Legal Privilege Legislation: Consequences for Patient Safety

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Abstract

Increasing awareness of the extent of preventable harm from healthcare has led to efforts to improve patient safety through a variety of efforts, including legislation. Extending legal privilege to quality and safety reviews leads to further harm for many patients, families and healthcare providers. The intentional isolation, silencing and exclusion after the incident undermines trust, prevents learning and impedes an opportunity to heal and recover for all those directly involved. Our case study examines Section 51 of British Columbia's *Evidence Act* (1996) and concludes that amending this legislation is an urgent and necessary step toward trauma-informed care.

Context

> "The harm starts afterwards."
> (Mother of premature infant)[1]

Awareness that harm to the patient may accompany efforts to heal dates back to more than 2,500 years ago. Hippocrates' familiar advice to physicians, *primum non nocere* [above all, do no harm], situates patient harm as *iatrogenic* – that is, arising from the provision of care itself, in contrast to the patient's underlying illness or injury. In the last 50 years, industrialized countries began to examine the extent of the harm experienced by patients, families, communities and caregivers. Some studies borrowed from emerging safety science to suggest systemic origins of the devastation. For example, studies in California (Mills 1978) and New York (Brennan et al. 1991) applied a systematic analysis to situations in which unintended significant harm was occurring in hospitals. By the end of the 20th century, various national reports, *To Err is Human* in the US (Institute of Medicine [US] Committee on Quality of Health Care in America et al. 2000) and *An Organization with a Memory* in the UK (Donaldson 2002), proclaimed a crisis in patient safety.

The reports focused professional, political and public attention to outcomes acknowledged as unacceptable and resulted in new legislation, policies and resources and the creation of patient safety departments and authorities. A study of progress across the US, 10 years after the release of *To Err Is Human*, (Landrigan et al. 2010) reflects much effort but limited reduction in harm. Recently, a review (Milligan et al. 2021) of Canadian legislative initiatives for patient safety also found little effect in safeguarding patients. Notably absent in these evaluations is consideration of the legislative provision of legal privilege for quality and safety committees that conduct case reviews. The purpose of such protected reviews is often described in terms of promoting learning and reducing avoidable patient harm.

It may appear unseemly to raise the issue of patient safety as Canada is wearily entering its third year in the COVID-19 pandemic. However, while the pandemic's toll in its first 22 months amounts to some 34,000 Canadian lives lost due to COVID-19, past incidence studies of preventable adverse events in Canada project over 70,000 deaths during the same 22-month period (RiskAnalytica 2017). Moreover, while the COVID-19 pandemic erupted globally in the first months of 2020, the burden of preventable harm and deaths related to patient safety incidents has continued as an endemic feature of healthcare systems around the world for decades.

Large studies in Canada (Baker et al. 2004; Matlow et al. 2012) have generally avoided examining the impacts of patient safety events on vulnerable populations, in particular racialized members of society. The recently released report *In Plain Sight* (Turpel-Lafond 2020) highlights the experience of Indigenous Peoples in British Columbia (BC). The report notes particular failures and mistreatment when reviews and investigations involve Indigenous persons. Specifically, reviews under protection of Section 51 of the *Evidence Act* (1996) reinforce systemic power imbalances and intergenerational distrust through non-disclosure of appropriate information, publication silence on issues and incidents of anti-Indigenous racism and a lack of effective examination of the role of racism in contributing to harm as experienced by Indigenous patients, particularly Indigenous women. These realities have led to a call for a culture of data sovereignty – the idea that patient- and community-led health organizations and Indigenous governments are the rightful owners of patient records and data regarding patient harm events including experiences of racism and/or medical errors:

> … the Review also stresses that the Ministry of Health must assume ultimate accountability to monitor change on the health system's problem of Indigenous-specific racism. This must be done in ways that uphold Indigenous data governance and in partnership with Indigenous peoples. The shared objective of relevant information being provided in a timely, actionable and ethical way must guide this partnership. (Turpel-Lafond 2020: 229–30)

As detailed in the report, current practices ignore "the roles and responsibilities of Indigenous governments, laws and jurisdictions, or the standards of the *UN Declaration* [on the Rights of Indigenous Peoples]" (Turpel-Lafond 2020: 229) and fail to collect and share important data on racism in healthcare:

> There is insufficient measurement and reporting on Indigenous-specific racism and cultural safety in health care ... There are major data and information gaps related to the experiences of Indigenous peoples in health care – particularly Métis peoples; and the system is not availing itself of opportunities to systemically examine the issue of Indigenous-specific racism using existing tools and data sets. (Turpel-Lafond 2020: 234)

These gaps have already led Alika Lafontaine, the first Indigenous president-elect (2022) of the Canadian Medical Association, and his brother Kamea, to create Safespace Networks (SN) to "empower racialized patients in health systems" and provide an alternative to current reporting systems (CMA Joule Staff 2021). SN is currently piloting the program with community groups, including the BC Association of Aboriginal Friendship Centres, to facilitate the collection of patient information, review data and work with local healthcare systems to proactively reduce patient harm. As this initiative demonstrates, if existing gaps continue to be unaddressed in healthcare reporting systems, we can expect increased rejection of current systems and, as a result, a significant credibility issue for these systems and those who lead them.

Overall, the report, *In Plain Sight* (Turpel-Lafond 2020), opens a critical social and political space to rethink and restructure the response to patient harm with processes that compel institutional learning and accountability in BC – an opportunity underlined by the current context of the COVID-19 pandemic. Patient safety issues, particularly issues of racism and gender bias against Indigenous women patients, have been extensively covered since the outbreak of COVID-19 and have increased public scrutiny on existing patient safety failures across the country. As Joyce Green argued over 20 years ago, Indigenous women are the "canaries in the conceptual mines of Canadian citizenship" (Green 2001: 718). From this perspective, centring the experiences and embodied expertise of Indigenous women is critical to identifying sites for change and methods of evaluation that will benefit all Canadians. The horrendous death of a 37-year-old Atikemekw woman, Joyce Echaquan, in a Quebec hospital in 2020 brought this issue to the forefront as reflected in the official coroner's report (Kamel 2020).

Section 51 of the *Evidence Act* in BC

The *Evidence Act* (1996) of BC was proclaimed in 1996. Section 51, hereafter noted as "S51," deals with healthcare evidence and focuses on the work of committees that are "charged with the function of studying, investigating or evaluating the medical or hospital practice of, or care provided by, health care professionals in that hospital" with a goal of "improving medical or hospital practice or care" (S51[1] subsections [b] and [c]) (*Evidence Act* 1996). Concepts such as patient safety, transparency, confidentiality and healing after healthcare harm are not mentioned in S51, nor is there any reference to working with a trauma-informed approach. Discussion of any consideration of the rights of recipients of care – the surviving patient and affected family – or the duties owed to them by organizations is also omitted.

S51 focuses instead on protections, through legal privilege, afforded to members of quality care committees. Members of duly constituted hospital committees cannot be forced to testify or answer questions about the work of the committee, nor can they be compelled to produce any documents relied on by the committee in any legal proceeding, as defined in S51. Patients and family members involved in an adverse event that is being investigated are not provided with similar protections. Presumably this is because patients and family members are not appointed to such committees. The authors are unaware of a single case where a patient or family member has been invited to join such a committee to contribute information or learn from the review of a case involving their care.

> [P]rivilege and confidentiality can be abused. When not applied in a principled and consistent manner, they can be used as an excuse to shield wrongdoing or even simply keep Canadians in the dark. (Wilson-Raybould 2021: 238)

S51 protections attempt to create the conditions to promote free and uninhibited discussion of what happened, including what might have been done differently, in a given case. In practice, this may include speculation, opinions or "best guesses" about the outcome if a different course of treatment had been undertaken. These discussions are not shared with the patient involved as outlined in subsection (5): "A committee or any person on a committee must not disclose information or a record provided to the committee … or any resulting findings or conclusion of the committee" (*Evidence Act* 1996). There are a few exceptions to this restriction, such as a hospital board of management or situations "for the purpose of advancing medical research or medical education" (*Evidence Act* 1996). The patient and family (and the broader community for that matter) are prevented from learning anything substantive about the work, findings or recommendations of the committee. Indeed, the word "recommendation" does not appear in S51.

It has been suggested that such extensive legal protections promote "secrecy" in the work of quality and safety committees. Rather than jumping to such a conclusion, we searched for other possible explanations. The *Section 51 of the Evidence Act: Toolkit for Health Care Agencies* (HCPP 2011) was prepared in 2011 (updated in 2013) by the Health Care Protection Program, which provides legal advice and indemnification for hospitals and some healthcare facilities in BC. In its preface, we are assured that "Section 51 is not intended to promote a culture of secrecy" (HCPP 2011: 3).

The Toolkit reflects the same proscriptive approach as S51. With respect to S51 committee membership (HCPP 2011: 11, 28), a broad cross-section of staff and management is recommended. Apparently, no role is envisaged for patients. The Toolkit asserts that a "properly constituted" S51 committee must have at least one registered (not specified in the legislation) healthcare professional. While patients are not proscribed from membership in such a committee, neither is their participation envisaged or encouraged.

The legislation is silent on who should lead an S51 committee, but the Toolkit recommends that the quality/risk manager (Q/RM) in a given facility assume responsibility for all activities of the committee (HCPP 2011: 16). Furthermore, it is also silent on the required training or experience for the Q/RM, and equally silent on training of unit managers or department heads required to make an "initial determination of the seriousness of the event and whether a quality of care review needs to happen" (HCPP 2011: 17). This conflicts with established tenets in the training and certification of patient safety investigators (Robson 2020). The ability to properly investigate, make findings and craft recommendations is an acquired discipline (not a "special power" conferred along with a degree in nursing, medicine or any other allied area of practice) recognized within the domain of safety science.

Both S51 (*Evidence Act* 1996) and the Section 51 Toolkit (HCPP 2011) stress that committee members must understand that all discussions and documents are privileged and confidential, extending equally to anyone invited to meet with the S51 committee. This applies to patients or family members (as "those who have direct knowledge of the event"), but that possibility is never mentioned even though the patient is surely at the centre of the adverse event that has produced harm (HCPP 2011: 20). Jurisdictions outside BC (for instance, Manitoba) have historically encouraged patients and family members to attend patient safety reviews, even accompanied by a support person including legal counsel. The Toolkit discourages the presence of support for anyone invited to the committee, with the exception of physicians whose legal counsel are "generally permitted to attend with their client" (HCPP 2011: 20). No such accommodation is provided for patients.

> Reviews under these provisions make matters worse for the patient, who is treated like a guinea pig for the betterment of a system that hoards knowledge from the patient. (Experienced lawyer)

An entire section of the Toolkit deals with the release of information to patients and substitute decision makers, stressing what cannot be released. Although the Toolkit notes (HCPP 2011: 23) the patient's right to their hospital medical record, this simply affirms the Supreme Court of Canada's decision in *McInerney v. MacDonald* (1992). Furthermore, "any additional factual information about the patient's care which has been learned in the course of the review but is not noted in the chart and should have been," should, according to the Toolkit, be disclosed to the patient (HCPP 2011: 23).

While the Toolkit asserts in its preface that "it is not the intention of Section 51 to promote a culture of secrecy," it is easy to imagine why the "patient or family may become suspicious and frustrated with the process" (HCPP 2011: 36). As the Toolkit warns, "It is important, to the extent possible, not to tie the actions implemented based on the recommendations back to the findings or conclusions of the Section 51 Committee or the evidence before it" (HCPP 2011: 36). With findings, conclusions and recommendations all withheld from the patient and family, how could they not react with suspicion and frustration?

> I knew there was going to be an investigation into my case. What I did not know was that I would not be privy to any of the details. I was told never to expect an apology or to see the results of the investigation. (Injured patient)

Finally, we considered the "Section 4.2 Release of Section 51 Information to Others" (HCPP 2011: 24–26) with particular reference to the release of S51 information to legal counsel. In those situations where a healthcare agency (for instance, a hospital) is facing potential or real civil litigation, it is "appropriate" to release information to the hospital's legal counsel. However, the same is not true for counsel representing the patient, which appears to be a rather blatant exercise in the abuse of power and perfectly legal injustice. Current management of complaints and investigations isolates, alienates and unnecessarily rejects those who most depend upon engagement to heal, in part due to interpretations of S51 (*Evidence Act* 1996).

The Experience in Other Jurisdictions

The challenges and constraints of S51 are not unique to BC. Similar legislation exists across Canada. In most cases, the legislation is included in the *Evidence Act* of a given province or territory. In the case of Ontario, separate legislation (*Quality of Care Information Protection Act* 2016) contains many of the same provisions that exist in other provinces. The protections for members of quality and safety committees are aligned, although the description of the limits of what information can be shared is somewhat more nuanced than is the case for S51. It is hard to imagine that the impact of such parallel legislation will be different from the experience in BC.

How are investigations handled in non-healthcare domains where safety is considered paramount? The Transportation Safety Board (TSB) of Canada, with more than 100 full-time accident investigators, provides an interesting contrast. The legislation (*Canadian Transportation Accident Investigation and Safety Board Act* 1989) indicates many similarities with healthcare legal privilege legislation, as well as some surprising differences.

Investigators and members of TSB investigations cannot be compelled to testify in subsequent legal proceedings, nor can documents be subpoenaed before such proceedings. There does not seem to be a clear description of who may (or may not) be added to a TSB investigation, in contrast to most of the healthcare legal privilege legislation that details the structure of quality and safety committees.

A significant difference is the requirement for public reporting of a TSB investigation. Section 24 (1) of the *Canadian Transportation Accident Investigation and Safety Board Act* (1989) directs "on completion of any investigation, the Board shall prepare and make available to the public a report on its findings, including any safety deficiencies that it has identified and any recommendations that it considers appropriate…" Furthermore, the act also states (Section 7 [2]) that "the Board shall not refrain from fully reporting on the causes and contributing factors merely because fault or liability might be inferred from the Board's findings" (*Canadian Transportation Accident Investigation and Safety Board Act* 1989).

Unintended Consequences of Legal Privilege Legislation

S51 of the *Evidence Act* (1996) in BC undermines patient safety in at least three important areas. Lacking a preamble to clarify the purpose of the legislation, we are left to guess whether this was intentional.

The first assault is on healing for all those involved when harm occurs. S51, along with its interpretation in the S51 Toolkit, denies patients and families a full and robust explanation of *what happened*. Shared understanding is a required element for everyone's healing. Moreover, the legislation interferes with a patient and family having direct contact with the providers involved in a harmful event. Such constraints prevent the possibility of dialogue and the provision of an authentic apology and set the stage for the development of compounded harm. Indeed, for many patients and families, the harm occasioned by how they are treated after the event is worse than the physical harm itself.

> The opportunities for subterfuge were enormous, and this did not serve to reinforce any sort of trust in the healthcare system. I am now completely medical avoidant. Any hopes for reconciliation and healing were quashed when I was denied access to critical information about my own healthcare. (Injured patient)

The second impact of S51 is its inhibition of learning. The opportunities to share information are narrowly defined, not just with the patient and family but also with the broader community, including the public that underwrites all the costs of our healthcare system. It is not clear whether most of the healthcare staff directly involved in the incident will have access to the lessons learned of a S51 safety review. Contrast this approach with the open reporting of TSB investigations, as well as with the recommendations of patient safety advocates (CPSI 2011). With impoverished learning comes the inability to effectively implement systemic changes that will reduce the likelihood of similar harm occurring in the future.

> There was no formal investigation after my husband's death, no curiosity. I was told that everything went well in the operating room, and it was not clear why he had died, but that "it happens every day." I learned later that the surgeon had not even bothered to read the autopsy report that detailed the cause of death. (Life partner of 35 years)

Most profound and serious of the unintended negative impacts of S51 is its undermining of trust in the healthcare system itself. Known as "institutional betrayal" (Smith 2017), this attacks the core of safe, good-quality care. The essence of healthcare is care or caring. Trust is the foundation of the relationship between patient and provider. When harm occurs with little or no explanation of what happened, trust in providers, and the system as a whole, cannot flourish. The experience of betrayal holds its own compounded harm, extending beyond the individual case, rapidly engulfing friends, family and the broader community with every retelling of the story and sowing the seeds of suspicion and wariness for others needing to rely on healthcare in the future. The health consequences of delayed diagnosis and shunned treatment due to such institutional betrayal are tragic. The erosion of public confidence in healthcare's purpose is catastrophic.

> When things go wrong, patients and families need to know what happened. We need to know what changes have been or will be made to prevent a similar event in the future. When patients and families sense that information is being withheld, we lose trust, and we are more anxious, fearful and angry. (A patient's perspective; CPSI 2011)

Conclusion

By analyzing S51 of the BC *Evidence Act* (1996) as a case study, this article has demonstrated at least three important negative consequences of the present legislation: the effective prevention of healing after harm, the inhibition of learning and the undermining of trust in the healthcare system. All three have a significant impact on patient safety, which continues to be a largely ignored and understated public health emergency in Canada today. The lack of transparency owing to the extraordinary level of protection via privilege for the investigation's participants, along with personal health information privacy laws, ensures that the public will learn little of the facts of the case or what will change as a result. Transparency is not the enemy of safety; it is an essential element. Why should the learnings be proprietary to only a handful when a whole country could benefit?

During the analysis of this case study, two important and previously unexamined issues emerged. The first is the virtual impossibility of any large organization or complex sociotechnical system to adequately investigate itself. The need for independent assessments of operations (including adverse events) has become apparent in many industries and social processes. Recent examples from the military and the police illustrate this conundrum. Any future modifications of S51 will need to incorporate the learnings from those examples.

The second important issue concerns the training of both staff and leadership who will be involved in conducting patient safety and quality reviews. Safety science has become a recognized discipline, and it is paramount that the principles and precepts developed in recent decades be applied actively and broadly to change the present unacceptable situation.

The *Evidence Act* (1996) provides rules for the legal system in BC. The legal system is fundamentally *transactional* in its approach to resolving problems and conflicts. S51 of the *Evidence Act* (1996) does not reflect the fact that healthcare is primarily a *relational* (not *transactional*) activity. The distinction between these types of activities is important as reflected in the following practical example provided by Roger Fisher during a seminar (titled "Program of Instruction for Lawyers, Negotiation Workshop: Basic Negotiation") in 1998[2]: "Buying a can of pop is quintessentially a transactional activity. Pay your money and get your pop. There is no relationship between the machine and the purchaser and no need or capacity to develop shared understanding."

Providing effective and successful healthcare requires the development and nurturing of relationships at multiple levels. Applying rules that may be appropriate for a transactional activity to healthcare amounts to trying to force a strangely shaped and constantly changing peg into a very tightly defined and circumscribed hole. Not surprisingly, this approach is not an effective way to promote healing – certainly not for the patients, families and healthcare providers who exist in a dynamically shifting relation to one another. It is time to move away from this model and toward healthcare that is comprehensively trauma-informed. While detailed recommendations are beyond the scope of this article, in general, this approach requires the *system* to make a paradigm shift from asking, "What happened and who is to blame?" to "Who has been harmed and what are their needs?" HQ

Acknowledgement

Amy Strachan, BSc, is the research group meeting planner and administrative coordinator at Healthcare System Safety and Accountability, Inc. She was the workshop coordinator for the first online eight-week SPHERE Workshop and managed the transition from the two-day intensive in-person workshop.

Declaration

Many of the authors have experience of unintended healthcare harm as either a patient or a family member; several individuals were not in a position to publicly declare authorship at this time.

Notes:

1. The several anonymous quotes that appear throughout the article originate from personal communication – verbal or electronic – with RR and are printed with the full informed consent of the individual.
2. "Program of Instruction for Lawyers, Negotiation Workshop: Basic Negotiation" attended by RR at Harvard Law School, one of four week-long workshops in the Program on Negotiation (1998).

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