



SANTÉ QUÉBEC

2025 – 2026 Annual Report

Implementation of the Complaint Review and Service Quality Improvement Process

This report was prepared by the MUHC Office of the Commissioner for Complaints and Service Quality on May 15, 2026.



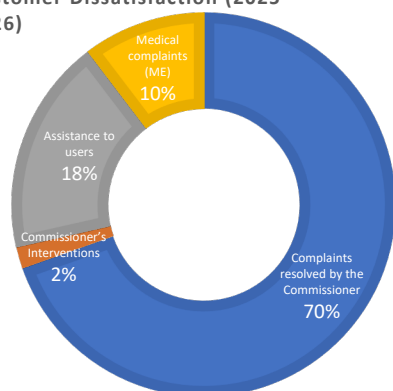
Table of Contents

Overview of the Commissioner's Activities at a Glance	1
List of Acronyms	2
Cover Letter to the Chair of the Institution's Board of Directors.....	3
Cover Letter to the National Commissioner	3
A Message from the Commissioner	4
A Glance at the McGill University Health Centre	5
Presentation of the Report.....	6
Key Figures for the Year	6
1. Summary of the Commissioner's Activities	8
1.1. General Complaints Handled by the Commissioner	8
1.1.1. Examples from the Handling of General Complaints	8
1.1.1. Examples from the handling of interventions	9
1.1.1. Examples from the handling of cases related to abuse.....	10
1.1.2. Summary of General Complaints	11
1.1.3. Summary of cases submitted to the Ombudsman	11
1.2. Interventions	12
1.2.1. Summary of interventions carried out	13
1.2.2. Summary of cases referred for disciplinary review.....	13
1.3. Summary of Assistance Cases	14
1.4. Summary of consultation requests.....	14
1.5. In the Field.....	15
1.5.1. Other activities of the commissioner.....	15
1.6. Abuse Section	15
1.6.1. Example of a Case Involving Abuse	15
1.6.1. Summary of Complaints and Interventions Regarding Abuse.....	16
2. Summary of the Medical Examiner's Activities	17
2.1. Examples from the handling of medical complaints	17
2.2. Summary of Medical Complaints.....	18
2.3. Summary of cases referred for disciplinary review.....	19
Conclusion.....	20
Appendices	21

Overview of the Commissioner's Activities at a Glance

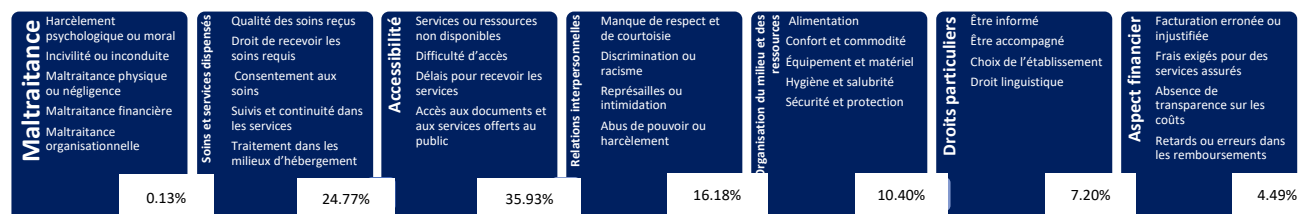
The overview of complaint management presents certain quantitative data.

Breakdown of Cases Related to Customer Dissatisfaction (2025–2026)



	Number	Change from the Previous Year
Cases involving dissatisfaction resolved by the Commissioner and medical examiners	2,485	13.52%
• Complaints resolved by the Commissioner	1,732	24%
• Actions taken by the Commissioner	45	36%
• Assistance provided to a user	452	-17.36%
• Medical complaints	256	15%
Corrective Actions	163	12.41%
• Complaints	110	10%
• Interventions	24	-20%
• Medical complaints	29	93.33%

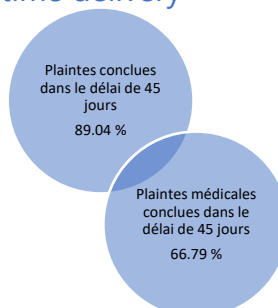
Reason for complaints



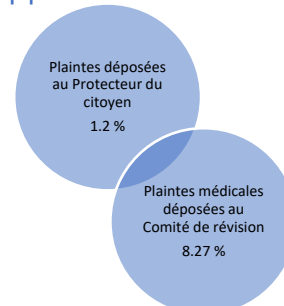
Complaints by Mission

Mission	Complaints and Intervention	Medical complaints
Hospital	1760	255
Long-term care facilities (MDA, CHSLD, RPA, RI, etc.)	12	1

On-time delivery



Appeals to a second



Complaints and interventions reported in connection with cases of abuse

Year	Number of closed complaint and intervention cases	Change from previous year (%)
2023–2024	12	71%
2024–2025	22	83%
2025–2026	17	-23%

List of Acronyms

CA	Board of Directors
CAAP	Complaints Assistance and Support Center
CH	Hospital
CHSGS	General and Specialized Care Hospital
CHSLD	Long-Term Care Facility
CHU	University Hospital
COMMISSIONER	Commissioner for Complaints and Service Quality
CU	User Committee
MUHC	McGill University Health Centre
CVQ	Quality and Oversight Committee
DGSI	Directorate General of Nursing
LGSSSS	Health and Social Services System Governance Act
REP	Complaints Review System
RSSS	Health and Social Services Network
SIGPAQS	Complaint Management and Service Quality Improvement Information System

Cover Letter to the Chair of the Board of Directors of the facility

Mr. Peter Kruyt
Chairman
Board of Directors
McGill University Health Centre

Dear Chairman,

In accordance with the Act respecting the governance of the health and social services system, I have the honor of submitting to you the annual report of the MUHC Commissioner for Complaints and Quality of Services for the period from April 1, 2025, to March 31, 2026.

Please accept, Mr. President, the assurance of my highest consideration.



Michael Bury
Commissioner for Complaints and Quality of Services
McGill University Health Centre

Cover Letter to the National Commissioner

Ms. Martine Gosselin
National Commissioner for Complaints and Service Quality
Santé Québec

Madame National Commissioner,

In accordance with the Act respecting the governance of the health and social services system, I have the honor of submitting to you the annual report of the MUHC Commissioner for the period from April¹, 2025, to March 31, 2026.

Please accept, Madam National Commissioner, the assurance of my highest regard.



Michael Bury
Commissioner for Complaints and Service Quality
McGill University Health Centre



A Message from the Commissioner

This year marks the introduction of a new standardized format for the annual reports of the offices of the Complaints Commissioner across Quebec. This approach aims to improve the comparability, quality, and efficiency of data analysis by the Office of the National Commissioner, as well as to better identify the challenges faced by users of Quebec's public health and social services system. As a result, the National Commissioner will be better equipped to make recommendations to Santé Québec's

National Oversight Committee, drawing on a comprehensive provincial overview of the challenges and opportunities for improving care and services.

For the 2025–2026 fiscal year, the predominant issues remain related to access and wait times. These challenges are largely attributable to high demand for specialized services and diagnostic tests, a shortage of human resources to meet that demand, or a combination of these factors. Although quantitative data provide essential information, they are not sufficient on their own to capture the full complexity of the situations people experience. They must be interpreted in light of the context in which events occur.

This understanding of the issues relies largely on the conversations we have with patients and their loved ones, which help us better grasp the concrete impacts of these situations on their care experience. Their contribution to the preparation of our annual report is essential, and we sincerely thank them for taking the time to reach out to us over the past year. Their participation remains indispensable to ensuring that the patients' perspective is fully understood and adequately represented within the healthcare system.

We would also like to highlight the excellent collaboration we continue to receive from all MUHC departments at every level, and we thank them warmly for it. In a context marked by growing pressures to do more with limited resources while maintaining the quality of care and services, we recognize that difficult decisions must be made on an ongoing basis.

A big thank you to my assistants, Stéphanie Urbain, Marjolaine Frenette, and Sonia Turcotte; to our administrative support staff, Shauna Jandron and Sarine Chahmalian; and to our medical examiners, Dr. Borod, Dr. Liben, and Dr. White. Without you, it would be impossible for me to fulfill this mandate in the service of the public. Finally, a big thank you to Dr. Dominic Chalut, who served as a medical examiner at the MUHC for 16 years before moving on to other professional challenges in 2025.



Michael Bury
Commissioner for Complaints and Quality of Services
McGill University Health Centre

A Glimpse into the McGill University Health Centre

		
		
	Population N/A	Service Area N/A
Facilities		
Long-term care facility: 1	Hospitals: 4	N/A
Human Resources		
Employees: 11,500+	Managers: 339 (42 senior managers)	Doctors: 1,414
Volunteers: 863	Interns: 5,000	Partner users: 76

Report Overview

This report is based on data collected throughout the year from patients, their loved ones, healthcare professionals, and members of the public who contacted our office.

The figures presented correspond to the number of requests or the proportion of people who expressed concerns in each of the categories mentioned. They do not necessarily reflect the number of complaints deemed valid. Rather, our analysis is based on the recommendations made in response to the issues raised.

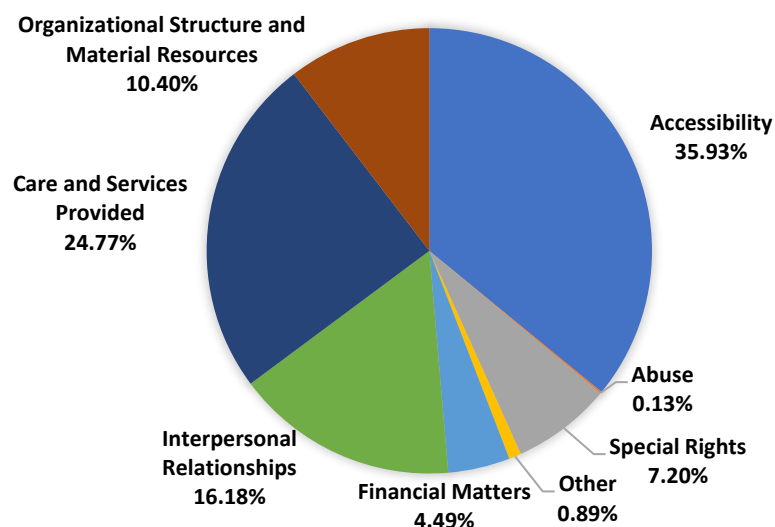
It is important to note that these indicators do not provide a comprehensive picture of the situation. Indeed, some problems cannot be resolved through local measures, as they stem from systemic or provincial factors. This reality underscores the importance of a contextual analysis by the local commissioner.

This is particularly the case for patients in alternative care (AC). These are patients from other facilities or regions who are occupying a bed even though they are ready to be discharged. However, their return or transfer is delayed due to insufficient capacity in their place of origin.

Key Figures for the Year

This chart presents data collected throughout the MUHC by our office during the 2025–2026 fiscal year and provides an overview of the main issues raised by patients and their loved ones during their interactions with our office.

- **Reasons for dissatisfaction raised by patients**

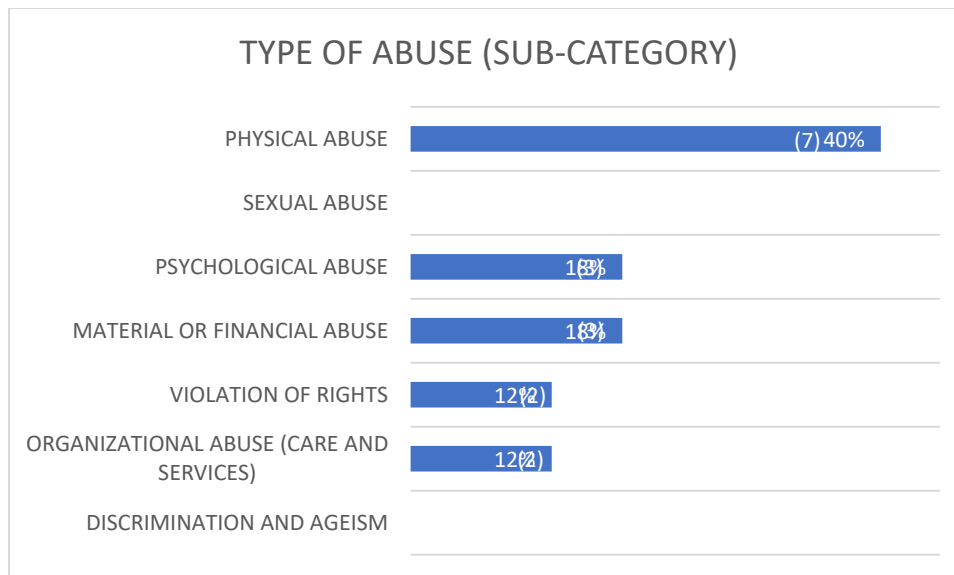


- **2,485: Total number of cases** received during the year, representing a 13.52% increase compared to the 2024–2025 fiscal year (2,189 cases):
- **1,732 complaint cases** resolved by the commissioner;
- **256 complaint cases** resolved by the medical examiner;
- **45 cases** in which the Commissioner intervened, including 40 (88.89%) following a report and 5 (11.11%) on his own initiative;
- **452 requests for assistance** submitted to the Commissioner by the user or a family member.

Measures (recommendations and commitments) are formulated when a complaint review identifies concrete improvements that can be implemented. They are generally discussed with stakeholders before being formalized, and follow-up is conducted according to an agreed-upon timeline. Cases for which measures have been identified remain open until our office receives confirmation that they have indeed been implemented. This year, 163 measures were implemented, of which 110 (79.13%) were initiated by the Commissioner and 29 (20.86%) by the medical examiner. Of those issued by the Commissioner, 26 (23.64%) were individual in nature and 84 (76.36%) were systemic in nature, with the vast majority (94) being commitments made by the entity in question; those from the medical examiners are distributed in the same way, with 2 (6.9%) being individual, 27 (93.10%) systemic, and of the total of 29, 25 were recommendations and 4 were commitments.

Type of abuse (sub-ground)

TOTAL: 17 (100%)



1. Summary of the Commissioner's Activities

Every year, patients and their loved ones contact our office with a variety of needs and concerns, ranging from minor but relevant situations to more complex and high-impact issues. These requests can cover several areas, including clinical care, the physical environment, interpersonal relationships, access, rights, and financial matters.

Below are a few examples of cases handled over the past year that we believe are representative of the diversity of inquiries our office receives.

1.1. General complaints handled by the Commissioner

1.1.1. Examples from the handling of general complaints

1st example

A family member of a patient contacted our office to express serious concerns regarding the management of a pressure ulcer. Over time, the wound worsened significantly, leading to the development of sepsis and the patient's temporary transfer to the intensive care unit (ICU).

Following our review of the situation, gaps in wound care training were identified, as well as a need to ensure the regular on-site presence of a wound care specialist.

Although the patient's clinical condition contributed to the rapid progression of the pressure ulcer, several areas for improvement were identified. Consequently, a wound care specialist now conducts weekly on-site visits; the specialized equipment required for wound care is now made immediately available by the wound care specialist rather than through the usual ordering process; and any stage 2 or higher-pressure ulcer now automatically triggers a request for consultation with the wound care service.

2nd example

A user with a disability contacted us and explained that coming to the Montreal General Hospital is difficult for her because the public restrooms for people with limited mobility are very low. Although they are equipped with grab bars and are more spacious, it is the height of the toilets that poses a problem, particularly in the main hallway, but also in the emergency department.

The review revealed that although the toilets complied with the standards in effect when they were originally installed several years ago, they are now non-compliant, as their seat height falls short of current requirements.

Consequently, toilet seat risers have been installed in the restrooms along the main corridor. The Accessibility Committee has also made it a priority for the new year to raise the toilet seats in the emergency department as well as in other key areas of the hospital.

This will benefit patients with limited mobility, while helping the MUHC meet its overall accessibility obligations.

1.1.2. Overview of General Complaints

For the 2025–2026 fiscal year, 1,746 complaints were recorded, representing a 22% increase compared to the 2024–2025 fiscal year. This increase can be explained in part by the fact that certain requests for assistance are now classified as complaints, while an increase in visits to outpatient clinics likely also contributes to this rise, rather than a specific decline in the quality of care and services. Among the 1,746 complaints, we received and addressed a total of 2,249 grounds for dissatisfaction, with the most frequently addressed concerns relating to accessibility (35.93%) and the care and services provided (24.77%). The average processing time was 17 days, down from 18 days in 2024–2025 and 23 days in 2023–2024.

Of the 2,249 grounds for complaints addressed, 110 improvement measures were identified. However, this does not mean that no further improvements are needed. Several complaints deemed valid were not followed by specific measures, since no action feasible at the local level could have had a significant impact within the scope of the facility’s mandate.

A classic example involves emergency department overcrowding or wait times for certain specialty appointments. These issues extend far beyond the institutional framework and are instead systemic problems at the provincial or national level.

1.1.1. Examples from the review of interventions

Example 1

An individual contacted our office to express concerns about what he considered to be excessive use of restraints on an elderly patient living with dementia. He raised concerns about the frequency and duration of these measures, noting that the patient had nonetheless suffered a fall and developed pressure sores as well as a loss of mobility, which he attributed to the use of restraints.

Restraints may be used in planned or unplanned situations to protect a person from harm to themselves or others. Each context has its own specific criteria, procedures, and consent requirements. Furthermore, the different types of restraints—chemical, physical, and environmental—are governed by distinct conditions and considerations.

Our analysis found that, given the complexity of the patient’s condition and the presence of aggressive behaviors posing a risk to herself and others, the use of restraint measures was clinically justified. However, we also identified a significant gap in staff knowledge and training regarding the distinction between planned and unplanned restraints, as well as the appropriate procedures for each. Furthermore, managers and assistant head nurses, who share supervisory responsibilities, had not been included in relevant training sessions for some time.

Our office issued recommendations specifically regarding the content of the training, the need to include managers and assistant head nurses in the training, and certain aspects related to documentation.

The expected positive outcomes of these recommendations underscore the importance of ensuring that managers and assistant managers receive adequate training to fully carry out their supervisory roles in complex situations, that the content of this training covers all necessary aspects, and that vulnerable patients receive the best possible care when restrictive measures are used.

2nd Example

Over time, our office has received several reports from patients regarding difficulties in obtaining follow-up appointments at a particular clinic. According to the information received, the situation appeared to be linked to persistent organizational challenges involving a physician. However, no patient wished to file a formal complaint, as the physician was highly regarded for his expertise and remained actively involved in their care.

A review of our office's case history related to this clinic revealed a pattern of similar concerns over a long period of time. Several attempts had already been made to improve the situation, but the difficulties persisted. In light of these repeated concerns, our office compiled all the information gathered over the years and brought it to the attention of the relevant higher authority.

A prompt intervention was subsequently carried out in collaboration with the physician in question, which led to improvements in the clinic's follow-up procedures. Since these changes were implemented, our office has not received any further concerns regarding this situation.

1.1.1. Examples from the handling of cases related to abuse

1st example

A patient who presented at one of the emergency departments at the McGill University Health Centre (MUHC) was considered a possible victim of financial abuse by a family member. The patient reportedly expressed reluctance to return home due to this alleged situation and contacted the police, although it is unclear whether a formal complaint was filed.

During the patient's stay, healthcare staff observed episodes of confusion, inconsistencies in the patient's account of events, and signs suggestive of a cognitive impairment, raising concerns about the patient's vulnerability and decision-making capacity.

Additional concerns were raised that the family member may have accessed the patient's bank account or withdrawn funds from it without authorization. However, these allegations could not be confirmed, as the patient did not have access to that account at the time of the events.

During the hospitalization, the patient's cognitive status improved, and he was reaffirmed as being capable of making his own decisions independently. The patient requested that visits by the family member continue to be permitted, while expressly asking that no medical information, discharge plan, or details regarding his future travel be disclosed to that person. Once medically stable and deemed ready for discharge, the patient was transferred to a new living arrangement and referred to community resources that the patient agreed to receive.

2nd Example

A middle-aged female patient with an advanced neurological condition and significant loss of independence was the subject of serious concerns raised by community care providers. The reports cited possible instances of neglect, inadequate care practices, and difficulties related to hygiene, safety, mobility, and access to recommended care and services. Concerns were also expressed regarding the family caregiver's refusal of certain professional services and medical recommendations.

The professionals involved in the case indicated that the situation could compromise the patient's safety and well-being, while noting that it remained difficult to determine whether the observed issues stemmed from intentional abuse, caregiver burnout, limited capabilities, or a combination of several factors. Given the patient's high vulnerability and the limited protective measures available, the care team considered the possibility of a supervised living environment to ensure her long-term safety and well-being.

After conducting a comprehensive assessment of her needs, a petition was filed with the court to have the patient admitted to a long-term care facility (CHSLD).

1.1.2. Overview of General Complaints

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A classic example involves emergency room overcrowding or wait times for certain specialized appointments. These issues extend far beyond the institutional framework and are instead systemic problems at the provincial or national level.

1.1.3. Summary of Cases Submitted to the Ombudsman

Under the health and social services complaint review system, when a person remains dissatisfied with the handling of their case or when the review exceeds the prescribed 45-day deadline, they may

appeal to the Ombudsman as a second recourse. For the 2025–2026 fiscal year, we observed a 50% increase in the number of cases referred as a second recourse, rising from 14 complaints filed in 2024–2025 to 21 complaints in 2025–2026. Given the 22% increase, bringing the total number of recorded grounds for complaints to 2,249, we do not consider this to be a cause for concern or a problem.

1.2. Interventions

An intervention occurs when the Commissioner’s office launches an investigation after receiving credible information suggesting that the rights of an individual or group may be at risk. This process may be initiated based on the Commissioner’s own observations or following a report received from the public.

Here are two examples of investigations completed by our office in 2025–2026:

1st example

An individual contacted our office to express concerns about what he considered to be excessive use of restraints on an elderly patient living with dementia. He raised concerns about the frequency and duration of these measures, noting that the patient had nevertheless suffered a fall and developed pressure sores as well as a loss of mobility, which he attributed to the use of restraints.

Restraints may be used in planned or unplanned situations to protect a person from harm to themselves or others. Each context has its own specific criteria, procedures, and consent requirements. Furthermore, the different types of restraints—chemical, physical, and environmental—are governed by distinct conditions and considerations.

Our analysis found that, given the complexity of the patient’s condition and the presence of aggressive behaviors posing a risk to herself and others, the use of restraint measures was clinically justified. However, we also identified a significant gap in staff knowledge and training regarding the distinction between planned and unplanned restraints, as well as the appropriate procedures for each. Furthermore, managers and assistant head nurses, who share supervisory responsibilities, had not been included in relevant training sessions for some time.

Our office issued recommendations specifically regarding the content of the training, the need to include managers and assistant head nurses, and certain aspects related to documentation.

The expected positive outcomes of these recommendations underscore the importance of ensuring that managers and assistant managers receive adequate training to fully carry out their supervisory roles in complex situations, that the content of these training sessions covers all necessary aspects, and that vulnerable patients receive the best possible care when restrictive measures are used.

2nd Example

Over time, our office has received several reports from patients regarding difficulties in obtaining follow-up appointments at a particular clinic. According to the information received, the situation

appeared to be linked to persistent organizational challenges involving a physician. However, no patient wished to file a formal complaint, as the physician was highly regarded for his expertise and remained actively involved in their care.

A review of our office's case history related to this clinic revealed a pattern of similar concerns over a long period of time. Several attempts had already been made to improve the situation, but the difficulties persisted. In light of these repeated concerns, our office compiled all the information gathered over the years and brought it to the attention of the relevant higher authority.

A prompt intervention was subsequently carried out in collaboration with the physician in question, which led to improvements in the clinic's follow-up procedures. Since these changes were implemented, our office has not received any further concerns regarding this situation.

1.2.1. Summary of Interventions Carried Out

During the 2025–2026 fiscal year, a total of 45 interventions were carried out, representing an increase of 12 interventions (36%) compared to the previous fiscal year. The main reasons for intervention, ranked in order of importance, are as follows:

- Care and services: 25% (15 interventions);
- Interpersonal relationships: 10% (6 interventions);
- Accessibility: 8% (5 interventions);
- Financial issues: 2% (1 intervention);
- Specific rights: 12% (7 interventions);
- Abuse: 24% (14 interventions);
- Organizational structure and material resources: 19% (11 interventions).

Following these interventions, 23 formal recommendations were forwarded to the relevant authorities, and they were fully implemented before the end of the fiscal year.

1.2.2. Summary of Cases Referred for Disciplinary Review¹

When issues arise regarding disciplinary measures against employees, the Commissioner forwards these cases to managers and human resources for disciplinary review. Although the institution retains the authority to decide on the measures it deems appropriate, it is required to notify our office of its decision. We then inform the complainant whether or not disciplinary measures were taken.

Over the past year, 2 cases involving 5 grounds for complaint were submitted for disciplinary review, along with one intervention. In all these cases, some form of disciplinary action was taken. Here is an example of such a case:

¹ LGSSSS, Art. 684

Example

A patient needed help with personal hygiene after using the restroom and used the call bell to request assistance. A nurse responded, informing her that attendants would be there to help her shortly; however, after an additional wait of about 20 minutes, the patient had to ring the bell again to get help.

When assistance was finally provided, the patient reported that some interactions with staff had been unprofessional and that care had been provided in a brusque manner and with a lack of sensitivity given her vulnerable situation.

Following discussions with the manager and the employees involved, it was determined that certain elements of the complaint were valid. Appropriate corrective and disciplinary measures were subsequently implemented.

1.3. Overview of Assistance Cases

Over the past year, 452 assistance cases were opened, compared to 546 the previous year. This decrease is primarily due to an adjustment in how certain requests were categorized in our system (complaints versus assistance cases), rather than a significant change in the delivery of care or services.

The majority of assistance cases (58.85%) involved support in filing medical complaints. In these situations, our office helps patients and their family members clearly articulate their concerns so that they can be properly understood and evaluated by a medical reviewer.

The remaining cases (41.15%) involved assistance related to care and services. These included requests for assistance with

- to change doctors (when possible and appropriate),
- to access medical information
- to get answers to questions about obtaining medical certificates or confidentiality
- to receive support in certain difficult situations
- to reach a resolution outside the formal complaint process

1.4. Summary of Consultation Requests

This year, our office received 158 consultation requests covering various issues, including access to care, access to one's own medical records or those of a loved one, the right to choose one's doctor, and access to services. However, the consultation topic that has drawn the most attention concerns the management of abusive behavior by patients and/or their family members. These requests come primarily from managers, assistant chiefs, physicians, and clinicians, sometimes with copies sent to their superiors.

This issue was raised by our office three years ago, at a time when it had been identified as a recognized need requiring action within the MUHC. A working group was then established to support the development of improved training and clearer guidelines and documentation. Previously, guidelines on this subject were scattered across multiple documents and did not consistently reach all levels of the hierarchy, which limited their effectiveness in supporting staff.

This issue is important to the Office of the Commissioner for two main reasons: first, we cannot provide guidance on how to handle such situations, as this could place our office in a conflict of interest should a complaint be filed regarding the handling of the incident. Second, this issue has broader implications for equitable access to care and services, since persistent abusive behavior can consume time, energy, and resources and take a toll on staff, to the detriment of other patients awaiting care.

Of the 48 consultations related to interpersonal relationships, 32 specifically concerned situations of abuse by a patient or a family member toward the treating team and the impacts on service delivery. At the time of writing this report, we are actively gathering the most recent information on the MUHC's approach in this regard. The appropriateness of making recommendations will be assessed in light of all available information.

1.5. In the Field

1.5.1. Other Activities of the Commissioner

Each year, our office implements various initiatives to promote the complaint review system, with the goal of demystifying the process and raising awareness among both the public and healthcare professionals. This year, presentations were given to students in the Social Work program at McGill University, as well as to surgical residents working at the McGill University Health Centre.

We also participate in the institution's Oversight Committee, which is tasked with monitoring the recommendations issued by our office, the Patient Experience Committee, which will help identify certain improvement priorities for the McGill University Health Centre's leadership; and finally, the Organizational Ethics Committee, which assists managers and physicians in making decisions consistent with the organization's mission and values in complex situations.

1.6. Abuse Component

1.6.1. Example of Abuse

1st example

A patient who presented to one of the emergency departments at the McGill University Health Centre (MUHC) was considered a possible victim of financial abuse by a family member. The patient reportedly expressed reluctance to return home due to this alleged situation and had contacted the police, although it was unclear whether a formal complaint had been filed.

During the patient's stay, healthcare staff observed episodes of confusion, inconsistencies in the patient's account of events, and signs suggestive of a cognitive impairment, raising concerns about the patient's vulnerability and decision-making capacity.

Additional concerns were raised that the family member may have accessed the patient's bank account or withdrawn funds from it without authorization. However, these allegations could not be confirmed, as the patient did not have access to that account at the time of the events.

During the hospitalization, the patient's cognitive status improved, and he was reaffirmed as being capable of making his own decisions independently. The patient requested that visits by the family member continue to be permitted, while expressly asking that no medical information, discharge plan, or details regarding his future travel be disclosed to that person. Once medically stable and deemed ready for discharge, the patient was transferred to a new living arrangement and referred to community resources that the patient agreed to receive.

2nd example

The patient was living with his son and reported that their relationship was strained. He stated that his son took his money every month, leaving him without access to his pension. The patient left his son's home and became homeless. This situation is believed to have contributed to a deterioration in his health, a fall, and ultimately his hospitalization.

The patient mentioned that he had received support from his religious community as well as from his pastor. According to the pastor, the patient also confided that his son had punched him.

The patient is deemed capable of making his own decisions and requests that no medical information or details regarding his hospital discharge be shared with his son. Visits, however, remain permitted, in accordance with the patient's wishes.

The patient has since been transferred to an alternative living arrangement.

1.6.1. Summary of Complaints and Interventions Regarding Abuse

The Act to Combat Abuse of Older Adults and Other Vulnerable Adults was enacted to strengthen and expand protection for vulnerable individuals, improve and centralize reporting mechanisms, raise public awareness, and reaffirm and clarify the responsibilities of all professionals in the health and social services network.

In this context, we report annually on the number of cases brought to our attention in accordance with legal requirements by clinical teams involved in identifying such situations. These cases are documented, tracked, analyzed as needed, and supported until they are resolved.

It is important to remember that competent individuals retain the right to make their own decisions, even when these may be perceived by others as not being in their best interest. That said, we are encouraged to note that, among the situations reported to us, the outcomes have generally led to an improvement in the well-being of the individuals concerned, most often through the creation of safer and more suitable living environments.

For the 2025–2026 fiscal year, the MUHC recorded 17 reports of abuse, down from 22 the previous year, including 3 complaints and 14 interventions. These reports primarily concerned situations of abuse committed by a family member or a third party, often of a physical, psychological, or financial nature, or a combination of all three.

These vulnerable individuals are generally identified by clinical teams during their visit to the emergency department or upon admission to the hospital.

2. Summary of the Medical Examiner’s Activities

Complaints against physicians, dentists, pharmacists, and midwives practicing in a public health facility fall under the responsibility of an examining physician. In most cases, a member of the Commissioner’s Office staff assists the complainant in ensuring that the complaint is formulated clearly and appropriately so that it can be fully understood by the examining physician assigned to the case.

The goal of this process is to continuously improve the quality of care and services and to maintain high professional standards.

If the complainant disagrees with the examiner’s findings, they may file a second appeal with the review committee. Here are two examples of cases handled this year:

2.1. Examples from the handling of medical complaints

1st example

A family member of a deceased patient filed a complaint regarding the care provided for a serious and complex illness.

The main concerns raised related to communication with the treating team, specifically whether the patient and their family had received sufficient information regarding the prognosis, the limitations of available treatments, and the various care options following the surgical procedure. Concerns were also expressed regarding the support and follow-up provided to the family throughout the course of care.

The complaint was the subject of a detailed review. The analysis confirmed that the patient’s condition was medically complex and required highly specialized care, including several major procedures. Following a thorough evaluation, it was concluded that the patient had received appropriate medical

care. However, the review also identified several valid concerns regarding communication between the treating team, the patient, and his family.

Specifically, areas for improvement were identified regarding discussions about treatment expectations, potential complications and limitations, continuity of communication among members of the care team, and the documentation of key exchanges in the medical record. The analysis also highlighted the importance of ensuring that patients and their loved ones are informed of all available care options throughout the course of the illness, including supportive care and palliative care when appropriate.

In light of these findings, it was recommended that the treating team participate in additional training on communication in the context of serious illness to further strengthen communication practices with patients and families facing complex medical situations.

2nd Example

A complaint was filed regarding pain management during a medical procedure performed as part of a specialized clinical program at the MUHC.

The complainant reported experiencing significant discomfort during the procedure, despite the measures put in place to ensure pain relief and sedation. The experience was described as distressing and raised concerns about the adequacy of pain management practices for patients undergoing similar procedures.

Following a review of the complaint, it was determined that the concerns raised were valid and that there was room for improvement in the program's current pain management approaches.

Consequently, it was recommended that the relevant clinical teams review current practices and evaluate potential measures aimed at improving patient comfort during such procedures.

A multidisciplinary review process was subsequently undertaken, and recommendations were submitted to the relevant committees regarding additional options to support pain management during certain procedures. Following their review and approval, changes were implemented to improve patient comfort and enhance the overall care experience.

2.2. Summary of Medical Complaints

This year, our office received 266 medical complaints, 56 of which were pediatric. This represents a notable 24% increase compared to 2024–2025 (215). These complaints involved 354 issues, the majority of which were related to care (62.15%) and interpersonal relationships (27.12%).

The average processing time increased to 41 days, compared to 18 days the previous year. The complexity of the cases, as well as the addition of two new medical examiners, likely contributed to these longer processing times. Among the concluded complaints, 25 individuals exercised their right to request a review, representing a 14% decrease from the previous year (29 out of 215).

A total of 29 recommendations were made in 25 cases, 93% of which were systemic in nature. The categories that generated the most recommendations were professional judgment/assessment (6) and interpersonal relationships (5).

2.3. Summary of Cases Referred for Disciplinary Review²

During the period covered by this report, no complaints were referred to disciplinary authorities by the examining physician in accordance with the provisions of Article 688.

² LGSSSS, Section 688

Conclusion

As we take stock of the past year, the lessons learned from public feedback, as well as numerous discussions held with various members of management, have highlighted a recurring reality: more so than in previous years, difficulties in accessing care are increasingly attributed to staff shortages and the need to optimize budgets. In several sectors, employees are not always replaced during vacation periods due to financial constraints; certain professionals remain difficult to recruit; and, in many areas, the demand for services exceeds the availability of resources.

This observation is not intended as a criticism of management or front-line staff, but rather as an acknowledgment of a situation that has gradually become more evident over the years and is impossible to ignore when examining the context surrounding the health care system's current challenges. This does not mean, however, that it is impossible to make improvements with the resources currently in place. In several sectors, opportunities for progress and significant efforts remain possible.

In particular, we continue to closely monitor the challenges related to medical imaging and are still awaiting the implementation of certain concrete measures. Similarly, the need for a clearer and more consistent approach to managing patients or family members who exhibit abusive behavior remains an issue for which we are actively awaiting a formal plan, among other issues affecting the quality and accessibility of care and services.

On an individual level, many experiences shared by patients and their loved ones continue to drive improvements in training, protocol revisions, and constructive organizational changes, demonstrating that there is no shortage of work or opportunities for improvement within the network.

The current reality remains that demand for health care services is extremely high, while resources are under significant pressure to meet that demand. We therefore encourage the public to stay informed about the various care options available to them, as well as the broader context in which services are provided, while teams across the network continue their efforts to improve care and access to services for everyone.



Michael Bury
Commissioner for Complaints and Quality of Services
McGill University Health Centre

Appendices

Appendix I – Number of cases involving abuse-related grounds compared to the previous year

Number of cases	Under review at the beginning of the fiscal year	Received during the fiscal year	Closed during the fiscal year	Under review at the end of the fiscal year
Complaints				
2025–2026	0	6	3	3
2024–2025	0	1	1	0
Interventions				
Upon inspection				
2025–2026	0	1	1	0
2024–2025	0	0	0	0
Based on reports				
2025–2026	0	13	13	0
2024–2025	4	17	21	0
Total 2025–2026	0	20	17	3

Appendix II – Level of complaint handling and intervention by grounds related to abuse

Type of Cases	Handling Not Completed					Processing completed			Total
	Abandoned	Discontinued	Denied	Rejected on summary review	Subtotal	Granted	Without relief	Subtotal	
Complaints	0	0	0	0	0	1	2	3	3
Interventions	0	0	0	0	0	7	7	14	14
Total	0	0	0	0	0	8	9	17	17

Appendix III – Number of reasons for abuse by type of perpetrator

Perpetrator of the abuse	Complaints		Interventions		Total	
	Number of reasons	%	Number of reasons	%	Number of reasons	%
Through a service provider	1	0.04	2	3.38	3	3.42
By a relative or a third party	0	0	12	20.32	12	20.32
By a user	2	0.09	0	0	2	0.09
Total	3	0.13	14	23.70	17	23.83

Appendix IV – Complaint and Intervention Records by Type of Abuse

Type of Abuse	Complaints		Interventions		Total
	Number of grounds	%	Number of grounds	%	(%)
Discrimination and ageism	0	0	0	0	0
Material abuse	0	0	3	5.08	5.08
Organizational Abuse (Care and Services)	1	0.04	1	1.69	1.73
Physical abuse	2	0.09	5	8.47	8.57
Psychological abuse	0	0	3	5.08	5.08
Sexual abuse	0	0	0	0	0
Violation of rights	0	0	2	3.38	3.38
Total	3	0.13	14	23.70	23.84

Appendix V – Description of Measures Taken by Type of Abuse

Reasons	Common Improvement Measures	Examples of concrete measures
Discrimination and ageism	N/A	N/A
Material abuse	Improved safety measures	With the support of the patient's three daughters, visitation restrictions were imposed on the person suspected of abuse. The patient was subsequently transferred to a rehabilitation center, where she receives psychosocial support as well as ongoing care from the interdisciplinary team.
Organizational abuse (care and services)	A well-meaning relative of the patient had a history of interfering with the patient's care due to personal beliefs and had filed an unfounded complaint of organizational abuse. The patient wanted to receive medical care but consistently redirected questions about his care to this relative.	A great deal of time was spent clarifying the facts with her, while establishing boundaries and a structure for visits. Since no other family member was able to support the patient, a compromise was reached that maintained the family connection with the patient while ensuring he received the necessary care he desired.
Physical Abuse	Improved Safety and Protection Measures	Increased supervision of the resident who was being violent toward other residents; use of red tape to mark a "do not enter" boundary zone
Emotional Abuse	N/A	N/A
Sexual abuse	N/A	N/A
Violation of rights	N/A	N/A

Appendix VI – Number of Cases and Proportion of Abuse Cases by Agency

Agency in question	Total number of cases closed	Proportion (%)
CH facilities	14	93.33
Public CHSLD facilities	1	6.67
Total	15	100.00

Appendix VII - Key Recommendations Made by the Commissioner During the Fiscal Year (Cases Not Involving Abuse (maximum one page))

Statement of the recommendation	Key findings leading to the recommendation	Agency involved	Follow-up/Status
1. For the next election, a communication will be sent to unit managers to further facilitate voting for the most vulnerable populations.	A patient in psychiatric care called our office on the day of the federal election, wishing to exercise his right to vote. Although the primary responsibility lies with Elections Canada, internal communications were insufficient to secure adequate and proactive cooperation from managers.	Internal Communication	Accepted: This will be implemented during the next elections.
2. Ensure that the hygiene products provided meet the requirements listed in the orientation guide in all units.	The daughter of a resident at a long-term care facility requested that certain hygiene products be ordered for her parent, but was told that the family had been providing these items since 2021. The products in question should be provided by the facility.	CHSLD	Accepted/Completed
3. Restore funding for the human translator for the case in question.	This mother of two children with complex needs speaks only a sub-dialect of a language. The translation app used by the department works in most cases but is not suitable for this situation. The budget allocated for the human interpreter, which had been initially planned, was cut. Thanks to our intervention, management agreed to restore funding for this interpreter, given the exceptional nature of the situation	Complex Care Services	Accepted/Completed

4. Recommendations to the unit manager to reinforce the requirement to complete an incident report whenever a Stage 2 or higher-pressure injury is identified, and to ensure that a request for an immediate consultation with the wound and ostomy care team is made. Ensure that interventions aimed at preventing and managing pressure ulcers—such as head-to-toe skin assessments, pressure point checks, and repositioning every two hours—are clearly documented in the daily monitoring sheet and signed by the nurse at the end of each shift, with the frequency of interventions indicated.	There were delays in in-person follow-up by the wound care nurse, and the required specialized products had to be ordered because they were not in stock, which led to further delays in wound treatment.	Care Unit	Accepted/Completed
5. That the charges for malaria screening (codes 41120, 41121, 41122, 45074), totaling \$840.78, be removed from the patient's bill.	A group prescription was activated even though the patient did not meet the criteria, resulting in unjustified charges for malaria screening.	Finance	Accepted/Completed

Appendix VIII – Key recommendations made during the fiscal year by the reviewing physician (one page maximum)

[See instructions in the writing guide]

Wording of the recommendation	Key findings leading to the recommendation	Relevant body	Follow-up/Status
1. a. It is necessary to inform the patient of the results of any abnormalities identified during an emergency department visit and to ensure that the patient fully understands them. It is recommended to communicate and document the steps to be taken in the event of persistent and/or worsening symptoms. b. It is recommended that the target timeframes for further investigations and/or specific treatment following discharge from the emergency department be clearly documented in the medical record.	The patient's urine test showed abnormal results. However, this information was not communicated to her. She did not learn of it until a week later, when she had to return to the emergency department.	The emergency department	Accepted/Implemented
2. Strengthen consent and documentation practices related to postnatal investigations and autopsies, while ensuring clear and consistent communication among all involved teams. Improve interdisciplinary collaboration, particularly between the genetics team and the Birth Center, to ensure that all aspects of the patient's care plan are	Since the parents had refused the autopsy, no genetic testing was performed. However, this information had not been clearly communicated beforehand, and issues surrounding consent had not been fully clarified at the outset of medical care.	Obstetrics	Accepted/Implemented

clearly communicated, coordinated, and appropriately implemented.			
3. It is recommended that the pain management protocols for oocyte retrieval at the MUHC Reproductive Center be reviewed by the Division of Anesthesiology. It is also recommended that a working group be established to evaluate approaches that could improve pain management during these procedures.	A patient who underwent a medical procedure as part of fertility treatment reported experiencing significant distress and severe pain despite receiving sedation. According to this individual, she remained conscious for much of the procedure, and her repeated requests for additional pain relief were denied due to the application of a standardized dosing protocol that was not adapted to the patient's individual needs or response.	Obstetrics	Approved/Performed Approval of the use of Pentrox for patients undergoing this procedure.
4. The physician, along with nursing and administrative staff, will review postoperative protocols and communication practices in the outpatient gynecology clinics. I have	The complaint regarding the lack of medical follow-up following a surgical procedure raises significant concerns about the continuity of care and the effectiveness of clinical communication mechanisms. Despite the presence of severe pain and symptoms deemed concerning, the patient's multiple attempts to contact the attending physician went unanswered, both before and after the procedure. According to the information gathered, even the steps taken by nursing and administrative staff to ensure follow-up were unsuccessful.	Gynecology	Accepted/Implemented

requested a follow-up report by January 31, 2026.	It was not until several days later, when the patient's condition had reportedly deteriorated, that medical contact was finally established.		
5. Develop clearer and more standardized protocols for the administration of oral contrast agents in patients at increased risk of aspiration. Strengthen communication and collaborative decision-making between intensive care and surgical teams when managing complex decisions related to imaging and procedures. Develop educational activities based on simulation and case studies focusing on the recognition and management of postoperative	The family raised concerns regarding postoperative care and the deterioration of the patient's condition following major surgery, particularly the decision to discharge him despite persistent respiratory difficulties, followed by readmission and hospitalization until his death. Concerns were also raised regarding clinical management, monitoring of complications, infection prevention, communication with the family, and	Thoracic Surgery	Accepted/Implemented

anastomotic leaks and related complications.	the coordination and continuity of care during hospitalization.		
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