BC-PAN Meeting Summary

June 15, 2022 | 9:00 – 4:00 pm

BC-PAN's first in-person meeting in two years was held at the College of Physicians and Surgeons of BC in downtown Vancouver, covering the topic of Communication in the morning and Virtual Care in the afternoon.

Key Learnings

Key learnings from the day-long meeting include:

- Advisors described good communication as:
  - Clarity of information
  - Cultural humility
  - Trust
  - Honesty and transparency
  - Respect and genuine compassion
  - Partnership-communication as a two-way street
  - Active listening that is patient and non-judgemental - creating a space that is conducive to understanding
  - Awareness and accommodation of spoken language or communication differences
- Patients do have different expectations of different types of practitioners, but there are also expectations of providers as a whole that transcend all health care professions. it is necessary to be cognizant of both forms in order to provide the best quality care.
- Ways that colleges can help support more effective patient/provider communication:
  - More signage in professional's office as to where to reach out to college for complaints (simple QR code to scan similar to what CPSBC developed).
  - Encourage people to provide input on ways their experience could be improved (easily accessible dialogue to improve care).
  - The word "complaint" can be scary and stressful- instead could say "provide feedback," "quality improvement," "your communication is a two-way street," etc. to support partnership in care idea.
- There are many pros and cons for virtual care, but the advisors provided several suggestions on ways it could be improved:
  - Make video mandatory
  - No cost or low-cost hubs for folks to access virtual health care

- More guidance for professionals around using virtual care
- Help the patient know they are in a safe and private place
- Hybrid model- a balance of virtual and in-person care
- Increased training for cultural differences

Meeting Purpose

Communication from a Health Care Provider to a Patient / Client

In reviewing complaints submitted to colleges, a number of colleges have found that many cases include instances of miscommunication or lack of adequate communication between the health care provider and the patient. These complaints include lack of respect, clarity, listening, understanding, plain language, and clear consent process.

The college partners are interested to hear from public advisors about their expectations for communication between health care providers and patients, specifically with regards to non-technical skills (sometimes referred to as "bedside manner"). This discussion will build on BC-PAN's discussions about consent (October 2021) and guidance for practitioners moving or leaving practice (June 2021).

Expectations for Virtual Health Care

Two years of experience using or being aware of virtual health care methods, colleges would like to know more about public expectations about virtual care. What type of care is well-suited to phone, video or in-person appointment? What does good patient-provider communication look like in virtual care? Are there unique considerations for virtual care by specific types of health services?

Most colleges have standards in place to guide virtual care, and the outcomes of this conversation will help review these standards. This discussion will build on BC-PAN's discussion about virtual care in September 2020.

Arriving

Tia gave a land acknowledgement.

Susan Prins, chair of the BC-PAN and a representative of the host college, welcomed the group.

Susanna acknowledged National Indigenous History month, opportunities to learn, and encouraged the group to read *Remembering Keegan: Case Study Reflection*, which was

contributed to by a BC-PAN public advisor and is an important guide in working towards addressing anti-Indigenous racism in BC health care.

Susanna also acknowledged that it is Pride month and mentioned opportunities to learn and celebrate.

Tia explained the new BC-PAN website, which can be found at www.bcpan.ca

Susanna reviewed the agenda for the day and went over COVID-19 protocols.

We discussed how the colleges will use the advisor input:

- Standards and guidance for practitioners
- Support complaints process
- Inform communication to the public

Participants

Public advisors present

- Annie Danilko
- Marty Lingg
- John Sherber
- Cindy Fu
- Terry Browne
- Joaquin Mercado
- Elena Kanigan
- Dianne Johnson

College partners present

- Susan Prins CPSBC (Chair)
- Doug Cheng CPSBC
- Suzanne Solven CPBC
- Andrea Bowden COTBC
- Lisa Bannerman COBC
- Alison Amratlal BCCNM
- Melanie Journoud CDBC
- Crystal Chung CTCMA
- Susan Paul CPTBC

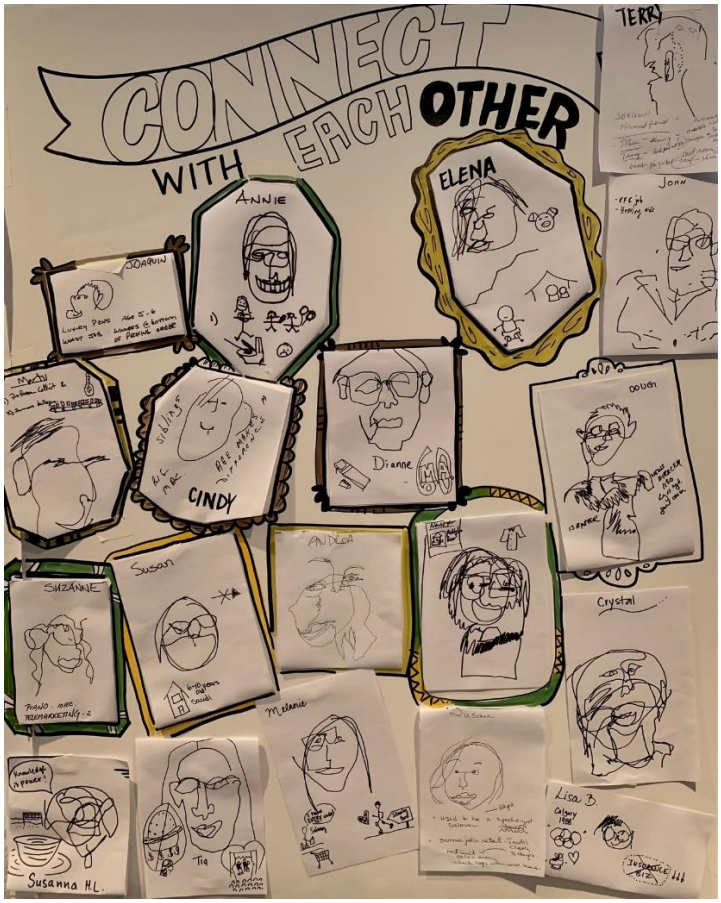
Others present

- Susanna Haas Lyons (facilitator)
- Tia Percy (minute taker)

Introductions

Erica Bota from Drawing Change introduced herself and invited the group to close their eyes and visualize painting freely and confidently on a massive canvas in front of a crowd. She played relaxing music and told everyone to imagine they are drawing people from the crowd, creating the most creative and beautiful piece of art.

Everyone then worked with a partner to draw the other person's face without looking at their page or lifting their pen. Then, the pairs interviewed one another, asking: "what is something few people know about you?" and "what is the worst job you've ever had?"



Communication

Communication context presentation

Susan Paul from COPTBC gave an introductory presentation on **communication/non-technical skills for health care professionals**:

- "Bedside manner" and tailoring communication style to each individual patient is absolutely key to a positive therapeutic relationship.

Greeting	preferred name and correct pronouns
Introduction	ourselves and describing our role in your care

Informing	what to expect
Language	respectful and plain language
Investing	time to develop a therapeutic rapport, acknowledging the power imbalance
Understanding	using an interpreter when necessary
Listening	actively to ensure we have understood correctly
Consent	obtaining your informed consent, re-visiting as treatment progresses
Inviting	questions and answering them fully

- 55-90% of communication is non-verbal, which is a very important statistic to know in order to understand the implications and importance of non-verbal behaviours in health care settings.

Derek Martinig from CPSBC gave a presentation on **types of complaints CPSBC usually receives**:

- Complaints are submitted in writing (by mail or email)
- In 2019 there were 993 complaints which is typical, but there was a 20-25% increase in number of complaints over the last couple years (replicated across the country)
- Communication issues are the main complaint every year
- Most complaints fall into three main categories
    - Clinical- case management, misdiagnosis, surgical complications, consent, prescribing
    - Conduct- communication, office management, medical records, access to care, advertising
    - Other- boundary violation, bylaw infraction, failure to comply with practice conditions, duty-to-report
- Derek reviewed two relevant cases of complaints regarding patient/provider communication issues

Advisor questions and contributions:

- Profanity is never acceptable in a professional setting, regardless of whether a person is comfortable with it in their personal life.
- It is valuable to have a complaints navigator who follows up and follows through with assistance in the complaints process.

    - Derek responded that the complaints navigator position is only a year old and there is currently just one person handling ~1200 complaints and they are still working on improving the role; ideally there will be more navigators to handle all the complaints and be more supportive through the whole process in future.
- An advisor has experienced doctors essentially saying "stop talking, I'm the doctor," and has only had one provider take the time and care to explain how to talk to doctors in a way that they will listen.
- Another advisor has experienced multiple instances of reporting providers' inappropriate behaviour to the college, but the college has sided with the physician.
    - Derek acknowledged the challenges of being a patient to report a complaint and he pointed to how the college must rely on the medical record.
- How are providers trained to communicate effectively, both before becoming a practicing health care provider and then especially after receiving a communication-related complaint?
    - Derek responded that there are often courses and training programs provided by various health-care governing bodies and inquiry committees to help improve provider communication.
- An advisor said that one of the main issues with the complaints process is that providers are not forthcoming about patient access to the college or other reliable, peer-reviewed resources.

Suzanne Solven from the COPBC presented **the importance of patient communication in pharmacy practice**:

- Responsibility of pharmacy professionals
    1. Ensuring the right patient takes the right drug at the right dose at the right time, and in the right way to ensure effective drug therapy and patient safety
    2. Clinical aspects of pharmacy care
- Tantamount to these responsibilities is the use of clear and effective communication at specific points throughout the dispensing or clinical review process
- The communication process is known as "patient counselling," and is actually a pharmacy bylaw. This includes a patient profile check, drug overview, directions for use, precautions, and monitoring outcomes and ongoing use of medications.
- There is a Practice Review Program in which pharmacies are checked regularly to ensure compliance with bylaws and standards.
- One thing the college plans in order to ensure and improve patient communication in the future is to implement a requirement for all pharmacies to post a list of

requirements (Patient Bill of Rights) that the pharmacists must adhere to, in a place that is visible to the patient, so they know what to expect.

Tia reviewed **previous BC-PAN input** on the subject, received through discussions about consent (October 2021), guidance for practitioners moving or leaving practice (June 2021), and record keeping

- Plain language: don't use jargon or inaccessible language
- Transparency: all aspects of what is being consented to are laid out honestly and clearly
- Not rushed: explanation is thorough, and enough space and time is given that the patient does not feel pressured
- Check for understanding: have patient repeat back to you
- Empathetic/considerate: personal circumstances of the patient are taken into consideration, efforts are made to address power, knowledge, and capacity barriers.

Discussion

In small groups, advisors described communication from a health care practitioner to the public:

1. *Think of a time that a health care practitioner communicated in a way that did - or didn't - meet you or your family member's needs. How would you describe the health practitioner's communication approach and manner (words, tone, body language, other)?*
2. *Define good practitioner to patient/client communication: What does it look like, sound like, feel like?*

Public Views on Provider-Patient Communication

Advisors described **poor communication** as:

- Lack of active listening- no further inquiry
- Lack of culturally safe care
- Disengaged and disrespectful
- Dismissive of concern "I've never heard of this"
- Rude- angry and yelling, called an issue "too trivial" to bother with
- Confidentiality is an issue in pharmacies
- Lack of communication between practitioners
- Accusatory "you must have done something to cause this"
- Lack of follow up
- Tense, condescending, demeaning

Advisor Examples:

- Patient was deaf, MD did not acknowledge, patient did not understand anything during unaccompanied consultation. When asked about consultation, patient reported not hearing anything and not knowing.
- Went to pick up prescription at pharmacy, one person took advisor's ID and asked advisor to move to second window without any guidance (as they were holding advisor's medication), no reason provided for passing advisor to another window/person, advisor had to talk to second individual, handed over medication, but no consultation provided. Advisor wondered if any important info missed after they exited pharmacy. Advisor shred that they didn't know that consult from pharmacist was required and didn't know who the two individuals they interacted with were.

Advisors described **good communication** as:

- Clarity of information
    - Clear direction for both patient and practitioner, avoid errors, confirm mutual understanding; roller coaster/blurry when not getting all info or clear information.
    - Clear information important when you can't speak for yourself or can't be accompanied (COVID-19 was limiting).
    - Difference between MD office versus hospital, where there may be more communication supports. Work environment matters.
    - Being proactive about communication and making sure people get information they need. Be open about what is possible and setting realistic expectations at the start.
- Cultural humility
    - Cultural nuances may not be immediately present
- Trust
    - Leap of faith to "trust" a provider
- Communication is a two-way street
    - Patient needs to be an active participant in effective communication (if they are able) or sometimes ask/tell practitioner how they would like to be communicated with.
- Honesty/transparency
    - Starts at the top at the Ministry of Health; a government entity needs to exemplify what/how professionals should behave. Difficult for public to navigate all layers of BC health care. Break down barriers among all layers with understanding and solutions.
    - Starts with practitioner's humility, if you don't follow guidance, I won't be able to help you. Be open to being vulnerable, not all knowing.
    - We are in this together and can learn from one another, share expectations we have from/ for each other.

- Check-ins
    - Following up, clarifying, basically making sure the patient is okay.
- Compassion/Genuine caring
    - All communication ties into compassion.
    - As stress goes up, compassion and communication go down. There also needs to be an understanding that professionals may be stressed and overworked. Easier to be more compassionate if practitioner is open about where they are at (tied to humility, honesty, and self-awareness).
- Partnership
    - There is still a barrier in communication between patients/clients and providers. Keeping in mind that it is a relationship that must be built like any other and it is a two-way street.
- Respect
    - Every person deserves respect no matter who they are, including respecting each others' time because especially in health care it is a small amount of time spent together and it is precious.
    - Often a long journey to get it
    - For better or worse, you sometimes have to demand the respect you deserve.
- Listening
    - Must be practised. And it is important to demonstrate that you were listening and understand, by paraphrasing back to the person what they said.
- Spoken language differences
    - Body language is still very relevant when there is a language barrier (maybe even more).
    - It is important to be prepared with language tools and options to show that you are committed to understanding and willing to try.
    - (rainbow = spectrum of diversity and being on same wavelength, inukshuk=strong build, many layers): diverse but able to communicate, may need additional support or additional education to communicate with signs/body, leverage smart phone translation devices.
- Creating a space that is conducive to understanding
    - Don't jump to conclusions, make assumptions, or rush.

Advisor Suggestions:

- More signage in professional's office as to where to reach out to college for complaints (simple QR code to scan similar to what CPSBC developed).
- MD example: why are you here and what do you expect from me as a practitioner? Gives room to say what can or cannot do. What my limitations are and why? Set the tone to listen to patient and say what is possible as part of communication.

Exchange on expectations both ways. Communication that is open and without judgment.

- Colleges have a power imbalance to address, encourage people to provide input in how to make a better profession (dialogue to improve care).
- Change wording of "complaint", it's too scary and stressful: provide feedback, learning, quality improvement, "your communication is a two-way street" to support partnership in care idea.
- Before Covid, a patient was able to have someone with them as an advocate or support, but that has been taken away. Therefore, the responsibility to support should fall to the health-care provider to be even more supportive, communicative and aware of the isolating and pressuring nature of post-COVID appointments. It also requires pre-planning on the part of the patient to ensure they receive the type of communication that best serves them.

Activity

Groups of advisors circulated around stations comparing expectations for different types of practitioners, exploring the question: *What are the shared and distinct expectations for communication from specific kinds of health care practitioners?*

Types of practitioners for reference:

Chiropractors provide assessments, advice and counseling on matters related to the condition of the spine or other joints of the body and the associated tissue, the nervous system and the overall health of the individual. They also provide treatment for nervous system, muscular and skeletal diseases, disorders and conditions through manipulation or adjustment of the spine or other joints of the body by hand or by using devices directly related to the manipulation or adjustment. (CCBC)

Dental Surgeons dentists, dental assistants, and dental therapists care for teeth. (CDSBC)

Dietitians design, implement and monitor nutritional care plans and medical nutrition therapy for individuals and/or groups based on current and relevant scientific, medical and nutrition information. (CDBC)

Nurses perform a wide range of health care functions. (BCCNM)

Midwives provide primary care to clients and their babies during pregnancy, labour, birth, and the postpartum period. (BCCNM)

Occupational Therapists help people improve, maintain, or restore their ability to perform everyday tasks. (COTBC)

Opticians fit, adjust, and dispense prescription and non-prescription eyewear, sometimes referred to as the "pharmacists of eye care." (COBC)

Pharmacy Professionals include pharmacists and pharmacy technicians. Pharmacists are medication experts who identify and assess drug-related and device-related problems and take action to prevent or resolve those problems; promote health and prevent diseases, disorders and conditions through drug therapy; as well as monitor drug therapy and advise on therapeutic values, contents and hazards of drugs and devices. Pharmacists and pharmacy technicians also compound and dispense drugs and devices. (COPBC)

Physical Therapists specialize in how the body moves. (CPTBC)

Physicians practise medicine. (CPSBC)

Surgeons perform surgery. (CPSBC)

Traditional Chinese Medicine (TCM) is an ancient system of holistic health care using methods such as cupping, herbs, meditation, tai chi exercise, and acupuncture. (CTCMA)

Acupuncturists use tiny needles on specific points under your skin to stimulate certain points of the body. (CTCMA)

DIETITIAN	DENTIST
How often should I see you and what for?	How often should I see you?
Difference between dietitian and nutritionist	Explain different types of dental specialists
Do I need a referral?	What is the patient's responsibility?
Are services covered by MSP or private insurance? How much do services cost?	Clearly explain fees
What is my responsibility as a client?	Standards of practice and what to expect
Explain standards of practice and what to expect	Conflict of interest when selling products
Conversation about preferred method of communication	Some won't take indigenous patients

Station 2

PHYSICIAN	PHYSIO/OCCUPATIONAL THERAPIST
Be heard and believed	When there is trauma/swelling, need to listen and believe what "normal" looks like for each individual
Convey their specific expertise and acknowledge when they should refer (don't let ego get in the way)	Transparent with their role/limitations with providing care- e.g. explain there will be homework
More cultural awareness and safety in their communication	Expected to spend more time listening than a physician

Focus on patient, not computer. Make them feel they are being listened to	
Open to different styles of communication and learning to facilitate comprehension	
Nodding does not confirm understanding, repeat back or confirm aloud that you understand	

Station 3

PHARMACIST	NURSE	MIDWIFE
Explain the different people/professionals involved, clarify role and what they offer	Explain what they are doing both before and during the processes	A person may not even know what a midwife is or does
Detailed description of medications- cautions/risks	Greeting/introduction/being warm and welcoming	Active consent
Documents to take home, with plain language and translations if necessary	Scope of practice, what services can you actually provide for me here and now?	Facilitate communication around pregnancy and birth among all involved parties (partners, family, etc.)
For seniors or people with hearing/language barriers: do they hear and understand?	Regular check-ins and checking for consent	Provide info on delivery options
Follow up/check-ins with long-term medications and patients		Realistic about capabilities/ what is the backup plan or person?
How to reach a pharmacist		Impeccable “bedside manner” and comforting presence as it is one of the most vulnerable experiences
		Explain credentials/experience/competency

Station 4

TCM/ACUPUNCTURIST (Traditional Chinese Medicine)	CHIROPRACTOR	OPTICIAN
Communication around diagnoses and holistic method of care (why are you working on one part when I thought my issue was elsewhere?)	Parameters narrower than physician- what to expect	Conflict of interest (pushing lens and frame sales)
Extra/careful communication when there is a language barrier	How does it fit with other health care practitioners and treatments, and will there be communication between complementary/primary care providers?	Transparency about process and options

Explanation of philosophy/history of the care, as it can differ from western medicine	Explanation of fees, upfront and in depth	Difference between optometrist, ophthalmologist, and optician
What can I expect as outcome and typical length of treatment	Explain where to learn more	Communication about credentials and impact on care
Explanation of fees, upfront and in depth		Explanation of fees, upfront and in depth
Explain where to learn more		Explain where to learn more
Ethical issues		

Key themes:

- Patients do have different expectations of different types of practitioners, but there are also expectations of health care providers as a whole that transcend all professions- it is necessary to be cognizant of both forms in order to provide the best quality care.
- Clear explanations of the roles of different levels or types of practitioners under each title (e.g. For nurses, what is the difference between RNs, LPNs, NPs, RPNs, and what does that mean for the patient/client when interacting with each of them?)
- Active and patient listening, confirming understanding (not rushing or making assumptions).
- Open to different styles of communication and learning to facilitate comprehension (making an effort to accommodate individuals' unique communication needs).
- Explanation of fees, upfront and in depth.
- Explain what they are doing both before and during the processes, transparency about process and options (informed and active consent).
- Communication around practitioner credentials and limitations (convey their specific expertise and acknowledge when they should refer- don't let ego get in the way).
- How does it fit with other health care practitioners and treatments, and will there be communication between complementary/primary care providers?
- More cultural humility training.
- More non-technical skills training and/or more effort and care to provide this in practice.
- What is my responsibility as a client? Being realistic about what is expected of a patient receiving treatment from a specific practitioner (communication goes both ways).

Virtual Care

Virtual Care context presentations

Doug Cheng from CPSBC gave a presentation on virtual care:

- Doug surveyed the group asking “before COVID-19, who had used virtual care?” and nobody had. There was an “almost overnight” shift to virtual care during the pandemic.
- Provider concerns about virtual care at the beginning:
    - Specialists being referred patients marked “urgent” when the patient had not been examined- the reason for the referral was actually because of an inability to do a physical assessment
    - Diagnostic facilities often unable to contact ordering physician
    - Pharmacists were uncertain whether they could or should fill prescriptions written by a physician in another province or jurisdiction
- Patient concerns about virtual care:
    - Patients referred to a specialist hundreds of kilometers away
    - Risk that virtual assessment misses holistic picture of patient—what about domestic violence, child abuse, substance use?
    - Some patients have special and unique needs that require sustained, necessary care
    - Virtual care options may be limited in remote, rural and Indigenous communities with connectivity issues
    - Some patients may not have skills or comfort to engage in virtual care
- The college published a virtual care standard (revised and renamed the previous “telemedicine” standard) in June 2021 to address these concerns and outline the appropriate use of virtual care:
    - Most appropriate when integrated into comprehensive, longitudinal care - which must be provided as indicated and required by patients
    - Access to in-person care must still be available
    - “Virtual first” visits have a role during pandemics and epidemics to screen patients for infectious diseases and stream them to appropriate locations for care
    - Registrants can only prescribe opioid medications, psychotropic medications or cannabis if they have an ongoing treating relationship with the patient or have personally examined the patient
- The standard includes a detailed consent process for virtual care, including the requirement to “explain to the patient the appropriateness, limitations, and privacy risks related to virtual care in plain language during initial visit,” and a requirement to document the consent (or lack of consent) given.
- Standard requirements for in-person visits:
    - Arrange for timely in-person visit if an adequate assessment cannot be done virtually
    - In-person assessment must be done by the registrant, or another registrant or nurse practitioner with whom the registrant has a pre-established agreement

    - Registrant must do a physical examination before referring a patient to a specialist if it is normally required
    - Unacceptable to defer a physical examination because a virtual visit does not allow for one
- An advisor said that in the same way that some offices are required to display proof of registration with a college, there should be a way for that to be visible or easily accessible for virtual care as well.

Alison Amratlal from BCCNM also presented on virtual care:

- The college reviewed their standards in the wake of COVID-19 and the uptick in use of virtual care, and decided that their existing standards are sufficient, in line with the philosophy that "care is care." The ideology implies that care delivered virtually should simply align with the same standards that are required of in-person care.
- The college restated its requirement that nurses and midwives must be registered with BCCNM to practise nursing virtually in BC.
- The BCCNM website has an FAQ and directs registrants and patients/clients to their other standards on best practices which also apply to virtual care.

Tia reviewed **previous BC-PAN input** on virtual care, shared during the September 2020 meeting:

- Consistency: virtual care should only be used when the quality of care is consistent with in-person care
- Confidentiality: the ways in which personal information is handled may need to be more clearly explained than when documents are physical
- Accessibility: the virtual option has served to both increase access to health care for those who previously may have been limited by physical or geographical barriers, but at the same time has highlighted inequities such as infrastructure and cost, as well as technological literacy issues- all of which providers must be cognizant of when choosing virtual care

Discussion

In small groups, advisors explored the following questions:

1. *Describe a great or challenging virtual health care experience you've had in the past couple years. Building on these stories, work together to create a list of the benefits and drawbacks of virtual care.*
2. *What would make virtual health care better for patients and clients?*
    - *Do your expectations change for specific types of health service providers?*

- *Are there unique considerations for video, phone, text, distance monitoring, etc.?*

Public Views on Benefits and Drawbacks of Virtual Care

Pros:

- Ease of prescription refill from doctor to pharmacy
- Convenient
- Professional
- Pre-booked phone appointment
- Value in psycho-social support for care teams to network
- Ability for those who can't or have challenges leaving home to access care (whether physical or psychological)
- Accountability
- Flexible timing
- Convenience of accessing results/some services
- Ability to connect in challenging circumstances
- Avoid unnecessary travel and associated costs
- Potential for integration of technology systems and different providers
- Can be pressure on either side to do something virtually that the other would prefer to do in-person
- Opportunity to learn tech skills (mostly a con, but maybe a pro)
- Ease of adding family member or translator to appointment
- Helps reduce power imbalance because both parties are in their own spaces

Cons:

- Vulnerable people not being seen, can perpetuate inequalities
- Delayed diagnoses
- Waiting too long to get and appt. and/or late calling
- Requirement to have a virtual call before being seen in person
- Inability to form a personal connection or strong therapeutic relationship
- Disparity in access
- Missing out on body language
- Technological difficulties, infrastructure issues
- Privacy concerns (showing body on video, shared computer in home or elsewhere, record storage unclear, etc.)

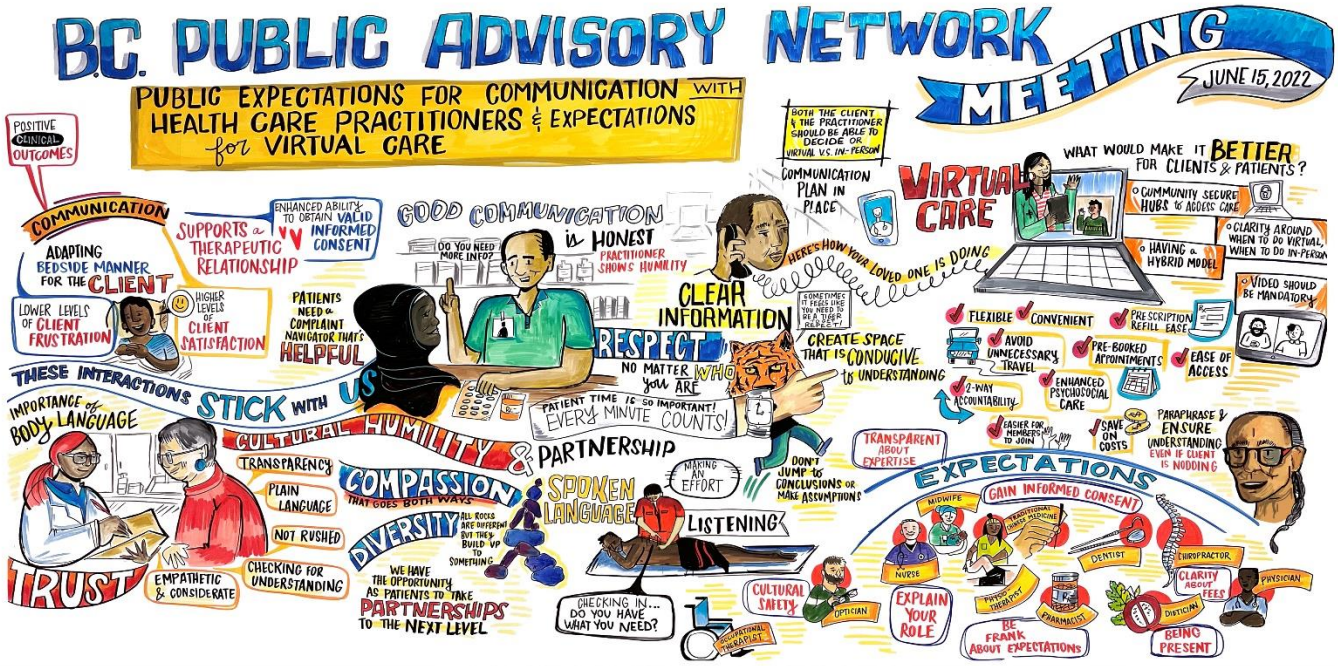
- Lack of consistency (may see a different person each time), potential lack of confidence knowing who you are actually talking to
- No follow-up mechanism
- Missing context/cues that come from seeing a whole person in real life
- Lack of clarity
- Requires different skills from providers, assessment of this method of care is more difficult
- Fear of litigation with physical assessments on video

Opportunities to improve virtual care:

- Make video mandatory
- No cost or low-cost hubs for folks to access virtual health (private and distraction-free spaces)
- More guidance for professionals around using virtual care
- Help the patient know they are in a safe and private place
- Hybrid model- a balance of virtual and in-person care
- Increased training for cultural differences

Wrapping up the day

Erica shared the final product of her all-day listening and graphic recording:



Susanna addressed some outstanding questions from the year-end advisor survey.

A fall meeting will be held virtually; date to be announced.

BC-PAN will be recruiting new advisors. All are encouraged to share the opportunity.