



British Columbia Public Advisory Network

## BC-PAN Meeting Summary

Enhancing communication and informed consent and Expectations of health care professionals when treating themselves, family Members, or others close to them

October 4 and 5, 9:00 a.m. to 12:30 p.m.

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## Meeting purpose

To seek input from public advisors to guide college partners on:

- Informed consent. How colleges may enhance communication to the public about an informed consent process.
- Dual relationships. The expectations of the public in relation to the few circumstances when health care professionals provide treatment to themselves, family members, and others with whom they have a close relationship.

## Key messages from public advisors

### Enhancing communication and informed consent:

- The process of informed consent should be clear and understandable to the public; use language and a method of delivery that makes sense to the patient. Avoid jargon and acronyms.
- The informed consent process should not be rushed. Colleges should consider creating resources that practitioners can refer patients to, so patients can do their own research, ask questions, and come to their own conclusions.
- It is helpful for the practitioner to ask the patient to relay back the information given to evaluate if they fully understand.
- Information provided in the informed consent discussion should include best- and worst-case scenarios of the treatment, alternatives, costs, evidence of outcomes, potential impacts on other aspects of life, and the complexity of the procedure.

### Expectations of health care professionals when treating themselves, family members or others close to them:

- College codes of ethics should include a definition of good judgement in dual relationships.
- Colleges can encourage the use of telemedicine to better support patients in accessing health care providers outside of their communities.
- Colleges should specify how practitioners should disclose dual relationships to patients so that the patient is aware of the implications of dual relationships and aware that they can contact the college if they have concerns. In social circumstances, it should be up to the patient on whether they would like to disclose the relationship.
- Colleges should engage people using different platforms to inform them of their expectations on dual relationships. Social media may be used in urban centers, but radio and community bulletins may be more effective in rural.

# Enhancing communication and informed consent

October 4, 2021

## Meeting summary

To support patients to be empowered partners in their health care, they need to understand the services and treatments being offered to them. Informed consent is the process where a health care provider educates a patient about the risks, benefits, and alternatives of a given procedure or intervention. Exploring what informed consent means to the public, how the process should look at all stages of care, and why it is important can help regulators understand public expectations how the consent process should work.

BC-PAN input on this topic will be used to:

- Create practice resources and advisory support.
- Update standards and guidance for practitioners.
- Help regulators develop a clear definition of “informed consent” that can be posted on websites and patient resources.
- Awareness raising when communicating with registrants about what is important to the public.

### Public advisors present

- Annie Danilko
- Cindy Fu
- Dianne Johnson
- Elena Kanigan
- Emanuela Silvestri
- Joaquin Mercado
- John Sherber
- Margaret Bricker
- Marty Lingg
- Shawna Bennet
- Terry Browne

### College partners present

- Andrea Bowden, COTBC
- Elizabeth Bruce, BCCNM
- Gillian Vrooman, CPBC
- Joanie Bouchard, CDBC
- Kelly Neton, CPSBC
- Lisa Bannerman, COBC
- Simon Auyoung, CTCMA
- Susan Paul, CPTBC
- Susan Prins, CPSBC

### Others present

- Susanna Haas Lyons, Facilitator
- Praise Osifo, Public Engagement Coordinator
- Joelle Berry, CPTBC Manager of Inquiry and Discipline

## Welcome and land acknowledgement

Andrea Bowden, COTBC Deputy Registrar, opened the meeting with a land acknowledgement. The colleges are privileged to conduct the BC-PAN's important work from unceded Indigenous territories.

### Team building warm up exercise: Strategies to engage in tough conversations

Susanna recognized September 30 as the National day for truth and reconciliation. Part of the BC-PAN's work is aligned with the goals of Truth and Reconciliation – to help college partners to understand marginalized perspectives in health care. Many people's needs, specifically Indigenous folks, are not met through health care. College partners are looking at how they can respond to Mary Ellen Turpel-Lafond's *In Plain Sight* Report.

Susanna encouraged everyone to continue to exercise leaning into tough conversations and bringing different perspectives to explore and to bring value to the work of the BC-PAN. She asked everyone:

*Think of an important and tough conversation you were a part of. What strategies did you use to engage constructively in the discussion?*

#### *Public advisors' strategies to engage in tough conversations:*

- COVID has put us in a situation where we are having to have difficult conversations that we may not have been prepared for. Start by asking yourself: Am I committed to misunderstanding this person? Or am I committed to learning?
- Knowing when to walk away. Difficult conversations don't always have to end with a resolution and sometimes the best thing is just to give yourself time away from the discussion.
- There may be a power differential that is perceived and sometimes you need to address that because it may be creating barriers to an effective relationship.
- If there is a predetermined outcome, then the conversation will not be productive. What happens at the end may not be anyone's satisfaction.
- Breathe: keep yourself in a calm state of mind. Listen: listen to what the other person is saying. Say something constructive for both parties.
- Practice communication skills during daily interactions. With friends, family, etc.
- Understanding and demonstrating respect. Know that it is a conversation, and you aren't here to fight.
- Be sympathetic, empathetic, and respectful. Know that you cannot win them all.
- Stay on topic: don't get drawn in emotionally and stick to the facts.
- Don't take it personally. Listen to the passion and listen to the solutions behind the passion.

## Meeting orientation

Susanna gave a brief overview of informed consent.

- This topic may be triggering for some.
- Informed consent has impacted many people throughout history. For example, war time medical experiments, residential school medical experiments, women's husbands provided consent for them until recently in 1980s mental institutions.
- To make good health care decisions the public must understand what their treatment choices will mean for their future.
- Communication plays an essential role in informed consent.

### *Poll*

Have you had an experience where a health care provider educated you about the risks, benefits, and alternatives of a procedure or intervention?

- Yes, many times – 30%
- Yes, one or a few times – 62%
- No – 8%

If you said yes, on average how satisfied were you with this process?

- Satisfied – 42%
- Neutral – 50%
- I do not recall/I have not had an informed consent experience – 8%

### Context presentation: Enhancing communication and informed consent

Joelle Berry, CPTBC Manager of Inquiry and Discipline, gave a presentation and provided context about informed consent in health care.

- Capable adults (19+) have the right to give consent, refuse consent, and revoke/withdraw consent.
- You also have the right to choose what to consent to, expect respect about your consent, and participate in planning and decision making of your health care. Applicable to 19+, infant act is different.
- In order to qualify for being informed consent, the following elements must be present:
  - Capable
  - Given enough information
  - Relates to the care proposed
  - Voluntary
  - No fraud or misrepresentation
  - Opportunity to ask questions and get answers
- Consent can be written, spoken, or behavioural.
- Exceptions where consent is not required for a health care provider to give you care is when the adult is incapable and a guardian gives consent, or when in an emergency.

- Consent is ongoing. Your health care provider should be checking in with you periodically to make sure you are consenting to treatment. If there are changes in your treatment, it warrants consent again.

*Advisor questions and comments, and responses from college partners:*

- Does going to an appointment on an ongoing basis imply informed consent since you are physically going to get that treatment?
  - To a certain extent yes, but this is overall contextual. If you have been adequately informed of your condition, treatment plan, alternatives, and given consent, then coming regularly to treatment implies continued consent. There still needs to be check-ins, and if there are changes the patient needs to be informed.
- Another barrier to informed consent is the patient’s reluctance to believe the practitioner’s information due to internet and social media input.
- Who exactly takes my consent? Is it practitioner, nurse, or the desk? Where does the authority lie?
  - All regulated health care professionals are required to directly obtain your consent through a conversation and in person. It should then be documented in your clinical records.
- Does implied consent in the field carry on or does it have to be obtained in different positions during the treatment process? Ex. Paramedic gets consent because person is unconscious, but the patient gains consciousness later.
  - Consent is a dynamic process. Once there is a change in the patient’s state or treatment, consent needs to be gotten again.
- What happens if your wishes aren’t honoured?
  - Consequences are of many different levels and depends on the harm suffered. The individual can make complaint to colleges, employer, and/or file a civil lawsuit.

**Advisor input: Informed Consent**

Advisors separated into breakout rooms to discuss questions and provide input:

***1. Think about a recent, or memorable, interaction with a health care provider. What happened, if anything, to help you feel well informed about your health care treatment or service? Did you wish anything went differently?***

- A parent has a child who is not mentally capable of providing informed consent even though it appears that the child, who is a young adult, says they do not consent.
- An advisor was given a good explanation before a surgery. If they were to opt out of the surgery, the alternative would have been a more invasive process. They felt well informed and consented to proceed with whichever process was most appropriate.

- Providing informed consent for a family member who was able to consent but did not speak English and did not fully understand what they were signing.
- Some things that are expected on a consent form was missing. Other options were not listed, only the surgical option was provided.
  - Part of informed consent should include consequences of not going forward with the treatment.
- An advisor overheard a conversation of practitioners seeking consent from a patient who was requesting a translator. The practitioners were impatient and told the patient they may not get help if consent wasn't given soon.
- At the dentist, a public advisor asked for a specific course of treatment based on cost, given their limited income. There was a miscommunication and misunderstanding about what was agreed to and they ended up being charged for the treatment.

## **2. What would a best-case scenario of informed consent look like?**

### **a) What information do you want to hear or know about the health care proposed for you?**

- Best- and worst-case scenarios, risks and benefits.
- Evidence to back up suggestions because some patients may research online.
- Additional plain language resources provided for those who want to do extra research.
- Upfront information on the costs of the treatment.
- Information about wait times and preparation before the treatment.
- Potential impacts on other aspects of life such as travel, work, family, etc.
- The complexity of the procedure; who will be involved in care, what information will be provided about the patient, etc.

### **b) What do you want the health care provider to do, or not do, as they share important information and risks regarding a patient's health care decisions? Consider what's needed before, during and after a treatment or service.**

- Do not rush the consent process, offer support if the patient is alone and offer time to make the decision.
- Provide the opportunity to ask questions and engage with the patient.
- Practitioners should explicitly express that treatments require consent, because not everyone is aware that consent is needed.
- Do not make assumptions about the choices or preferences of the patient.
- Offer pre-reading material if possible so the patient can be prepared for the appointment.
- Address all stages of the procedure.
- Be empathetic and considerate of the patient's lived experience.
- Be mindful of context. Non-invasive procedures require a different amount of care than surgery or cancer treatment or taking blood.

- There are opportunities for discrimination when collecting consent. If practitioners assume that the patient cannot understand the description of the treatment, language used may not be clear, truthful, or complete.
- Ask the patient to repeat back their understanding of the treatment to ensure that the information has been understood. Reaffirm consent.
- Be clear and understandable; use language and method of delivery that makes sense to the patient. Avoid jargon and acronyms.
  - It may be useful to get the medical team to assist. Some practitioners struggle to convey information simply. Send someone else in the team to make sure that the person has an understanding.
- Emailing the consent form before the interaction so people can go over it prior to visit. Having a chance to do the research if you desire so you can come in with questions. Multiple points to be informed.

**3. How could the Colleges support the informed consent process? What kind of resources or support should be offered to the member of the public, if any, and why?**

- Develop a college-specific standardized consent form with important sections highlighted. So, if there is a section (ex. “risks”) that is not completed, the patient can flag it and ask questions.
- Educate the public on what informed consent is and what their rights are.
  - Can be done through signage in points of care and digestible public resources like FAQs. Include translated resources.
- Engage with practitioners and have them reflect on informed consent via a workshop or webinar.
  - Provide training that addresses biases practitioners may have regarding informed consent.
- Have information on websites for people to further understand what they have consented to. Having general information available about different types of procedures. Or showing someone having that procedure for people who learn better written.

**4. When would you expect a more in-depth discussion about consent?**

- Procedures that entail high bodily risk or adverse side effects.
- Various outcomes of the procedure or treatment.
- High impact on daily life.
- When there are many alternatives available.
- When pain management is required.
- Procedures that requires medication.

**5. For a repeated health care service, like physical therapy, how often should a member of the public be asked for consent, and why?**

- Patients should be verbally reminded of their rights to consent and withdraw consent every interaction.
- If there has been a change in treatment, condition, or another issue present.

#### **6. Why is informed consent important to the public?**

- We only have one body and one life. Our choices are ultimately personal decisions.
- Understanding the process helps to ensure the best possible outcome.
- Helps to build trust between the patient and practitioner.
- Everyone should receive the same level of respect and treatment.
- When providing consent, the we are putting our health and wellness in the hands of a practitioner. It is our right and responsibility to do so with the best possible information.

#### **Group discussion on informed consent**

Public advisors answered on a piece of paper:

***If you were asked to observe an informed consent process, what 3 things would you be looking for to judge that it was effective, and why?***

- The consent process must be meaningful and empathetic. The personal circumstances of the patient are taken into consideration.
- The process is equitable; there are efforts made to address power, knowledge, and capacity barriers.
- Patient acknowledgement showing breadth of understanding.
- The treatment, alternatives, risks, and effects are presented to demonstrate impact without pressure and is done with care. Clear information and transparency.
- Enough time is provided, with an opportunity to ask questions and gain additional reputable information.
- Physical or electronic documentation of consent.

# Expectations of health care professionals when treating themselves, family members or others close to them

October 5, 2021

## Meeting summary

Dual relationships occur when a health care professional treats family members, close personal friendships, commercial relationships or others with whom they have a non-professional relationship. Dual relationships are often unavoidable in small communities such as rural and remote locations or communities of shared identity. Some of the key considerations are the welfare of the person being given health care, effectiveness of service or treatment, avoidance of harm and exploitation, conflict of interest, and the impairment of clinical judgment.

The discussion may be used to help inform college practice standards and guidelines, as well as materials for educational purposes, including:

- CPSBC is currently reviewing their practice standard, titled *Treatment of Self, Family Members and Others Close to You*.
- CPTBC is looking at rural and remote practices – in relation to an urban centre norm.
- CCBC is looking to understand public expectations to inform standards for dual relationships
- Some colleges, like COBC and CTCMA, do not have a standard in place and want to hear the BC-PAN's input to inform future practice standards updates and development. Input may be considered for content to be added to patient relations materials, input for Patient Relations Committees, Inquiry Committees and Quality Assurance Committees.

### Public advisors present

- Annie Danilko
- Cindy Fu
- Dianne Johnson
- Elena Kanigan
- Emanuela Silvestri
- Joaquin Mercado
- John Sherber
- Margaret Bricker
- Shawna Bennet
- Terry Browne

### College partners present

- Andrea Bowden, COTBC
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- Lisa Bannerman, COBC
- Simon Auyoung, CTCMA
- Susan Paul, CPTBC
- Susan Prins, CPSBC

### Others present

- Susanna Haas Lyons, Facilitator
- Praise Osifo, Public Engagement Coordinator

## Welcome and land acknowledgement

Public advisor Margaret Jones-Bricker opened the meeting with a land acknowledgement.

## Meeting orientation

Susanna stated the purpose of the day's meeting: to understand expectations of the public in relation to the few circumstances when health professionals provide treatment to themselves or those whom they have a close relationship with. Sometimes in rural communities, your dietician or physical therapist may have kids who go to your school, or be a coach, etc. Colleges have provider boundary standards and resources to avoid harm and exploitation, conflict of interest, and impairment of clinical judgement.

## Context presentation: About the Colleges' approaches for when health care professionals treat themselves, family members or others close to them

Kelly Newton, CPSBC Policy and Engagement Lead, gave an overview of CPSBC's *Treatment of Self, Family Members and Others Close to You* practice standard.

- Treatment of family and friends, as well as self-treatment, should be avoided and health care professionals should refrain from accessing their own health information or the confidential health information of family members or friends.
- Treatment generally includes examining a patient, ordering tests and interpreting results, making and communicating a diagnosis, making referrals and prescribing medications or taking other measures.
- The standard applies when physicians and surgeons treat individuals with whom they have a personal or emotional involvement with, leading to difficulty providing objective diagnoses and care.
- When the patient is a member of the family or a close friend, it may be difficult for a physician to:
  - obtain a detailed (and accurate) medical history
  - conduct sensitive examinations
  - remain objective
  - provide comprehensive treatment options
  - maintain confidentiality
  - access medical records and provide appropriate documentation
- CPSBC's practice standard principles include college expectations that practitioners:
  - Exercise good judgement when deciding whether to provide medical treatment to anyone they have a close relationship with.
  - Not provide medical treatment to the individuals listed unless the medical condition is minor or urgent and no other physician or surgeon is available.
  - Not provide repeated or ongoing management of a disease or condition to the individuals listed, even where the disease or condition is minor.

- Not prescribe narcotic medications or psychoactive medications to the individuals listed.
- Re-evaluate their relationship with the individuals listed when the nature of the relationship has changed to determine if they can still provide care without bias.
- Transfer care of the individual to another qualified health-care professional as soon as it is practical if their professional judgement has been reasonably affected by changes in the relationship.
- BC-PAN input will be used to review this practice standard and create a new “What to Expect” patient resource.

CPTBC has been challenged to rethink their standard because it may not meet the reality of rural practitioners. CPTBC students did qualitative research on dual relationship boundaries and how it looks in rural and remote communities and used the term ‘screen door consultations’ to describe ways that professionals interact with their community. Professional and personal lives are interwoven in ways that aren’t common in urban areas.

CDBC encourages the public to utilize virtual care and dial 811 if they are looking for a dietician outside of their community.

*Questions, answers and comments, and responses from college partners:*

- When complaints or concerns are brought to your attention, who is bringing the concerns forward?
  - Complaints regarding dual relationships are very few and far between. Complaints on this topic is more common in urban areas.
  - Sometimes colleges hear from insurers that there is potential for a conflict of interest. Insurers may question health professionals’ objectivity if they are writing a report about a patient to ensure that the report is truly objective and is not influenced by the patient who is a friend or family member.
- Medical records and privacy are important aspects of this discussion, and this could cause privacy concerns.
- There is a sociological difference for people in small communities for what people know about you. In urban communities their social interactions are more controllable about who knows what about them.
- If you are a practitioner and have an office and you have your boundaries around confidentiality, what is your obligation in terms of the staff that you have hired?
  - Medical Office Assistants fall under practice standards, so they have the same privacy obligations as the practitioner.

**Plenary group discussion**

Advisors responded in the chat, answering:

***What might be the key risks associated with a health care professional treating friends, family or themselves?***

- Breach of confidentiality/protection of personal information.
- The pre-established level of trust impeding objectivity: when you are being treated by someone who you are familiar with, there is pre established trust that you think that they know what is best for you and you may not be as inclined to ask questions. One may be reluctant to ask questions because it may seem like they don't trust the practitioners or respect their professional opinion and may fear that it will affect their other relationship.
- Social or personal embarrassment resulting from breach of confidentiality.
- Fraud in extreme cases (insurers and completing documents).
- Long term responsibility of outcomes: if a health care practitioner gives medical advice to a family member and the outcomes are negative.
- Greater emotional involvement on the part of the practitioner when caring for someone close to them.
  - Burn outs of medical practitioners, work extends beyond the working context and into personal lives.
- Acting without clarity.
- Not fulfilling the professional role that the practitioner plays within the relationship and the burden of a health problem that cannot be easily solved.
- Indigenous people have issues with therapists breaching confidentiality: it is hard for secrets to stay secret because therapists and those who caused trauma are within the same community. Can therapists from a different community be brought in so sessions can be more confidential?

***When might treating a close friend or family member be appropriate? When might it not?***

- In an emergency when someone needs services immediately.
  - Ex. A friend of an advisor fell out of her bed and broke her hip. She called her son who is a doctor and he assessed her hip and arranged for her to go to the hospital.
- Treating minor, non-urgent conditions one time. Ex. Standard first aid.

**Advisor input: Expectations of health care professionals when treating themselves, family members or others close to them**

Public advisors went into breakout rooms to discuss:

***1. What considerations should there be for health care practitioners who are working in remote and “niche” communities where there may be few health professionals available?***

- If a patient has the same practitioner as their partner or another family member, confidentiality issues may arise.
  - Sharing a health care provider may be problematic. It is important for the practitioner to recognize the conflict.

- There should be an easy and understandable way to recognize, declare, and manage a conflict of interest.
  - Ways to mitigate risks of confidentiality breaches, fraud, and preferential treatment.
- Practitioners should establish a reputation for maintaining confidentiality.
- There needs to be explicit guidelines in place for administration and HR staff because they may be the source of disclosing confidential information.
- Clearly outline that it would be the client’s choice to disclose a dual relationship, not the practitioner.
- Balance the risk of dual relationships with the benefits to patients, like having a practitioner who has an ethnic/language bond and trust that comes with this.
- Managing professional and personal relationships should be part of professional training.
- Recognize that trust can be a benefit and a downfall.
- Practitioners must be careful when providing medical advice to friends and family.
- The location of where treatments occur plays a large role because the professional environment may impact the perception of the relationship.
  - Minor and urgent conditions are likely to occur outside of an office setting.
  - Boundaries are less clear in a social environment compared to professional.
- Ensure that there is clear and transparent record keeping.
- If there is no easy option to leave the community to get care from another practitioner, patients may choose to not get care.

**2. Which principles in CPSBC’s Treatment of Self, Family Members and Others Close to You practice standard are most important to you? Why?**

*Note: the lettered statements are from CPSBC’s practice standard and the sub-bullets are advisor comments*

- A. Exercise good judgement when deciding whether to provide medical treatment to anyone they have a close relationship.
  - What is good judgement? There should be a college definition.
  - Colleges codes of ethics should include what good judgement is especially regarding dual relationships.
- B. Not provide repeated or ongoing management of a condition, even when the condition is minor.
  - The more times a practitioner provides care, and nothing goes wrong, the practitioner may get used to providing this on-going care.
  - This is contingent on access and scarcity of resources.
  - May be difficult to practice if the practitioner has specialized knowledge.
- C. Not prescribe narcotic medications or psychoactive medications.

- Important to manage risk for practitioners.
  - If there is a limited supply of medications, there may be potential for practitioners to give preferential access to medications.
  - CPSBC should consider adding cannabis to this principle.
- D. Re-evaluate relationships with family members and others close to practitioners when the nature of the relationship has changed if they can still provide care without bias.
- The practitioner must re-evaluate the relationship for bias.
  - From our conversation on informed consent, the practitioner is obligated to make the patient aware of all their care options, so the patient has control of directing their own care.
  - Colleges can provide a standard disclosure statement addressing the dual relationship that is transparent to the patient and lists the options for the patient to help facilitate a transfer of care if needed.
- E. Transfer care of the individual to another qualified health care professional as soon as it is practical if professional judgement has been reasonably affected by changes in the relationship.
- Important to manage risk for practitioners.
  - Virtual care is an important resource to offer to rural communities because it provides alternatives.

**3. Which expectations in CPSBC's practice standard would be helpful for the public to know about? Why?**

1. Not provide repeated or ongoing management of a condition, even when the condition is minor.
  - Helps the public know that there are circumstances where a practitioner close to them can offer treatment, but it should not be on an ongoing basis.
2. Exercise good judgement when deciding whether to provide medical treatment to anyone they have a close relationship.
  - List clear ways in which health professionals will address the risks of the dual relationship.
  - The public may assume competency of the practitioner which may affect the relationship.

**4. How could these be communicated to the public in an understandable way?**

- In visual form, i.e. a poster, brochure.
  - Disseminate in centers where people can expect to receive this information. Community newsletters, long term care facilities, assisted living, medical offices, etc.
- In rural communities, radio is often used to provide information. It is especially useful for seniors.

- A short informative ad may be an affective way to communicate this on social media and television.
- Be aware of the digital divide between different generations.
- Communicate this information directly to the patient. The onus is on the professional to disclose and refer the client to any resources.
  - The practitioner can direct the patient to the colleges' resources.
- Not many people use the college websites, but a "what you need to know" section on the website may be helpful.

***5. What should colleges do to support patients in these circumstances to ask questions of their practitioner, seek alternative treatments or a second opinion without fear of harming the relationship?***

- Be aware of social/cultural implications. In some communities, harmony is very valuable.
- Help patients become aware of the professional duties in a relationship and college guidelines.
- With the advantages of telemedicine, colleges can support practitioners and patients to access other health care providers outside of their communities.
- Make sure the public knows that the relationship can be terminated; frame it around informed consent.
- Use scenarios and previous conversations to explain the nuances of dual relationships.
- Requiring that college's Code of Ethics be visible in the practitioner's office and can inform clients on expectations of the therapeutic relationship.
- Support practitioners on how to manage dual relationships and provide guidance on how to address and disclose the relationship with patients, with what resources to refer the patient to, all in the best interest of the patient.
- Address referral issues with practitioners so they can make referrals in an unbiased way.
- Provide specific administration staff resources.

***6. How would you want to learn about college standards on this topic?***

- Videos with scenarios
- Community resources
- Learning resource section on college website
- Directly from the practitioner when it is relevant
- With Indigenous patients, refer them to relational care, trauma-informed care, and health care reconciliation resources.
- Social media (short YouTube videos, Instagram reels/Tiktoks, and Facebook).
- Use effective Twitter hashtags to get into niche communities.

## Co-developing the BC-PAN's meeting evaluations

Susanna led an activity to brainstorm ways that the group can evaluate the quality of BC-PAN meetings. Advisors were asked questions on how the group works together, how colleges support and engage with the BC-PAN, and their personal experience.

## Closing

Susanna gave an outline of next steps for the BC-PAN:

- The BC-PAN is working on a video to promote the work we do to the public and other stakeholders.
- The BC-PAN is planning on updating the website to be more modern, organized, and include more content.
- We hope that the next BC-PAN meeting in February will be in person in Vancouver. This is contingent on health and safety protocols. Updates will be given when available.