required by the complainant, they are welcome to submit additional information to their file if they desire. This response is then sent to the physician, with an invitation to comment and expand on initial response. The current system has no hard timelines for this response process and is open to multiple correspondences between physician and complainant to ensure that all information is gathered and both parties feel able to provide their full account. Following the subject physician's response, the College uses panels of the Inquiry Committee to review complaints based on clinical, conduct or boundary concerns. If a complaint results in regulatory criticism, the College may take some of the following actions:

- interview the registrant to discuss the matter in more detail
- request the registrant take certain educational courses
- seek a signed commitment in regard to the registrant's future practice
- hand out a formal reprimand to a registrant
- place a registrant's practice under certain restrictions
- cite a registrant for their conduct and require them to attend a public hearing
- in extreme circumstances, the Inquiry Committee may refer the matter to the Discipline Committee for consideration of additional outcomes, including suspension or erasure of licensure

A complaint may also prompt the Inquiry Committee to launch a more general investigation into a registrant’s practice. This will result in a more comprehensive review. Whatever the outcome of a complaint, a copy of the decision is placed on the registrant’s permanent record at the College.

Key emerging themes

Through the comprehensive desktop research conducted, as well as interviews with 14 key informants, several key themes emerged throughout the critical review process. These themes are detailed in the section below.

Accessibility

One of the most glaring gaps identified throughout the critical review was the inaccessibility of the College’s current complaints process. Desktop research, as well as interviews with both Indigenous health partners and College staff clearly revealed that the process is complicated, impersonal, and form-based, making it difficult to find and use in the way that the College expects it to be used. Currently, the process requires complainants to find the College’s complaints form on its website, download, and write down their experience in detail—by hand, for those who do not have the correct computer program— scan and submit the form electronically, by fax or mail. This step of the process poses several barriers to people who may not have reliable internet access, people who have limited digital literacy, or who do not own printers or scanning devices. “The process is daunting and there is nothing simple about it,”² explained one Indigenous liaison nurse. For people who have just had a racist and harmful experience, frustrations such as these can be the difference that determines whether they go through with making a complaint or not. Additionally, while the process is available in nine languages, including English, Korean, Arabic, and Punjabi, it is not available in any Indigenous languages, which poses significant barriers to many Elders and other Indigenous Peoples. The College does arrange translation, however, and if needed a note-taker or scribe.

The process relies heavily on formal, bureaucratic English, which is not accessible to everyone.



The process is daunting and there is nothing simple about it.

–Interviewee



In some cases, service providers were unaware of the College’s complaints process. Interviews with Indigenous health experts and advocates also revealed the need for the College to be more proactive about sharing information about the complaints process itself and the various steps it involves. It is important for patients and families to have early access to information about their options when they feel as though they have experienced harm; they need to know that the recourse available to them is going to be culturally safe and accessible for them to engage with in a way that will bring them comfort or resolve.

In addition to improving the accessibility of the complaints process, the critical review unveiled the need for more public education about patient rights and the standard of care

² Interviewee #1, 2022.

that all people are entitled to when they receive health care. Awareness of the College's complaints process is limited and "people don't even know when they haven't received adequate care,"³ explained one interview participant. Racism is not always an easy to define or detect experience; it is often an internal feeling that an Indigenous person walks away from a harmful encounter feeling. If patients, specifically Indigenous Peoples, are provided with more access to tools and resources regarding their rights as recipients of health-care services, they would likely feel better equipped to identify when they have experienced harm and make a well-informed decision about whether to pursue action.

However, as long as the process involves several tedious steps, many people feel as though they simply do not have the time, energy, or access to necessary supports to go through the currently complex, time-consuming, and impersonal complaints process.⁴ The College has demonstrated it understands the difficulty of navigating the current complaint process by creating their one complaint navigator staff position. This staff member provides the important human, empathetic touch to people as they move through the process, and this review revealed the need to substantially increase the number of these positions and enable them to work flexibly with other community partners to deliver care in a culturally safe manner.

Lack of cultural safety and cultural humility

Barriers to making complaints

The challenges that exist for many First Nation, Inuit and Métis patients filing a complaint begin long before they even officially engage with the complaints process. There are several compounding barriers that exist which often limit or stop Indigenous people from making a complaint in the first place, and these barriers largely begin with the mistrust that many have of the medical system in general. A great deal of this mistrust is rooted in the traumas experienced by First Nation, Inuit and Métis people in British Columbia and are rooted in historic and ongoing colonial violence, including the residential school system, the Sixties Scoop, racist practices such as birth alerts, and the epidemic of missing and murdered Indigenous women, girls, and 2SLGBTQQIA+ people. These colonial policies and practices, among others, have significant connections to the health-care system, and continue to have deep, intergenerational impacts on people, families, and communities. Therefore, the relationship that many Indigenous Peoples have with the medical system is characterized by mistrust and a lack of safety.

With no pre-existing relationship to build trust from, Indigenous patients generally expect that making a complaint to the College, a body that they do not know or trust, will have negative results for them and their future care or that their complaints will not be taken seriously. This mistrust is understandable and unsurprising however, it has led to a lack of complaints made by Indigenous Peoples and families, and therefore there is a lack of quantitative data to demonstrate the volume of harmful experiences that Indigenous patients face in the health-care system every day. This lack of data presents a significant challenge within itself, further explained by the *In Plain Sight* (IPS) report:

³ Interviewee, 2022.

⁴ Interviewee #12, 2022.



Over the past three years, only 355 complaints involving Indigenous people were identifiable when searching complaints data, a small number when compared to the many negative experiences shared with the Review. This is consistent with the findings of the IPS, in which Indigenous respondents were significantly less likely to report being willing to make complaints. Indigenous respondents were also significantly more likely to indicate that a key barrier to filing a complaint is the belief that it would not be taken seriously.⁵



Several interviewees further described this skepticism of the complaints process, noting that after having been met with racism by a physician or surgeon, patients do not want to experience such racism over again by engaging in a complaints process that is directed by the very College that the physician or surgeon belongs to. They also explained that Indigenous patients are often concerned that making a complaint will have negative impacts on the quality of future care, and so they choose to not go through the process at all. Without any assurance that a complaints process will provide safe, culturally relevant options and meaningful resolution to harm caused, Indigenous Peoples generally choose to not engage in the College's complaints process as it currently stands. Ultimately, there need to be better, more culturally relevant ways to encourage and support First Nation, Inuit, and Métis patients in sharing a complaint, and helping them to feel as though their complaints are actually being heard by the College.

This work should be grounded in the principles of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), which BC has legislated through the Declaration on the Rights of Indigenous Peoples Act (DRIPA). The BC government passed DRIPA into law in late 2019, which, among other things, mandates the provincial government to bring all of its laws into alignment with the spirit and principles set out in the UN Declaration. UNDRIP protects and upholds several categories of rights of Indigenous Peoples, including economic and social rights which encompass the various intersections of mental and physical health and health care.

According to Article 21(1) of UNDRIP, "Indigenous Peoples have the right, without discrimination, to the improvement of their economic and social conditions, including, inter alia, in the areas of education, employment, vocational training and retraining, housing, sanitation, health and social security."⁶ Through these types of legislative rights, the College must recognize its role in supporting the improvement of Indigenous Peoples' social circumstances through the delivery of culturally safe and appropriate health-care services, including complaints processes.

⁵ *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care*, 2020, page 44. <https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Summary-Report.pdf>.

⁶ The United Nations Declaration on the Rights of Indigenous Peoples, 2007, Article 21(1). https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf.

Healing and resolution for Indigenous patients

Once a complaint is made by a patient who is First Nation, Inuit or Métis, the potential options for healing and resolve are limited in their capacity to address the harm in ways that are meaningful to the complainant. Currently, remedial, and disciplinary measures made available by the College lack transformative or restorative approaches that promote healing in a good way for patients and families. Many interviewees spoke about the need for the College to do more to implement principles of transformative justice⁷ in the ways that it attempts to protect and support Indigenous patients who have experienced racism or harm by a physician or surgeon.

The First Nations Health Authority (FNHA) sets high standards for prioritizing cultural safety in their practices, including in their processes for receiving complaints about health-care providers. The FNHA works in partnership with the different First Nation communities in each region of the province to identify options for healing after harm has been caused, which may involve the provision of medicines, the support of an Elder or other people who can help someone along their healing journey. The FNHA also works to facilitate healing processes between patients and cooperating health-care providers. For example, the FNHA works with families to determine whether they are open to engaging in a healing exercise or ceremony (i.e. Healing Circle, Learning Circle, blanketing ceremony etc.) with the physician or surgeon in question, and supports in the coordination of the event, at the direction of the patient and/or family.

Of course, any form of community or family based remediation process must be done on a case-by-case basis and should respect the specific guidelines and protocols the family or individuals involved. “Everything has to be directed by the clients. They say how they want to feel safe within the space,” explained one expert from FNHA’s Quality Care and Safety team.

Currently, the College has an informal, ad hoc-style relationship with the FNHA. The College’s one complaint navigator works closely with the FNHA to support culturally relevant healing options, yet it is not a formal or structured process, and relies on positive personal relationships. The critical review process revealed a strong appetite for hiring more complaint navigators at the College to work with FNHA liaisons in the work of building formal networks to provide a continuum of culturally safe and respectful healing options and care.

Formal complaints vs. soft complaints

The critical review process revealed that there is significant desire for the College to give patients an alternative to participating in the formal complaints process and providing an informal or ‘soft complaints’ option instead. Many people who feel as though they have experienced harm want to share their story without going through a long, drawn-out process that takes time, energy, attention, and often requires a patient to relive painful experiences. However, there is no mechanism for a patient to simply register a complaint or tell their story without going through the entire intensive process. “I hear a lot of ‘soft complaints’ where people feel like they had a situation that they could have complained about, but they do not want to because they do not want to go through the process, or they are concerned that the

⁷ The United Nations Declaration on the Rights of Indigenous Peoples, 2007, Article 21(1). https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf.

quality of their care will decline even further. The process itself is a barrier,” explained one interviewee with experience supporting people through the complaints process.

“ I hear a lot of ‘soft complaints’ where people feel like they had a situation that they could have complained about, but they don’t want to because they don’t want to go through the process, or they are concerned that the quality of their care will decline even further. The process itself is a barrier. ”
–Interviewee

Research showed that there is interest in having informal mechanisms for submitting soft complaints whereby a patient can share their experience with the College without the expectation that further consequences will result from their testimony. The purpose behind this type of option would be to ensure patients know that even if they choose to not go through the entire complaints process—interviews, written forms, and often painful conversations about the harm caused—they still have an alternative avenue through which they will feel heard and validated in their experience. “Some people just want to be heard, give the information to the College and leave it there,”⁸ said one expert. Interviewees, including Patient and Family Experience professionals and Indigenous Health leaders, agreed that while people want to be able to identify that something negative happened with a particular physician or surgeon, that does not mean that they want to go through the College’s entire formal process. Many patients and families just need to know that there is a place for them to go and share their story in an informal way when they feel as though they did not receive an appropriate standard of care.

Communication

The College’s approach to communicating about complainants was identified by different interviewees as “cold,” “impersonal” and “too business-like.” The first point of contact and communication that a patient receives from the College after making a complaint is a standardized notice confirming receipt of the complaint. The message is impersonal and does not acknowledge that the complainant has had a negative experience; this can make or break someone’s impression of the process and ultimately, their decision to move forward with the complaint altogether. There is delicacy around the College’s communication approach to ensure it is not construed as an admission of guilt or wrongdoing on behalf of a registrant. However, carefully following processes and legislation is not mutually exclusive with communicating in a way that acknowledges someone was hurt. “They don’t want to take on guilt, but [the College] also can’t say they are going to be open and kind, and then not acknowledge the experience that a person has had,”⁹ explained one interviewee.

“ The College’s role is in health care and humanity. They need to be professional, understanding, and kind. ”
–Interviewee

⁸ Interviewee #2, 2022.

⁹ Interviewee #2, 2022.

Examples of this “cold, not feel-good”¹⁰ communication approach includes templated letters, automatic email replies, and standardized forms that do not make complainants feel as though their story is being taken seriously by a person or organization who cares about their experience.

The automated and impersonal nature of these forms and processes means that the burden of explaining or ‘proving’ wrongdoing falls to the patient to prove that harm has occurred. Conversely, Indigenous patient support workers explained that onus should be on the physician or surgeon to prove that they did not do harm and provided adequate care: “They need to sit down and example what it means to implement Indigenous ways of caring, understanding, communicate respectfully,”¹¹ shared one interviewee.

According to 11 of the 14 experts interviewed, another significant obstacle in the current process is the lack of in-person options for patients to make their complaint, follow-up with their file, or receive one-on-one support. This is a major gap when it comes to ensuring a safe process for First Nations, Inuit, and Métis people because for many, community and connectedness is extremely important, particularly for providing support during times of pain or trauma. Racism and race-based discrimination is deeply rooted within the intergenerational traumas of many First Nations, Inuit and Métis people, families, and communities, and when someone has been the target of racism, it is vital that they be provided with a safe space to tell their stories.



When you can visually see the non-verbal cues, it’s a whole different perspective.

–Interviewee



In general, filling out a standardized form with details of a painful experience is not an approach that feels inviting or safe for Indigenous patients who have experienced harm. It also does not allow for stories to be conveyed in fulsome ways, because important elements such as body language and emotion are left out. These non-verbal cues are critical in a person’s conveyance of their experience because a great deal of the story is captured within them. One Indigenous liaison nurse explained this incompatibility poignantly, saying, “Indigenous people do not describe their symptoms the way that a doctor or physician wants to hear it. They tell it in a story. As a First Nations woman, I can hear it, but most other people cannot.”¹² The way that First Nation, Inuit, and Métis people generally share stories is not necessarily conducive to the current complaints process which places value in impersonal language and business-like communication. However, it is up to the College to adjust its systems to make them safer for Indigenous people and ways of being—not the other way around.

Resolution and accountability

Because of the risk-averse nature of the medical system, the College’s complaints process continues to prioritize the job security of physicians and surgeons over the care and safety of patients. For cases involving racial bias and discrimination, the recourse for the physician or surgeon involved is often the San’yas training course; the two-day training course on cultural

¹⁰ Interviewee #2, 2022.

¹¹ Interviewee #4, 2022.

¹² Interviewee #1, 2022.

safety and anti-Indigenous racism. The course is widely used and recognized as providing crucial foundational knowledge, however, these training courses are largely understood to be the first step in providing baseline understandings about the histories of Indigenous Peoples in Canada, and the realities of the systemic racism that they continue to face. As medical professionals who must care for all people, this baseline knowledge is not enough for ensuring they are providing culturally safe and appropriate care. As one Indigenous health professional explained, “San’yas is the foundational knowledge to bring folks up to a level playing field, but it’s only the bare minimum [...] What comes after San’yas?”¹³

“

There needs to be a no tolerance policy. It should be just as serious as medical malpractice.

–Quality and Safety Analyst

”

When a physician or surgeon exhibits racism or racial bias in their practice, there needs to be stronger repercussions than simply taking a two-day course; options for transformative learning, action, and contrition need to be treated more seriously. “There needs to be a no tolerance policy. It should be just as serious as medical malpractice,” said one patient quality and safety analyst.

“

Our view of healing is different... our idea of resolution is not always solved by money.

–Elder participant

”

Self-identification and data collection

Issues of poor accountability are further compounded by the fact that there remains a large gap in race-based data to measure the volume of racist encounters that exist within BC’s medical system. Despite the numerous accounts of anti-Indigenous racism in health care that are detailed in *In Plain Sight*, and the College’s general recognition of its existence within the health-care system at large, this data gap is a challenge. The College currently has no formal mechanism for asking complainants whether they identify with a racialized or marginalized group, resulting in a lack of quantitative data to indicate the number of Indigenous patients who experience harm or racism by its registrants. As long as the College is relying on quantitative forms of data collection to ‘prove’ these experiences are happening, there needs to be more options for collecting that information.

The critical review involved research and several detailed discussions about the College’s collection of race-based data and the implications of doing so. It was noted by two different interviewees, as well as in conversations with the Indigenous Advisory Panel members, that some Indigenous patients may likely feel suspicious or even unsafe if asked by the College to disclose their racial identity. Due to the historical and ongoing systemic racism that First Nation, Inuit, and Métis people regularly experience at the hands of the health-care system, there is significant apprehension when it comes to identifying themselves based on their racial or cultural identity for fear of further maltreatment. However, research also indicated that knowing the racial identity of a patient is important in protecting the distinct rights that

¹³ Interviewee #8, 2022.

are carried by Indigenous Peoples in Canada. “Identification is important because we have unique legislative rights as Indigenous Peoples,”¹⁴ explained one interviewee.

The collection of such data can be a powerful tool in advancing human rights, according to the BC Office of the Human Rights Commissioner report, *Disaggregated demographic data collection in British Columbia: The grandmother perspective*. The report considers the benefits and the risks of collecting demographic data and details the principles that must be applied at each stage of data collection in order to ensure it is done in an equitable, just, and safe way.¹⁵

Ultimately, the report identifies that the collection of race- based data, specifically for Indigenous populations, should be done:

“

...to reveal and address systemic inequalities in social determinants of health and access to health care.¹⁶

”

“

While no patient can be forced to disclose whether they identify with a specific racial, ethnic, or cultural group, efforts to collect such information from people who are willing to provide it “has the power to reveal systemic inequalities and lead to positive policy.¹⁷

”

¹⁴ Interviewee #4, 2022.

¹⁵ *Disaggregated demographic data collection in British Columbia: the grandmother perspective*, B.C. Office of the Human Rights Commissioner, 2020. BCOHRC_Sept2020_Disaggregated- ed-Data-Report_FINAL.pdf (bchumanrights.ca).

¹⁶ *Ibid*, p. 82.

¹⁷ *Ibid*. p. 84.

Critical review: a future state

Based on the key themes and outcomes of the critical review process, a series of recommended actions for change have been identified. These recommended changes are intended to paint the picture for a future state of the College's complaints process that will be safer and more accessible for Indigenous patients to fully participate in a way that is meaningful to them as First Nation, Inuit and/or Métis people. The recommended actions for a future state of the complaints process are grouped into the following categories:

1. a future state of available options
2. a future state of communications
3. a future state of healing and resolution
4. a future state of transparency and accountability

A future state of available options

1. Provide in-person options for patients to share experiences

Many Indigenous people are raised within oral cultures and traditions and may be more comfortable telling stories or recounting events in their own words. In addition to this, retelling stories of harm or trauma is a deeply personal experience and using online standardized forms to do so makes the complaints process highly impersonal and feel less humane. Providing patients and families with in-person options to share their experiences before a formal or informal complaint is made is an important initial step in making Indigenous patients feel safer and more heard when they choose to bring a complaint forward. When in-person options are not possible or not preferred by a prospective complainant, phone or video calls are alternative middle-grounds which still add a more human element to the process.

In summary, a future state of the complaints process should include:

- Complaint navigators who offer in-person appointments for patients who would like to make a formal complaint. If an in-person option is not possible or not preferred, complaint navigators should offer phone or video call options.
- Complaint navigators who are thoroughly trained in Indigenous cultural safety, culturally safe practices, the histories, and realities of Indigenous Peoples in British Columbia, and anti-racism. Training should be renewed annually.
- Complaints navigator who are trained to be responsible for:
 - speaking and behaving with kindness and compassion
 - explaining the standard of care that all patients are entitled to, and understanding whether the standard of care was met
 - providing information and relevant resources to the complainant about the options available to them
 - typing out complaint statements as dictated by the complainant

2. Provide option for sharing 'soft' complaints

Cultural Safety and Humility in the Regulation of Health Professionals Declaration of Commitment

"Implement and sustain change by facilitating processes where organizations and individuals can raise and address problems without fear of reprisal."

Even with more personalized options for sharing a complaint, it is likely that some Indigenous people may still decide to not move forward with an official complaint due to the time-consuming and potentially retraumatizing nature of the formal process. The existing lack of trust in the health-care system in general also will likely play a role in patients choosing to forego the College's formal process.

People want access to an alternative process through which they can share a story of improper care with the College one time, feel validated in their experience, and not have to participate in a drawn out and emotionally taxing process. Giving patients a mechanism for sharing soft complaints will encourage more people to come forward and feel safe in doing so.

Communication with patients about this option is extremely important. People need to be given the option of the soft complaints process at the very beginning of the complaints process, and complaint navigators will be responsible for sharing the details of the process with patients to ensure they make the decision that is right for them. Part of the complaint navigator's role will be to immediately establish the patient's expectations for outcomes of soft complaints process. This option is intended as a means of provide patients with a platform to share their experience to 'get it off their chest,' which means that except for extenuating circumstances (i.e. criminal activity has taken place), there will likely not be formal consequences or disciplinary action enforced for the physician or surgeon involved, and this will need to be made clear to patients who choose to submit a soft complaint.

In summary, a future state of the complaints process should include:

- A soft complaints process that includes:
 - Collecting stories and testimony from patients who feel as though they have received improper care. Records of the soft complaints are to be kept anonymous.
 - Allowing patients to share their experiences one time, without having to engage in a formal or long-term process.
 - Exploring possible options to have community- led complaints, where the collective membership launches a complaint rather than one individual.

3. Include soft complaints in data and reporting

Despite soft complaints most often not resulting in any firm outcomes or disciplinary action for the physician or surgeon involved, they still capture important experiences and information, and therefore should be recorded and included in the College's annual reporting. Anonymous records of soft complaints will be kept by complaint navigators to be counted and reported on in the College's annual reports.

In summary, a future state of the complaints process should include:

- the College recording and keeping anonymized records of all soft complaints; and
- the College's using its annual reporting to share aggregated data on the quantity of soft complaints received each year, in addition to its reporting on formal complaints.

4. Provide information about different complaints options on the College's complaints webpage

To learn how and where to go to submit a complaint, members of the public visit the College's complaints webpage. This is where the College provides information about what to expect from the complaints process, what can and cannot be done by the College, and what the process is likely to involve. Upon the development of in-person appointments and the soft complaints process, information for these options should be clearly outlined and provided on the complaints webpage. This will be important for patients to understand early on that they have different options for making a complaint, including how to navigate the complaints processes of different health authorities, and for them to understand the potential avenues for recourse that are available to them.

In summary, a future state of the complaints process should include:

- a section being added to the College's Complaints webpage that contains information about submitting complaints in-person or via phone/video call appointments, how to schedule them, and what they involve
- a section being added to the College's Complaints webpage that contains information about soft complaints, how to make them, and what the process involves

5. Modify the online complaints form to be a fillable form

The accessibility of the current online form used to digitally submit a formal complaint is limited in part by the fact that the form is a static PDF document on the College's website. Currently, the form requires users to download and print it, fill it out by hand, scan and resubmit the form online; a process which is difficult for many people who have limited digital literacy, or who do not have access to printers or scanning devices. One simple way to mitigate the current barriers of the form is to make it into a fillable form on the College's website so that it may be filled out and submitted all in one place. If a prospective complainant prefers to fill out the form by hand, that option will remain available to them.

In summary, a future state of the complaints process should include:

- transforming the College's online complaints form into a fillable form or fillable PDF that does not require printing or scanning

A future state of communications

6. Review and revise College's communications materials regarding complaints

The communication style that the College employs when engaging with complainants and families is currently being described as cold, too business-like, and impersonal. "If they want to do better, they have to find a way to be kinder and softer when communicating,

acknowledging pain and anguish and frustration,”¹⁸ explained an interviewee who supports the public through the complaints process.

It is understood that the College cannot concede guilt or wrongdoing on behalf of an individual physician or surgeon and cannot acknowledge harm done by them without investigating, but that does not mean that the College cannot acknowledge that harm has been experienced by a patient. To build trust with Indigenous people and patients, the College’s communications and messaging must show kindness and compassion and set an example for what it means to implement Indigenous ways of caring, understanding, and respectfully communicating in challenging circumstances. While templates and standardized language for communication is often necessary for efficiency purposes, it is also important for the College to be genuine in its communications with complainants.

Public communications materials related to the complaints process should be reviewed and revised with the lens of incorporating language that is more compassionate and sensitive to complainants’ experiences. These revised materials should strike a better balance between recognizing that a person feels as though they have experienced harm, and not making statements or assumptions about the culpability of the physician or surgeon in question. These approaches to communication can significantly influence a patient’s decision to follow through with their complaint, and the College must do more to make the process more welcoming to those who feel as though they have not received an adequate standard of health care.

In summary, a future state of the complaints process should include:

- a review of all materials that the College uses to communicate with complainants throughout the complaints process
- identification of opportunities to infuse more compassionate language into communications materials
- revisions to communications materials to make them more compassionate and respectful

A future state of healing and resolution

7. Formalize the partnership with the First Nation Health Authority and/or other Indigenous health organizations.

Cultural Safety and Humility in the Regulation of Health Professionals Declaration of Commitment

“Create a climate for change by forming a coalition of influential leaders and champions who are committed to the priority of embedding cultural humility and safety into the regulation of BC health professionals.”

Cultural safety should be embedded within the College’s own processes and procedures. However, as a non-Indigenous organization in the early stages of its reconciliation journey, the College is likely unable to deliver on these commitments and responsibilities entirely on its own. The FNHA sets high standards for prioritizing cultural safety in their practices—

¹⁸ Interviewee #2, 2022.

including receiving complaints—and currently has an informal working relationship with the College. The FNHA provides culturally safe and region-specific supports to First Nations communities and people across the province. Their approach to working with communities respects the differing region-specific guidelines, protocols for different Nations, and creates space for culturally safe remediation options for patients such as Healing Circles and Learning Circles. According to staff from both the College and the FNHA, this partnership has been largely successful over the last year or so, and they would like to see it continue.¹⁹ To advance its work advancing cultural and clinical safety for Indigenous Peoples, the College should focus on advancing these kinds of successful partnerships with trusted Indigenous leaders and organizations.

It should be noted, however, that there is currently a significant burden being placed on the time and energy of FNHA liaisons. Their role can be emotionally and mentally taxing, and a formalized relationship with the College whereby College staff are relying upon FNHA for increased guidance and support will likely add to these already challenging positions. In addition to exploring how to formalize this relationship, resources must also be made available to ensure these supports can be provided in a safe and sustainable way for the individuals who occupy the roles of complaint navigator and liaison officer.

There are various options that may be explored for formalizing the College's relationship with the First Nations Health Authority. Through a memorandum of understanding (MOU), formal partnership agreement, or some other method, the College's relationship with the FNHA may be formally ratified to support the advancement of the good work already being done. Formalizing the relationship will facilitate the processes of supporting patients, sharing information where appropriate and legally allowed. In the future, the College should also explore engaging in similar formal partnerships with health organizations that deliver culturally safe care to Métis and Inuit populations in the province.

Cultural Safety and Humility in the Regulation of Health Professionals Declaration of Commitment

"Create a climate for change by encouraging, supporting and enhancing cultural safety and cultural competency amongst health professionals in BC."

In summary, a future state of the complaints process should include:

- an exploration of options for engaging in an official partnership with the First Nations Health Authority
- formalization of the College's partnership with the First Nations Health Authority to facilitate collaboration in supporting Indigenous patients through the complaints process
- identification of organizations that deliver culturally safe health-care services to Métis and Inuit populations in BC and explore potential opportunities for partnership

¹⁹ Interviewee #6 and Interviewee #7, 2022.

8. Expand options for transformative justice and healing

Options for patients and families

Throughout the critical review process, it became clear that the College's current complaints process lacks options for remedying harm done in a way that takes on a lens of transformative justice. For First Nation, Inuit and Métis patients and families, accountability for wrongdoing can take several different forms. Once it has been established that a physician or surgeon has been racist towards their patient or has not delivered the standard of care to a First Nation, Inuit and Métis person, the College must be open to facilitating different processes for acknowledging and remedying the harm done, and these processes must be guided by the individual patient.

This is where the College's partnership with the FNHA (and in the future, organizations to serve Inuit and Métis populations) is crucial. Indigenous complainants should be given the opportunity to discuss and determine the approach to justice that they believe would be most meaningful for their personal healing and, if desired, healing the relationship with the physician or surgeon in question. Through its partnership with the FNHA and organizations whose services are rooted in supporting the cultural needs of Indigenous Peoples in BC, the College should support, facilitate, and when appropriate, fund alternate approaches to transformative justice and accountability for its registrants. Examples of these may include blanketing ceremonies, brushing off ceremonies, learning circles, or other measures options determined in partnership with the individual or family who has experienced the harm.

One of the most vital aspects of the College's role in supporting these alternative options is to ensure it is done on a case-by-case, person-by-person basis. Each First Nation, Inuit, and Métis person and/or family should be asked how they would like to have a situation addressed based on their cultural and spiritual needs, and to avoid any pan-Indigenous approaches to the province's extremely diverse populations.

Options for registrants

There must also be a shift in the depth and diversity of options for transformative learning and accountability that are available to registrants who have caused harm. As part of the critical review, many interviewees discussed the importance of going beyond San'yas and exploring accountability opportunities for physicians and surgeons to engage in cultural safety learning that is meaningful, experience-based, and consistently ongoing throughout their career. When a physician or surgeon has treated a patient with racism or discrimination and have not done their job. These circumstances must be treated with serious consequences and pathways to reduce the possibility of the physician or surgeon reoffending, and part of this includes identifying supports for registrants who require professional development in the areas of anti-racism and the delivery of culturally safe health care.



It's the experiential learning that will help staff to gain empathy and understanding.



–Interviewee

One interviewee likened a physician or surgeon's racism to an illness or disease that needs to be treated, noting that when they are facing personal illnesses, physicians and surgeons are provided with supports to ensure that they can still do their job. "In the same way that if a

physician was struggling with addiction themselves, the same rigour needs to be applied to supporting them in learning anti-racist practice and behaviour,²⁰ they said. As part of an improved complaints process, there needs to be stricter requirements about the form and frequency of registrants in continued learning and professional development surrounding anti-racism. Experts and rightsholders involved in the critical review process agreed that any training, professional development, or education opportunities provided to registrants are evidence-based and rooted in critical race theory; these are core requirements of any meaningful anti-racism work.

Exploring options in partnership with the FNHA for experiential professional development opportunities such as field studies, community-based learning, land-based learning, and others will allow the College to identify new remedial steps that will come after San'yas as part of the mandatory steps in the disciplinary process. "It's the experiential learning that will help staff to gain empathy and understanding,"²¹ explained one program manager, and so in addition to providing families with more options for healing, the College must also be responsible for supporting the development, learning, and accountability of its registrants.

In summary, a future state of the complaints process should include:

- offering alternative, culturally relevant options for healing to Indigenous patients and families, guided by them and in accordance with local protocols on a case-by-case basis
- requirements for registrants to advance their cultural safety training and experiences which build upon the San'yas course

A future state of transparency and accountability

9. Provide option for complainants to identify their racial and cultural identity

Collecting race-based data as part of the complaints process is a step that the College can take in being more transparent and accountable for the harm that First Nation, Inuit, and Métis people are experiencing. By providing complainants with the option to choose whether to identify their racial and cultural identity as part of the complaints process, the College will better be able to identify, measure, and be transparent about the racism that Indigenous patients are experiencing at the hands of its registrants.

“

We are not measuring race; we are measuring racism. Racism is a system failure; that must be clear when talking about race-based data.²²

”

–Gwen Phillips

This should be done in a way that puts the onus on College staff and complaint navigators to ask patients if they want to self-identify as part of a racialized group, thoroughly explain the purpose of collecting demographic data of complainants, how it will be used, and assure

²⁰ Interviewee #8, 2022

²¹ Interviewee #10, 2022.

²² *Disaggregated demographic data collection in British Columbia: the grandmother perspective*, B.C. Office of the Human Rights Commissioner, 2020, p. 9. BCOHRC_Sept2020_Disaggregated-Data-Report_FINAL.pdf (bchumanrights.ca).

them that it will be protected under the requirements of relevant privacy legislation. Further, to avoid collecting this information in a pan-Indigenous way, the detail with which patients are able to self-identify will be important. For those who do identify as First Nation, Inuit, Métis, or a combination of these Indigenous identities, options should be provided to further identify the Nation or cultural groups that they belong to. Creating space for individual patients to identify their distinct cultural backgrounds will be important in ensuring that the supports provided to them throughout the complaints process are appropriate and relevant to them.

In summary, a future state of the complaints process should include:

- the option for complainants to identify whether they are part of a racialized population
 - For those who self-identify as First Nation, Inuit, and/or Métis, further options should be provided for identifying which Nation or cultural group(s) they belong to, if desired
- complaint navigators who are responsible for clearly and sensitively articulating the College's reasoning for requesting, collecting, and reporting on the racial and cultural identities of complainants

10. Include demographic data in College's end of year reporting

The College needs to be transparent about and accountable for the number of complaints they receive from Indigenous and racialized patients each year. Currently, the College's Annual Reports include information about the general themes of complaints received throughout the year, the number of complaints concluded by subcategory (clinical, conduct, boundary, other) and by disposition (no criticism, criticism, abandoned/withdrawn, dismissed by the registrar, other).²³ Annual reporting also includes the number of complaints that have led to investigations, and the number of investigations that were concluded by disposition. However, there is no information provided within the College's public reporting regarding complaints made specifically related to racism or racially discriminatory practice.

Including the data that is collected by the College in its annual reporting is a crucial step in openly acknowledging that racism is happening among its registrants and demonstrating that it is prepared to hold those individuals accountable for the harm that they cause to First Nation, Inuit, and Métis patients.

Cultural Safety and Humility in the Regulation of Health Professionals Declaration of Commitment

"Engage and enable stakeholders by openly and honestly addressing concerns and leading by example, identifying and removing barriers to progress."

In summary, a future state of the complaints process should include:

- disaggregated demographic data of complainants presented in the College's annual reporting

²³ Annual Report 2021/22, College of Physicians and Surgeons of British Columbia, 2022. 2021-22-Annual-Report.pdf (cpsbc.ca)

11. Use end of year reporting as a means of truth-telling

In addition to presenting the demographic of complainants in the College's end-of-year reporting, it is extremely important for the College to demonstrate that it is learning from the complaints it receives and striving to address racism within health care at the systemic level. Patients want to know that when they bring complaints forward, they are not just becoming a statistic; they want to know that it is going to lead to an improvement in care for themselves and for others. The College must find a way to demonstrate that improvements to care are being considered and made as a result of the complaints that are being brought forward.

Through its annual reporting, the College should tell the story of these learnings and continuous anti-racism work. This would be a positive step in College's work of being accountable to the complainants and the public who it serves; acknowledging that it has a role to play in addressing racism in BC's health-care system and demonstrating an active commitment to ongoing improvements to its own processes, procedures, and expectations of its registrants.

Currently, the College's Annual Report includes data on how many registrants have completed Indigenous cultural competency courses that year, but little else about how registrants, including those who have had complaints brought against them, are engaging in continued learning on how to deliver culturally safe care. With the expansion of options for transformative justice and healing (recommended action item #8), the College has an opportunity to use its annual reporting to do more truth-telling about the ways that it is taking steps to embed cultural humility and safety into its complaints process, and its organizational structures more generally.

Cultural Safety and Humility in the Regulation of Health Professionals Declaration of Commitment

"Implementing and sustaining change by leading and enabling successive waves of actions until cultural humility and safety are embedded within all levels of health professional regulation."

In summary, a future state of the complaints process should include:

- more detailed truth-telling in the College's end of year reporting about the measures taken to advance the cultural safety, humility, and learning of all registrants, including those who have had complaints made about them.

Additional considerations

During the course of the research, we identified concerns that were out of scope of the complaints process review. Below are some of the concerns that were raised in several interviews, and we felt they should be acknowledged in this report.

Racist assumptions on Indigenous patient medical files

We heard from interviewees that staff working in hospitals who see Indigenous people many times made assumptions of health symptoms and based decisions on cause without a thorough medical assessment referred to by what they call “frequent flyers.” One person talked about two Elders complaining of headaches and showing signs of slurring their words, and being confused and unbalanced. The Elders were sent home twice with no medical treatment done. One of the Elders passed away at home and it was later learned he had a stroke.²⁴ Examples such as this are not the exception. Another person interviewed stated, “We no longer are asking if racism exists we know it does. The question now is how we are going to deal with it.”²⁵

Others mentioned that being identified as Indigenous on their medical record would create a change in the health provider.

Representation of Indigenous leadership across the College

There needs to be a broader understanding that recognition of leadership is more than defined by education, or resumes, but recognizing that the learned experience and knowledge of leaders in a community and the positive impacts they have in a community. There is opportunity to bring those unique perspectives across the College to enhance overall acceptance and understanding.

Youth complaints and experiences

Young people experience harm in different ways than adults. While there are layered pieces of legislation related to the protection and privacy of children and youth, it is important to note that if and when they experience racism or harm from a physician or surgeon, they may react or communicate about their experiences differently than adults. Youth may feel unsafe sharing their experiences, even in the presence of a parent or trusted adult, however this cannot be a reason for their experiences to go unreported or unaccounted for.

Support for physicians and surgeons

There needs to be continued support of learning for physicians and surgeons. The College needs to have the authority to apply better processes for anti-racism training and on-going training much in the same way that there are supports for physicians and surgeons struggling with addictions. That same rigour needs to be applied to supporting physicians and surgeons in learning anti-racism practices and behaviour. Indigenous patients do not always know how to articulate their symptoms to a healthcare provider in a straightforward factual way. When a physician or surgeon shows frustration, Indigenous patients have tendency to shut down leaving the physician or surgeon without the facts they need to get to an assessment.

²⁴ Interviewee #12, 2022.

²⁵ Advisory committee, 2022.

Correlation between burnout and racism

The research suggested there was a correlation between physicians and surgeons' job stress/burnout and signs of racism showing and/or their unconscious bias surfacing around Indigenous patients. There needs to be experiential learning for physicians and surgeons and opportunities for them to have support when experiencing burnout, but it can materialize into signs of racism.

Complaints to the College and health authorities

Finally, there needs to be better communication, awareness, and coordination among the different complaints processes so that Indigenous patients have a better understanding of all of their options. We found there was a general lack of understanding by Indigenous patients of where to go to submit a complaint. Many incidents happened in hospital settings and our research showed that Indigenous complainants would log their complaint with the hospital. They would go through the process only to have a negative experience. When they learned they could also lodge a complaint with the College, they felt reluctant to relive the experience again for fear that they would have the same negative experience.