



**Citizen Advisory Group**

Saturday, February 2, 2019

9:30 a.m. – 4:00 p.m.

Facilitator: Misha Glouberman

375 University Ave, Suite 803

Toronto, ON, M5G 2J5

## AGENDA ITEMS

### **Item 1: Public Engagement**

Sponsoring Partnership Member:

- College of Naturopaths
- College of Physicians and Surgeons

### **Item 2: Patient Bill of Rights**

Sponsoring Partnership Members:

- College of Opticians
- College of Naturopaths
- College of Pharmacists
- College of Physicians and Surgeons

### **Item 3: Public Confidence in Governance of Health Regulatory Colleges**

Sponsoring Partnership Member:

- College of Dental Hygienists
- College of Denturists
- College of Physicians and Surgeons

## IN ATTENDANCE

Citizen Advisory Group Members	15
Facilitator	Misha Glouberman
Partnership Chair	Lisa Pretty, College of Physiotherapists of Ontario
Partnership Co-ordinator	Olivia Kisil, College of Physiotherapists of Ontario
Citizen Advisory Group Partners	Craig Roxborough, College of Physicians and Surgeons of Ontario Tracey Sobers, College of Physicians and Surgeons of Ontario Margot White, College of Naturopaths of Ontario Glenn Pettifer, College of Denturists of Ontario Deidre Brooks, College of Opticians of Ontario Jane Keir, College of Dental Hygienists of Ontario
Note Taker	Andrea Szametz

## AGENDA ITEM 1 - PUBLIC ENGAGEMENT

### *Sponsoring Partners:*

- College of Naturopaths
- College of Physicians and Surgeons

### **Following a definition from participants on “public engagement”, the following was noted:**

- The public’s awareness of regulatory Colleges and two-way communication are important; there is a comfort that people feel in communicating with the College
- Accessibility is important
- There is some confusion in the public about some professions (e.g., optician, optometrist, ophthalmologist – who does what). There should be a component of education about who is in what profession and what each does
- Colleges look to tap into this group’s thoughts and expectations (e.g., policies, programs, initiatives by the College, etc.)
- What can the College do to tell the public about its existence as an organization?
- Engage participation on a broader level – think about the different segments among the public and the caregivers associated with those people; the patient is at the centre of education, decision-making, etc.; focus on the word “public”
- Partnership and collaboration between people, the College and the public

### **Groups:**

#### **Why would it be helpful to raise public engagement? Does it matter?**

- Healthcare professionals and Colleges are often “removed” from patients and what is needed by patients may “get lost” in the medical process (need better engagement of health professionals)
- If the doctors have the knowledge we need to improve health and if the patient has information to improve their own health (“you are expert on you”), sometimes our voice isn’t being heard. There is a teaching method that should be part of what the professionals need to know and help provide better care
- The patient learns their rights and their responsibilities; patients need to fully disclose their issues. Public engagement with the colleges is important
- Is there consumer satisfaction with service delivery? It should be experience-based: understand the public’s concerns (experiential to helping patients)
- Helps patients make informed decisions
- Informs the Colleges if initiatives are working by asking patients for feedback on them

#### **Increasing patient motivation in engaging with the College:**

- It is a very visual society and for someone to be motivated they have to have something in front of them and not just read it. Make it interactive such as catching your eye, your attention, etc. Get involved directly rather than just reading on the website
- The public doesn’t usually care about the Colleges; they care about health issues, and not where they originate from; by targeting collectively, it will likely then engage more of the public

- Lack of communication/connection between the Colleges; public may not understand who governs what or where to go
- Some members of the public might want more alternatives to traditional medicine (e.g., naturopaths: they have greater clarity about their profession with the public)
- Customer service component: how was the recent experience with your doctor? Outreach by the professional to the patient as follow-up: how was that experience? As there are often waiting lists, the waiting room is also an opportunity to provide materials, etc. for the public to be engaged and to learn more about the profession
- Patients could be engaged in the waiting room, which is one way to provide information
- The public would want to know that the Colleges are going to take the feedback seriously, and this would then better engage patients (e.g., satisfaction surveys in waiting rooms and updates on what has happened since a previous progress report)
- Any feedback to the Colleges is valuable; follow-up with patients is important to show that the Colleges are listening and progress has been made; some initiatives may take longer than others due to “process”
- Provide updates on initiatives, surveys, etc. that show the public what has been done, changed, etc. That also further motivates patients
- Colleges cannot get feedback directly from patients – it is difficult and challenging
- Having deadlines and milestones is important
- The public may not know that there is a public advocate in some hospitals. Forms need to be filled and they are used as a teaching tool. Maybe there’s an experience gap between hospitals, doctors and the College
- Opportunity for engagement with a message or public announcement that explains “what is a health regulatory College”; the word “College” confuses some members of the public.

#### **More public members on committees – how to get them:**

- Reaching out through Health Quality Ontario; there are two existing patient advisory groups that do this
- Social media reaches a lot of people
- Use *Vitality* magazine and other related magazines to reach out
- Contact different patient organizations whose members may utilize different organizations (e.g., Canadian Spotlight Association); within these organizations, there should be highly experienced advocates who would agree to get involved
- Engagement with the public when it’s very niche: what are the barriers?
- Tailor the communication to each demographic (e.g., younger population; someone who has experienced something such as an illness) – “your opinion matters”

## AGENDA ITEM 2 – PATIENT BILL OF RIGHTS

### *Sponsoring Partners:*

- *College of Opticians*
- *College of Naturopaths*
- *College of Physiotherapists*
- *College of Physicians and Surgeons*

### **Usefulness of the Patient Bill of Rights:**

- Acknowledges patients' rights, confidence, voice (Bill of Rights: we can give input), protection, resolution (health issues)
- Sets minimum expectations on both sides (e.g., standards of professionalism which is a benchmark/what to expect)
- Emotional standpoint: more at ease in knowing your options in case of a problem
- Comfort level with parameters and boundaries; more respect for the individual (it's a new era)
- Levels the playing field (power imbalance, so helps in informing both sides)
- Having this document provides a higher comfort level
- The Patient Bill of Rights might give older patients more confidence in asking questions about their healthcare in the presence of a medical professional

### **How do we help people find documents they are looking for/where would you look?**

- Having it where people can see/access it (e.g., screens in waiting rooms; make it visually engaging, it fills time and space)
- Ensure it's also available elsewhere in the office and it is "accessible" to the lay person with easy/simple language; use audio
- Needs to be very visually appealing and make sure it's at eye-level if posted on a wall so people see it while seated rather than from the vantage point of standing; put a sign on the door to catch people's attention.
- Make it part of the intake process – keep it concise, acknowledging the appointment, etc.
- Concerted effort to make a universal bill of rights (most bills from Colleges are similar so if it's across the board, it's easier to disseminate and easier to find)
- In other professions, there is verbal engagement with the patient and they can be given their rights during intake
- Make it more accessible in simple language and consider more languages than just English and French
- Consider more seniors' newspapers, retirement homes, intake forms etc. where this could be posted and include the Patient Bill of Rights
- Post where people go such as drug stores, coffee shops, libraries, etc. and where they would see it and possibly share with others
- Engage doctors or nurses to provide information – give it to them and look beyond the doctor's office for other opportunities
- Consider another document targeted at youth or children (their rights as a patient). If you learn it early, you'll know for life what your rights are. Consider introducing it in the schools or possibly making it mandatory
- Encourage Colleges to step up their regulatory authority – some of this is optional and some is part of the regulatory program – make posting Bill of Rights required by Colleges

### **Are the Colleges the right people to write these documents?**

- Must be in collaboration with patients
- Who makes up the College – professionals, educated people? Make sure it is unbiased, and explains the Ministry of Health role, which represents the public of Ontario (support was expressed for this) as well as patients
- There is a gap but how do you fill the gap? The gap is if the patient is at home and going to community services, then it's a problem if they have to navigate several bills of rights. Encourage the Colleges to think about the patients in terms of breaking the silos. Strong support from attendees was noted in that it would be useful for the Ministry of Health to be involved because Colleges are there to protect the patient so the Colleges have a responsibility to make that clear (their rights) and the Ministry of Health hopefully is there for the same responsibility – both can be involved (i.e., on one side is self-regulation and on the other side is the consumer; the Minister of Health represents patients)
- Health professions have their own associations; Colleges represent the protection of the public
- The majority of attendees agreed that a written collaborative agreement with the Ministry of Health was beneficial and each profession could tweak their bill of rights (if one version is used)

### **Should bills of rights be universal or profession-specific?**

- Universal and specifics could be adjusted. What would the specifics entail? (e.g., universal with tweaks)
- “As someone receiving healthcare, I would want one set of rights,”
- Have a basic set of rights and then each profession has the unique aspects of their profession added; all in agreement with this approach. It also creates less bureaucracy with one version (universal makes it simpler, easier to disseminate and is consistent) and society as a whole likes to keep things simple (i.e., makes life easier)
- For different professions, they can explain their scope of practice so it provides both rights and scope (e.g.: “For more specific information, go to: [College website].”)
- Shows consistency among the Colleges and doesn't cause problems of inconsistency or inequality
- Easier to disseminate information to one College rather than 26
- All in agreement: one set of rights is preferable

### **How should patient responsibility be integrated or accounted for?**

- Patient responsibility: counterintuitive to patient's needs – are they complying? Marginalizes patients such as certain populations (e.g., homeless) that can't take responsibility for certain things
- Consider a situation such as someone who could not go through a treatment, was not taking their meds and had a caregiver – that puts a lot of responsibility on the caregiver (“marching orders”)
- “Responsibility to take care of yourself” or “Make the decisions yourself”
- Recognition that a doctor cannot compel an individual to take a test; a patient needs to know it is important that they take that test (“you are in some way responsible for your health”)
- It was pointed out that it was not appropriate to assume someone can take responsibility for their own care but there is reason to hope that patients should be more transparent with their

doctors (e.g., they don't want to take a test that their doctor has ordered). The reverse side is that the doctor could discharge the patient.

- Ask doctors to pose other questions to their patients (e.g., having a holistic view of the patient's situation and circumstances). Consider if it's a broader issue around family, etc.
- Youth may not share information with the doctor because the doctor would share the information with their parents
- "Responsibility": things you can do as a patient to get the best out of your appointment such as honesty of conversation, patient has autonomy of their decisions – "things patients can do" is useful in educating patients about their rights
- Patient responsibility: some people bristle at the notion of it but some people want to take accountability for their health – that is, more about what you can do to make it better – and patient empowerment (patient gets more involved in their health care)
- "Patient": it's also the family, extended care, etc. that is involved
- Bill of Rights: refer to patient and family (and who the patient wants to engage)

### AGENDA ITEM 3 – PUBLIC CONFIDENCE IN THE REGULATORY PROCESS

#### *Sponsoring Partners:*

- *College of Dental Hygienists*
- *College of Denturists*
- *College of Physicians and Surgeons*

#### **How much confidence do you have in the regulatory process?**

- Have confidence because of the media (e.g., serious breaches of trust, etc.) talks about discipline actions and it has instilled confidence that something has been done in ensuring there is a process (4 agreed; 4 disagreed)
- In the past, confidence hasn't been there and the Colleges need to change their images. There was a perception in the past that it was for the profession and not patients (such as an old boys' club) (majority agreed)
- There are some situations where doctors who are accused of sexual abuse are still practising; people are not as trusting in the "system"
- Are there a lot of things that people don't report because they have no confidence in the system? This could be like a vicious circle.
- It is not fair to lump all health professions with the same brush but there is room in the confidence about the rigorous process that professionals have to go through to get registered
- Nature of self-regulation: who will handle the misbehaviour of doctors if it's doctors doing it?
- Is there an easy way for the doctor to lose their license after harming a patient, that gives confidence to the public?
- Rating level of confidence in regulatory process: high: 2 medium: 6 low: 5

#### **What are the governance structures that could maximize public trust and confidence?**

- Separation of policy by person and role – Council, administration, discipline
- Ratio may need to change so there is more citizen than professional representation (i.e., majority is citizens)

- Important that professionals still have good representation (at least 50% and don't get rid of them) as there is already a power imbalance
- Example from Scotland: it was proposed that it be 50/50 plus a chair (a simple majority of lay people rather than professionals). There was no preference from the group whether the chair be a public member or not, rather the individual be fit for the position. The key is that all board members have experience in corporate governance and undergo a competency test to ensure the person can be a good "governor". Both professional and public members should have competency
- Representation should be stratified with different demographics for professional and public members; have representation from caregivers
- Would like more transparency about rigours that registrants have to go through (e.g., to protect the public). Consider this is a public relations angle and important but happens further down the ladder
- Competency complemented by board training
- Discipline: should be separation between governance of College and those who deal with disciplinary matters, especially around complaints (i.e., for independence and leading to public confidence)
- If someone had past involvement in the association and was then going to the regulatory College, think about the length of a cooling-off period for them (e.g., 2-3 years)
- Discipline Committee: separate governance from discipline? It was suggested that it's a conflict of interest in areas such as policy-making
- Include caregivers in the mix

**Participants were asked to share their top two priorities:**

Change ratio: 11

Separate governance from discipline and complaints: 8

Competency for all members: 3

Stratified representation: 3

Caregivers: 2

More transparency or rigorous: 2

Separate policy from administration: 1

Chair should be a public member: 0

**Consideration of separate governance and discipline:**

- Hierarchy about governance (no level above governance)
- Like other structures of government, it's like legislators who make laws then can't implement them
- Conflict of interest: if you set the policy, you might have an attachment to it and when disciplining someone you don't necessarily want to go against your own policy
- Could it be a conflict of duty? What are the rules, etc. in weighing the credibility of the patient's complaint? You need to be clearly unattached or not have a conflict of loyalties

## AMALGAMATION

### Should a number of like professions be in one College?

- Too much redundancy: “yes” mostly (no: 1; not sure: 1)
- RNs, RPNs and PSWs: difference in scopes of practice and wouldn’t want PSWs with RNs and RPNs; it depends on the scope of practice and while the vast majority are okay, there are some downsides
- Confusing that there’s so many different Colleges and it is harder for the public to find and go to the right College
- Having one College for many professions can blur the lines and make it confusing. In protecting the public, it is not sure how it works as it creates confusion with the public in understanding where to go
- Might lead to more holistic care
- For example, from the public perspective, dentists, dental hygienists and denturists under one roof could be easier for the public; one College for eye care makes sense
- Accountability of each practitioner – the standards of care may have higher scrutiny, which is in favour of making it simpler for the public
- Could be confusion among the public if several like professions are under one College
- Likely easier if like Colleges were amalgamated
- Could be logistical from professionals’ perspectives and while it’s easier for the public, it may not be for the professionals; with their amalgamation, it may not work as well and could make it more difficult to access them
- If the issue is where to complain, consider a central intake portal, which then forwards the complaint to the applicable College. There was agreement this is a very positive approach
- A central organization can get more done in looking at broader implications and if it’s simpler

### “College” is a confusing term for the public. What’s a better name?

- Unanimous consensus that “College” is confusing to the public as it denotes an educational institution to them
- Suggested alternatives:
  - Governing Public Council of [Profession]
  - Governing and Regulatory Body of [Profession]
  - Licensing Authority of [Profession]
  - Somewhere in the title be clearer what College does – i.e., it is a regulatory body
  - Opticians Regulatory Body of Ontario (or authority) (Physicians Regulatory Authority (insert profession))

### Vote on sample wording other than “College”:

Licensing Authority of Chiropractors: 4

Professional Regulatory Authority of Naturopaths: 4

Governing Public Council: 3

Governing Regulatory Body: 3

Professional Regulatory Body of Dentists: 0