Health profession regulators: A Case Study on the BC College of Nurses and Midwives

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BC College of Nurses and Midwives Case Study

Abstract

The role of professional health regulators and how they resolve complaints against practitioners has been examined and studied in many jurisdictions in the west**.** Much of the research has focused on the impact the complaint process has on disciplined professionals and complainants. This research has not included researching into how the public awareness of regulatory college and how their understanding of regulatory colleges informs the public's expectations on how complaints can and should be resolved. In the context of a Canadian province's nursing regulatory body, this research attempts to understand the public's awareness of the BC College of Nurses and Midwives (BCCNM), capture their perspectives on the standard complaint process, and gauge their support for an alternative dispute resolution process. This study focuses on BCCNM's current complaint resolution process and explores an alternative dispute resolution process that is administered at the College of Nurses of Ontario. The study uses one-on-one interviews and a focus group to collect the data. By using these two qualitative methods, this study collects data on the participants' awareness of BCCNM, their understanding and expectations of a standards complaint process, and their perspectives and receptiveness to an alternative complaints process. The findings from this study reveal the participants have some awareness of BCCNM and general understanding of health profession regulators. Their expectations for complaint outcomes did not fully align with the college's mandate and regulatory right-touch philosophy. The participants' supported the alternative dispute resolution process but raised concerns about transparency and future public protection.

Keywords: health profession regulation; regulatory colleges; public awareness; transparency; alternative dispute resolution; ADR; complaints process; complaints; public complainants; nurses; discipline; right-touch regulation.

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Chapter 1: Introduction

The path that led me to this research stems from my interest in exploring how the esoteric world of health profession regulation can be relevant and accessible to the public. Effective and engaging communication is an integral component to achieving this objective. In my pursuit to deepen my understanding of communication, I surveyed several graduate programs related to communications and digital media. The Master of Arts in Communication and Technology resonated with me because of its focus on both theory and practice. The program seemed like it would complement and strengthen my skills and knowledge as a professional communicator. The blended learning aspect was particularly appealing to me because it allowed me to continue work full-time. I expected the two three-week-long Spring Institutes to be intense and immersive and they did not disappoint. Coupled with the six online classes, the curriculum equipped me with the knowledge necessary to pursue my research on health profession regulation and complete the capping project for the MACT program.

As a senior communications professional working for British Columbia's largest health professional regulator, I have a keen interest in regulation and thorough knowledge of its importance to society. As in many other countries, such as the United States and the United Kingdom, modern health profession regulation is about 100 years old in Canada. Self-regulating professions emerged in the 19th century stemming from calls from a variety of stakeholders expressing concerns for healthcare quality, access and professional training (Adams, 2020). Regulatory practices—including requirements needed to enter and maintain a practice within a health profession—evolved over the course of the 20th and 21st centuries in response to changes to education, the healthcare environment, and expectations from the public and other

stakeholders of healthcare professionals (Adams, 2020). In Canada, health regulators are commonly called "colleges" but they are also called "boards" and "councils" in other jurisdictions. The legal obligation and mandate of these regulatory bodies is to protect the public by regulating their registrants (BC government, 2021). They do this by:

- determining registration requirements
- setting standards of practice
- recognizing education programs
- maintaining a registry of practising registrants
- addressing complaints—including conducting investigations and referring serious matters for disciplinary action about their registrants—when practice and ethical standards are not met

These pillars of health profession regulation are shared not only within Canada by its provinces and territories but also by many western countries (Leslie, K., Moore, J., Robertson, C. *et al.*. 2021). In Canada and the United States, health profession regulation is a provincial or state responsibility. Other countries, such as Australia, Ireland, and the United Kingdom, health profession regulation administered nationally or jointly at a regional level. As shown in the chart below, the trend in health profession regulation for many years now is the establishment of acts or laws that apply to all health regulated health professionals in their respective jurisdictions, which provide consistent mandates and obligations for all health profession regulatory bodies.

Table 1

Health Profession Law/Legislation — Canadian examples	
Northwest Territories	Northwest Territories Health and Social Services Professions Act
British Columbia	BC Health Professions Act
Alberta	Alberta Health Professions Act
Manitoba	Manitoba's The Regulated Health Professions Act
Ontario	Ontario Health Professions Act
Nova Scotia	Nova Scotia Regulated Health Professions Network Act
Prince Edward Island	Prince Edward Island Regulated Health Professions Act
Newfoundland	Newfoundland Health Professions Act

Table 2

Health Profession Law/Legislation — International examples	
Australia	Health Practitioner Regulation National Law Act 2009
Ireland	Regulated Professions (Health and Social Care) (Amendment) Act 2020
United Kingdom	National Health Service Reform and Health Care Professions Act 2002
Oregon, USA	Chapter 676 — Health Professions Generally
Washington State, USA	Regulation of Health Professions

Today, in Canada and around the world, many health professional regulators are experiencing a trend in increased public and government scrutiny over concerns they are doing too little to protect the public (Cayton, 2019; Durcan, 2019). In the past two decades, news headlines have been scattered with scandals and investigations about alarming incompetent and unethical professional conduct (c.f.Goodwin, 2018; Contenta, 2017). Governments and their agencies, especially those in the UK, Australia, Canada, Ireland, and the US, have responded by examining the strengths and weaknesses of their respective regulatory bodies to determine the best options for improving health regulation (Healy, 2011).

Many governments have revamped regulations and restructured regulatory bodies to address the short-comings of health professional regulation and to bolster public confidence in

these agencies. Governments are taking these steps because health regulation is essential and foundational to safe health care. In March 2018, the British Columbia provincial government commissioned Harry Cayton — an international advisor to the Professional Standards Authority and a leader in the field of professional regulation — to conduct a review of the College of Dental Surgeons of British Columbia's (CDSBC) administrative and operational practices after a series of unrelated complaints were made about the college (BC Government, 2018). Additionally, Cayton was asked to review B.C.'s health profession regulatory system (BC Government, 2018). This review mirrors other evaluations of regulatory bodies conducted in Australia, Ireland, New Zealand, and other parts of Canada (Professional Standards Authority). Cayton's May 2019 report to BC Ministry of Health prompted the ministry to strike a steering committee that, in turn, made five recommendations to revamp the province's Health Professions Act (Steering Committee on Modernization of Health Professional Regulation, 2019). The steering committee's recommendations included:

- Improved governance: competency-based board appointments and balanced ratio of public–registrant board memberships, reduced size of boards, and board member compensation.
- Improved efficacy by amalgamating and reducing the number of regulatory colleges: Reduction in the number of regulatory colleges — from 20 to five.
- Strengthening the oversight of regulatory colleges: Increased accountability to the Legislative Assembly
- Complaints and adjudication: New independent discipline process; changes to the regulatory college roles in the complaints process; increased transparency; enable

> regulatory colleges to make public comments about known complaints; ensuring past conduct is considered; time limits and timeliness; responses to sexual abuse and sexual misconduct; and better information amongst regulators and health agencies.

After the *Modernization of Health Professional Regulation* report was released, the B.C. government surveyed public and other stakeholders to gather feedback on the report to gauge support for government's proposed reforms. This survey found the public and stakeholders did indeed support the proposed measures and further found some respondents were interested in regulatory colleges adopting "Indigenous approaches to justice be integrated within complaints and adjudication (as determined through engagement with Indigenous communities and organizations), and that regulatory college investigators and inquiry committee members are trained in cultural safety and humility" (BC Government, 2019). This feedback opens the door to exploring alternative methods to resolving complaints.

When the public is confident in their healthcare systems, which includes health regulators, they will have greater assurance that the healthcare they receive is provided by a qualified and capable professional. Although changes to regulation and the regulatory framework are shifting how regulation is conducted, the mandate for health regulators remains the same: protection of the public. One important outcome of the plethora of health regulation changes has been to call for greater accountability and transparency from health profession regulators particularly in regard to addressing complaints against health professionals (BC Government, 2019, p. 18). Health profession regulators are one avenue for patients who want to complain or raise concerns about the care they have received from a regulated health care professional. If the regulatory body concludes the complaint has merit, it will investigate further and determine a

resolution that best protects the public. Examples of the BC College of Nurses and Midwives (BCCNM) complaint resolutions include dismissing the complaint if the regulator finds there is no foundation to the issue(s) raised and/or risk to the public; requiring the registrant to upgrade their education or skills; instilling limits on the registrant's practice; and, in extraordinary cases, cancelling the registrant's licence.

The following literature review includes research on the broader topic of trust and government regulation of health professions with a focus on nursing professionals; an examination of complaints in the regulatory environment; and finally, an examination of alternative dispute resolution process. The majority of the research is limited to sources that were similar to the regional and cultural environments that mirrored or were very similar to health regulation in Canada. As a result, most of the research originated from Canada, the United States, Northern Europe, and the United Kingdom.

The content is summarized into three main themes: Public Institutions: Understanding Public Trust and Confidence; Regulatory Bodies and Nursing Regulation; and The Complaint Process, and Alternative Dispute Resolution.

Chapter 2: Literature review

Understanding Public Trust and Confidence

For democratic societies, trust is foundational to a functional healthcare system, which comprises a multitude of services delivered by healthcare and administrative professionals through agencies and institutions, and overseen by licensing agencies and health profession regulators. Each component plays an important role to ensure safe and ethical care (BC Government, 2022). Health profession regulators are an important part of most healthcare systems, even when the public is unaware of their role in the administration of healthcare. It is through the delegated authority from government that health profession regulators are able to deploy their set requirements for health professionals to work in their healthcare systems (BC Government, 2021). Effective governments depend on their citizens' trust in institutions that operationalize many government policies, programs and regulations (OECD, 2017). Trust in governments and their institutions and regulations vary throughout the world. Amongst Organisation for Economic Co-operation and Development (OECD) countries, Canada sits in the top third of countries where its citizens assess their confidence in their national governments (OECD, 2017). An extension to trust in institutions is trust in government to regulate in the best interest of the public. The public has confidence stakeholders act "in the efficiency and appropriate use of public resources for equal benefit for all citizen's well-being and environmental protection". In the 2015 Statistics Canada report, *Public Confidence in Canadian Institutions*, the study found Canadians had a high degree of confidence in key institutions, specifically policing, education, banking, and the courts and justice system (Statistics Canada, 2015). At the same time, it also noted that trust in public institutions was not consistent throughout the country. British Columbians and Quebecers had lower confidence in these major

institutions compared to those surveyed in other provinces (Statistics Canada, 2015). This report, which was based on Statistics Canada's survey, *2013 General Social Survey*, also found age, gender, and ethnicity played a role in Canadians' confidence in large institutions (Statistics Canada, 2015). First Nations people were found to have the lowest confidence in Canadian institutions. Statistics Canada repeated the survey in 2020 with a focus on visible minorities and selected sociodemographic characteristics but it did not include data for First Nations people so it is not known if there has been a change in confidence for First Nations people (Statistics Canada, 2020). Overall, visible minorities, as a group, reported slightly higher levels of confidence in Canadian institutions compared to non-visible minorities. The survey found confidence in Canadian institutions dropped modestly or remained the same for all of the institutions measured since the last survey. The most significant drop in public confidence was in police services, which fell from 76% for have great confidence or some confidence in policing to 69% for visible minorities and 67% for non-visible minorities. Looking further into public opinion of those who administer government institutions—that is the civil servants or bureaucrats—a 2019 survey found civil servants ranked lowly on the scale of trustworthiness by Canadians. According to a survey about global trust in professions, civil servants fell into the 16th percentile, which was slightly higher than compared to politicians (10%) (Ipsos, 2019). Another survey conducted in 2021 by Ipsos found broad support for the Canadian public health care system but also found 74% of Canadians strongly agree or tend to agree that they were concerned the system was overstretched. This survey also found 27% of the Canadian respondents believe the health care will deteriorate in the future (Ipsos, 2021). Taking a closer look at public opinion on the institution of Canadian healthcare, a longitudinal study found a growing number of people were losing confidence in the healthcare system and wanting "fundamental changes are needed to

make it work better" (Duckett & Kempton, 2012). This study did not probe into the public's confidence or trust in the administration of professional regulation. Drilling further down to how the public perceives health professionals, nurses fare better in public opinion than the system they routinely work in. Studies have shown that nurses are routinely ranked highly by Canadians as highly trustworthy professionals (Narrative Trust, 2021; Ipsos, 2010). A Gallup poll in the U.S. found the public gave nurses the highest profession rating for honesty and ethical standards, above doctors, teachers, and pharmacists (Saad, 2020). There are potentially many factors that may influence how people ascertain their level of trust in organizations, professions, and government. This paper will look at income and perceived power and knowledge as key influencers on public trust.

Income. Gauging public trust in government is routinely studied by governments and academics alike. The level of public trust in government may also be a factor in the public's trust and confidence in governments' agencies, such as its regulatory bodies. One possible factor that may play a role in determining the trust in government agencies is income. Studies suggest income equality could be a contributing factor in shaping the public's trust in government institutions. University of Texas public affairs professor Donald Kettl argues that the "core of the problem of wholesale distrust, however, is the fundamental problem of income inequality" (Kettl, 2018, p. 297). The OECD looked at how inequality affects public trust. Its study suggested that in countries, such as Denmark and Sweden, the highest levels of income equality correlated to high levels of public trust (OECD, 2017). Using OECD's statistics on trust, Morrone et al. go further to suggest that the relationship between trust and income inequality is so strong that inequality is one of the best predictors of trust (2009). This study suggests income disparity could contribute to the public's B.C. government institutions, such as its regulatory

bodies. Understanding if income disparity contributes to mistrust in government institutions may provide insight into whether there is a segment of B.C.'s population that would be reluctant to pursue a complaint about a government organization's services and/or processes. If there was evidence to support this suggestion, then institutions could target measures to support and possibly encourage individuals in lower incomes to consider filing a complaint when the services fail to meet acceptable standards. Further research is needed to understand if there is a relationship between income and trust pertaining to the public and health profession regulatory bodies.

Power and knowledge. Just as income inequality can contribute to distrust of government and institutions, so can lack of knowledge and power, which can also be described as epistemic injustice. An epistemic power imbalance occurs when holders of knowledge exclude, silence and/or dismiss others (Hutton & Cappellini, 2022, p. 2). British philosopher Miranda Fricker first coined the phrase epistemic injustice to describe when "a gap in collective interpretive resources puts someone at an unfair disadvantage when it comes to making sense of their social experiences" (Fricker, 2007, p. 1). Epistemic asymmetries and differential power relations can be experienced by the public when accessing government services, such as healthcare (Carel and Kidd, 2017). In epistemic injustice in medicine and health care, authors Havi Carel and Ian Kidd describe how healthcare relies on complex structures of epistemic norms that are both implicit and explicit. Healthcare professionals have knowledge derived from education and training that most patients/clients do not possess, thus creating knowledge asymmetries (Carel and Kidd, 2017). Within the healthcare system, patients/clients can be vulnerable to epistemic injustice. On the extreme end of epistemic injustice, healthcare providers may deem a patient as being cognitively unreliable and/or emotional unstable that, in turn,

negatively impacts the patient's credibility when describing their symptoms or concerns (Carel and Kidd, 2014). The question this finding raises is whether or not epistemic injustice spills into the complainant's experience with the regulator. Epistemic injustice may be a factor in how public complainants' concerns are processed. Additionally, some types of complaints could be more susceptible to epistemic injustice.

O'Donovan and Madden (2018) analyzed complaint files from the Irish Medical Council. They sought to understand why the vast majority of complaints submitted by the public were deemed unwarranted of inquiry and were subsequently dismissed by the medical professional regulator. Through their analysis they concluded that there were three probable reasons for the Irish Medical Council's high dismissal rate: regulatory illiteracy, epistemic injustice, and symbolic power (O'Donovan and Madden, 2018). The cases of regulatory illiteracy were ascribed to circumstances where the complainant was unaware or did not have knowledge about the regulator's *threshold of seriousness.* Regulatory illiteracy would be attributed to cases considered trivial or without substance (O'Donovan and Madden, 2018). The second category for dismissing complaints, epistemic injustice, described cases that were dismissed because of who made the complaint and how the complaint was communicated (O'Donovan and Madden, 2018). The systematic dismissal of patients' complaints because they were inarticulate or perceived as cognitively or emotionally unreliable strikes at the core of epistemic injustice. The final reason for the council's dismissal of complaints was attributed to symbolic power that O'Donovan and Kidd describe as the medical profession's history of self- regulation that defines professionalism in terms of their understanding of medical professionals. This is problematic for complainants because they are asked to describe how their medical practitioner "fell short, by omission or commission, of the standards of conduct expected among medical practitioners"

(O'Donovan and Madden, 2018). Without the insight, education, and knowledge of a medical practitioner, complainants are unlikely to adequately explain how their medical practitioners failed to meet the professional standards. Although O'Donovan and Madden do not study how the dismissals affect complainants, it would be reasonable to suspect the experience would have a negative impact on individuals' confidence and trust in the medical council.

Regulatory Bodies and Nursing Regulation

Regulatory Colleges. As found in many other countries (Australian Health Practitioner Regulation Agency, 2015; Ministry of Health Manatū Hauora, 2014; Professions Standards Authority, 2020a), each province and territory of Canada works towards ensuring health professionals are safe, competent and ethical to practice—fundamental tenets to health professional regulation. Entry to practice requirements for regulated professions set the minimum education and skills that need to be achieved before an individual can be admitted into the profession and legally use the protected title, which allows the individual to practise their profession (McDougal, Bitz, Derouen, Nagel, Thomas et al., 2011, p 34-35). These requirements often include completion of some form of registration or licensing examination. Only individuals who meet these requirements are registered to practise in their profession and permitted to refer to themselves as a regulated professional by using their associated professional designation within the jurisdiction they are registered or licensed. Credentialling professionals "is one of the key mechanisms that assures patients that the care they receive is provided by qualified, capable and competent professionals" (BC Government, 2019, p. 2). Whether patients are seeking care from a physician, dietitian, optician or from the many other health professionals, professional

credentials are integral to instilling confidence the care they seek is safe, effective, and ethical. This component of the health care system is used widely around the world.

Regulating health professionals and establishing standards for all practitioners of the same profession has a long history. Nearly 2500 years ago Hippocrates was the first to refer to ethical principles and assert that medicine was to protect the interests of the patient; thus, establishing the Hippocratic Oath, a moral code for medical practitioners (Askitopoulou & Vgontzas, 2018, p. 1482). The earliest set of laws pertaining to physicians' practice date back to 1740 BC and are known as the Code of Hammurabi (Violato, 2016). However, it was not until the nineteenth century that a variety of self-regulated health professions began to emerge in Canada, the United Kingdom, and the United States. The creation of these entities stemmed from a variety of stakeholders calling for healthcare quality, access and professional training (Adams, 2020, p. 2). Nursing regulation was one core health professions. In western countries, it is about 100 years old, which is relatively recent when compared to the medical profession. In British Columbia, government enacted legislation requiring nurses to be registered in 1912 (CRNBC, 2012). Stievano et al. critically looked at the history of nursing and synthesized the factors that initiated the advancement of nursing regulators. These researchers found two historic and contextual triggers that have evolved nursing regulation. The first impetus grouping they identified was education, migration and internationalization, policy and regulation. The second impetus comprised demographics, economics, history of registration, and historical changes in nursing practice. Understanding of the evolution of nursing regulations helps facilitate the continued harmonizing of nursing practice education and standards around the world. For example, migration and internationalization of the nursing workforce have helped homogenize practice and professional standards that in turn have helped "develop standardized education

tracks and an easier recognition of competencies to reduce delays in transnational nursing movements and to foster a better comparability in credentialing across different geographies" (Stievano et al, 2019). The modern framework for regulators is shared across most health professions. Doctors, dentists, nurses and other health professionals are part of a regulated licensure system that has standardized education and professional standards respective to their profession that they must adhere to. Knowing the drivers of evolution offers regulators foresight to anticipate, adapt and prepare for domestic and global catalysts of change. There are growing demands amongst health regulators and regulation experts for greater transparency for the public (Kushner, 2015). Professional self-regulation has been "questioned by civil rights activists, patients and consumers, policymakers and others, who argued self-regulation was prone to abuse of privilege, ineffective, and outdated" (Adams & Wannamaker, 2022, p. 2). Recognizing this trend in expectations can be used as a help to measure the effectiveness in the way and amount of information is shared with the public at large and public complainants.

Right-touch regulation. How health professional regulators regulate came under public and political scrutiny after a widely publicized report on a UK hospital where several deaths were found due to substandard healthcare between 2005 to March 2008 (The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013, p. 7). "These shocking events have brought about change in social and political views of care, with patient and public expectations of health care in general, and the regulator a more effective and efficient solution to problems of quality" (Cayton & Webb, 2014, p. 198). To address the findings in the Mid Staffordshire report, the concept of right-touch regulation was developed, in part to elevate the joint responsibility for managing risks in health care between all the parties involved. 'Right-touch' regulation provides a means of tackling an issue in such a way that an appropriate balance of the responsibilities of

professionals, employers and regulators can be achieved. In the past 10 years, many health profession regulators in Canada, Australia, UK, and the US have adopted the principles of *right-touch regulation* (Professional Standards Authority, 2018, p. 3). In the Professional Standards Authority's 2015 report, *Right-touch regulation revised*, describes the six tenets of right-touch regulation as:

- Proportionate: regulators should only intervene when necessary. Remedies should be appropriate to the risk posed, and costs identified and minimized
- Consistent: rules and standards must be joined up and implemented fairly
- Targeted: regulation should be focused on the problem, and minimize side effects
- Transparent: regulators should be open, and keep regulations simple and user friendly
- Accountable: regulators must be able to justify decisions, and be subject to public scrutiny
- Agile regulation must look forward and be able to adapt to anticipate change

These principles guide regulators as they manage complaints about practitioners and the steps they take to resolve complaints. Taking a right-touch regulation approach can help regulators balance the public's need to be protected while ensuring the resolutions are in proportion to the context of the complaint. Not only does this ensure disciplinary decisions are appropriate to the situation but this approach also ensures the decisions are "justifiable under scrutiny" (Russell, 2016, p. 40).

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Although Australia and the UK health profession regulators are established at a national-level and the Canada and the US are situated at the provincial and state level, these regulatory bodies are all given authority to regulate health professionals through legislative laws passed by their respective governments (Adams & Wannamaker, 2022, p. 1). Australia, Canada, the United Kingdom and the United States fall into the "Anglo-American model" where organized professionals are granted power by the state to govern their own affairs, including defining the entry to practice requirements and managing complaints against health professionals (Adams, 2020, p. 2). As found with other regulated health professions, Canadian nursing regulatory bodies establish the education requirements for the entry to practice, set the professional and practice standards, and determine the requirements for professional development and annual re-licensing. It is important to emphasize this point because it is these standards and requirements that health professionals are held accountable to. A complaints system is in place, in part, to ensure the standards are taken seriously by nurses (Gunther, 2015). When the college becomes aware of any of these standards not being met, which is typically by way of a written complaint, the college must intervene to protect the public. For example, in most circumstances colleges intervene in a nurse's practice after they have received written complaints about the nurse (CRNBC, 2012). In British Columbia, the BC College of Nurses and Midwives[1] (BCCNM) receives and investigates complaints about nurses from nurses' employers, other health professionals, and members of the public. Complaints are investigated and can go through an inquiry or a disciplinary process, with the majority of complaints being resolved through the inquiry process. Thus, most final decisions are made by an inquiry committee. After the

[1] On Sept, 4, 2018, the College of Licensed Practical Nurses of British Columbia (CLPNBC), the College of Registered Nurses of British Columbia (CRNBC), and the College of Registered Psychiatric Nurses of British Columbia (CRPNBC) amalgamated to become the BC College of Nursing Professionals (BCCNP). On Sept. 1, 2020, BCCNP amalgamated with the College of Midwives of British Columbia to become the BC College of Nurses and Midwives.

complaint is resolved, the complainant is advised of the outcome. As with other regulatory colleges in Canada, BCCNM has the power to suspend or take away licences, impose fines and issue reprimands, and they have a duty to inform the public and employers about serious matters (BCCNM, 2021). While each province and territory share similar complaint processes, each jurisdiction must adhere to their respective provinces' health profession legislation. All of the regulatory bodies recognize one another's licensing credentials that give nurses relatively easy labour mobility within Canada. To support licence recognition, nurse regulators work together to ensure nursing standards and nursing education across the country are harmonized. While all of the jurisdictions work together to establish best practices for resolving complaints, it is unlikely full harmonization would be possible in the foreseeable future because each province sets its own health profession legislation.

The complaint process. Since 2015, three Western provinces' nursing regulators have engaged in external reviews of the regulatory processes, including their complaint processes. Both the College of Registered Nurses of BC (CRNBC) and Saskatchewan Association of Registered Nurses (SRNA) commissioned the UK's Professional Standards Authority (PSA) to conduct their respective reviews. The College and Association of Registered Nurses of Alberta (CARNA) commissioned Harry Cayton to conduct its 2019 review. All of the reviews were led by Harry Cayton, former chief executive of the Professional Standards Authority in the UK from 2007– 2018. The intent of each of these independent reviews was to gauge each regulator's "performance against other regulators, to confirm where it was performing well and to identify any areas for improvement" (PSA, 2016). There are important benefits to having jurisdictions undergo consistent reviews. The reports build a pool of knowledge for nurse regulators and establish shared goals and objectives, which in turn facilitates the harmonization of nurse

regulation in Canada. Cayton identifies important gaps in college's regulatory functions and makes recommendations that are achievable and reasonable for colleges to address. The research into the complaints process emphasizes the nurse and the risk to the public.

Transparency

In each of the PSA/Cayton reports, Cayton cites insufficient transparency in some parts of the complaints process for all the nursing colleges. In the CRNBC report, there were recommendations to clearly set out on the college's website its approach to publication and disclosure of information arising from complaints cases that described which sanctions would be published, what information would be anonymized, and the "timescales for publication" (PSA, 2016). In order to adhere to this recommendation, the college would need to provide easy-to-understand information for the public that explains the complaints process and a general guide to the length of time required to resolve a complaint. The report suggests that without clear and user-friendly information about complaints process (Appendix B, Figure 1), public members may be dissuaded from pursuing a complaint as the process may appear too daunting or irrelevant to their concerns. The report prepared for CARNA called for greater transparency in its discipline notices (Cayton, 2019). Each of the reports emphasize that regulators should be open and keep their regulatory processes simple and user-friendly (Cayton, 2019). Greater transparency could provide a better understanding of health regulators' purpose and provide insight into how the colleges fulfill their mandate to protect the public. In turn, greater public awareness could lead to a better understanding of the role health regulators play in health care. However, other research suggests that a careful and strategic approach should be taken when an agency is increasing transparency of its operations and decision-making process.

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The Grimmelikhuijsen et al. report found the effect of increased transparency about how decisions are made is dependent on the regulatory domain. The researchers conducted a survey testing the impact on the public when exposed to increased transparency of a routine decision versus the effect of increased transparency in a regulatory enforcement. This Dutch study focused on three regulatory sectors: finance, health, and education. They found overall decision transparency significantly increased citizens' trust in the health and education sectors. However, the study found that only the education sector saw an increase in public trust after increasing "rationale" transparency in its regulatory decisions (Grimmelikhuijsen et al, 2019, p. 12). This study suggested the degree to which people feel removed from a situation or occurrence may explain the discrepancy in transparency-trust relationship discrepancy between regulatory agencies. Thus, the more familiar the public is with a specific sector, the more likely it will be influenced by changes in transparency. The authors concluded "transparency about regulatory decisions can increase citizen trust in a regulatory agency, but that magnitude of the effect is moderated by characteristics that are specific to the regulatory domain." Grimmelikhuijsen et al observed that transparency can be interpreted differently by different consumers of the information, and perhaps most disconcerting, is that it can also obscure information. This notion is also raised by Portia Roelofs, who writes in her article, *Transparency and mistrust: Who or what should be made transparent?*, that there's growing evidence that different presentations of transparency can affect trust positively or negatively. She offers the type of information governments and their agencies share may not be the transparency citizens seek or want, and it may actually increase distrust (Roelofs, 2019). This suggests the importance of public engagement to ensure the type of information being shared—and how it is shared in terms of context and presentation—meets the needs of the intended public.

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The research paper, *Linking transparency to trust in government and voice,* looked at government transparency from a different angle. The study looked at how trust and transparency can be affected by the medium (web versus social media) in which it is presented. Turning to psychology research, it was found that when there is detailed information provided to person, the individual is inclined to perceive the content more negatively than if less detailed information was provided. The reasoning for this finding is that the detailed information allows the reader to scrutinize and critique the content more thoroughly (Porumbescu, 2017). This phenomenon suggests distributing information on social media may provide a more positive response to content posted on a website.

> *Greater use of public sector social media accounts was found to have a significant positive relationship with perceptions of government competence, benevolence, and honesty. However, greater use of government websites for information was negatively related to perceptions of government honesty and lacked a significant relationship with perceptions of competence and benevolence* (Porumbescu, 2017, p. 530).

Further research is needed to understand why government social media content may be more trusted compared to government website content. Factors—such as plain language or web users actively seeking content versus web users passively receiving content through their platform feeds—may also play an important role in shaping public opinion on the different mediums governments use to disseminate information. While it would be appropriate to ensure complaint information is posted on a college website, disseminating content through social media, such as Twitter, may facilitate greater trust in the regulatory college, provided the content is derived from the college's official social media accounts. Social media, specifically Twitter

and Facebook, are platforms that can be used to quickly disseminate regulatory notices into the public sphere. The greatest operational hurdle is developing policies to determine the types to notices to post on social media and/or determining if all notices are systematically posted onto a college's social media channels. The actual process of posting disciplinary notices is simple. After a notice is posted onto the college website, the college's social media manager would publish a corresponding tweet or Facebook post that includes a link to the full public notice on the college website.

Complainants' perspective. Because the Australia health regulation is managed at a national level, whereas in Canada health profession regulation is a provincial responsibility, the Australian Health Practitioner Regulation Agency (Ahpra) works with 15 national boards. These health profession boards represent an array of health professionals ranging from physicians and nurses to psychologists and pharmacists. These national boards are similar to Canadian provincial regulatory colleges except Ahpra is responsible for registering health professionals and maintaining the registry. Ahpra and the national boards help protect the public by regulating Australia's registered health practitioners (Ahpra, 2020a). Ahpra conducted an experience survey with health practitioners and complainants in 2017–18. The purpose of the study was to understand how both complainants and registered health practitioners experienced the complaint process. The survey found that 70% of practitioners were satisfied with the outcome of the complaint whereas only 18% of complainants were satisfied with the outcome of their complaints. Both groups described the complaint process as "not fair or impartial, and lacked transparency and adequate updates" (Biggar, Lobigs, Fletcher, 2020). The high degree of dissatisfaction amongst complainants was broken down in four key areas: fairness, communication, outcome, and timeliness. The authors of the study attributed some of the

dissatisfaction to an unclear understanding of the role of the regulator and their thresholds for investigating a complaint (Biggar, Lobigs, Fletcher, 2020). A lack of understanding of the regulator's role in resolving complaints could contribute to unrealistic expectations for a complainant. This lack of understanding or awareness of the regulator may, in turn, play a role in shaping the public's perception on colleges' transparency about complaints and their complaint processes.

Approaches to complaint resolutions. The Ontario Nurses College (CNO) oversees nursing regulation for Ontario. As in other Canadian jurisdictions, CNO's complaint process is intended to protect the public and improve nurses' practice; it is not intended to punish nurses (Hamilton-Jones, 2016).[2] Complaints made by the public are resolved either through its investigative process or alternative dispute resolution (ADR) process. CNO is just one of three nurse regulators in Canada that offers an ADR option for eligible cases. For ADR cases, if all parties (complainant, nurse, and CNO) involved in the complaint agree to resolve the complaint, they will work together to address the issues that caused the complaint. At the end of the process the nurse will agree to undertaking a number of activities and agree to reviewing the CNO practice standard documents deemed pertinent to the issues raised in the complaint. In some cases, the nurse may also meet with the manager of complaints and the investigator assigned to the case, to discuss their reflections. The outcome of ADR is confidential and not made public (Hamilton-Jones, 2016). The investigative process, which is a standard complaints resolution process used in other Canadian and many other western jurisdictions, is used when the nurse or

[2] This approach is often referred to as *right-touch regulation*. The philosophy behind right-touch regulation is based on "the minimum regulatory force appropriate to manage the risk posed by practice, to protect the public" (Professions Standards Authority, 2018). While right-touch regulation is commonly practised in Canada and other countries, the research on this topic focuses on applying the practice and the impact on health professions involved in a complaint about their practice; it does not offer insight into the public's expectations into how complaints are resolved.

the complainant does not agree to participate, or the complaint is not suitable for the alternative resolution process, such as in cases of alleged abuse (CNO, 2018). Appendix B, Figure 2 provides a visual representation of the ADR process compared to the standard complaint resolution process. CNO's ADR process engages the complainant, the nurse and CNO to work together to address the complaint (CNO, 2018). With the exception of Ontario, Alberta and the Northwest Territories, the ADR process is not used in other jurisdictions in Canada. CNO conducts an ongoing satisfaction survey of both public complainants and nurses who have had complaints made about them. This literature review did not reveal any other nursing regulators in Canada conducting research on complainants' experiences of the complaint process. In 2012, CNO embarked on this research to address its performance measurement gap. Up until this time CNO did not have quantitative measures on nurses' or complainants' experiences with their complaint process and the college wanted to find out if public complainants believed their complaint process met its objectives of both protecting the public and remediating nurses (Hamilton-Jones, 2016). In 2016 CNO reported the findings from data collected from 2012–2015 in the Journal of Nursing Regulation. Similar to the Australian survey findings conducted by Ahpra, the CNO surveys found 60% of nurses who chose to pursue their complaint through the ADR process reported being very or somewhat satisfied with the process. In comparison, only 24% of complainants reported being very or somewhat satisfied with the investigative process. For nurses, the satisfaction with the alternative dispute resolution process was higher (76% very or somewhat satisfied) than the standard investigative process (71% very or somewhat satisfied) (Hamilton-Jones, 2016). The survey illustrates that both complainants and nurses were more satisfied with the alternative dispute resolution process than the more traditional investigative

process. This article offers some insight into the Canadian perspective. However, without reliable data, it's difficult for regulators to know how to address complainant dissatisfaction.

In the United Kingdom, the Health & Care Professions Council[3] (HCPC) is the regulatory body for 15 health professions, such as dieticians, art therapists, and paramedics (HCPC, 2018). Both the United Kingdom and Australia share a similar regulator structure where the individual regulatory bodies have an oversight body that manages the licensing and maintains the registries. In 2009, the HCPC asked a market research company, Ipso MORI, to conduct qualitative research with past complainants to gather their views on the complaint process (Ipsos MORI, 2010). The qualitative data revealed aspects of how the process personally affects complainants. Participants described being a complainant as embarrassing and they felt stigmatized, despite being the wronged party (Ipsos MORI, 2010). This report did not explore this finding in detail and the recommendations did not address this issue directly. Interestingly, the interviews also revealed that participants felt it was important for the HCPC to explain how and why decisions were reached when complaints are resolved. The report made several recommendations, including making improvements to the existing complaint information with the intent of managing the complainants' expectations of the process. In particular, Ipsos MORI recommended providing complainants with a *roadmap*, using clear and plain language, to describe potential outcomes and the probable length of time for each stage of the complaint process (Ispos MORI, 2010). This study offers Canadian nursing colleges an example of how they could gather qualitative data about complainants and their experiences.

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[3] The Health & Care Professionals Council was formerly called the Health Professions Council.

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Renée Bouwman et al delved into researching patients' perspectives on complaints made to regulatory bodies. The researchers cited growing public concern over the effectiveness of health profession regulation due to widely publicized health scandals in the UK and New Zealand (Bouwman et al, 2016). In their article, *Patients' perspectives on the role of their complaints in the regulatory process,* they researched patient complaints and regulators' accountability in health care. The authors questioned how regulators value patients' complaints and explored how complaints should be used to improve the regulatory process. Taking a quantitative approach, Dutch complainants were surveyed about: the characteristics of the complaint; their motives for making a complaint; and the outcome of their complaint. Bouwman et al concluded that regulators should move away from traditional complaint resolution processes and take a more strategic and responsive approach that goes beyond just assessing complaints against clinical standards. This approach could contribute to greater understanding of systemic issues that affect health care delivery. This study also illustrates the missed opportunity by both health regulators and health care agencies to harness the insights of complainants that could be used to improve health care delivery, particularly when harmed patients fail to make complaints in the first place.

Alternative Dispute Resolution (ADR)

Alternative Dispute Resolution (ADR) has been used for decades to resolve disputes, especially legal and union disputes (Donald, 2004). ADR typically refers to a structured problem-solving process involving at least one aspect of "negotiation, arbitration, mediation and conciliation" that occurs outside a court or formal regulatory processes. In jurisdictions that offer

ADR as a means to resolve complaints about health professionals, only non-egregious matters can be considered for ADR (Ferris, 2004).

The Ontario Nurses College (CNO) offers ADR as a mechanism to resolve complaints only if everyone involved in the complaint agrees to participate. CNO provides a facilitator to work with the nurse and the complainant to discuss the complaint and generate ideas to resolving it. The college's perspective is that ADR provides the nurse with an opportunity to reflect on their practice and learn from the experience (CNO, 2018). ADR presents an opportunity for nurses to show they are willing to keep learning and striving to maintain and exceed the college's standards of practice. At the college, this is called reflective practice (Hamilton-Jones, 2016). Within the nursing profession reflective practice is an accepted form of professional development that facilitates insight and subsequently promotes practice change (Bolg, Dwyer, Doherty, Pignataro, & Renaud, 2020).

After the facilitator concludes the discussion and mediation between the complainant and nurse, a resolution agreement is drafted and signed by all parties: the complainant, the college, and the nurse, who must fulfill the terms of the agreement (CNO, 2018). Unlike the standard complaint resolution process that is used by both Ontario and British Columbia (BCCNM, 2021), the ADR process is confidential and the resolution agreement is "not published in the college's public register or made available to any current or future employer" (CNO, 2018). The college's commitment to keep the ADR process confidential and not publicize the complaint about the nurse is undoubtedly an incentive for nurses to acquiesce to resolving the complaint about them through the ADR process. The confidential aspect of the ADR process introduces a paradox for regulators. On one hand there is evidence public complainants are more satisfied with the

complaint outcomes yet the confidential nature of these resolutions is at odds with the literature that supports the public's expectation for increased transparency from government agencies.

Complainant: investigative complaint process vs. ADR. Health regulatory bodies rely on their investigative and disciplinary complaints process to ensure professional and practice transgressions are addressed, which also communicates to the public and nurses that infractions are taken seriously (Gunther, 2015). In addition, complaint resolutions typically conclude with corrective or remediation measures intended to reduce the risk of repeated harm, and in turn, protect the integrity of the profession (Gunther, 2015). The complaint process may satisfy the college's duty to protect the public but often does not meet the needs of the complainant, who are left out of the complaint process and only advised of the outcome. In the Ahpra study of the complaints process, which is similar to the BCCNM complaint process, the authors found a significant number of complainants felt alienated by their experience of the complaint process (Biggar et al, 2020). This finding was echoed in the Professional Standards Authority's report, *Public Response to Alternatives to Final Panel Hearings in Fitness to Practice Complaints*. In this study, 45 in-depth interviews and five focus groups were conducted with patients who had made complaints about a health professional and members of the public. The complainants in the study expressed that they found the process stressful. Both groups indicated an interest in an alternative to the existing process and anticipated that it could bring "benefits to all parties involved" (Professional Standards Authority, 2013).

In Steve Vinay Gunther's research on ADR in health regulation, he found that complainants sought the following outcomes to their complaints:

- Acknowledgment of their experience
- Insight into the professional's behaviour

- An apology or expression of regret
- Assurance the behaviour/event would not happen again
- Repair to relationship or reconciliation

The investigative process endeavours to protect the public good rather than making amends with the complainant, which aligns with a regulatory body's mandate to intervene when a practitioner's practice is unsafe to ensure no future harm will come to other patients. This mandate does not extend to ensuring restitution or conciliation is achieved with a complainant. The ADR process could be an attractive alternative for complainants (Ferris, 2004). When a complainant seeks to be actively involved in resolving their complaint, the standard investigative process may not meet their expectations in resolving their complaint because they have a limited

Table 3

College of Nurses of Ontario complaint process comparison (Hamilton-Jones, 2016)

	Standard Investigative Process	**Alternative Dispute Resolution Process (ADR)**
Registrant and/or complainant do not want to use ADR to resolve the complaint	Yes	No
Complainant participates in resolving complaint	No	Yes
Process used to resolve serious complaints	Yes	No
Mediator participates in the complaint resolution	No	Yes

Resolution of complaint is confidential and not attached to the nurse's record	No	Yes

role in the process. Managing expectations is integral to complainant satisfaction with how their complaint is resolved. In 2011 the Health Professions Council in the United Kingdom commissioned qualitative study to gather the public's opinion on using a less formal alternate dispute resolution to manage complaints. The study found varying degrees of support for ADR partially due to the participants' perception of a mediated process and misunderstanding of investigative process (Ipso MORI, 2011).

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Research questions

The administration and principles of health regulation are relatively consistent amongst the health professions in Canada and other liberal democracies. Legislation, whether it be at the national or provincial/state level, sets the regulatory bodies' scope of functions and mandate. Nursing regulation and, specifically, nursing regulation in British Columbia, is the focus of this research. As an employee of the BC College of Nurses and Midwives (BCCNM), the investigator is familiar with college's processes and the Health Professions Act (Government of British Columbia, 2022) under which the college operates within. Although the focus is on nursing regulation, the research and findings could be applicable to other health regulators in B.C., and other regulators outside the province. B.C. is on the cusp of modernizing its Health Professions Act. In anticipation of these changes to the health regulatory environment, the research will attempt to gauge the public's awareness and understanding of BCCNM, and its perspective on making complaints. Further, this research plans to examine the public's expectation of the complaint process and whether there might be interest for less formal alternative dispute resolution process to resolve complaints about a nurse. Understanding how the public understands the complaint process will help regulators bridge communication gaps and improve the effectiveness of increased transparency that is sought by government (Steering Committee on Modernization of Health Professional Regulation, 2019). The following research questions are general areas of interest that will be further refined:

Research questions

Q. 1. What is the public's awareness of health regulators, including the BC College of Nurses and Midwives?

Q. 2. What is the public's view on how complaints against nurses are presently resolved in B.C. and their views on an alternative dispute resolution process?

Chapter 3: Research Design and Methodology

Research design

To study this subject, a qualitative approach is being taken to explore the perspectives of people who are external to health regulation. Taking a qualitative method approach is better suited to gaining a deeper understanding of this subject, potentially capturing any complex characteristics (Tracy, 2013, p. 230). It was noted in the literature review that there are many possible variables that can contribute to the public's awareness of health professional regulators and their level of understanding and confidence in regulators' complaint processes. The participants' narratives can provide a rich dialogue that can be analyzed for this research (Bamberger, Rugh &, Mabry, 2012, p. 293). A case study format has been chosen because it supports a close examination of a subject in a real-life context. The research will focus on nursing regulation in British Columbia. BC College of Nurses and Midwives (BCCNM) —the college that regulates nursing professionals in B.C.—will be the primary subject to explore questions that may reveal practical and actionable information and/or issues that can be addressed by the regulator. With more than 64,000 registrants, BCCNM is the largest health profession regulatory in B.C. The researcher's knowledge and understanding of the BC College of Nurses and Midwives makes it a suitable organization to focus on. This approach will allow for the in-depth study of BCCNM by examining how well it is understood by the participants and by exploring their perspectives on the current complaints process and explore their thoughts on an alternative dispute resolution process if this process might be considered by BCCNM. The strength of a case study is that it draws a "holistic understanding of a topic by understanding it as

one part of a dynamic setting where multiple factors come into play" (Merrigan et al, 2012, p. 144).

Taking a cross-sectional approach will allow the researcher to collect the opinions and perspectives on this topic at a point in time. Research into the public's perspective on complaints and the complaints process also offer an opportunity to explore their thoughts on the current standard complaints resolution process and explore what strengths or weaknesses they may perceive with an alternative dispute resolution process to resolve complaints. For this study, the research methods aims to achieve two goals. First, it should facilitate the exploration of perceptions and ideas from people who may have little or no knowledge of BCCNM. Second, the study will attempt to find out if the ADR process is seen as a satisfactory alternative to the standard complaints process.

Health profession regulation continues to evolve and transform in order to reflect the ongoing growth and changes in the health care system (Wenghofer & Kam, 2017, p.30). Each component of a health regulator's mandate—setting entry-to-practice requirements; setting practice standards; maintaining standards through annual re-licensure and ongoing learning; and managing a complaints program to mitigate against unsafe practitioners practising—can benefit from periodic evaluations to explore how effective the processes are meeting their mandated goals and the public's expectations. Examining the complaints process by gathering the perspectives from members of the public offers real-life context (Merrigan, Huston, & Johnston, 2012, p. 145) that can provide practical insights to further evolve the current processes. At the same time, there is an absence of research on opinions on the alternative dispute process to resolve complaints about health professionals in Canada. Two previous studies explored public complainants' perspectives on the complaint process. Hamilton-Jones's 2016 study compared the

standard complaint process with an alternative dispute resolution process using complainants' feedback while the Bouwman et al. 2016 study investigated expectations and experiences of patients who complained to the regulator. Hamilton-Jones used a quantitative approach and Bouwman et al. used a mixed research approach. These two studies offer important yet broad insights derived from the quantitative methods. To better understand the public narrative and build on these two studies, the research approach chosen for this study is qualitative to explore the perceptions held by members of the public about awareness of BCCNM and the complaints process. The quantitative approach offers an opportunity to capture subtle distinctions of opinions that may be informative to understanding how to address, if any, misperceptions of BCCNM and its complaints process. The qualitative approach offers the researcher an opportunity to probe ideas and perceptions using interviews. The interviews will be followed by a focus group for two reasons. First, the focus group will allow the researcher to examine the interviewees' data and then further refine the questions to examine areas of the subject that may have nuances that could shed deeper insights into this topic. Second, the focus group may identify areas where there is consensus within the group and areas that may be contentious. Taking a case study approach provides an opportunity to delve into individuals' perspectives within a real-life context that is focused on a single health profession regulator. The findings could be applicable to other health profession regulators. Using BCCNM as a case study should provide an opportunity to contribute a deep understanding of members of the public's expectations of regulatory bodies. In order to adequately address the research questions two different qualitative research methods have been selected for this study. The researcher has chosen to start with two semi-structured, individual interviews and then be followed by one focus group. Together these two methods together will provide a narrative that is rich with data

to address the research questions. The interviews will probe how aware the participants are of regulatory colleges in general and specifically BCCNM. They will also provide data on the participants expectations on how complaints should be resolved in general terms. The learnings from the interview may offer insights that can be further explored with the focus group.

Interviews

Collecting people's opinions and experiences about health regulators and the standard complaints process can be achieved by conducting interviews. The interviews are well suited to delve into nuanced feelings and opinions (Denscombe, 2010, p. 174). Interviews can present opportunities that can "elucidate subjectively lived experiences and viewpoints from the respondents' perspective (Tracy, 2013, p. 132), which support and align with the research objectives. The interview guide is found in Appendix E. These interviews will be used to explore: level of awareness of a regulatory college; understanding of complaint process; threshold of event(s) or criteria required to precipitate making a complaint; reasons for hesitancy; concerns about process; and expectations of complaint process and outcomes. The interview guide is broken into three sections. The first set of questions are focused on the interviewees' awareness and trust of health regulators. The second set of questions focus on the participants' views on making complaints with further exploration into identifying barriers/hesitancies. The third and final set of questions pertain to two scenarios (Appendix A) with the goal of using the earlier discussion to probe more deeply into the ideas and perspectives raised in the first two sections. The first scenario is about a professional conduct breach where a nurse inadvertently exposes the identity of a patient in a disparaging manner on Facebook. The purpose of presenting scenarios is to explore how the interviewees view professional misconduct cases and the role of

the regulator in resolving complaints. The second case study will explore the interviewees' response to a case about a clinical care error in emergency that results in some harm to a patient. In addition to exploring the same issues in the first case study, the second case should allow the researcher to explore how the interviewees' expectations of the college changes or remains the same when comparing these two scenarios. Appendix F includes the full interview guide and the focus group facilitator guide.

The interviews were planned to be one hour to 1.5 hours, one-on-one videoconference meetings using Google Meet.

Focus groups

The rationale for conducting a focus group is to explore the range of views on this research topic (Denscombe, 2010, p. 177). They are an effective research method to produce insights known to result from group interaction or group effect (Tracy, 2013, p. 167), which would not otherwise be captured if solely collecting the data through interviews. CNO's 2016 survey provided valuable quantitative research that compared satisfaction between complainants who went through the standard complaints process with those who chose to go through ADR process but it did not delve into the explanation for the complainants' perspectives nor capture the perspectives of the public before entering into a complaint scenario. The focus group is suitable for gathering this data. Additionally, conducting the focus group after the interviews will permit further exploration into perspectives raised in the interviews. The focus group will follow the interviews to allow for fine-tuning the focus group facilitator guide from what was learned from the interviews. Based on the data collected in the interviews, additional questions may be added to help explore the group's awareness and expectations of BCCNM and the complaints

process. Unlike the interviews, it is anticipated the focus group will provide unique data on how the group (Carey and Asbury, 2012, p.17) understands health regulation and the complaints process. Unlike the interviews, the focus group participants' discussion may build on one another's experiences and perspectives and identify areas where there is consensus or a collective viewpoint shared by the group. The focus group guide breaks the questions into two sections: Part I — awareness, transparency, trust; and Part II — BCCNM complaint process. The former set of questions are designed to follow upon the responses from the interviewees and further focus on the group's awareness of BCCNM and/or other health professional regulators and their subsequent thoughts on transparency and trust. The group will be introduced to two stories that appeared in the media about complaints made against nurses. The purpose of presenting these stories is to discover if the participants recall the media stories and provide examples of complaints brought to the college to aid the discussion. The first media story describes a nurse[4] who had been disciplined for breaching the college's professional and practice standards. The discipline pertained to a financially abusive relationship between a nurse and an elderly couple. The second media story describes the outcome of a case[5] about a nurse

[4] Following the investigation, a report was made to the Inquiry Committee, and a citation was authorized. The citation notified Ms. Tinkham, and the public, that a hearing would be held Feb. 24, 2017. The hearing would examine allegations that, while purporting to provide nursing care to a client, Ms. Tinkham: Caused the client to appoint her as attorney in relation to his financial affairs by power of attorney; received other personal benefits, including payment for dental work and living in a mobile home owned by the client, and being named as an owner in joint tenancy of the mobile home; issued cheques upon or received payments from the client's bank account totaling more than $11,000; and retained ownership of the mobile home when it was transferred to her upon the client's death. The college submitted that Ms. Tinkham's violation of professional standards was severe, involving long-term exploitation of a nurse-client relationship with an elderly and infirm couple [BCCNM (formerly CRNBC), 2017]. Laurie Tinkham's professional conduct story appeared in CBC news, Victoria Times–Colonist, and the Vancouver Sun.

[5] Kimberly Redlack entered into a consent agreement in November 2021 with BCCNM to address practice issues that occurred during December 2019 and July 2020, related to leaving her colleagues during a code white, failing to demonstrate adequate clinical skills in managing a resident's diabetes and hypoglycemic event, and not meeting BCCNM's documentation and medication practice standards. Redlack agreed to: remedial education in medication administration, communications, diabetes, and ethics; supervision for six months; a learning plan, and a regulatory practice consultation (BCCNM, 2021).

disciplined by BCCNM for inappropriately restraining a patient. In addition to the questions already developed for the focus group, there will be further probing into this area based on the data from the interviews.

In the second half of the discussion, the group will be presented with both the standard complaints process and the alternative dispute resolution process to collect their thoughts on these mechanisms for resolving complaints about health professionals. Figures (Appendix B) will be presented to help illustrate the complaints process and allow the participants to visually process and compare the two methods for resolving complaints. The focus group will be held using Google Meet for a one-hour, videoconference meeting.

For the focus group participants, a short pre-interview survey (Appendix F) will be administered to gather basic background data that can be used to familiarize and build rapport with the participants, and provide the participants with some background information about health profession regulation.

Participant selection

Convenience sampling and recruitment

Five to eight participants are planned to be recruited primarily through word-of-mouth. A recruitment poster will be posted at the local library in Richmond, B.C. In addition, the researcher will reach out to their own network of colleagues to identify individuals who may be interested in participating in either research activity.

Inclusion criteria

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The inclusion criteria are intentionally broad with only minor exclusion criteria. The objective of the selection criteria is to include individuals who are consumers or potential consumers of health care in British Columbia and/or potential advocates for others who are recipients of health care. Thus age, education, ethnicity, and other demographic values will not be given preference in the participant selection.

Shared criteria for both the interviews and focus group

- Adults 18+
- Residents of British Columbia
- Individuals who are not current or former regulated health professional, e.g., nurse, physician, physiotherapist, etc.
- Individuals who are not current or former health regulator employee, e.g., current or former employee of BC College of Nurses and Midwives, College of Physicians and Surgeons of BC, etc.

Interviews

Interviews can offer the researcher an opportunity to reach deep understandings of a topic (Bamberger, Rugh & Mabry, 2012, p. 307). In this study, the plan is to recruit participants who have different perspectives on health care and the recipients of health care, specifically nursing care:

- One individual who has either personally received care from a nurse or observed a family member or friend who received care in the past 24 months.

- One Individual who has not received care from a nurse or observed a family member or friend receive care from a nurse in the past 24 months.

The aim for these semi-structured interviews is to explore the research questions with the participants. If the interviews provide unanticipated data that could benefit this study, the focus group interview guide can be adjusted to further explore topics raised in the interviews.

The criteria is intended to screen out participants who have had direct professional interaction with a regulatory college and, thus, may have difficulty providing a public perspective.

Data

For both research activities, the events will be audio recorded. The recordings of the discussions will be transcribed.

Data analysis

Preliminary analysis will be conducted as soon as possible after each research activity to capture any rich non-verbal details that will not appear in the transcript (Cary and Asbury, 2012, p. 81). The transcribed data will be organized into qualitative code for interpretation and inductive analysis. Additional observations and notes from the interviews and focus group will also be converted into the code. The code will be broken into categories and then themes for interpretation and analysis.

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Ethics Approval

An application for ethics approval for this research was submitted to and granted by the University of Alberta's Research Ethics Board (REB). The content and nature of this study is considered "minimal risk." The ethics application included details on how the anonymity of the interviews and focus group participants would be established. The application also included details about how the participants' confidentiality and privacy of information would be maintained as it pertained plans for storage, retention and eventual disposal plan of the data. Each of the participants' agreed to and signed the Information Letter and Consent Form, which provided the details about confidentiality and data storage security. The forms are found in Appendix D.

Chapter 4: Findings

Adjustments to research

Recruitment for both the interview and focus group participants proved to be more challenging than was anticipated. The ongoing Covid-19 public safety protocols required the researcher to recruit primarily through word-of-mouth. Although the original intention was to recruit one interview participant who had recently received care from a nurse or had observed a relative or friend receive care from a nurse, both of the interview participants did not have recent interactions or observe interactions with a nurse. There were originally five people confirmed to participate in the focus group but two of the participants were unable to attend the focus group just prior to the discussion. Thus, there was not sufficient time to replace these individuals with other participants. Pre-survey was not conducted as it was found informally during the recruitment process that the participants—for both the interviews and the focus groups—that none of the participants had any experience making a complaint about a health professional.

Interviews

Two male participants were interviewed in November 2021. One of the interviewees was a second-year university student in his late teens who was also the first generation of immigrant parents. The other interviewee was a male mid-career public service worker. They were both recruited through word-of-mouth. The interviews were audio-recorded and then transcribed. The data was anonymized to maintain the privacy of the participants and is found in Appendix F. The original plan for the interviews was to interview one individual who had no recent experience receiving or observing care from a nurse and one individual who had

experience receiving or observing care from a nurse in the past three years. Neither participant had recent interactions with the health care system, specifically with nurses, in the past three years. Both interviews were conducted via video conferencing using Google Meet. As was planned, the interviews were broken into three parts: Part I explored awareness, transparency, and trust about health profession regulators. Part II — making complaints, barriers/hesitancies. Finally, Part III — introduced two case study scenarios and the BCCNM complaint process.

Interview introductory questions — Part I

Awareness of heath profession regulatory bodies. The first set of questions were designed to determine the participants' level of awareness of health regulation. Both of the interviewees were asked what they knew about health profession regulators. One of the interviewees had never heard of the term nor did he know what a regulator was. He said, "Actually, to be quite honest, I know nothing about health regulators. I don't even know what that is." However, when prompted the participant had heard about the College of Physicians and Surgeons of British Columbia. The other participant had some knowledge of health profession regulators, citing his partner was an operating room nurse and his mother was a retired nurse. He also noted that he was aware of the various colleges and that he was interested in following current events. Although he had not heard of the BC College of Nurses and Midwives, he indicated that he was familiar with BC Nurses Union (BCNU), which is the largest nurses' union in British Columbia. In general terms, he knew from media news stories that regulatory bodies had a licensing role for health professionals and they dealt with disciplinary matters. His understanding was that the regulatory bodies manage disciplinary matters at "arm's length from government." The interviews revealed a broad spectrum of understanding health profession regulators but neither had specific knowledge of BCCNM. However, both interviewees'

recognition of the College of Physicians and Surgeons of BC suggests some peripheral knowledge of health profession regulators.

Trust and transparency of health profession regulators. The interviewees were given an overview of health profession regulators and a media story about a nurse who had been disciplined for breaching the college's professional and practice standards. The discipline pertained to a financially abusive relationship between a nurse and an elderly couple. Neither of the participants were familiar with the case presented about a nurse disciplined by the college, which appeared in mainstream media three years earlier in 2018. The first interviewee supported established standards for nurses because they are often in "position of power . . .[and] educated professionals, so they should definitely have some sort of code, or code of standard for them." He expected that there should be an agency that ensures nurses practice ethically and abide by a code of ethics. He also thought there should be mechanisms in place to monitor the finances of clients who are vulnerable to financial abuse so that the system was not dependent on other health professionals to report unethical conduct to the college. The other interviewee felt it was important for the college to take action, in part, to protect "credibility of the profession." He suggested that news stories about nurses acting unethically undermine public confidence in health professionals. He felt the actions taken by the college were "reasonable." Neither respondent indicated interest or concern about the disciplinary process. The interviewees had divergent perspectives on how the discipline case against Tinkham was resolved. Whereas one interviewee felt the college's action against Tinkham was too lenient, the other interviewee thought the action was "reasonable" but was "a more severe penalty than what [he] . . . would expect." The latter interview participant's perspective may have been influenced by insights made from observing his mother who had been a nurse.

Interview questions — Part II

Making complaints, barriers/hesitancies. The interviewees were asked to reflect on their experiences making complaints in general about any type of business or organization. One of the interviewees could not recall having a specific experience making a complaint and attributed the lack of experience to his young age. He suggested that he did not have skills necessary to make complaints, adding "I feel like, . . . not a lot of people have taught me how to complain, they'd always say, 'Oh I'm gonna complain,' but nobody has taught … the logistics of how to file a complaint." As a university student, he expressed concern about completing teacher assistant (TA) evaluations. He is reluctant to provide negative feedback out of concern that his feedback could negatively impact the TA's future with the university. The other interviewee had not made a complaint to any government agencies in the past three years, but he had recently made a complaint about a restaurant. He approached the business using an online form on its website. He received a response immediately from the business and was satisfied with how his complaint was managed. Although he was displeased with the restaurant when he first lodged his complaint, the business's response and the subsequent compensation he received compelled the interviewee to feel more favourable to the business. He reported, ". . . it certainly removed the negative feeling I was having." After the issue was resolved, he indicated that he would return to the restaurant because he was satisfied with the outcome.

Interview questions — Part III

Case study scenarios and BCCNM complaint process expectations. Both interview participants were introduced to the figure that illustrates the standard complaint process at BCCNM and were presented with two hypothetical scenarios. Neither participant raised concerns about the standard complaint process.

BC College of Nurses and Midwives Case Study

The first scenario (Appendix A) described a nurse disparaging her colleagues and her patient on her personal Facebook account. Prior to being asked their thoughts on the scenario, the interviewees were provided with background information about professional conduct nurses are expected to adhere to:

> *Nurses have ethical and legal responsibilities to protect clients' privacy and the confidentiality of clients' personal and health information. When clients entrust their information to a nurse, they expect and rely on it being kept confidential (BCCNM, 2019, p. 1).*

One of the interview participants was supportive of health care professionals having an outlet to vent about their challenging work experiences or work environments. However, he was concerned the nurse's insensitivity to the patient reflected the nurse's attitude to patients in general and remarked, "if I knew that my nurses had that view on people, I would not want them trying to save my life." The second interviewee also felt the tone of the nurse's Facebook post was inappropriate. The public aspect of the nurse's post coupled with the identifying details were problematic for both interview participants. Both participants expressed concern about the breach of confidentiality, citing the exposure of the patient's identity and their medical condition as key violations to the patient's privacy. The participants felt the post was grounds for making a complaint but neither were sure where to make the complaint. While they both had clear ideas on how they would like to see the complaint resolved, they were uncertain which agency would resolve the complaint. How the matter would be resolved was a greater priority than the authority that dispensed the discipline.

The second scenario (Appendix A) described a nurses' medication error that occurred in an emergency setting. Prior to being asked their thoughts on the scenario, the interviewees were provided with background information about a medication practice standard nurses are expected to adhere to:

> *Nurses may administer, dispense, or compound medications to or for a client by:*
>
> - *Acting with a client-specific order from an authorized health professional ('require an order').*
> - *Acting within their autonomous scope of practice ('do not require an order').*
>
> *Nurse practitioners, registered nurses, and registered psychiatric nurses also have the authority to prescribe certain medications within their autonomous scope of practice under the Nurses (Registered) and Nurse Practitioners Regulation, and the Nurses (Registered Psychiatric) Regulation* (BCCNM, 2020).

Both participants accepted that nurses are as fallible as the rest of the public and errors will occur in health care. One of the participants suggested, "I think it's normal for health care professionals to make mistakes, and if every single nurse was fired for a mistake, I feel like this world would have no nurses." They both agreed upon on the premise that nurses can and will make mistakes in their practice. Both interviewees felt that if a serious error occurs, it is important to determine the root cause of the problem in order to ensure the error does not happen again. In response to this scenario, if the interviewees were to pursue a complaint about the medication error, one of the interviewees would be inclined to submit the complaint directly to the hospital while the other would pursue the complaint with the college. While one of the interviewees would want to seek financial compensation for their pain and suffering, they both

wanted to ensure the error was not repeated and suggested the nurse complete additional training or education. The results from the interviews contributed to one minor amendment to the focus group discussion guide to include an additional example of a media story about a discipline case to further explore with the participants' recall of a nursing regulatory body.

Focus groups

The focus group was held in November 2021. The participants consisted of three female participants comprising a university student in her thirties, a freelance writer in her sixties; and a full-time accounting professional in her fifties. The university student resided in Kamloops while the other two participants lived in Victoria. They were recruited through word-of-mouth. None of the participants had recent interactions with the health care system, specifically with nurses, in the past three years. The focus group was audio-recorded and then transcribed. The data was anonymized to maintain the privacy of the participants and is found in Appendix F. The original plan was to recruit no more than eight participants for the focus group. The one-hour long focus group was conducted via video conferencing using Google Meet. The focus group was broken into two parts: Part I explored awareness, transparency, and trust about health profession regulators. Part II — the BCCNM complaint process and introduction to an alternative resolution process.

Focus group introductory questions — Part I

Awareness of heath profession regulatory bodies. Everyone in the group had heard of the College of Physicians and Surgeons of BC with various degrees of understanding about a professional health regulatory body's purpose and mandate. One individual in the group knew about the BC College of Nurses and Midwives because she had a sibling who was a nurse.

BC College of Nurses and Midwives Case Study

Although no one in the group could specifically recall the name of the nursing college, there was consensus—if not an expectation—that there would be a parallel regulatory body for nurses as there is for physicians. One participant noted, “I guess I assumed there probably would have been one [nursing college] but I don’t really know the name. . . I had heard of the physician one.” When the group was probed about what they thought the regulatory body’s responsibilities were, there were varied understandings amongst the group. One participant suggested that the college registers nurses “so they are licensed to practice and [the college] administers their fees and takes complaints.” While another offered that the college “set the standards for practice and ethics.” There was mixed awareness that health profession regulatory bodies, including BCCNM, provide access to their registries for the public to search for the current registration status of a health professional. One participant remarked, “Oh no, I didn't realize that, no.” While another added, “You can find out about individual nurses and their history and stuff.” The consensus amongst the participants was that it was valuable to know about the college’s registry. One participant said, “I think that's really helpful.”

The group was asked what they thought the college’s role is in resolving complaints about nurses. Each of the participants had general awareness of complaints against nurses through stories that appeared in the media but there was not a strong understanding of the college’s role in resolving these complaints. One participant was not confident complaints were resolved and suggested the stories were not actual formal complaints but instead were individuals “chatting their mouth off to the media.” There was also confusion about which public body was responsible for resolving patients’ complaints. One example cited was an issue that appeared in the media about a patient in Island Health. The participant understood the issue to be

related to the health authority rather than BCCNM because it was "against the whole health system."

As with the interview participants, the focus group was provided with an overview of health profession regulators and a media story about a nurse who had been disciplined for breaching the college's professional and practice standards. The participants all agreed the nurse should have been disciplined for her actions but expressed surprise that the action was not more punitive. No one questioned the college's authority to take these measures. One member of the group expected the financial penalty to be more severe while another member thought the prohibition from practising as a nurse should have been longer than five years or even permanent. Additionally, the group discussed if this nurse were to return to practice, that there should be conditions on her practice. They also looked for assurance that her practice would be supervised to ensure there were no further ethical breaches. As the participants further explored this topic, they expected oversight of the nurse if she returned to practice. The group was presented with an additional example of a resolved complaint involving a nurse who failed to meet documentation and medication standards. The group did not raise concerns about how the complaint was resolved but were curious to understand the nurse's education qualifications. One participant asked, "How did she pass to get her certification to practice?" The interest in this question was shared by the rest of the group. The group was then asked if they were aware they could look up a nurse's registration status on the college's website to see if a nurse held a current licence or if there were any conditions on the nurse's practice. There was mixed awareness of this resource and, while they all agreed there was value in knowing this information was available to them, it was also deemed that it was information that the public "probably need[s] to know when [they] need to know." The group considered how this information could be conveyed

to the public. There was support for the idea to have regulatory college information where care is provided. In addition, a question was raised about the role unions play in resolving complaints. The participants were satisfied to learn that the nurses are often counselled and or represented by their union during the complaint resolution process.

Focus group — Part II

Resolving complaints through the standard complaints process and introduction to an alternative dispute resolution process. Overall, the group was satisfied with the standard complaint process but they had concerns about potential barriers to complaints being made and decision-making bias on the inquiry committees. The group was presented with a chart that described the standard complaint process at BCCNM. The group did not have concerns about the process. One participant observed, "It's pretty straightforward" and this sentiment was shared by the other participants. The group was presented with the outcome of a resolved complaint[6] about a nurse who had used force to restrain resident, which was in contravention of the care facility's policy. The group was asked what they thought about the process. There was concern over the requirement for complaints to be in writing and this requirement could be a barrier for some potential complainants. One participant expressed, "It's not open to everyone because what if you have somebody who can't write?" While another participant also suggested, "It's not common today, but there are people who can't write or there's a language barrier."

The group was interested in the composition on the BCCNM inquiry committee, which evaluates and determines how the complaints should be resolved (BCCNM, 2021). The

[6] Shannon Bay agreed to a consent agreement with BCCNM to remediate practice issues that occurred in September 2019 related to using physical force to restrain a resident contrary to the resident's care plan and the facility policy. She voluntarily agreed to a public reprimand, meeting with a BCCNM Practice Support Consultant, completing two remediation courses, and agreed to not to repeat the conduct.

participants were interested to know if there were a sufficient number of committee members to mitigate the potential for bias that could affect the committee's decision-making. One participant said, "If it's just one person that reviews [the complaint], sometimes you can have biases." The participants were also interested in how the committee members were prepared for the committee work. One participant asked, "Do they have any training? Do they have any ethical training or anything like that?" One of the participants expressed that it was important the public committee members were "professionals" as they would be privy to medical records. Although the group was interested in the composition of the inquiry committee members and their professional backgrounds, when they were asked if they would want to know who the committee members were, none of them wanted to know this information. However, they thought this information could be of interest to complainants.

The next step in the standard complaint process considered by the group was the investigative stage. Each participant expressed the importance that the investigations be conducted by professionals. There was concern that the investigators do not interact directly with the complainant. "I think there's parts of the situation that they might not realize that needs to be asked about first by somebody that's investigating it. And if they don't go back and get those details, the person that's getting the complaint against them. It could be either good or bad . . ." This comment was supported by the other two group members.

For the final step of the complaints process, the group was asked about their thoughts on mailing the complainant a letter about how their complaint was resolved. Each of the participants were supportive of this step and thought it was "important" for the complainant.

The participants were introduced to the alternative dispute resolution (ADR) process that is used in Ontario. One of the participants thought it was similar to the restorative justice

model used in the criminal justice system and observed, "They're starting to go that way and work with healing circles and indigenous justice and stuff like that. It's really interesting." Another participant thought the process was similar to a process used in organizations to resolve conflict with employees. All of the participants thought the process would be beneficial to the complainant. They supported one participant's position the ADR process "was beneficial for the complainant as opposed to just having it resolved away from them and then just hearing at the end what happened." There was also consensus that the ADR process offered the complainant "closure" of the incident. The opportunity for the complainant to be actively involved in resolving the complaint would also give the complainant "reassurance" the incident was resolved. One participant suggested there was value in the complainant having the opportunity to hear the nurse's perspective. The complainant "would see both sides" of the parties involved in the incident.

The group was asked which complaint process would be most suited to resolve the complaint about the misuse of restraints. Each of the participants chose the ADR process. There was consensus about the importance of having face-to-face contact with the nurse. One participant said, "I would want to be comfortable that the nurse was aware of my concerns. And I want to be comfortable that the nurse is okay to go back and keep working with elderly people."

The discussion shifted to the weaknesses of the ADR process. The participants raised the question about complaints being resolved without punitive action and required remediation activities. All of the participants felt the ADR process needed to be reserved for cases when nurses did not need to remediate their practice through learning activities such as education courses. It was also raised in the discussion that there should be the ability to monitor nurses' practice after a complaint was resolved through the ADR process. The suggestion to include an

avenue for potential remediation and monitoring was supported by all the participants. The group expressed limited support for keeping the ADR resolutions confidential. This was a contributing factor to the group's position that only select cases should be permitted to go through the ADR process. One participant felt keeping the outcomes of the resolutions confidential lacked accountability: "…because you sit down and discuss and reflect, but there's no further actions taken, so like, how much accountability is there besides it's a big pain in the butt to sit down and talk with somebody that's complained about you?" This sentiment was supported by the other participants.

Chapter 5: Discussion

General themes

General themes surfaced in this research around awareness of health profession colleges in general and BC College of Nurses and Midwives (BCCNM); the purpose of regulators; expectations of regulatory colleges from individuals; support for the alternative dispute resolution process (ADR) process with caveats related to confidentiality.

The discussion is broken into four sections: a.) observations and outcomes related to the planned study methodology; b.) awareness, trust and transparency; c.) alternative dispute resolution (ADR); and d.) limitations of the study.

Planned methodology outcomes

The research plan entailed conducting two separate one-on-one interviews followed by a focus group. All of these activities were conducted online using Google Meet. Logistically and technically, the interviews and focus group were conducted according to the plan.

Participants

The participants did not have past direct experience with any health professional regulators. The composition of the participants met the intended recruitment plan with the exception that neither of the interview participants had recent experience receiving or observing care from a nurse. Having limited exposure or understanding of health regulators helped ensure the participants' opinions were likely not influenced by knowledge or past experiences with a health profession regulator. In order to give the participants a satisfactory understanding of regulatory colleges, an extensive overview of the purpose and mandate of health regulators and

their processes was provided to both the interviewees and focus group participants (Appendix E). In the case of the focus group, because no one person had extensive knowledge of health profession regulators, the group shared this commonality that helped put everyone on an equal footing. The benefit of this group attribute was that it helped avoid the situation where one participant dominates the conversation and or the other participants defer to the most knowledgeable participants. The downside of this attribute was that participants may have been tentative to fully express their opinions on the questions asked as they may have not been confident of their perspectives and/or opinions because these individuals did not have first-hand experience with a health profession regulator. The emphasis on the discussion focused on the group collective rather than individual opinion.

Videoconferencing

In regards to the focus group, the participants were invited to turn off their video cameras if they thought that would make them more comfortable. However, all the participants chose to keep the video cameras on. The video experience permitted the participants to see one another, which allowed the participants to not only see who was speaking but it also facilitated some nonverbal communications, such as head nods and hand movements. This nonverbal communication would not have been possible if one or more of the participants chose to turn off their camera. However, there was at times a minor delay in the audio that might have made the conversation more cumbersome. In-person focus group might have derived greater engagement amongst the participants. Compared to in-person focus groups, the online data collection may have been somewhat inhibited because the virtual environment may hinder interaction amongst the participants, thus making the data less rich and deep (Carey & Asbury, 2012, p. 20).

Awareness, trust and transparency

BC College of Nurses and Midwives Case Study

None of the interviewees or focus group participants were explicitly aware of BCCNM. It was only when the College of Physicians and Surgeons of BC (CPSBC) was mentioned specifically that the participants could recall or better understood the nursing college. There may be a couple of factors to explain this result. First, CPSBC is the oldest regulatory college in B.C. and its disciplinary cases often garner media attention, thus giving CPSBC greater prominence in the public sphere. Although the participants may not have known this fact per se, CPSBC has been periodically in the media for decades, which may contribute to greater awareness of this organization. Second, most individuals have at some point in their lives have had a regular family physician (BC College of Family Physicians, 2020, p 8). Compared to the physician-patient relationship, most patients' interactions with nurses occur within institutions, such as hospitals or schools where patients/clients or students may receive care from more than one nurse. The nurse-patient relationship is often more situational compared to the longer-term relationship family physicians frequently have with their patients, which may also contribute to patients having a more accurate understanding of a general practitioner's occupation compared to their understanding of a nurse's occupation. The closer doctor-patient relationship may contribute to greater interest in CPSBC in general. Patients may be more engaged when they hear media stories about CPSBC because of their current or previous experience with their own family physician feeling more relevant to themselves. Additionally, patients' previous experiences with family doctors may also give them a perceived better understanding of physicians' profession compared to other types of health practitioners. Examining other health professions that typically have long term relationships, such as dentistry or physiotherapy, could help determine if the practitioner-patient relationship has any bearing on the awareness of the practitioners' respective regulatory body.

BC College of Nurses and Midwives Case Study

Although most of the research participants were not directly aware of BCCNM, the participants quickly understood the nursing college was a regulatory institution parallel to CPSBC. Using CPSBC as a reference point was a useful mechanism to help the participants understand the role and responsibilities of BCCNM. In each research session, the participants were given an overview of the college's mandate and core responsibilities. Their response may be the result of the participants just learning about the college and being unfamiliar with the college rather than evidence that they had confidence or trust in the organization. However, their response is consistent with Statistics Canada's research that found Canadians have confidence their institutions (Statistics Canada, 2015).

Using BCCNM as a case study, it was difficult to assess how transparency influences the public's trust in regulatory bodies. Before individuals can gauge the level of an institution's transparency based on how the institutions conducts its operations, there needs to be awareness of the organization in the first place and a defined understanding of what constitutes as *awareness*. Both the interviewees and the focus group participants in this study where surprised yet approving of the fact that most health profession regulatory bodies, including BCCNM, provide public notices about complaints and offer easy-to-use online databases to look up registrants' registration information. BCCNM, like many health regulators, may be already offering sufficient information about its activities but additional research would need to be undertaken to validate that colleges are achieving the level of transparency that is desired from industry experts, provincial governments, and the public. Complainants would be the most suitable group to explore perceptions of colleges' transparency due to their vested interest in colleges' complaint processes and outcomes. They would also be more aware of the type of information that the public may seek from the college.

BC College of Nurses and Midwives Case Study

In both the interviews and the focus group, most participants expressed some dismay in the penalties nurses received after going through the college's disciplinary process. There was the suggestion the complaint resolutions were lenient. This sentiment was strongest when there was perceived physical harm to the patient. The scenarios presented to the interviewees were uncomplicated and excluded small details or emotions that may accompany actual complaints. This approach facilitated the interviewee to focus on the key elements of the event. In one of the interviews, when the participant was presented with the scenario where he was the patient harmed by a medication error, his response was, "it would depend on how unwell I felt. But I would definitely file a complaint. And I would definitely try to get some sort of compensation, monetary compensation for my pain." He also hoped that the nurse would receive additional training so the error would not be repeated. This latter view was also shared by the other interviewee, who expected after such an incident that there would be an investigation and action would be taken to ensure "there should be checks and balances so those kinds of things don't happen."

When the focus group was presented with the Tinkham case—where the nurse crossed nurse-client boundaries—all of the participants were surprised with the resolution, which they expected to be more severe. The nurse was fined $17,500 and prohibited from practising for five years. One participant said, "I just think that there should have been some sort of compensation to the victims as well." While another participant shared, "Five years with no licence, like that's it." In both the interview scenario and the focus group discipline case, the participants supported the notion of taking measures to ensure the reprimanded nurses does not repeat their transgression or errors, which aligns with the right-touch principle of proportionate (Professional Standards Authority, 2015, p. 3). Additionally, the participants' expectation aligns with

regulatory bodies' mandate to protect the public (BC Government, 2021). However, neither the principles of right-touch regulation nor the college mandate to protect the public include principles or provisions to compensate or reconcile with the complainants. The research suggests there is a possible incongruency between the public's expectation on how complaints may be resolved and the regulatory bodies' authority to resolve complaints, which is confined to putting limits and conditions or cancellation of a practitioner's licence and/or levying fines to recover or partially recover costs incurred to discipline the practitioner (BCCNM, 2022, p.192, 195). It is outside the college's authority to order registrants to compensate complainants. Right-touch regulation focuses on the problem and resolves complaints in a manner that is appropriate to the risk posed. This gap between public expectation and a regulator's authority is likely not easily reconciled. While the principles of right-touch regulation have been adopted by many health profession regulators, including BCCNM, the public is likely unaware of this regulatory philosophy that guides how colleges resolve complaints. There may be little value in elevating the general public's understanding and awareness of regulators' mandates and authorities. One focus group participant questioned the value in the public being aware of regulatory colleges and stated, "[You] probably need to know when you need to know." This assessment is insightful. The one group of the public that would benefit most from understanding a college's mandate and authority are complainants. Focusing efforts on increasing complainants understanding of a college's mandate and the limits of its authority would help manage complainants' expectations of the complaint process and the final complaint resolution.

Alternative dispute resolution (ADR)

The focus group was mostly supportive of the alternative dispute resolution to resolve complaints. The group observed that the ADR process resembled the restorative justice model

used in the criminal justice system, and they saw parallels to similar work using healing circles and Indigenous justice. The key benefit all of the focus group members identified was that it gave the complainant a direct role in resolving their own complaint. In that regard, the ADR process empowers the complainant to move beyond being a passive participant in the complaint resolution process. This familiarity and receptiveness to alternative processes suggests there may be support amongst the public for ADR. However, the one barrier to ADR amongst the focus group participants is the confidentiality aspect to the resolutions. The proposed ADR presented to the focus group participants, and the one that is practised at the College of Nurses of Ontario (CNO), would not publish ADR complaint resolutions, nor would these complaints be reported on registrants' public record. This approach could be perceived by the public as furtive and a contradiction to the right-touch regulation tenet of ensuring transparency in college activities. A key incentive for registrants who have complaints against them to participate in the ADR process is that the complaint resolution is confidential. This incentive is in direct conflict of the college's obligation to ensure its complaint resolutions are transparent and available to the public. As previous research has shown, such as the 2016 CNO study, public complainants are more satisfied the ADR process than the regular complaint process. It may be necessary to address the potential transparency issue with the ADR process, which is likely a key factor to its success at the College of Nurses of Ontario. The confidentiality provision that permits ADR complaint resolutions to remain confidential could be barrier to being adopted by the college. Finding a solution to satisfy the college's obligation to conduct its work transparently and protect the public while maintaining confidentiality about public complaints may be challenging. Public notices about complaint resolutions are an important measure the college takes to protect the public. Additionally, ADR complaint resolutions would not appear in nurses' public records thus

this information would not be available from the college's website, which employers and the public use to check the registration status of a nurse and view any discipline notices.

Limitations of the study

Conducting this qualitative research during the COVID-19 pandemic posed some challenges in recruiting participants. Both the interview and focus group research activities may have benefited from additional participants. Although there were no significant issues with conducting these activities via Google Meet, face-to-face research may also have been more conducive to creating a more comfortable environment for the participants, which in turn may affected conversation and produced different data.

Additionally, after evaluating the data, the study would have benefited from including questions about right-touch regulation and exploring the participants' perceptions of what nurses do in their practice. Right-touch regulation reflects the priorities and values that guide how the college fulfills its mandate. These two areas would have provided a stronger understanding of these topics, which are important to getting a fuller understanding of the public's view of BCCNM and the nursing professionals are registrants of these colleges.

Conclusion

The study aimed to gather insight into two questions:

Q. 1. What is the public's awareness of health regulators, including the BC College of Nurses and Midwives?

Q. 2. What is the public's view on how complaints against nurses are presently resolved in B.C. and their views on an alternative dispute resolution process?

For the first question, overall, there was not a high degree of awareness of health regulators amongst the participants. With the exception of some recall of the BC College of Physicians and Surgeons, the participants were unfamiliar with the regulatory bodies. However, there appeared to be an expectation that these organizations should exist but, as one participant noted, they are not something the public needs to know about until they have a need to know about them. This notion is problematic without knowing if patients/clients have the support or skills to discover BCCNM or any other health regulatory body when they want to raise concerns about the care they received. It may not be sufficient to leave it to individuals to learn about health regulators on their own. Additional research could explore the steps individuals take to go from being fully unaware of the college to understanding its role in regulating health professions and making a complaint. Former public complainants would be a suitable group to study.

The second question explored the participants perceptions of the current complaints process and a proposed alternative dispute resolution process. The participants expressed general satisfaction with the standard complaints process, but they were not fully satisfied with the outcome of the resolution examples that they were presented with. They expressed concern the resolutions were somewhat lenient. At the same time, there was also recognition that it was

difficult to fully judge the outcomes because the published agreements did not reveal details that may have provided important contexts for the resolutions. While the participants expressed support for resolving complaints to improve nurses' practice to ensure safe patient care, there was also some expectation for nurses to receive penalties for failing to meet their professional standards, particularly when they failed to meet ethical standards. The other part of the research question explored the participants' perspective of an alternative dispute resolution process offered by the College of Nurses of Ontario. This process was well-received by the participants. ADR was viewed as empowering the complainant, which suggests the participants may have perceive the standard complaints process as a passive process that may not fully satisfy the complainants' needs. The participants expressed favour of the ADR process over the standard complaints process with one important caveat. The confidentiality of the ADR resolutions was a significant detractor for the participants. Additional research could explore how the public would respond to a hybrid ADR process that was more transparent while applying many of the positive attributes of ADR or restorative justice processes. There may be benefit to also conduct this research with another health regulatory body in British Columbia to compare if individual's perceptions on colleges and their complaints process share similarities or differences based on the health profession.

This research set out to study the public's awareness of health regulators and BCCNM. It also explored their views on the standard complaints process and an alternative dispute resolution process currently offered by the College of Nurses of Ontario. Although the participants were not act specifically about their opinions on right-touch regulation, their opinions on how complaints were resolved contributed to a greater understanding on this philosophy that has been adopted by BCCNM and many other regulatory bodies. Further

investigation into the public's perspective on right-touch regulation would be useful to developing information about the complaints process intended for public complainants.

The findings from this research provide insights that could be used to inform changes or additions to the public-focused content on the BCCNM website. Efforts could be taken to increase the public's awareness of regulatory colleges, including BCCNM, of their regulatory mandate, authority, and philosophy. Advertising and marketing campaigns could be obvious options to raise awareness. However, other initiatives—such as editorials, letters to the editor, and social media campaigns—could also help narrow the chasm between the public's awareness and understanding of regulatory bodies. Additionally, offering information in a variety of formats, such as infographics and videos, and languages to support the public, and potentially complainants, understand the complaint process.

Introducing an alternative dispute resolution option for resolving complaints would require satisfactory complaint resolution reporting mechanism that both satisfies the college's obligation to be transparent while facilitating a complaint process that incentivizes or encourages registrants to work with complainants to resolve complaints. Research into understanding how complainants experience the complaint process could assist in evaluating the need for an ADR option. However, even if future research found evidence that public complainants experience disappointment or unmet expectations going through the existing complaint process, addressing such issues by offering ADR would have to be weighed against the college's obligation to transparently conducting its regulatory.

This study looked primarily at the public's awareness of BCCNM and other regulatory colleges and, secondarily, at its perspectives on the complaints process. There would be value understanding how complaints are resolved at other regulatory colleges under the same Health

Professions Act. Such a study could shed light on any colleges that are able to both meet their primary responsibility to protecting the public and being transparent while striving to meet complainants' needs for validation and reconciliation. Further understanding of this topic could focus on complainants' and nurses' experience going through the complaint process and explore if epistemic injustice plays a role in the complaint process. This research could reveal issues complainants may encounter during the complaint process. Most importantly, such insights could be used to guide changes to improve the process.

References

Adams, T. L. (2020). Health professional regulation in historical context: Canada, the USA and the UK (19th century to present). *Human Resources for Health, 18*(72). Retrieved from https://doi.org/10.1186/s12960-020-00501-y

Adams, T. L., & Wannamaker, K. (2022). Professional regulation, profession-state relations and the pandemic response: Australia, Canada, and the UK compared. *Social Science & Medicine, 296,* N.PAG. https://doi-org.login.ezproxy.library.ualberta.ca/10.1016/j.socscimed.2022.114808

Askitopoulou, H., & Vgontzas, A. N. (2018). The relevance of the Hippocratic Oath to the ethical and moral values of contemporary medicine. Part I: The Hippocratic Oath from antiquity to modern times. *European Spine Journal, 27*(7), 1481–1490. https://doi-org.login.ezproxy.library.ualberta.ca/10.1007/s00586-017-5348-4

Australian Health Practitioner Regulation Agency. (2020a). Who we are. Retrieved from https://www.ahpra.gov.au/About-Ahpra/Who-We-Are.aspx

Australian Health Practitioner Regulation Agency. (2020b) How we manage concerns. Retrieved from https://www.ahpra.gov.au/Notifications/How-we-manage-concerns.aspx

Australian Health Practitioner Regulation Agency. (2015). Regulatory principles for the national scheme. Retrieved from https://www.ahpra.gov.au/About-AHPRA/Regulatory-principles.aspx

Bamberger, Michael, Rugh, Jim & Mabry Linda. (2012). *RealWorld evaluation: working under budget, time, data, and political constraints* (2nd ed.). SAGE Publications.

BC College of Nurses and Midwives. (2021). BCCNM 2020 Annual Report: We're all in this together. Retrieved from https://www.bccnm.ca/Documents/governance/annual_reports/BCCNM_2020_Annual_Report.pdf

BC College of Nurses and Midwives Case Study

BC College of Nurses and Midwives. (2022) Bylaws of the British Columbia College of Nurses and Midwives. Retrieved from https://www.bccnm.ca/Documents/regulation/bylaws_2020/BCCNM_bylaws_consol_4.pdf

BC College of Nurses and Midwives. (2017). Notice: Laurie Tinkham, discipline order. Retrieved from: https://www.bccnm.ca/Public/complaints/Pages/Notice.aspx?NoticeID=194

BC College of Nurses and Midwives. (2020). Notice: Shannon Bay, consent agreement. Retrieved from: https://www.bccnm.ca/Public/complaints/Pages/Notice.aspx?NoticeID=655

BC College of Nurses and Midwives. (2020) Practice Standard for BCCNM Nurses: Medication. Retrieved from: https://www.bccnm.ca/RN/PracticeStandards/Lists/GeneralResources/RN_PS_Medication.pdf

BC College of Nurses and Midwives. (2019). Practice Standard for BCCNM Nurses: Privacy and Confidentiality. Retrieved from https://www.bccnm.ca/RN/PracticeStandards/Lists/GeneralResources/RN_PS_PrivacyConfidentiality.pdf

BC College of Nurses and Midwives. (2021). Notice: Kimberly Redlack, consent agreement. Retrieved from: https://www.bccnm.ca/Public/complaints/Pages/Notice.aspx?NoticeID=744

BC College of Nursing Professionals. (2021). How BCCNM resolves a complaint. Retrieved from https://www.bccnm.ca/Documents/complaints/ChartHowtoResolveComplaint.pdf

BC College of Family Physicians. (2020) Family Doctors Care: The Role and Value of Family Physicians in British Columbia. Retrieved from https://bccfp.bc.ca/wp-content/uploads/2020/02/Position-Paper.pdf

BC Government. (2018). Board appointments help dental college put public first. Retrieved from https://news.gov.bc.ca/releases/2018HLTH0016-000357

BC Government. (2019). Steering Committee Modernizing the provincial health profession regulatory framework: A paper for consultation. (2019). Modernizing the provincial health profession regulatory framework: A paper for consultation. Victoria: BC Government. Retrieved from https://engage.gov.bc.ca/app/uploads/sites/578/2019/11/Modernizing-health-profession-regulatory-framework-Consultation-Paper.pdf

BC Government. (2022). About B.C.'s Health Care System. Retrieved from https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system

BC Government. (2021). Professional regulation. Retrieved from https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/professional-regulation

Biggar, S., Lobigs, L. M., & Fletcher, M. (2020). How can we make health regulation more humane? A quality improvement approach to understanding complainant and practitioner experiences. *Journal of Medical Regulation, 106*(1), 7-15. doi:10.30770/2572-1852-106.1.7

Bolg, J. R., Dwyer, P. A. , Doherty, D. P. , Pignataro, S. J. & Renaud, A. M. (2020). The Impact of Critical Reflective Inquiry Education on Experienced Nurses' Insights Into Practice. Journal for Nurses in Professional Development, 36(2), 68–73. doi: 10.1097/NND.0000000000000606.

Bouwman, R., Bomhoff, M., Robben, P., & Friele, R. (2016). Patients' perspectives on the role of their complaints in the regulatory process. *Health Expectations, 19*(2), 483-496. doi:10.1111/hex.12373

Carel, H., & Ian, J. K. (2017). Epistemic injustice in medicine and healthcare. *The Routledge Handbook of Epistemic Injustice* (pp. 336-346) Routledge. doi:10.4324/9781315212043.ch32 Retrieved from https://www.routledgehandbooks.com/doi/10.4324/9781315212043.ch32

Carel, H., & Kidd, I. J. (2014). Epistemic injustice in healthcare: A philosophical analysis. *Medicine, Health Care & Philosophy, 17*(4), 529-540. doi:10.1007/s11019-014-9560-2

Carey, Martha Ann & Asbury, Jo-Ellen. (2012) Focus Group Research. Left Coast Press.

Cayton, H. (2018). *An inquiry into the performance of the College of Dental Surgeons of British Columbia and the Health Professions Act*. Retrieved from https://www.professionalstandards.org.uk/docs/default-source/publications/inquiry-into-the-performance-of-the-college-of-dental-surgeons-of-british-columbia.pdf

Cayton, H. (2019). A review of complaints processes and outcomes conducted for the College and Association of Registered Nurses of Alberta. Retrieved from https://www.nurses.ab.ca/docs/default-source/latestnews/cayton-report.pdf?sfvrsn=2df588fc_6

Cayton, Harry, Webb, Kate. (2014). The benefits of a "right-touch" approach to health care regulation. *Journal of Health Services Research & Policy, 19*(4), 198–199.

College of Nurses of Ontario. (2018). Addressing complaints process guide. Retrieved from http://www.cno.org/globalassets/docs/ih/42017_resolvingcomplaints.pdf

College of Nurses of Ontario. (2016). Privacy and Confidentiality: Case Studies. Retrieved from https://www.cno.org/globalassets/4-learnaboutstandardsandguidelines/prac/learn/webcasts/privacy-and-confidentiality-casestudies.pdf

Contenta, S. (2017, June 12,). Nurses college under fire over Wettlaufer case. The Star Retrieved from https://www.thestar.com/news/canada/2017/06/12/nurses-college-under-fire-over-wettlaufer-case.html

CRNBC. (2012). Annual report 2011-12: Reflecting on our past, envisioning our future. CRNBC. Retrieved from https://www.bccnp.ca/bccnp/Documents/Legacy_annual_reports/CRNBC/2011_2012_annual_report_CRNBC.pdf

Denscombe, Martyn. (2011). The good research guide: For small-scale social research projects (4th ed.). Open University Press.

Donald, A. (2004). Alternative dispute resolution: Managing upsets and keeping people safe. *Evidence-Based Healthcare & Public Health, 8*(6), 412-413. Retrieved from https://doi.org/10.1016/j.ehbc.2004.09.038

Duckett, S. & Kempton, A. (2012). Canadians' views about health system performance. . *Healthcare Policy/Politiques De Sante, 7*(3), 85–101. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3298024/

Durcan, R. (2019). The Cayton Report: The wolf finally arrives. *Grey Areas,* (No. 236) Retrieved from https://www.sml-law.com/wp-content/uploads/2019/05/Greyar236.pdf

Ferris, L. E. (2004). Alternative dispute resolution and disputes concerning physicians' practices or services. *Medicine and Law, 23(1),* 147-148.

Fricker, M. (2007). Epistemic injustice. Oxford: Oxford University Press. Retrieved from http://dx.doi.org/10.1093/acprof:oso/9780198237907.001.0001

Global trust in professions:Who do global citizens trust? (2019). Retrieved from https://www.ipsos.com/sites/default/files/ct/news/documents/2019-09/global-trust-in-professions-trust-worthiness-index-2019.pdf

Goodwin, D. (2018). Cultures of caring: Healthcare 'scandals', inquiries, and the remaking of accountabilities. Soc Stud Sci, 48(1), 101-124. doi:10.1177/0306312717751051

Government of British Columbia. (2022). *Health Professions Act: Chapter 183*. Retrieved from https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96183_01

Grimmelikhuijsen, S., Herkes, F., Leistikow, I., Verkroost, J., de Vries, F., & Zijlstra, W. G. (2019). Can decision transparency increase citizen trust in regulatory agencies? Evidence from a representative survey experiment. *Regulation & Governance, 0*(0) doi:10.1111/rego.12278

Gunther, S. V. (2015). Alternatives to adversarial processes in the regulation of professional ethics. *Psychotherapy & Politics International, 13*(3), 217-232. doi:10.1002/ppi.1365

Hamilton-Jones, Michael. (2016). The Complaints Process in Ontario: Analyzing the Experiences of Nurses and Complainants. *Journal of Nursing Regulation, 7(2),* 21-26. doi:10.1016/S2155-8256(16)31074-2

HCPC. (2018). Professions and protected titles. Retrieved from https://www.hcpc-uk.org/about-us/who-we-regulate/the-professions/

Healy, J. (2011). Improving Health Care Safety and Quality. London: Routledge, https://doi.org/10.4324/9781315588049

Hutton, M., & Cappellini, B. (2022). Epistemic in/justice: Towards 'Other' ways of knowing. *Marketing Theory*. https://doi.org/10.1177/14705931221076563

Ipsos. (2021). Global Health Service Monitor: A Global Advisor Survey 2021. Retrieved from https://www.ipsos.com/en-ca/news-polls/healthcare-systems-global-access

Ipsos. (2012). Life-savers, medical professionals top the list of most trusted professionals. Retrieved from https://www.ipsos.com/en-ca/news-polls/life-savers-medical-professionals-top-list-most-trusted-professionals

Ipsos MORI. (2010). Expectations of the fitness to practise complaints process: Research for the health professions council: Final report. HCPC. Retrieved from https://www.hcpc-uk.org/globalassets/resources/reports/expectations-of-the-fitness-to-practise-complaints-process.pdf

Ipso MORI. (2011). Mediation research. Health Professions Council. Retrieved from www.hcpc-uk.org/globalassets/resources/reports/mediation-research.pdf

Ipsos MORI. (2019). Veracity Index 2019: Trust in professions survey. Retrieved from https://www.ipsos.com/sites/default/files/ct/news/documents/2019-11/trust-in-professions-veracity-index-2019-slides.pdf

Kettl, D. F. (2018). Earning trust in government. *Journal of Public Affairs Education, 24*(3), 295-299. doi:10.1080/15236803.2018.1426923

Kidd I. J., Medina J. and Pohlhaus G. (2017) *The Routledge handbook of epistemic injustice* (2017). Milton: Routledge. Retrieved from http://ebookcentral.proquest.com/lib/ualberta/detail.action?docID=4834237

Kushner, H. (2015). *What is the public interest demand for openness and transparency?* Vancouver: Kushner Law Group. Retrieved from https://www.clearhq.org/Resources/Documents/CLEAR%20-%20Presentation%20-%20Kushner%20Paper.pdf

Leslie, K., Moore, J., Robertson, C. *et al.* Regulating health professional scopes of practice: comparing institutional arrangements and approaches in the US, Canada, Australia and the UK. *Human Resources for Health* 19, 15 (2021). https://doi.org/10.1186/s12960-020-00550-3

McDougal, Brenda, Bitz, Karla, Derouen, Sue, Nagel, Judith, Thomas, Katherine, et al. (2011). The 2011 Uniform Licensure Requirements for Adoption. *Journal of Nursing Regulation, 2*(3), 19-22. https://doi.org/10.1016/S2155-8256(15)30272-6

Merrigan, G., Johnston, R. T., & Huston, C. L. (2012). *Communication research methods* (Canadian ed.). Oxford University Press.

Ministry of Health Manatū Hauora. (2014). Professional and regulatory bodies. Retrieved from https://www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/professional-and-regulatory-bodies

Moore, Tom, McKee, Kim, & McLoughlin, Pauline. (2015). *Online focus groups and qualitative research in the social sciences: their merits and limitations in a study of housing and youth.* People, Place and Policy Online, 9(1), 17–28. https://doi-org.login.ezproxy.library.ualberta.ca/10.3351/ppp.0009.0001.0002

Morrone, A., Tontoranelli, N., & Ranuzzi, G. (2009). How good is trust?: Measuring trust and its role for the progress of societies. *OECD Statistics Working Papers, No. 2009*(03) Retrieved from https://doi.org/10.1787/220633873086

Narrative Trust. (2021). Canadians place the highest level of trust and confidence in healthcare professionals, including doctors and nurses, followed by a high degree of trust in school teachers and police services. Confidence and trust are significantly lower for provincial governments and federal politicians. Retrieved from https://narrativeresearch.ca/canadians-place-the-highest-level-of-trust-and-confidence-in-healthcare-professionals-including-doctors-and-nurses-followed-by-a-high-degree-of-trust-in-school-teachers-and-police-services-confiden/

O'Donovan, O., & Madden, D. (2018). Why do medical professional regulators dismiss most complaints from members of the public? Regulatory illiteracy, epistemic injustice, and symbolic power. *Journal of Bioethical Inquiry, 15*(3), 469-478. doi:10.1007/s11673-018-9869-2

OECD. (2017). Trust in government. Retrieved from https://www.oecd.org/governance/trust-in-government.htm

Porumbescu, G. (2017). Linking transparency to trust in government and voice. *The American Review of Public Administration, 47*(5), 520-537. doi:10.1177/0275074015607301

Professions Standards Authority. (2020b.) International reports. Retrieved from https://www.professionalstandards.org.uk/publications/international-reports

Professions Standards Authority. (2016). *A review conducted for the College of Registered Nurses of British Columbia.* Professional Standards Authority. Retrieved from https://www.professionalstandards.org.uk/docs/default-source/publications/special-review-report/a-review-conducted-for-the-college-of-registered-nurses-of-british-columbia-(april-2015).pdf

Professional Standards Authority. (2019). *A review conducted for the Saskatchewan Registered Nurses Association.* Professional Standards Authority. Retrieved from https://www.professionalstandards.org.uk/docs/default-source/publications/international-reports/a-review-conducted-for-the-saskatchewan-registered-nurses-association-(may-2019).pdf

Professions Standards Authority. (2020a). How we work. Retrieved from https://www.professionalstandards.org.uk/about-us/how-we-work

Professions Standard Authority. (2013). Public Response to Alternatives to Final Panel Hearings in Fitness to Practice Complaints: Research Report. Retrieved from: https://www.professionalstandards.org.uk/docs/default-source/publications/research-paper/public-response-to-alternatives-to-final-panel-hearings-2013.pdf?sfvrsn=6

Professional Standards Authority. (2018). Right-touch regulation in practice international perspectives. Retrieved from https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-regulation-in-practice---international-perspectives.pdf?sfvrsn=a5b97520_4

Professional Standards Authority. (2015). Right-touch revised. Retrieved from https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-regulation-in-practice---international-perspectives.pdf?sfvrsn=a5b97520_4

Roelofs, P. (2019). Transparency and mistrust: Who or what should be made transparent? *Governance, 32*(3), 565-580. doi:10.1111/gove.12402

Russell, K. (2016). Due Process and Right-Touch Regulation Strengthen Regulatory Decision Making. Journal of Nursing Regulation, 7(2), 39–42. https://doi-org.login.ezproxy.library.ualberta.ca/10.1016/S2155-8256(16)31077-8

Saad, L. (2020). U.S. ethics ratings rise for medical workers and teachers. Retrieved from https://news.gallup.com/poll/328136/ethics-ratings-rise-medical-workers-teachers.aspx

Sansom, C. M. (2017). Creating a complaint resolution analysis for professional accountability and public protection. *Journal of Nursing Regulation, 8*(1), 38-45. doi:10.1016/S2155-8256(17)30073-X

Statistics Canada. (2013). General Social Survey: An Overview, 2013. Retrieved from https://www150.statcan.gc.ca/n1/en/pub/89f0115x/89f0115x2013001-eng.pdf?st=an3UNhlB

Statistics Canada. (2015). Public confidence in Canadian institutions. Retrieved from https://www150.statcan.gc.ca/n1/en/pub/89-652-x/89-652-x2015007-eng.pdf?st=ZYx0lZXo

Statistics Canada. (2020). Table 43-10-0062-01 Confidence in Canadian institutions, by groups designated as visible minorities and selected sociodemographic characteristics, 2020. Retrieved from https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=4310006201

Stievano, A., Caruso, R., Pittella, F., Shaffer, F. A., Rocco, G., & Fairman, J. (2019). Shaping nursing profession regulation through history – a systematic review. *International Nursing Review, 66*(1), 17-29. doi:10.1111/inr.12449

The Mid Staffordshire NHS Foundation Trust Public Inquiry. (2013). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf

Tracy, S. J. (2013). *Qualitative research methods. [electronic resource]: Collecting evidence, crafting analysis, communicating impact.* Wiley-Blackwell.

Veale, J. A. (2014). Systemic Government and the Civil Servant. *FORMakademisk*, 7(3), 1–25. https://doi-org.login.ezproxy.library.ualberta.ca/10.7577/formakademisk.792

Violato, C. (2016). A brief history of the regulation of medical practice: Hammurabi to the national board of medical examiners. *Journal of Science & Medicine,* Retrieved from http://www.imerg.org/wp-content/uploads/2016/08/Violato-2016-History-of-medical-practice.pdf

Wenghofer EF, Kam SM. (2017). Evolving professional regulation: Keeping up with health system evolution. *Healthcare Papers*. 16(4):30-35. doi:10.12927/hcpap.2017.25204

Appendix A

Interview scenarios

Scenario I

Your cousin is a well-known local fiction writer in your town. She was recently rushed to the ABC Hospital for reasons unknown to you.

A friend shares a Facebook post made by a nurse and asks you if the patient—referred to in the post—is your cousin.

The nurse posted the following on her social media page the same day your cousin was rushed to the hospital:

“Can this shift be any longer? It started out with a waiting room full of nagging people that don’t seem to know what “emergency” means. Then I had to deal with the drama of trying to transfer a minor “celebrity” (400 lbs!) with COPD down the hall to the ICU, those ICU nurses are such divas and I wasn’t in the mood for their whining. Anyone around ABC Hospital want to save me with a drink to get me through the next 10 hours of my shift.”

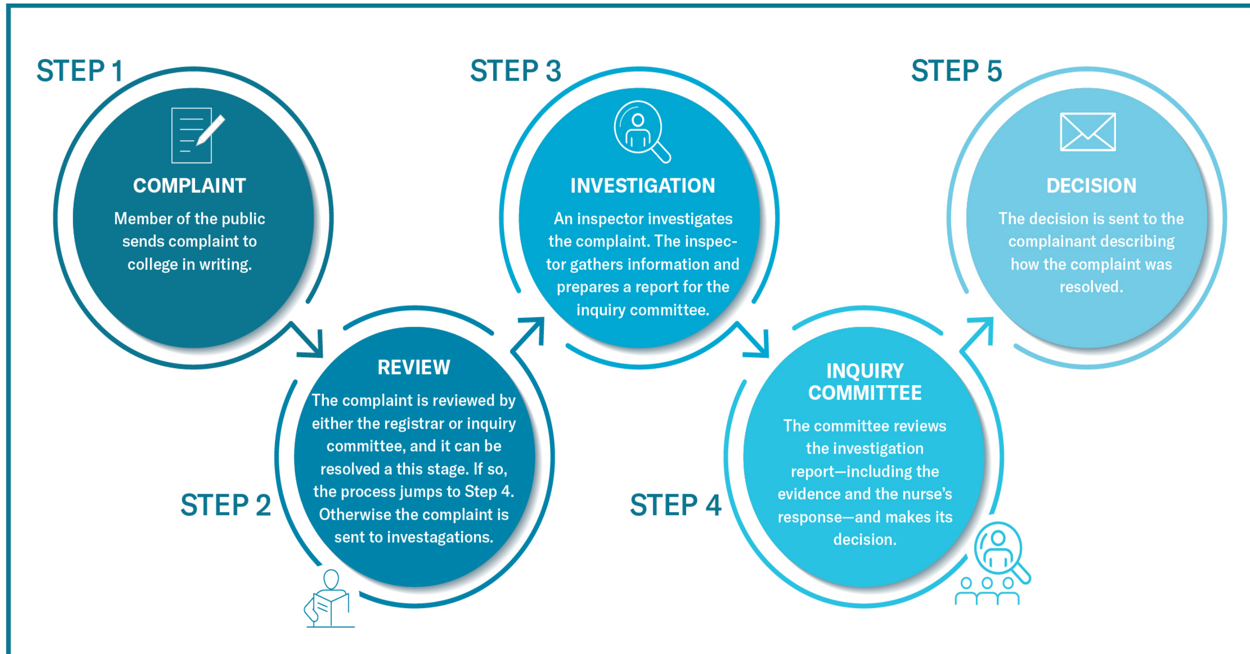
You suspect the patient the nurse is referring to could be your cousin.

Scenario II

You are rushed to your local emergency room with signs of a serious allergic reaction (anaphylaxis). A nurse administers medication to help alleviate your symptoms and tells you that you should start to feel better shortly. Immediately, you feel severe, crushing pain flow through your body that causes you to pass out. Two weeks later, you are still experiencing some chest pain, palpitations, and exhaustion. When you follow up with your family doctor, your doctor tells you that—based on your hospital report—she suspects the drug was administered incorrectly. It appears it may have been injected into vein instead of your muscle. This error can cause mild but reversible damage to the heart.

Appendix B

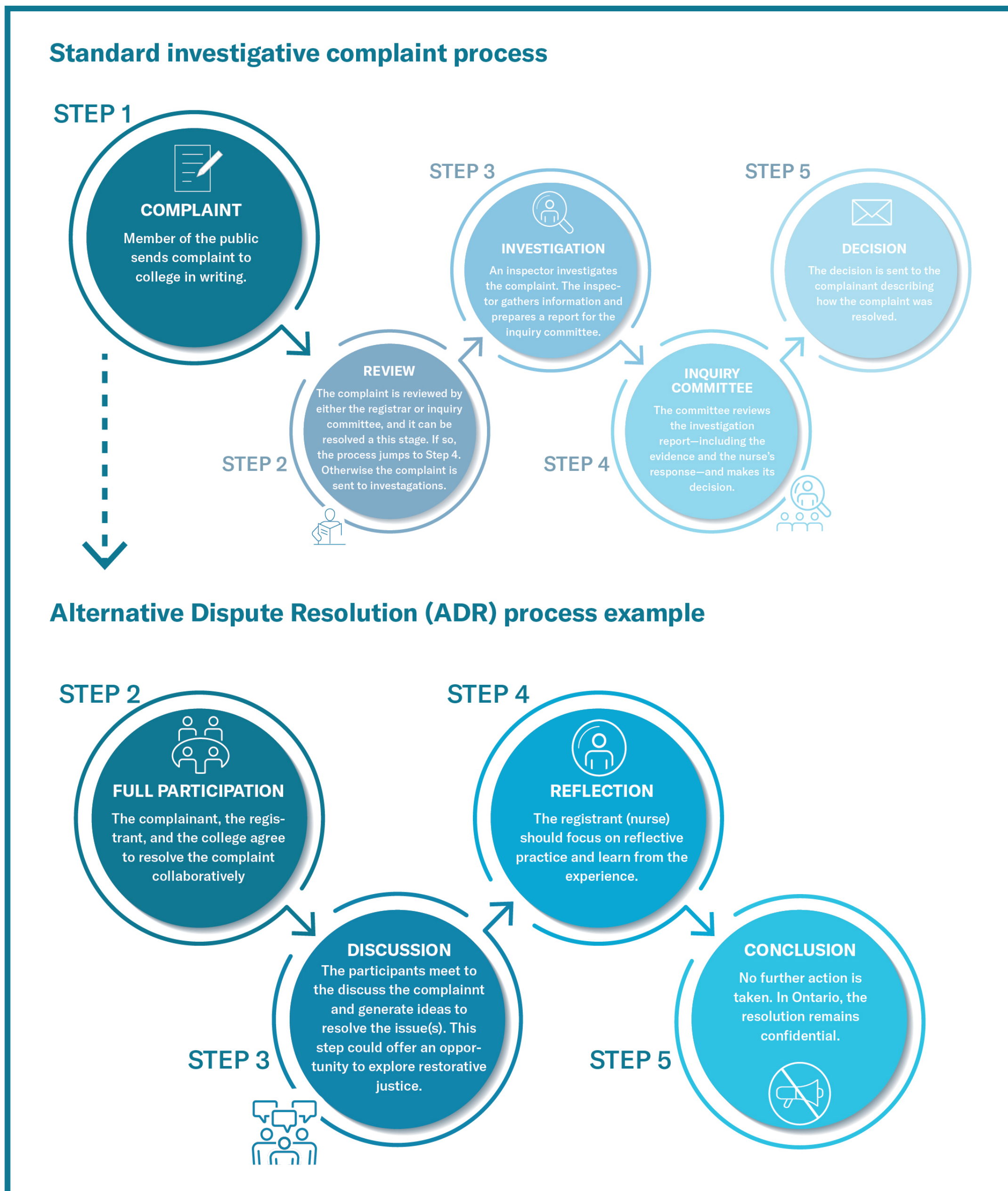
Figure 1
Standard complaint process



This investigative complaint process is used by Canadian health regulators and in many other countries (BCCNM, 2021; Sansom, 2017; Ahpra, 2020b) Most complaints are resolved in the investigative process with either no further action or a consent agreement where the registrant agrees to specified terms.

During an investigation, an inquiry committee may impose interim limits or conditions on, or suspend, a registrant's licence to practice when it appears necessary for public protection even though allegations remain unproven (BCCNM, 2020).

Figure 2
Alternative Dispute Resolution Process



Serious complaints are ineligible for ADR. For example, allegations of abuse must be investigated according to governing legislation. Also, the investigation process is used if the registrant or the complainant does not want to participate the ADR process.

Appendix C

Participant recruitment poster

The Public's Perspective of a Health Regulator's Complaint Process and an Alternative Dispute Resolution Option

The purpose of the study is to document public awareness and opinion on the standard regulator complaint process used by B.C.'s nursing regulatory college. This study will also explore the public's thoughts an alternative dispute resolution process to resolve complaints. This research will contribute to subsequent research and projects in this topic.

Recruiting

One-on-one interviews

Two people:

- One person who has received care from a nurse or observed the care of a family member from a nurse in the past two years.
- One person who hasn't received care from a nurse or observed care of a family member from a nurse in the past two years.

Focus group

Six to eight people

All participants must be 18+ years.

Dates

Interviews: July 26–30, time to be determined

Focus group: Aug. 9, 1 p.m. – 2 p.m.

Contact
Elizabeth Bruce
ebruce@ualberta.ca
604.999.8947

UNIVERSITY OF ALBERTA
FACULTY OF EXTENSION
COMMUNICATIONS & TECHNOLOGY

Appendix D
Consent forms

Focus group consent form

INFORMATION LETTER and CONSENT FORM — Human Study – Pro00113221

Study Title: The Public's Perspective of a Health Regulator's Complaint Process and an Alternative Dispute Resolution

Principle Investigator
Elizabeth Bruce
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604-999-8947

Supervisor
Dr. Stanley Varnhagen
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Background
I am working on my capstone project that is a final component of my Masters of Arts in Communication and Technology (MACT) graduate program at the University of Alberta. My research study is on the public's awareness of health regulatory bodies and their role in B.C. My research is independent of any of health regulatory body. This study will also gather feedback on how regulatory bodies handle complaints from the public. All of the health regulators in B.C. share the same mandate and obligations. For my project, I will just be looking at only one regulatory body but the findings from this research may also be applicable the other health regulators in B.C. This is not a funded project.

I am recruiting participants for one focus group with 6-8 focus group participants

Purpose
The purpose of the study is to document public awareness and opinion on the standard regulator complaint process used by B.C.'s nursing regulatory college. I am also exploring the public's thoughts how complaints are resolved. It is hope that this research will contribute to subsequent research and projects in this topic.

Study Procedures
If you agree to participate, you will be asked to complete a short online survey that will take about 2-3 minutes to complete. During the focus group, I will ask you and the other participants to share your thoughts on this topic. You will be asked to provide comments and opinions and

discuss your thoughts about health regulation and the complaints process. The focus group will take between 45 – 60 minutes. The focus group will be conducted via Google Meet, an online video-conferencing application. You may leave the focus group at any time, which you can do by telling the group know that you need to leave. No explanation is required.

The focus group will be conducted via video conferencing and it will be audio recorded. The video will not be recorded. You have the option to turn off your video camera. A written transcript will be made from the audio recording and then the original recording will be kept for a minimum of five years. You can ask to review the transcripts.

Benefits
While there are no costs involved in participation, there will be no direct benefits participating in this study. I hope that the information we get from doing this study will help inform my understanding of the public's perspective of the complaints process. If you would like to receive a copy of my final report and/or any other publications associated with this project, please provide your preferred contact information at the end of this form.

Risks
I do not anticipate any risks associated with your participation in this study.

Measures to maintain confidentiality
I will record and transcribe the focus group. The transcripts, any notes, and the responses to the pre-focus group survey will be kept secure and stored on a password-protected computer. Only myself and Dr. Stanley Varnhagen will have access to these records. Data that includes your personal identifiers will be destroyed as soon as it is no longer needed. All other data—electronic and paper documents related to this project and the original recording of the focus group—will be destroyed five years after this project is completed. Your identity will be anonymized in the transcript and in the subsequent report. It is the joint responsibility of the researcher and participants to maintain anonymity and confidentiality of the focus group. Participants in the focus group are asked to refrain from discussing about the focus group outside the group but neither anonymity nor confidentiality can be guaranteed.

Voluntary Participation
Your participation is voluntary. You have the right to refuse to participate in this study. If you decide to participate, you may decline to answer any questions that you do not wish to answer. Your data will not be linked to your identity. Due to the interrelated nature of the discussion, it will not be possible to withdraw your data from the focus group transcripts. There would be problems interpreting the results if some of the conversation was missing. You can receive a copy of the final report by choosing this option below.

Further Information
The plan for this study has been reviewed for its adherence to ethical guidelines by a Research Ethics Board at the University of Alberta. For questions regarding Participant rights and ethical conduct of research, contact the Research Ethics Office at (780) 492-2615 or email reoffice@ualberta.ca

YES	NO	
◯	◯	I support the use of my information in the course final research paper resulting from this interview.
◯	◯	I would like to receive a copy of research paper resulting from this interview. If yes, please provide your preferred e-mail address:

Participant

I, ____, have read and understand the information given in this form and all my questions have been answered to my satisfaction. I have had sufficient time to consider whether or not to participate in the study and consent to participate. I understand that my participation is completely voluntary.

_____________________________________ _____________________________

Signature Date

Please keep this form for keep the consent form for future reference. After you electronically sign this form, please email it to:

ebruce@ualberta.ca

Interview consent form

UNIVERSITY OF ALBERTA
FACULTY OF ARTS

INFORMATION LETTER and CONSENT FORM

Study Title: The Public's Perspective of a Health Regulator's Complaint Process and an Alternative Dispute Resolution

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Background

I am working on my capstone project that is final a component of my Masters of Arts in Communication and Technology (MACT) graduate program at the University of Alberta. My research study is on the public's awareness of health regulatory bodies and their role in B.C. My research is independent of any of health regulatory body. This study will also gather feedback on how regulatory bodies handle complaints from the public. All of the health regulators in B.C. share the same mandate and obligations. For my project, I will just be looking at only one regulatory body but the findings from this research may also be applicable the other health regulators in B.C. This is not a funded project.
I am recruiting:

- Two public members for one-on-one interviews

Purpose

The purpose of the study is to document public awareness and opinion on the standard regulator complaint process used by B.C.'s nursing regulatory college. I am also exploring the public's thoughts how complaints are resolved. It is hope that this research will contribute to subsequent research and projects in this topic.

Study Procedures

If you agree to participate, I will ask you to share your thoughts on health regulators (colleges), making complaints, and reflections on two scenarios. We will talk about how complaints should be handled and how the regulatory college can support complainants.

Prior to the interview, you will be asked to complete a short online survey that will take about 2-3 minutes to complete. The interview will take between 60–90 minutes and will be held using video conferencing (Google Meets). Only the audio will be recorded.

The video *will not* be recorded. You have the option to turn off your video camera. A written transcript will be made from the recording and then the original audio recording will be kept for a minimum of five years. You can ask to review the transcripts.

Benefits
While there are no costs involved in participation, there will be no direct benefit participating in this study. I hope the information I get from doing this study will help inform my understanding of the public's perspective of the complaints process. If you would like to receive a copy of my final report, please provide your contact information at the end of this form.

Risk
I do not anticipate any risks associated with your participation in this study. Unless you give your explicit permission, you will not be associated with your interview data in any resulting publications.

Voluntary Participation
Your participation is voluntary. You have the right to refuse to participate in this study. If you decide to participate, you may decline to answer any questions you do not want to answer.
If you would like to review your data, you must make your request through email or telephone within one week after the interview.
You can withdraw your data from the study without any negative consequences. You have up to10 days to remove you data from the date of your interview or three days after receiving the transcripts, if requested.

Measures to maintain confidentiality
The transcripts and any notes will be kept secure and stored on a password-protected computer. Only myself and Dr. Stanley Varnhagen will have access to these records. Data that includes your personal identifiers will be destroyed as soon as it is no longer needed. All other data—electronic and paper documents related to this project and the original recording of the interview—will be destroyed five years after this project is completed.

Further Information
The plan for this study has been reviewed for its adherence to ethical guidelines by a Research Ethics Board at the University of Alberta. For questions regarding Participant rights and ethical conduct of research, contact the Research Ethics Office at (780) 492-2615 or email reoffice@ualberta.ca

BC College of Nurses and Midwives Case Study

YES	NO	
		I consent to the data collected in the interview to be used for this research.
		I would like to receive a copy of research papers resulting from this interview. If yes, please provide your preferred e-mail address:

Participant

I, ____, have read and understand the information given in this form and all my questions have been answered to my satisfaction. I understand that my participation is completely voluntary.

_____________________________________ _____________________________

Signature Date

Please keep this form for keep the consent form for future reference. After you sign and scan this form, please email it to: ebruce@ualberta.ca

Appendix E

Pre-interview/focus group survey and interview and focus group guides

UNIVERSITY OF ALBERTA
FACULTY OF ARTS

Pre-interview/focus group survey

Purpose: The purpose of the pre-interview survey is to establish an understanding of the participants' experience of receiving care from a nurse and if they have ever made a complaint. This information will be considered when finalizing the focus group guide. **Note: This survey will be administered through Google Forms.**

This survey should take about 2–3 minutes to complete.

Name: ___________________________________

1. Town of residence ____________________
2. Last time received you care from a nurse
   - ❍ Six months ago
   - ❍ Six to 18 months ago
   - ❍ 18 months to 3 years
   - ❍ More than three years
   - Never or cannot remember
3. Have you ever made a complaint about a health professional?
   ❍ Yes ❍ No

If yes, where did you make the complaint? e.g., health agency (hospital), health authority (Quality Care Patient Office), or regulatory college, such as College of Physicians and Surgeons).

Interview guide

Part I — awareness, transparency, trust

1. Can you tell me a little bit about what you know about health regulators.
2. Have you heard of the nurses regulatory agency prior to this meeting?

   If no, Have you heard of the College of Physicians and Surgeons of BC or other college (regulatory body)?
   [If no, provide explanation of a regulatory college and its mandate, and the role of an association.] 6

   If yes, Can you tell me what you know about them?
   What do you think is the purpose of a regulatory agency?
   [Provide additional background about a colleges and professional associations if necessary.]
   What would you do if you wanted to learn more about a college? Have you ever visit a regulatory college's website? If so, why?

3. When you hear news stories about people who have experience problems with the care they received from a health professional, did you notice the regulatory agency in the story? What do you think of the regulatory agency role in the story?

   Can you recall stories in the news about a patient who raised concerns about a nurse/doctor/or any other health professional?
   If applicable, What did you think of the college's role in the story? Had you heard of this story? What did you think of the actions of the college?

   [If the participant is unaware of a news story, provide details about a recent news story — the final outcome of this case was that the nurse received a reprimand, including a notice that her registration would have been cancelled if she hadn't let it lapse, and she was fined $17,500.]
   Is there anything missing from the story that you think the public should know?
   What is important to you about this case?
   How well do you think the college managed this case?

Part II — making complaints, barriers/hesitancies

4. Changing the subject for a moment, I want to ask you about making complaints. In the past couple of years, have you made a complaint about a business or government service (car repair, city, BC Ferries, contractor, tradesman, ICBC)?

   If yes, Who did you first contact and why? How would you describe the experience of actually making the complaint?

What could the business/government agency done to improve the experience?

Was the outcome of your complaint what you expected?

How satisfied were you?
If the situation repeated again, would you make another complaint? Why/why not?

Focus group guide

This guide is subject to change to address topics raised in the preceding interviews.

Part I — awareness, transparency, trust

1. Health regulators often work quietly in the background in the health care system. Many people are unaware that there are 19 health regulator colleges in B.C. What do you think the public knows about health regulators?

2. Do you think the public has heard of the agency that regulates the nursing profession prior to this meeting? How well do you think this is known? (Skip to b. If they are aware of BCCNM.)

    a.) If no, Have you heard of the College of Physicians and Surgeons of BC or other college (regulatory body)?
    [If no, provide explanation of a regulatory college and its mandate, and the role of an association.]
    b.) If yes, Can you tell me what you know about the college?
    Do you think people have a good understanding what the college does?

    c.) [Provide additional background about a colleges and professional associations if necessary.]
    What would you do if you wanted to learn more about a college? Have you ever visit a regulatory college's website? If so, why?

I want to give you quick overview of the what health regulatory colleges do:
Regulatory colleges protect the public by regulating their registrants. They do this by:

- setting entry-to-practice requirements e.g., many regulatory colleges require applicants to have a degree/diploma, meet a specified English -language proficiency level, and pass a national/international exam in their field. The health practitioner cannot call themselves a registered/licensed health professional until they registered with their college.
- approving education programs offered by universities and colleges
- setting practice standards
- Maintain a current list or registry of registrants that anyone can look up on their website
- Conduct annual registration renewal with their registrants that also checks that they are maintaining and building on their skills and knowledge.
- Manage a public complaints and professional discipline process. All written complaints must be investigated. Colleges have the power to take disciplinary action if a health professional's practice is determined to be unsafe or unethical.

BC College of Nurses and Midwives Case Study

3. When you hear news stories about people who have experience problems with the care they received from a health professional, what do you think of the regulatory agency and its role in the story?
   What do you think the regulatory agency's role should be in resolving complaints?

   Can you recall stories in the news about a patient who raised concerns about a nurse/doctor/or any other health professional?
   If applicable, What did you think was the college's role in the story?
   What did you think of the actions of the college?

   [If the participant is unaware of a news story, provide details about a recent news story.

   Synopsis: Former B.C. nurse fined for exploiting elderly couple in 'very unusual' relationship. An investigation conducted by the nursing college found she violated professional boundaries and that she was financially abusive relationship with an elderly couple.
   The nurse persuaded the seniors to pay for her dental work, new glasses and medication valued at $1,600 a month, on top of a monthly stipend. She bought a mobile home with the couple — named in documents as Mr. and Mrs. W. The couple left that home to the nurse upon their deaths. She also assumed power of attorney for Mr. W in 2012, giving her the right to make financial and legal decisions on his behalf. The nurse met the seniors more than seven years earlier while she was working for Nurse Next Door, which is a private agency that provides care to seniors in their homes.
   The nurse cut ties with Nurse Next Door but continued to work exclusively with the couple, listing her work address as their home address when she renewed her provincial nursing licence.
   The nurse was fined $17,500 for misconduct and ordered to pay the college's legal fees of $16,535 last fall. She was also handed an official reprimand, lost her licence to practice, and can't apply to have her licence reinstated for at least five years.

   Is there anything missing from the story that you think the public should know?
   What is important to you about this case?
   How well do you think the college managed this case?

BC College of Nurses and Midwives Case Study

Part II — BCCNM complaint process

Introduce standard complaint process using diagram (Appendix B). I want to walk to briefly through the most common way complaints are resolved at the BC College of Nurses and Midwives. (Brief overview).

4. Do you have any questions about this process?

   To help you understand the complaint process, I want to give you an example of real complaint made about a nurse named Shannon who worked in a long term care facility. In 2020 a complaint about Shannon was made to the college. The complainant told us that Shannon used physical force to restrain a resident and this force was contrary to that resident's care plan and the facility policy. The college investigated the claim and found the allegations were true. As a result, Shannon voluntarily agreed to:
   - a public reprimand
   - meeting with a BCCNM Practice Support Consultant
   - completing two remediation courses
   - not to repeat this conduct

5. What are your initial thoughts on this process?

6. What do you think are the strengths of this process?

7. Are there any weaknesses?

Introduce alternative dispute resolution process using diagram. (Appendix B)

8. Do you have any questions about this process?

9. What are your initial thoughts on this process?

10. What do you think are the strengths of this process? (See Appendix B).

11. Are there any weaknesses or concerns that you have about this method of resolving complaints?

12. When do you think this process could be used?

Part III — conclusion

We've covered a lot of information today. Do you have some final thoughts? Are there any outstanding questions?

Appendix F

Transcripts — interviews

Recorded: Nov. 14–15, 2021

PI = Principal Investigator
For anonymity purposes, participants are not identified and the transcripts have been merged together.

Part I - awareness, transparency, trust

PI: Feel free to ask any questions or for any clarification that you may have. My first starting point, can you tell me a little bit of what you may know about health regulators?

I**NTERVIEWEE:** To be quite honest, I know nothing about health regulators. I don't even know what that is.

INTERVIEWEE: I know a little bit. My mother was a nurse, retired now, and my partner is an operating room nurse currently. So in terms of the regulatory bodies, I'm aware of the colleges, the various colleges. I had an incident a number of years ago with my daughter in healthcare, and so her mother made a complaint through Fraser Health body, but that would be about my extent of it. And I'm a fairly... I'm sort of interested in current events, so I like to say I'm familiar with the colleges and whatnot and... But yeah, that's about the extent of it.

PI: Have you heard of the nurses regulatory agency? It's called the BC College of Nurses and Midwives. We've changed our name a few times.

I**NTERVIEWEE:** Yeah, and I don't know them specifically. I'm familiar with the BCNU and the union structure, but not that group... Not that body specifically. Yeah.

PI: Okay, have you heard of the College of Physicians and Surgeons of BC?

I**NTERVIEWEE:** Yes, definitely, yeah.

INTERVIEWEE: Yes, I have heard of that.

INTERVIEWEE: Yes, I have heard of that.

PI: Can you tell me what you know about them as far as what their responsibilities are? Using maybe the College of Physicians as a reference point?

INTERVIEWEE: Well, I guess my understanding of it is it's the regulatory and the sort of licensing body, I guess is the best word for it. I know, usually it ends up in the media when there's disciplinary matters and things like that. So I know there's an internal disciplinary structure that's sort of arm's length from government, but that's probably the extent of it.

PI: Okay, so that's essentially what a health regulator is. The College of Physicians is a health regulator, and there are about 21 health regulators, and we call them colleges in Canada. And they regulate health professionals. And so essentially how they work is, let's say you were going to be a nurse or a doctor, you would go through school, and you would take all the courses that you need to take. Well, that curriculum needs to be approved by the health regulator. The College of Physicians, they approve the university's education programs, and so you go through school, and then you would, at the end of that, you would write an exam and that exam is recognized by the college.
If there's any other requirements that you need, you'd have to meet. I think for all of the colleges, you have to pass what we call a CRC, a criminal record check. There's a few other things like that, that you need to meet before you would be eligible for registration. And then once you become registered, you renew every year. That's the background. If you wanted to know more about a college, what would you do if you wanted to learn more?

INTERVIEWEE: I would probably google it and search online. I think that would be the easiest and quickest way for me to do it.

PI: Yeah, that's right? If you have any... If this ever comes up for you ever again. Have you ever done that? Have you ever visited a regulatory college's website?

INTERVIEWEE: Have not, given I didn't know it existed.

PI: So, I've given you a little bit of a background about how you get registered, every year when you belong to a college. Because I work for the nursing college, I'll use nurses as an example. They need to renew their registration every year, and they need to attest with a few things. They have to say that they're doing things to keep up their education so that they are doing it with their quality assurance or continuing competence. And that may be, they're taking courses on things, or maybe they're reading journals, keeping up on whatever, especially if they're specializing in that particular area that they're working on. They may even be working on things like better communication skills and different aspects of their practice. It doesn't have to be clinical, necessarily, but they need to be doing things that are improving or maintaining their nursing competencies, so they'll do that. When they renew, they'll either they'll need to demonstrate that they're doing that by providing us with information, but otherwise they just really attest that they were doing that. The other thing, too, that the college does. There's the education piece, then there's the registration renewal piece. We want nurses to meet the competencies, get registered, then we want them to maintain them. But if they don't meet those competencies or standards, then they can end up in, basically a disciplinary process. If people have complaints about a nurse, they would complain to us, and then they would be process. Maybe you haven't heard news stories about people who had experienced problems with the care that they receive from health professionals, whether it's a nurse or maybe a physiotherapist or a doctor. **Did you notice if in those news stories? Did you notice anything about the references to the health regulator? Have you heard any news stories like that?**

INTERVIEWEE: No, not often. I usually just hear that they're just complaining.

INTERVIEWEE: Not that I've heard recently. A lot of the things in the news recently have been to do with long-term care or those sort of things. So yeah, I can't say that I can recall

anything recently that's come up, yeah. In the media, I'm just trying to think. No, nothing that comes to mind.

PI: I have a couple of stories that were in the news. This one that I'm going to tell you is sort of an extreme example of someone getting into trouble and got a complaint against them. Her name was Laurie Tinkam, and she was a former Vancouver Island nurse. She had originally worked for an agency was working for an elderly couple, but she quit the agency and worked directly for this elderly couple. She persuaded this couple, these seniors, to pay for her dental work, her glasses, her medication at about $1600 a month on top of the monthly stipend that she was charging them to work for them. She was using her position as a nurse and this relationship that she developed with them to benefit beyond the point we would consider acceptable. In her case another nurse complained about her and brought the case to us, and so the college started an investigation on this nurse. This nurse, she went on to assume a power of attorney, so she had legal power over this couple, and she ended up buying a mobile home with them, so she was a part owner in this home that they had bought. They subsequently died, and she had all these assets from this. So inappropriate conduct of a nurse, that she shouldn't have been doing any of that. She argued that she was paying their bills, but she was paying their bills with their money. She went through this complaint process, and the college found that had broken the rules of being a nurse, and she was fined in total about $17,000, plus she was stripped of her licence. That story was in the news. It was quite a while ago, you would have been too young to probably remember it. That's a story about a bad nurse. It's not common to we have these type of big stories like this. There are about 65,000 nurses in the province, and we get about 300 complaints, and most of those would not be of this type of issue, they're often more minor, but they do come up. There’re all sorts of different kind of complaints people can have about nurses. Anyhow, that’s one sort of a story about a nurse. **What do you think about that? What do you think the public needed to know about that nurse?**

INTERVIEWEE: Wow. Okay.

INTERVIEWEE: Strikes me as important... Well, it certainly is sort of the credibility of the profession is one of the things that's at stake. And, you know, those are the kind of stories that

sort of incite the public. And so that would be important for this to be dealt with for that reason. You know, and in terms of the act itself, I guess it's not really considered criminal, but certainly it, you know, you'll expect the college to do something about that. Like you... And it sounds like they did, like that sounds like a reasonable... That's a more severe penalty than what I would expect from a boss like that, to be honest. So...

INTERVIEWEE: I think there should definitely be a question of where she received her education and how she got her qualifications, because when I think of nurses or just anybody in the healthcare, I think that their priority other than making money should be helping people, given that they're in a position where they're constantly working with a vulnerable population, whether it be somebody with any ailments, like physiotherapy, like somebody with back pain that's really minor to somebody in a seniors home that's like... That has dementia, they cannot remember anything, and they don't even know who they are sometimes. These type of healthcare professionals are working with extremely vulnerable populations, they should have some sort of ethics or code of conduct that they should abide by, and something like this should have never happened.

INTERVIEWEE: Because they're essentially in a power of authority or a position of power, because they're seen as educated professionals, better than the normal human, kind of. So they should definitely have some sort of code, or code of standard for them. That's what I see.

PI: Yeah, and I guess in that case, what would you say was important to you about that case?

INTERVIEWEE: I think the lack of somebody doing something about it, I think it had to take the elderlies to pass away and give this X nurse all their money, basically, and then for somebody to be like, wait for another nurse to think about them.

PI: Right. Yeah, that's a good point.

I**NTERVIEWEE:** And similar to... I think similar to politicians, I think physicians or healthcare professionals, should also have people tracking their... Or at least some sort of... Keeping track of

their finances, so they're not doing under-the-table transactions kind of like this one, in my opinion.

PI: Yeah. Thinking about the outcome of this... Ultimately this nurse lost her right or her privilege to practice as a nurse, and then she was charged a fine of $17,000. **How well do you think the college managed that? Is that what you would expect in this type of case? Does that seem like a fair?**

INTERVIEWEE: I feel like this is... I feel like what she did was borderline fraud and based on what I've heard, I feel like she committed fraud, some sort of fraud and I think that by having, in my opinion a very light sentence for her crime, I feel like it sets a bad precedent for future cases and that the college should be a little bit more heavy on their punishment... On the nurses punishment, to set a stronger precedent on how this nurse should have been punished. If that makes sense.

Part II - making complaints, barriers/hesitancies

PI: Yeah, yeah. Okay, I'm going to change the subject for a little bit. Let's not talk about colleges for a moment, I just want to talk about complaints in general, and I'm going ask you, if you in the past couple of years, **have you made a complaint about a business or government service? It could be anything like a car repair or a complaint to the city or even something like BC Ferries or ICBC contractor tradesmen.**

INTERVIEWEE: I have not filed any complaints with any kind of government agencies.

PI: That's alright.

INTERVIEWEE: Not ever in my life.

PI: Not yet. Alright, well that's fair enough because you're just a young guy.

INTERVIEWEE: I am very young.

PI: That's said. Complaining is not easy, when you get to that point where you're frustrated, it's not an easy task.

INTERVIEWEE: Definitely.

PI: Yeah well, It's hard to, it's hard to know what the process and what to expect.

INTERVIEWEE: Yeah, that's a really good point. I feel like I just living in general, not a lot of people has taught me how to complain, they'd always say, "Oh I'm going complain. "But nobody has taught you the logistics of how to file a complaint.

PI: That's a really good point and what to expect when you make your complaint. If you know that the outcome may not be something that you would find satisfactory, then maybe you're not going put the effort, or if you do know that you can be sat... Like that, you're going be happy with the outcome but yeah, having that information upfront, but that's a really good point. I mean we're aren't taught how to complain and being constructive in making complaints. Do you provide feedback to your profs?

INTERVIEWEE: We do. I think that would be like a form of... I know that for school, at least for TA's teaching assistants, they really value their TA evaluations because professors and their supervisors take those a little bit more seriously, especially if they're negative, then they might reconsider what type of future positions or if the TA is allowed to TA again.

PI: Yeah.

INTERVIEWEE: And knowing that, I think that kind of... That's kind of shocking because I asked my TA once, I was like, Why do you care so much about the evaluations? Because I know that when professors get their professor evaluation, even if you write a scathing review to the university, nothing will ever really happens so why TAs care so much, and then they told us that because they're not at that level of prestige they're still technically just a graduate student, just a glorified student, they take their evaluations much more seriously so to know that I was like

wow, I should be careful on how I write my TA-reviews, because I could ruin their lives in some sort of fashion.

PI: Yeah, yeah. It's true, it's funny. Well, that's a perfect example of when you know what the potential consequences can be, or when you know that it doesn't matter. If you know that the consequences could be quite significant, you may, depending on what you want, it does have a bearing on. Potentially you could complain in one of those evaluations.

INTERVIEWEE: You definitely could. I feel like it's so much more different than "In real life" because outside of school, because when I work in retail and somebody files a complaint against me or whoever is working at the time, there are almost zero repercussions on us because most of the time, either our manager or corporate knows that nine out of 10 times, it's literally not our fault unless we're cursing at our customers or being blatantly rude to them, almost none of the mistakes that happen are our faults, and we have absolutely zero control about certain situations. So they just say, "Oh, that's fine," and then we laugh at the customers about how annoying or how do you say it? How rude they were to us, instead of us having any repercussions at all, .

INTERVIEWEE: I've made a complaint to a retail business like a restaurant...

PI: Okay.

INTERVIEWEE: I think by the last three... You said the last three years, right?

PI: Oh I guess in the last kind of current memory.

INTERVIEWEE: Yeah. Never to sort of like, yeah, never to like a body like ICBC or anything like that, no.

PI: With the restaurant, who did you talk to first?

INTERVIEWEE: I contacted them through their website, their contact form. It ended up going to the manager of the business.

PI: Yeah.

INTERVIEWEE: I used a contact form on there, just on their website or whatever. I didn't research it, I didn't address it to anybody particular, I just sent it on through.

PI: Oh, okay. And did you get a response?

INTERVIEWEE: I did. Yeah, yeah. I got an emailed response because I provided my contact information and whatnot and got a written response and, you know, a bit of compensation there.

PI: Were you satisfied with the outcome of it?

INTERVIEWEE: I was, yeah, yeah. I mean, it basically replaced the meal, and that was my complaint, so, yeah.

PI: Oh okay. Is there anything else they could have done to improve that experience other than making sure that it is done right the first time?

INTERVIEWEE: Yeah. Not really, it was a personal response, like it wasn't a kind of a form thing. And in this case, the compensation sorta took care of the problem. So no, I mean, there's nothing else really that they could have.

INTERVIEWEE: It was prompt enough. It was in within days and that sort of thing.

PI: That's good. After that experience, did your opinion of the business change? Do you feel more favourably, less favourably?

INTERVIEWEE: Well, maybe a little more favourably. I mean, it certainly removed the kind of negative feeling I was having. So I guess it probably ended up being neutral, but you know, it removed that... I was going to feel more negative about it if it hadn't been resolved so... If that makes sense.

PI: If you hadn't complained, would you have gone back?

INTERVIEWEE: I would have been less likely to go back. I can't... I'm not going to lie and say I'd never go back. But you know, I'd make a... You know when you're doing that thing, where do you want to eat tonight? It probably wouldn't be there if I hadn't. So if that hadn't been resolved.

Part III — case study scenarios and BCCNM complaint process expectations

PI: All right. All right. I'm going to show you a chart.

INTERVIEWEE: Okay.

PI: I'm going show you how the college resolves most complaints. This is what they call a consensual complaint process, and it's how they get to the end of it where they have a consent agreement. So this is sort of the standard complaint process, and this is pretty consistent to , not just in BC, but in Canada, even in a lot of countries in the world, and how they manage complaints or health professions, it's pretty standard. So what happens is when a complaint comes in, it must be in writing, and I believe that's a legislative requirement that it must be in writing. And then the second step is it's reviewed by the college and a committee, and the inquiry committee is a group of volunteer nurses and public members who regularly meet and review complaints, so they would take in that, kind of the first pass at this, and they would see if there's a way to resolve it without having to escalate it to an investigation. We have a number of investigators on staff who will go and they will go and investigate the complaint, they all go to the site of where the complaint was made or where it may have taken place, and they'll look at the records, they will look at documentation. They'll talk to some people and from that we decide what's going on, and then they'll write a report and it goes to a committee, and the committee is

made up of people who are volunteers. A lot of them are nurses, and so it's sort of a peer review, but there's also public members who sit on the inquiry committee also. We have a number of different committees and doing the same work because there's so many that go through this process, and so then they review it, they look at it and they will make. Then it goes to the step four and they'll look at that. They'll want to see what the nurses response is, and then they'll make a decision, and essentially when they come to the decision is through this process, and sometimes this can take quite a while, depending on things like documentation, documents not being available, or the people are not available as time goes by, so sometimes it's the complaint process, although maybe not a serious situation, but they can take several months, sometimes, if it's just kind of a matter of things just not being available. In that period, so you made the complaint, let's say January 1st about a nurse, and so at the end of it, a decision may have been made, and at that point, it's only at the decision point that the complainant will really know what's going on, occasionally they do try to give them a status report of where it is, but generally if you make a complaint, you don't really have any involvement in the complaint process until the very end, and then at the end of it you'll find out what was decided, and often what happens is the complaint, the nurse will enter into an agreement to resolve the complaint, so let's say I'm a nurse and I was not doing my documentation well, I was skipping steps and continuously doing this and it was becoming an issue, and so what may happen is, or that was found the part of my problem with my practices that I'm not documenting properly and I'm not meeting my standards that are set for me. I may agree to take a course on documentation, I may do a few other things maybe I have to be supervised for the next six months or a year or two years. It really depends on what the complaint is or what it's all about. And so that will be how it will be resolved and then so what you complained and then you're going see, Oh, okay, this is how it was resolved. You don't have any role in that process. And then what we do for most cases, we will publish that on our website, so if I had a complaint against me and I entered into this consent agreement that I'm going do X, Y, Z, and then the college is going publish your name and all the details.

PI: Basically, the agreed to actions that will show up on the website, and that's generally how they are resolved. Most nurses work for an employer, so a lot of them belong to BCNU, so they would probably go through the process, they may have some representation from BCNU to support them through the process. That's one aspect to it. Yeah, so that’s generally how we

resolve them, and as I said, we probably have about 300 or so that go through, go through this process, at any given year. **Do you have any questions about that?**

INTERVIEWEE: No, not yet.
INTERVIEWEE: okay.

PI: That takes us through the general process. Alright, so the next thing I'm going to do is I'm going to read to you, and I've taken this from existing professional conduct cases that I think Ontario had on their website that they were using, I think for training purposes. So I'm going to give you a couple of examples, and I just want to get your thoughts on how the case came about. So this is the background, so nurses must protect any information that they learn about their clients that are in their care, clients need to be confident that the nurse will protect their personal information and basic dignity. If they breach this trust, even unintentionally, it can damage that nurse-client relationship, co-worker relationships and the general trustworthiness of the nursing profession. You don't want to be hearing gossip because a nurse was breaching confidentiality.

PI: This is the scenario. Your cousin is a well-known local fiction writer in your town, and you aren't living in a very big town. She was recently rushed to the ABC hospital for reasons unknown to you, so you know that your cousin went to the hospital for some reason. And then a friend shares a Facebook post made by a nurse and asks you if the patient referred to in the post is your cousin. And the nurse posted the following on her social media page, the same day your cousin was rushed to the hospital, and what the nurse wrote was, 'Can this shift be any longer? It started out with a waiting room full of nagging people that don't seem to know what emergency means, then I had to deal with the drama of trying to transfer a minor celebrity, 400 pounds with COPD down the hall to the ICU, those ICU nurses are such divas and I wasn't in the mood for their winning. Anyone around ABC hospital wants to save me with a drink to get me through the next 10 hours of my shift?' So that's the end of the post, and you suspect the patient that the nurse is referring to could be your cousin, because maybe she weighs 400 pounds. What are your initial thoughts when you hear about this case?

INTERVIEWEE: I feel like it's okay for, I think nurses or healthcare professionals to kind of... How do you say this, rant...

PI: To vent

INTERVIEWEE: To vent yes, to vent about like how hard their day is, because it probably is very hard, but to including pictures of any patients, I think that's a breach of confidentiality, because what if they... Like these patients don't want to have other people know that they were in the hospital? What if they were one of those like, Oh, I don't want... What if they were literally a celebrity, and like let's say they are like somebody with a great, huge following and they didn't... Literally did not want people to know that they're in XYZ hospital. And then all of a sudden there's a rush of people there, I feel like that's breaking a lot of codes of conduct, and I feel like that's wrong, if that kinda makes sense.

PI: Yeah

I**NTERVIEWEE**: And to be so specific about like a patient like weighing 400 pounds, I think is also sort of either a breach of confidentiality or just a lack of respect for people as human beings, as patients as human beings.

INTERVIEWEE: Well, it's clearly violating your cousin's privacy by describing his medical condition, I think you said it's COPD and he's overweight or something. Those are just totally private things that shouldn't be shared in social media. The whole I understand that very little good comes from social media, in my opinion, but the whole, the rant, the kind of the busy night rant part of it is a little bit inappropriate, but the privacy things are really inappropriate. Oops. If that makes sense. But those would be my things.

INTERVIEWEE: Yeah, and if they were to think like that, because for most people social media do represent their actual views on people, if I knew that my nurses had that view on people, I would not want them trying to save my life, because what if afterwards they tell people

like, Oh my God, I just saw somebody with the nastiest tumor ever or whatever. That would hurt my feelings as a human being and also just hurt me.

PI: Yeah, no, it would be awful, awful to have that experience. So in this case, let's say this indeed is a relative of yours that the nurse referred to in that Facebook post, what would you think that your cousin should do?

INTERVIEWEE: I would encourage them to complain, just to take screenshots of it, and I'm not entirely sure who I would complain to, but I'd have to go down the road and find, you know, that I'd find... Yeah, certainly to the hospital or to and see where it goes.

I**NTERVIEWEE**: I think my cousin should definitely screenshot the post, screenshot basically the information of the nurse, because it is on a Facebook post from what you said. And I would literally tell them to file a complaint with the hospital because there is no way that this is okay. It's definitely a breach of some sort of patient confidentiality, identifying them or something.

PI: So let's say that happened and let's say because they could make the complaint to the hospital and that would be one way... One place to make that, because the hospitals do take those complaints. If it went to the college, how would you think that that complaint should be resolved, **like what do you think would be a satisfactory way of resolving?**

INTERVIEWEE: Well, that person obviously needs to be reminded of their kind of ethical responsibilities, I don't think it can get you fired or anything, but certainly that would be something I'd expect a disciplinary note on their file or something. And if it's an education piece where they don't understand, I'd be surprised that they don't know that that's something they shouldn't be doing, but I guess maybe it's like there's an education component in there too. Right? So, yeah.

I**NTERVIEWEE:** I think a satisfactory resolution would definitely be like first and foremost, an apology, and second would be a suspension for the nurse in question, because I don't think anybody in such a... Working in the healthcare profession should be able to get away with

essentially mocking a patient and taking a photo of the patient without their consent and posting it online.

PI: No. Yeah, and they do... And as you mentioned before about the ethics, they do have a Code of Ethics that they're supposed to adhere to, so that certainly would be... Would certainly be a breach of the code of ethics and in confidentiality.

INTERVIEWEE: hmm

PI: Okay, that's good. I have another scenario. This one's a little bit more about clinical care. And so the background for this one is that so the administration of medication, it's a basic nursing skill. Medication standards align the nurses accountabilities and their responsibilities when performing activities involving medications. In BC, the medication practice standard is principle based, which means that it uses general statements. Nurses need to use their critical thinking and knowledge, skills and judgment when making decisions about medication activities. They standards because there's just so many medications and so many different skills involved, it just refers to those principles and it doesn't say it's not that prescriptive in how they do their work.

PI: So this is the incident, you are rushed to the local emergency room with signs of a serious allergic reaction. So maybe you're having an anaphylactic reaction. A nurse administers medication to help alleviate your symptoms, and tells you that you should start feeling better shortly. However, you immediately start to feel this severe crushing pain flow through your body that causes you to pass out. Two weeks later, you are still... So you recovered, you are still experiencing some chest pain and some palpitations and exhaustion. When you follow up with your family doctor, your doctor tells you that based on your hospital report, that she suspects that the drug was administered incorrectly and it appears that it was injected into your vein instead of into your muscle. And that caused some mild but reversible damage to your heart. So not a good experience for having an allergic reaction. What are your first thoughts on that?

INTERVIEWEE: Well, what are my thoughts on that? That's a pretty scary thing to have happen. Yeah, I guess I would question how mistakes like that happen, that would be my concern is how does something like that happen, if it was just a matter of administered incorrectly then that's pretty... That's concerning. Or I guess that's something... There's obviously a check or balance that didn't happen or yeah. I'd be pretty upset.

I**NTERVIEWEE:** I think if I were in their position, and I had suffered essentially from somebody's mistake, I would... I don't know if I would press... It would kind of depend on like how unwell I felt. But I would definitely, I would definitely file a complaint. And I would definitely try to get some sort of compensation, monetary compensation for my pain.
Because I think this is very similar to like, if you were in a car crash, and you had some sort of... Like, it was definitely not my fault. Let's say I got in a car crash, I was going straight and somebody left turns me and they crashed into me. I would... And I was like very heavily injured. It's definitely not my fault. And I think I would deserve some sort of monetary compensation, I think it's the same thing, as this one. Their mistake, this, whoever administered the drug for me, made a mistake, and it caused me pain and suffering, I think I would deserve some sort of monetary compensation for it. And I would hope that this person, this medical professional, this nurse or doctor would receive some sort of extra training, so they don't hurt somebody else as well.

INTERVIEWEE: That's kind of my take on that

PI: Yeah, yeah. So what would you do to resolve any concerns, **would you raise it with your doctor or would you think you'd want to take it further than that?**

I**NTERVIEWEE:** Well, I would definitely raise it with my doctor, I didn't want to play it out whether there's some kind of recovery or something that needs to happen, that would be the priority, but I think I would make a complaint. I would certainly make a complaint to the hospital, I mean, that sounds like something, if it could happen to me, it could happen to someone else. There's obviously a practice that should, again there should be checks and balances so those kind of things don't happen so... I would say something.

PI: So you'd want to know that there's some steps taken.

INTERVIEWEE: Yeah to at least... Yeah.

INTERVIEWEE: Well, I think I would just expect them to investigate it to the point where they understand why it happened, or if it's just... I don't know... If it's just human error, it's human error, but it's not... That's not just a good enough... I don't know if that's a good enough answer without determining if that were really the cause or if it was just really human error. So, usually that's getting blown a little far down the road but, we wanted to know that it was... Well, the problem was identified at the very least... And then action moves from there.

I**NTERVIEWEE:** I think it's normal for healthcare professionals to make mistakes and if every single person, every single nurse was fired from a mistake, I feel like this world would have no nurses. But I so I won't say like fire her, but I definitely... Or him or them but I definitely say that like they need training they need to be retrained not just for like because I was injured and I had pain and suffering but also for the people to come because if everybody went through this specific nurses hands and they had extra pain and suffering throughout their life, I feel like that's a fault on their behalf and that the college should reconsider how they hand out certifications for people to practice medicine or practice nursing. I hope that makes sense.

PI: Yeah, no, it does. I mean, the colleges mandate is to protect the public. And that's exactly if someone's not safe, we need to do things to... We need to intervene and make sure that if they're going continue practicing, that they practice safely. So in this case, you're right. I mean, they need to be doing... They may need some supervision, or they may need to, I guess, if you were looking at it from the hospital's perspective is that they need to look also at the workplace environment and they would need to go, maybe we have a workplace that's not safe. Maybe there's too much chaos that... And when you have chaos, you're going have more error, maybe they don't have enough people on staff or there could be different elements to it and so that would be from the employer's perspective that they would be looking at it, more looking at it from the individual, that nurse, how can we make sure that that person is going be safe and maybe they have to have supervision or maybe they need to take a course or something along

those lines, or in some circumstances, maybe they shouldn't be working in some practice areas. And there are cases where we pull people say that they can't work in particular practice areas because they're not safe. But yeah, that's the process. Anyhow. So we've covered a lot of information in the past hour. Now you probably know more than you ever wanted to know about health regulators.

INTERVIEWEE: I do

PI: Yeah. That's it. So we've covered a lot of new information the past half hour or so. Any other thoughts or questions that you have?

INTERVIEWEE: I don't think so. I mean, that makes sense. Like we talked at the beginning, I'm familiar with the College of Physicians and Surgeons, so this sounds like something very similar, kind of a parallel body for nurses obviously and their associated groups, so no I mean it makes sense.

INTERVIEWEE: No, I think I... I think I've learned.

PI: Awesome. All right, well, thanks again and have a good night.\

INTERVIEWEE: You too have a great night. Thank you so much.

PI: Thank you, take care.

INTERVIEWEE: Bye-bye

INTERVIEWEE: Bye. Bye now.

Focus group transcript

Recorded: Nov. 24, 2021
PI = Principal Investigator
For anonymity purposes, participants are not identified in this document.
Part I — awareness, transparency, trust

PI: In preparation for the big rain that's coming up, another round.

SPEAKER?: Yeah.

SPEAKER?: Absolutely.

SPEAKER?: Yeah.

PI: I'm talking about health regulation, and so I'm just kind of go through a series of different questions and... And we could just kind of jump in and... Add your thoughts. So the first thing that I talk about is health regulators. They often work quietly in the background. There are about 19 health regulators in the province, and they would cover things like massage therapy, acupuncturists, doctors, of course, dentists, that kind of practitioner. Thinking about that, what do you think the public knows about health regulators?

SPEAKER?: If I'm speaking as the public, probably not a lot.

SPEAKER?: Yeah, I agree, not a lot...

SPEAKER?: I would agree.

SPEAKER?: Maybe that they're there.

SPEAKER?: Yeah, not what they do, per se.

PI: Do you think the, the public has heard about the college or the agency that regulates nurse... The nursing profession prior to this meeting?

SPEAKER?: I have, because I've ... I know a nurse.

SPEAKER?: Yeah, I don't know that I have, I assumed... I guess I assumed there probably would have been one, but I don't really know the... Its name. I've heard of the, the Physicians one, but...

SPEAKER?: Yeah.

PI: Right. And that's the same. I'd describe it like the sibling of these different colleges. The College of Physicians and Surgeons would be another. The one I work for, is the BC College of Nurses and Midwives. We have had a lot of changes over the one past few years. From 2005 and 2018, we were the College of Registered Nurses of BC, then we amalgamated with other nursing colleges, so with the psychiatric nurses and the, licensed practical nurses, and then we became the College of Nursing Professionals. And then during COVID, we amalgamated with the Midwives, at the end of last year, in September 2020. So now we're the College of Nurses and Midwives. What do you think we do? What do you think the colleges do?

SPEAKER?: You probably just have, have all the nurses registered, so they're licensed to practice, and administer their fees, and take complaints. And beyond that, I'm not 100% sure.

PI: Yeah, that's a big, big chunk of what we do.

SPEAKER?: Would you set the standards for practice and ethics for them as well?

PI: Yeah, yeah, definitely. That's another big part our role.

SPEAKER?: Yeah, handle regulations and communications.

PI: Yeah, we definitely do lots of that. Our authority comes from government, from under the Health Professions Act, and this would apply to all the colleges. We set the, the Entry to Practice standards. Regulatory colleges require applicants to have a degree or diploma in a particular, so a nursing degree or a nursing diploma. They may need to meet language proficiency levels, and they may need to pass a national or international exam.

PI: And all of these practitioners that are regulated, they cannot call themselves a registered or licensed health professional until they're registered with their respective college. It's the first part of the registrant being part of a regulated college. Colleges also approve the education programs that are offered by universities and colleges. And as M~ mentioned, they set the practice standards and the ethical standards. That's a big component of what happens, and that's ongoing work. And sometimes that does tie into legislation, so then the standards will change.

5 MINUTES

PI: On government's approach to certain topics particularly, and this would be more federal, it would be about medications and specifically more narcotics. Each of the colleges maintain a current list or registry of all the registrants, so if you wanted, you could look up any registrant, and you could see if they were in good standing. That's the only type of practitioner that you'd want to see. But you could also see if they've had any complaints against them. Some of the colleges provide more information, the physicians will provide where they went to school.

PI: You used to be able to see how long someone had been into practice, but we removed that. Not all the colleges have the same information, so that's a little bit of a difference from college to college. They also conduct that annual registration renewal, which they have to come up with a bit of money to maintain their registration. At that point, they also validate that they are maintaining their practice, i.e., they're going to school taking courses or doing certain activities that ensure that they're building on their knowledge/profession.

PI: And then the last big piece is we manage the public complaints. Or, and any complaint for that matter. And the discipline process. All of the complaints that come in, they have to be in writing before we investigate. All the colleges have the power to take disciplinary action or enter into consent agreements with health practitioners if they are determined to be unsafe or unethical. That's a big part of our work. To give you in a sense of how many complaints we get. There are about 65000 registrants in the province, nurses and midwives, and there's not that many midwives. There's probably only about 500 out of that 65,000. In a given year, we receive about 300 and 400 complaints. So in proportion to the 65,000, it's a fairly small number of people that get complaints against them. A small number end up in a disciplinary process. That's the background of regulation. Really quick high-level view. When you hear news stories about people who've experienced problems with the care that they received from a health professional. Can you recall the regulatory agency, or the college mentioned in the news story and the role? And have you thought about what that college's role is in resolving those complaints?

SPEAKER?: No, a lot of time, it's just a complaint to the media and nothing's really followed up, or it's, it's not an actual lodged complaint, you know what I mean? Like, it's just somebody kind of chatting their mouth off to the to the media.

SPEAKER?: Well, there's one in the media right now about...

SPEAKER?: Yeah, I can't really remember. Oh, sorry. Go ahead.

SPEAKER?: Yeah, and... There's one right now of, of a woman in Inland Health, but that's kind of a... I think that's more of a health authority thing rather than a regulatory one, because it's not against one person, it's against the whole health system.

SPEAKER?: Mm-hmm.

PI: Yeah, and that's a really good point, is because when someone raises a complaint, they can probably do it in three different ways. They can make the complaint directly at the agency or hospital or wherever that care is happening, that's where... A logical place for the complaint.

They could also make the complaint at the health authority for the Quality Practice Office. They can make the complaint specifically to that professional's college, so there's sort of three routes. And certainly, we will get complaints where a lot of times, we'll say, "You know what? This probably needs to be served... Or is best served being resolved at the place of employment, it makes more sense." And maybe it's more of a staffing issue rather than issue of a person's practice.

PI: I know there's a few... There're a few big ones that are going on right now. There was one in the Interior with the nurses that didn't want to be vaccinated. They were opening up a clinic, which is fine, as long as they are not practicing nursing, because they're not allowed to do that. I have an old one. This is from a few years ago, and I can't remember where it took place. This one did get a fair bit of news, but I think it happened about 2012. I think it was resolved around 2017. There was a former nurse and she was fined for exploiting an elderly couple for her unusual relationship with them. We had a complaint; it was received from another nurse. We found this nurse violated her professional boundaries and she was financially abusive to this, this couple.

PI: The back story of it was that she originally started working for this couple as a nurse through the agency, Nurse Next Door. And then she developed this relationship with this couple and she was working exclusively with them. She discontinued her work for the Nurse Next Door. And as she did that, she persuaded the seniors to pay for her dental work, her glasses, medications—valued at $1600 a month. And then on top of that, she received a monthly stipend. She ended up buying a mobile home with them, and then she also managed to have power of attorney after one of them, the wife, died and the husband continued on. She was able to make the financial and legal decisions for him, on his behalf.

SPEAKER?: Wow.

PI: She positioned herself taking care of all of their finances, which is crossing that boundary for what you would expect from a nurse. When they went through the investigation and she did not feel that she did anything wrong. She was fined $1,000, almost $18,000. And she was ordered to pay the college's legal fees, which were another $16,000. And then she was given a reprimand

and she lost her practice. And she's not allowed to apply for practice for at least 5 years. I don't believe she's applied for practice since then. I don't know if this story is familiar to you. As I read the details to you, is there anything there that you'd think that you expect that to be the action that the college would take, or would you expect a different outcome? Any thoughts on how that was resolved?

SPEAKER?: I would have expected that she would have more monetary, penalty, if she had taken that much money from them... The, the older couple, I would expect that she would pay the whole amount back that she had extorted out of them.

PI: Yeah it's... That's interesting, because it... This was our first case where we fined someone. Up until 2013. And her case is kind of particularly bad, but she was the first time we levied a fine against someone.

SPEAKER?: Mm-hmm.

SPEAKER?: Hmm.

SPEAKER?: And it wasn't actually the people that complained, it was someone else?

PI: Yeah. In...

SPEAKER?: That makes it a bit awkward, I would think.

PI: Yeah, no, that's...

SPEAKER?: Her pay that money back.

SPEAKER?: Yeah.

PI: I don't know where. If it went to the estate. She was fined and would've paid us back then, so that went back to the college. As far as her misappropriating all the other money, Anyone wanted to take a civil suit against her, but there weren't living relatives or any next of kin.

SPEAKER?: Mm-hmm.

PI: I, I think she able to keep all the money that she managed to collect from this couple. You'd think that the fine should have been heavier?

SPEAKER?: Well, I just think that there should have been some sort of compensation to the victims as well, right?

PI: Yeah. I would, and what complicated. By the time the case was brought to us, both of the seniors had passed away.

PI: Yeah.

SPEAKER?: Hmm.

SPEAKER?: I'm surprised...

SPEAKER?: So...

SPEAKER?: Five years with no license, like that's it.

PI: Yeah, no, that's...

SPEAKER?: I would have thought that would have been longer.

PI: Longer, yeah, that they would be forbidden from ever practicing.

SPEAKER?: Yeah.

PI: Is that something that you would think that would be preferred as a...

SPEAKER?: Well, longer than five years, and...

PI: I don't know if this was a decision. When they came up with that, but I suspect one of the reasons why they chose five years is because, after you've been out of practice for five years, you have to do a lot to get back into practice.

SPEAKER?: Oh, okay.

PI: To reinstate, so then you need to do a lot of education and there's another. It's fairly onerous to get your license back.

SPEAKER?: Right.

PI: It does raise a lot of questions. Let's say she did apply and met all the requirements, got her registration back. As a member of the public and this person's back in practice, what do you think at this point. Would you expect her to have some limits on her practice ?

SPEAKER?: I would. I would expect someone to be checking in, because it's more of an ethical thing, and most often, people don't change their ethical practices.

SPEAKER?: Yeah.

SPEAKER?: Like...

SPEAKER?: Not generally, no.

SPEAKER?: No.

SPEAKER?: Maybe, can they... Can you restrict where she practices? Like, not in... You know, is that something that's possible, maybe? That she isn't in that kind of situation?

PI: We can because it's not specified. I don't know if I have all the details of her actual case. How they resolved the case, but yeah, and that is something that we do. If someone has an issue, an example would be people that have substance abuse issues. If they want to continue practicing, they need to be supervised. Because it's a problem. They will have certain conditions where they're not allowed to be in a role. Or they're not allowed to be in a supervisory role because that's where they seem to get into issues. They need to be supervised in how they work. We definitely can limit, or restrict the areas that they're working or the type of work that they're doing.

SPEAKER?: I think that would be appropriate for sure.

SPEAKER?: Mm-hmm.

PI: I'm going move on. I'm going read one more to you, and this one. Let's see. This one's fairly recent and this is a consent agreement, and it's quite short. Between December 23, 2019 and July 14 in 2020, this nurse, her name was Kimberly from Smithers. Her problem with her practice was that she left during a Code White, which I believe is a mental health situation (violence). Failing to demonstrate adequate clinical skills in managing resident's diabetes and a hypoglycemic event and in not meeting the college's documentation and medication practice standard. There's not a lot of detail on what happened, but it is the overview of what she did. She agreed to conditions, limits and conditions on her practice: She needs to take a remedial education in medication administration, communications, diabetes and ethics. There're four things that she needs to do remedial education on. She needs direct and indirect supervision on her nursing practice for six months and she needs to develop a learning plan and tell the employer and the college what she's going to do to achieve those things. And she needs to meet with the college's practice consultants to address some of her foundational issues underpinned in the agreement. That's another type of complaint that we had. Again, I suspect the complaint came

in from a nurse and not from a patient. The majority of complaints we get about nurses are from other nurses or other health professionals. For every public complaint, we probably get 10 complaints come from health practitioners.
That makes sense, because they can observe. They know what the nurse should be doing versus the patient who may not be aware.

SPEAKER?: Yes.

PI That's another one that was resolved. Do you have any thoughts on that particular case?

SPEAKER?: At that point, I'd be asking how did she get her certification? How did she pass and, get her certification to practice?

PI: Yeah, that is a good question. And how long has she been in practice.

SPEAKER?: Mm-hmm.

SPEAKER?: Yeah.

SPEAKER?: Yeah.

SPEAKER?: Yeah.

PI: Well, maybe sometimes the challenging thing about it too, is that also it's the practice environment. You've all heard about nursing shortages. There're staffing shortages, and certainly COVID is currently making the work environment really challenging for all kind of health practitioners. That plays into it. When they look at these cases, they look at that and go, "Okay, is this a situation where... " Someone maybe that they haven't been in practice very long, they may be set up to really fail because they just don't have the skills and experience to manage a difficult work situation, so they are not being supervised. That's something that colleges don't have authority to tell the particular practice area, let's say it's a ward on a hospital that maybe is having

continuous problems, there may be systemic issues in that environment. The outcome is that the nurses are not meeting their nursing standards and maybe making some mistakes.

SPEAKER?: As well.

SPEAKER?: So it comes down to training them as well. Mentoring.

PI: Yeah.

SPEAKER?: Yeah.

PI: Yeah. I'll move on to one more question. Is there anything specific when you think about these complaints or I'm telling you about these complaints, of how they're resolved? Were you aware that these are available from the colleges?

SPEAKER?: No.

SPEAKER?: No.

SPEAKER?: What do you mean? Aware that...

PI: That you would be able to find out if you had a concern? So let's say you did have someone doing some home care and you were concerned about the care you received, and maybe you thought, "Maybe I may make a complaint or I want to know if this nurse had any issues with her practice?" Would you think to look up on the college's website?

SPEAKER?: No. But you can, you can find out about individual nurses and their history and stuff?

PI: Yeah.

SPEAKER?: Oh no, I didn't realize that, no.

PI: Is that something that you think that the public would benefit from knowing about that?

SPEAKER?: Probably a need to know when you need to know, I think.

PI: And where do you think they should know about that? Where would you find that out?

SPEAKER?: Oh geez.

SPEAKER?: Well...

PI: Yeah, one thing that the college of physicians is talking about having family practitioners put up signage up in their office that tells them about the college and where they can…

SPEAKER?: Yeah, yeah.

SPEAKER?: Yeah, that would be one place, yeah.

PI: And if you knew about that, possibly people would be aware that other colleges have the same. They may not have posted in their office, but possibly that they would transfer that knowledge to the other colleges.

SPEAKER?: And they, and all colleges have the ability, like a massage therapist, if I wanted to know more about a massage therapist.

PI: Yeah.

SPEAKER?: That's available?

PI: Yeah.

SPEAKER?: Okay.

SPEAKER?: I think if you're going do it for doctors, you should do it for everybody, like put it up.

SPEAKER?: Yeah.

SPEAKER?: Yeah.

SPEAKER?: The dentist.

SPEAKER?: Yeah.

PI: Yeah.

SPEAKER?: With nurses though, you're sort of like, when you would really need them is at a hospital and...

SPEAKER?: Yeah.

PI: Yeah.

SPEAKER?: Are you going put a sign board on them, or is it going be posted in the room, or... You know.

PI: I think logistically, it's probably not possible with nurses, because you're right.

SPEAKER?: Only if you're going hire a private... You know, a nurse to do something for you, I was thinking that would be the most important. I mean...

SPEAKER?: Yeah, they give you an information slip at the beginning of your hiring, whatever, yeah.

SPEAKER?: Consent form or whatever? Yeah.

PI: I can show you. (Web page is shown to group.) Here is an actual notice about an individual, and I'll just show you quickly. We can use Kimberly's example. I'll just take her name here. Go to the home page for the college of BC College of Nurses and Midwives. And I'm going search for a nurse, I can also do a search for a midwife. There are two different databases. We have to use one for nurses and I'm going put in that last name that we came across, and I'm going do a search. And so there she is, and so you can see Kimberly, she's authorized to practice, but as you can see here, she's got some conditions and limitations, and she has a history of suspensions, and so you can see that there, and then where she's working. And then you can see the details which takes us back to the that original notice. Any thoughts about this?

SPEAKER?: It's pretty easy, .

SPEAKER?: Yeah, I think that's really helpful, and...

PI: All of the colleges have their own. You can look them up, but they all have pretty much the same type of information. I do think that physicians probably has the most extensive one, but moving along.

SPEAKER?: And so do you work with the unions then as well, like because you would have the unions involved in something like, like posting something like that.

Part II — BCCNM complaint process
Introduce standard complaint process using diagram.

PI: Yeah, that's a really good point. Probably about 80% of nurses work for belong to a union, which is BCNU typically. You're right, when they get into these agreements, they often have the representation from BCNU to help them negotiate and guide them, provide advice on how to proceed when they have a complaint against them. I think they also at times will provide legal counsel when they go into these agreements. This ties in quite nicely to the next thing that I want to talk to you about. And that's about the complaint process itself. I'm going walk you through it, and I again, show you my screen again, going get this.

SPEAKER?: I'm on my phone, so it's not very large when it comes on, so.

PI: Oh, okay, so I'll walk you through it

SPEAKER?: Yeah.

PI: This is the typical complaint process and this is how the majority of complaints are resolved. If it's a serious complaint or the nurse, I got to say nurse because that's primarily who we're talking about. When a nurse doesn't want to negotiate a resolution, then they will go through a disciplinary process, which was the case of the woman that had absconded with that money from that couple. So in this case, what we have is (Can you still, you can still see that tab?)

SPEAKER?: Yup.

PI: So, it starts off, it has to be written, and so that comes in, that's how we take them in. And then what happens is it's reviewed by us initially and or inquired by either the registrar or the inquiry committee. If it looks like someone makes a complaint because maybe the nurse was rude (we all get complaints like that) we'll try to resolve it at site level and try not to escalate it. Some will come in and they will not need further review. However, if it looks like there is some merit that requires more investigation, then it goes to our investigators and they'll go and dive in and try to find a little more about the either incident or the case that they're, the complaint is about. They will send investigators probably often to the site, they'll look at the documentation to look at that.

PI: The one thing I want to point out on that is that when it comes in as a complaint, that's the person who made that complaint, they've passed it to us, and now we're going to take that and we're going do the investigation. We may give the complainant an update but for the most part, they're not involved in the process anymore, they passed on information on to us, unless we have some clarification that we need to go back and get some more details. It goes to the investigation process. It goes to an inquiry committee and they will make recommendations on how they think that should be resolved, and at that point, they will ask the nurse to respond to the allegations that were made against them and they'll try to get some resolutions. It goes back to the committee and, at this point, the nurse will work with us to agreeing to the conditions that they found, like the one I just showed you about Kim Redlack. This is the how all complaints, not just in BC, the rest of Canada, this is typically how all complaints are resolved. This is a very typical process. Certainly if there was a serious case that they will go through to a discipline process. But this is our typical, typical approach and any thoughts or questions about it?

SPEAKER?: It's pretty straightforward.

SPEAKER?: Yup.

SPEAKER?: Yup.

PI: Alright. And it's what you would expect how they would be resolved? I got one more example about a complaint. So, we have one case that came in about a nurse that worked in long-term care. It was in 2020 and the nurse's name was Sharon... Oh no. Pardon me. Her name's not Sharon, it's Shannon. Shannon used physical force to restrain a resident, and this force was contrary to what the resident's care plan was and the facility policy. When we investigated the claim, we found that the allegations were true, and as a result, Shannon voluntarily agreed to a public reprimand, meeting one of our practice consultants, and completing two remedial courses, and was obviously told not to repeat this conduct. And that's how it went through this process. And, and do you have any initial thoughts on that?

SPEAKER?: I think from a person as a parent in a care home, I would want to know why she, like, chose that route first of all. Was it like, lack of training, lack of experience, or was it like a personality thing, and she's done this to residents before? Like, for me, as a complainant, I would want to know that she's not going be going on to doing this to other people as well, right?

PI: Yeah.

SPEAKER?: Yeah. That's a tough one. Like, how was the patient acting? And like, I don't know, what caused her to do that and how severe was it? And, kind of just a reprimand is... I don't know, it's hard to know without knowing all the...

SPEAKER?: Mm-hmm.

SPEAKER?: Facts surrounding it, right?

SPEAKER?: Yeah.

PI: I'm going come back to that, because I think you guys raise a couple of really interesting points on that. Looking at this process, what do you... Do you think there's any strengths in it? Or, what would you think the strengths are?

SPEAKER?: Gotta read that again. Hang on.

PI: I guess even just walking through. What do you think about the complaint coming in as in writing?

SPEAKER?: I think that limits certain people...

PI: Yup.

SPEAKER?: It's not open for everybody because what if you have somebody that can't write? It's... You know.

PI: Yeah.

SPEAKER?: It's not common today, but there are people that can't write, or it's a language barrier ...

PI: Still, there's some downsides to having that. So potentially, a written complaint can have... Can be a bit of a barrier.

SPEAKER?: Yup.

SPEAKER?: On the review committee, whether it's like one person or more than one person, because if you get... If it's just a one person that reviews it, sometimes you can have some biases.

PI: Would you like to know who's on the committee?

SPEAKER?: I mean, not necessarily...

SPEAKER?: As a complainant? Uh, what do you mean?

SPEAKER?: Well, I think maybe, whether they're peers, or professionals, or up there... You know what I mean? Like, as your review committee, who are they? Like are they a group of peers or are they people that are...

PI: They have two or three different committees that do the same work. And there are made up of nurses, who are registrants. They will sit... they act as peers. And we also have members of the public who also sit on these committees.

SPEAKER?: Mm-hmm.

PI: Because they're volunteers. That's why we have multiple committees doing this work, because it's fairly onerous work. When they get together, they spend half a day together, going through, going through the complaints. Would that be something that there's some value in knowing?

SPEAKER?: Yes.

SPEAKER?: Do they have any training? Like, do they have any ethical training or anything like that? Like, the volunteers, have they had any... I mean, obviously, the nurses would have. I took Health Care Ethics. But like, any of the, you know, with the public or anything like that, what they have any ideas... Any of that?

PI: That's a really good point. They do get an orientation, but as far as how are they vetted? So, that would be a question, maybe. How do we assess their ethics? A lot of the complaints that come in may have an ethical component to the complaint.

SPEAKER?: Yeah. And that's... I don't know, I'm a philosophy major, and that is... Ethics is huge. So yeah. A lot of stuff I wouldn't have known, just coming off the street.

PI: Alright. Some thoughts around the investigation. What do you think about that? How do you think we should be going about investigations?

SPEAKER?: I think it should be a professional. I don't know, necessarily. Well, if it's a volunteer, they should be a professional person especially if they're checking like, medical records and that kind of complaint.

SPEAKER?: Yeah.

PI: They are. They're staff for the college.

SPEAKER?: Cool.

PI: That do the investigating. Yeah.

SPEAKER?: And they go back and talk to the complainant?

PI: They do not.

SPEAKER?: The terms?

PI: I don't believe they do.

SPEAKER?: Oh.

PI: That's a good point. I'm afraid I don't know that. I know if they need clarification, they may go back to the case manager and then have the case manager talk to the complainant. I don't know if the investigators talk directly to the complainants.

SPEAKER?: Okay.

PI: But is that something that you would, would expect that that would be a direct...

SPEAKER?: Well, because I think, I think as somebody that's putting... Lodging a complaint, I think there's parts of the situation and stuff that they might not realize that needs to be asked about first by somebody that's investigating it. And if they don't go back and get those details, stuff can get lost in translation or just not actually talked about, and that could go both ways for the person that's getting the complaint against them. It could be either good or bad, right, you know?

SPEAKER?: No, it's true.

PI: So moving to the inquiry committee, so if the investigation happens, they write a report, it goes to the inquiry committee, the inquiry committee looks at it. They hand it over to the nurse so that they can see if they can respond to the complaint that's been made against them. Does that seem like a reasonable approach?

SPEAKER?: Is that a different committee than the review committee?

PI: Uh, it's the same.

SPEAKER?: Okay. That makes sense to me.

SPEAKER?: Yeah.

PI: Would there be any value in having a, a different set of people looking at that?

SPEAKER?: No, I think people who'd already know are aware.

SPEAKER?: Yeah, I would agree.

SPEAKER?: It would make sense to have the same people.

SPEAKER?: You don't want too many cooks in the kitchen.

SPEAKER?: Yeah.

SPEAKER?: Enough but not too many.

PI: The last step in the decision that we mail it, the decision to the complainant. How do you feel about that?

SPEAKER?: I think that's important.

SPEAKER?: Mm-hmm.

SPEAKER?: I think so too because in the area that I work at, they've started doing more mediation type stuff because they found when they did the... Like if they had a complaint against an employee and they did an investigation, and then all of a sudden hit this employee with like a decision, especially for the complainant and the employee. It didn't always often resolve the issue, and so they've started using more mediation and started doing that. Actually, before the review process even, seeing if they can just get it resolved that way. I don't know if that makes sense in this situation but...

PI: It does. You've, you've segued it perfectly for me.

SPEAKER?: Mm-hmm.

SPEAKER?: Thank you.

Introduce alternative dispute resolution process using diagram.

PI: I want to introduce an Alternative Dispute Resolution. Before I go through that, was there any weaknesses?

SPEAKER?: Yeah, I think if it's a nurse to nurse, if there is nurses, like it's, it's more of an employee relation kind of thing if it's a nurse to nurse, if they're both working on the same floor or in the same area and, you know, it could cause other issues.

SPEAKER?: Yeah.

SPEAKER?: Yeah.

PI: Okay. I'm going show you an alternative. So this would require a legislative change, and it is Ontario, and I think may be another province that has introduced this, but Ontario has been doing this for a number of years and they've have found it fairly successful. So this is the original. Can everyone see this?

SPEAKER?: I'll have to get my . . .

SPEAKER?: Sorry, M.

SPEAKER?: That's okay. It's just you know, if I had done this in the living room where my other computer is, it wouldn't have worked. There're too many people floating around.

PI: you can see the standard process, and they both start the same. You need to send the complaint in, in writing, so that's how they both start off. Rather than it going through this traditional process, there's this alternative dispute resolution, and like I said, Ontario offers this, and so I think a number of the Ontario colleges offer this process. Now, not all, complaints would be eligible to go through this process. If it's serious, certainly anything of any kind of abuse, they would not be eligible for going through this process. The other aspect of it is that the nurse needs to agree to want to go through this process, and so does the complainant. Now, this is a big, big difference from the other process, whereas the other process, the complainant really does not have a role in how it's resolved. In this one, everyone has full participation. So as, as M~ mentioned, like this is where the college acts more as a mediator into resolving the complaint.

SPEAKER?: Yeah.

PI: If all parties are in agreement, they will all sit down together and work together to resolve the complaint. Now, this is an opportunity for the complainant to ask questions and learn more about how maybe the incident happened, they have a discussion. A big part of it is wanting the nurse to reflect on the event or what happened and learn from that experience, and the conclusion is that

there's no further action taken. Now, unlike the standard investigative process, for the most part, unless they have a fitness to practise, which is considered anyone who has like a either a mental health or a drug and alcohol or substance abuse issue, it’s considered fitness to practise. We'll still publish the details about their resolution. How their complaint was resolved, but we don't publish their name. But otherwise, if it's not a fitness to practise, all other complaints, the nurse's name is published with their complaint. Now, so the difference between this the Alternative Dispute Resolution is, once it's resolved, there’s no further action. The resolution remains confidential. It's a more positive experience for the complainant as they go through it; they're involved in how it's resolved. Thoughts on that?

SPEAKER?: It's really similar to the restorative justice model in the criminal justice system, how they're starting to go that way and work with healing circles and indigenous justice and stuff like that. It's really interesting.

SPEAKER?: I think most governments are adopting something like that, especially for employee relations and that kind of... That kind of area is... I haven't seen it with the public so much as in how you're using it, but with employees, it's starting to become more of a practice.

PI: What do you think the strengths are of this process compared to the other process?

SPEAKER?: It could give the complainant some closure and, and reassurance.

SPEAKER?: Yeah, I think it might be more been... I guess... I don't know the right word, beneficial for the complainant as opposed to just having it resolved away from them and then just hearing at the end what happened.

SPEAKER?: I think it's especially beneficial for, say like that one situation with the in the care home.

PI: Right. Yeah, if we were to walk the that particular incident where there's a complaint about the resident being restrained, and so they're walking through this process.

SPEAKER?: Yeah, with the families and the, I mean, possibly the resident and the nurse. Yeah, you could get... It would be a whole lot... I think it would... You would see both sides.

PI: Mm-hmm.

SPEAKER?: And you could come to some sort of resolution.

PI: And I guess the flip side of this is, is there any weaknesses for this process compared to the other resolution process?

SPEAKER?: Can I ask, is it always going to be resolved with no further action?

PI: Well, that's, that's a good... That's a good question to ask... would you like to see that as an option?

SPEAKER?: No, I'm just thinking you have to be... I think you'd have to be fairly careful of what complaints you would put through that process if it's always going end with no further action. Yeah.

SPEAKER?: Yeah.

PI: I guess my question would be, what kind of cases do you think then would be eligible for this process that you would like? What would your expectation, who would be... What kind of complaints would be eligible for this resolution?

SPEAKER?: Yeah, that's a tough one because I don't really know.

SPEAKER?: Yeah, I don't think no further action is in the situations you've given us, there is no further action, right? Because it either goes through retraining or some sort of, you know, ongoing process to monitor that.

SPEAKER?: Yeah.

SPEAKER?: That...

SPEAKER?: Unless it was a big misunderstanding, then it... No further action, right?

SPEAKER?: Yeah.

SPEAKER?: Yeah.

PI You'd, you would like to see if there's some remediation required, that somehow that would be built into how it's resolved?

SPEAKER?: Right.

SPEAKER?: Yeah, a monitoring process.

PI: If you were in a circumstance of, let's use the long-term care case. How would you want to have your complaint resolved?

SPEAKER?: I would through the second process, but...

SPEAKER?: Yeah.

SPEAKER?: Yeah, through the second process, actually, right? I would want to be comfortable that, that, that nurse is aware of my concerns, and, and I want to be comfortable that that nurse is okay to go back and, and keep working with elderly people, right? You're not monitoring the situation, that person could go back in and not just restrain other elderly people, but they could be doing other things, right? Like it could be just the tip of the iceberg that they just got caught on this one incident.

SPEAKER?: Yeah, I agree.

SPEAKER?: Yeah.

PI: Is there another way to be resolving complaints? So are we looking at another step to this process, whether it be between four and five? Let's say there were remediation, outcomes, so that the going through that process, the expectation is that there is... We'll also do some workaround how they do their practice. How do you feel about that being confidential?

SPEAKER?: Like an action step?

PI: Yeah, so I'd say, yeah, between four and five, there's actions that the nurse needs to undertake, but the outcome is that there would be no this would not be public. It wouldn't be published on the website.

SPEAKER?: I think it depends what they are... If the nurse was, like there were certain parts of the public they weren't allowed to work with, there's certain restrictions they had, I think that shouldn't be confidential. Maybe next steps for training and stuff could be confidential, but like depending on what's going on with their licensing, I think, shouldn't be confidential.

SPEAKER?: I kind of guess it depends on what the complaint is and the seriousness. It's so difficult to...

SPEAKER?: Yeah.

SPEAKER?: Imagine, but maybe the step between four and five is maybe a review, is there... Like who is involved in the discussion part? Step three. Besides the participants, like the complainant and... Is there, you know, other... Like a review committee or like, who's involved in...

PI: It would be a mediator

SPEAKER?: Oh, one... Yeah. And then maybe the review... Is there a place in that process to... For the mediator to give recommendations or...

PI: Yeah, that's a good... Is it going through the Inquiry Committee? I guess how to enter the stage, is that something that would make sense. To be eligible, that it would first need to be maybe approved by the Inquiry Committee, that that would be the case. The nurse is motivated... Would be motivated to go through this process, because they're not going to be named publicly, so that's certainly a motivation for them to want to come to the table and discuss what happened. And I think of the philosophy is that when people reflect on their practice and are accountable, and that does change people the way they do their work. Perhaps more so than if they just have a punishment assigned to them.

SPEAKER?: Is there accountability with this model though? Like there is, because you sit down and discuss and reflect, but there's no further actions taken, so like, how much accountability is there besides it's a big pain in the butt to sit down and talk with somebody that's complained about you?

SPEAKER?: Yeah.

SPEAKER?: You know what I mean?

PI: Yeah. No, that's a really good thought on that. So there's some strengths, but is that a weakness?

SPEAKER?: I think it's a bit of a weakness, yeah. If they know ahead of time there's no further action and it's going be... That it's not going to be public at the end of the day, is... I don't know, it's a bit of a weakness.

PI: Yeah.

SPEAKER?: If there was a review after it, and... I don't know, I guess like a... The mediator is satisfied as well as the other participants.

PI: That's right. Well, and I think my understanding with the Ontario process is that they cannot kind of arrive at some sort of consensus. I guess at any point, this... They can go back, this can be kind of sent back to the more... The traditional process of resolving complaints.

SPEAKER?: Oh, okay.

PI: I don't know how well-spelled that is. It gets very specific maybe in the legislation about those crossroads — when it needs to be redirected back. So as we start thinking about it a little bit more, you can see where there's all types of complaints that come in. What would be eligible? If you're thinking about kind of those conditions about what cases that would end up in this. I think they're running quite a few in Ontario, that go through this process.

SPEAKER?: I think it'd be more re-training kind of things where you want to mentor somebody, maybe have a new nurse that's... Her training is not quite fully there, that, you know, needs some extra help or some extra training, or someone like that that you know is going be a good nurse or a good practitioner or whatever is... In their field, is just inexperienced.

PI: So maybe that would be one of the criteria to be eligible to follow through this process?

SPEAKER?: Possibly.

SPEAKER?: Yeah.

SPEAKER?: Possibly.

SPEAKER?: But then you're not going... It's not going be resolved with no further action because there isn't going be further action because she's going have some... Or he's going to have

some further training and some mentoring and some monitoring and some... Right? Like there is...

PI: This does fall more along the lines of the restorative justice approach, and I guess that's another, another way of looking at this way of resolving. Are you surprised that this, this would be offered? Maybe the question is, would you want to see this in BC?

SPEAKER?: As a complainant, I think, I think I would like to have this option, depending on my complaint.

SPEAKER?: Yup.

SPEAKER?: Yup.

SPEAKER?: Yeah, yeah, certainly, depending on...

SPEAKER?: Yeah.

SPEAKER?: Complaint, for sure.

PI: The Ontario, when they, they did a study, I think in 2016, and what they found is, for the most part, when the public made complaints, they were more satisfied with the outcome of how their complaint was resolved going through the alternative dispute resolution process than the other process. So, it seemed like it was fairly well-received

SPEAKER?: I think that... Yeah, that's not surprising. I don't think just because they're more informed and more part of it, right? Like you said, there's more closure.

PI: Yeah, when you're looking at the person across the table. They need to answer, account for what happened.

SPEAKER?: Yeah.

PI: And then, you know seeing I guess that a human-being and there are circumstances in hearing their side of the story. So we've covered a lot. You probably now know way more than you ever wanted to know about health regulation and ...

SPEAKER?: Oh no, you know my sister.

PI: That's good. Yeah, yeah, you're getting, immersed in, in health regulation. I super appreciate you sharing your thoughts and, and your time to help me with this, because I do appreciate it. You had some really good comments that will be very useful for me.

SPEAKER?: Well, get it done.

SPEAKER?: Awesome, done.

PI: Yeah, exactly.

SPEAKER?: Yup.

PI: Yeah. do you have any other questions or thoughts about what I just shared with you?

SPEAKER?: That was interesting.

SPEAKER?: Yeah.

SPEAKER?: Mm-hmm.

PI: Oh, oh, good.

SPEAKER?: Yeah.

PI: Well, for myself anytime I see a practitioner I'm going see a massage therapist or physiotherapist, I always look them up, always.

SPEAKER?: Well, I...

PI: You got to.

SPEAKER?: I didn't know that, so I find that...

PI: Yeah.

SPEAKER?: It was definitely beneficial to know that, yeah.

PI: Yeah, dentists, like you name it.

SPEAKER?: Dentists.

PI: Well, there's one in the Kamloops area that's in quite a bit of trouble right now.

SPEAKER?: Yeah.

PI: Yeah.

SPEAKER?: He's always on our, on our radar. I'm from Kamloops, so we've got all sorts of issues going on here, right now.

PI: You've got some... You have some naughty practitioners over there.

SPEAKER?: We do, we do. Our hospitals having issues, Yeah, it's fun.

SPEAKER?: Yeah, that's the one that is in the news right now, that Royal Inland...

SPEAKER?: Yeah.

SPEAKER?: Is with the woman whose foot's rotting off of her body, they just aren't doing anything.

SPEAKER?: Oh, oh.

PI: Oh, I didn't hear that one.

SPEAKER?: No, I didn't hear that one.

SPEAKER?: I didn't hear that one either.

SPEAKER?: Yeah, she says something going on... I think it's her foot. Something's happening to her and there's so many COVID patients in there that she's not a priority and she's watching part of her body just like...

SPEAKER?: Ah.

SPEAKER?: Mmm.

PI: That's horrible.

SPEAKER?: I know, it's really horrible, really, really horrible.

PI: For the most part, you know, most, most nurses anyway are, are fine and upstanding and doing what they need to be doing. But like every profession, every kind of walks in society, there's a small, small group of people that, for whatever reason, they aren't working to the way

they should be. Or there's some ethical issues and that's a whole different kind of thing, but fortunately they're a small minority. We do need to address them.

SPEAKER?: Mm-hmm, yeah.

PI: Yeah.

SPEAKER?: Yeah.

Part III — conclusion

PI: Anyways, if you have any other thoughts or anything you want to follow up with me later, just shoot me an email or give me a call. Thank you again. Enjoy the rest of your evening.

SPEAKER?: All set.

SPEAKER?: All right.

SPEAKER?: Thanks, nice to meet you.

SPEAKER?: Thanks, bye.

SPEAKER?: Bye.

PI: Bye.

63 MINUTES

Appendix H
University of Alberta Research Ethics Approval

Elizabeth Bruce <ebruce@ualberta.ca>

ARISE: Ethics Application has been Approved Pro00113221

arise@ualberta.ca <arise@ualberta.ca> Fri, Oct 29, 2021 at 8:51 AM
Reply-To: arise@ualberta.ca
To: ebruce@ualberta.ca

Ethics Application has been Approved

ID:	Pro00113221
Title:	The Public's Perspective of a Health Regulator's Complaint Process and an Alternative Dispute Resolution
Study Investigator:	Elizabeth Bruce
	This is to inform you that the above study has been approved.
Description:	Click on the link(s) above to navigate to the workspace.
	Please do not reply to this message. This is a system-generated email that cannot receive replies.

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