Framework for a Model Patient-Practitioner Relationship Program for BC Health Regulators

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1. Legislative Framework

All Colleges regulated under the *Health Professions Act (HPA)* are required to establish a program to deal with patient-practitioner relationships:

> Section 16 (2) (f)
> … to establish, for a college designated under section 12 (2) (h), a patient relations program to seek to prevent professional misconduct of a sexual nature.

2. Program Position Statement

Health care practitioners regulated by Colleges of the BC Health Regulators provide health care that is built on a foundation of trust and respect. Patients trust their professional practitioner because they believe the practitioner has special knowledge, skills and abilities and uses these to provide safe, effective and ethical care. Practitioners demonstrate respect for patients by acknowledging their position of power and maintaining professional boundaries.

A Patient-Practitioner Relationship Program helps both patients and practitioners understand the need for boundaries in establishing the context and limits of care. The professional relationship between the professional and the patient exists for the patient's benefit. Setting boundaries requires the practitioner be a professional and to ensure that the autonomy and dignity of patients is maintained.

3. Key Concepts and Definitions

"*Professional misconduct*" is defined in the HPA (Part 3) to include "sexual misconduct, unethical conduct, infamous conduct and conduct unbecoming a member of the health profession".

"Dual relationships" in the health service context pertains to relationships in which the registered professional has more than one relationship with the service recipient. An example of a dual relationship is providing clinical services to a family member or friend.

"Conflict of Interest" arises where a reasonable person could form the view that a professional's ability and obligation to act in the patient's best interests may be affected or influenced by other competing interests. Such conflicts of interest can be real, potential or perceived. Conflicts of interest occur in a variety of circumstances including financial, non-financial, direct, and indirect transactions with patients and others.

"Informed consent" is defined in S. 7 of this Framework.

4. Principles for the Patient-Practitioner Relationship Program

a) Each program is developed in the context of the type of health care and the health care environment in which it is provided.
b) Each program must establish appropriate professional boundaries between the registrant and the patient, ensuring that:
   (i) the patient is able to provide full, free and informed consent;
   (ii) patient autonomy is maintained at all times; and
   (iii) the practitioner provides objective care to every patient.
c) Each program must have clear, concise and accessible information and materials for both registrants and the public.
d) Each program must provide training for College staff to support their understanding of the program and how it applies in practice.
e) The program is designed to enhance the registrant's capacity to understand and set boundaries and communicate those effectively to every patient.

5. Patient-Practitioner Relationship Program Elements

Each College's patient-practitioner relationship program must address the following areas:

a) romantic or sexual relationship with patients;
b) treatment of partners, spouses, or other family members;
c) relationships with former patients;
d) "bartering" or exchanging health care services for other services with a patient;
e) monetary gain from patients outside of the cost of the service/care provided;
f) use of social media;
g) non-trivial gifts from patients;
h) care of family members in emergency situations; and
i) guidance for practitioners working in small, rural or remote communities.

6. Shared Underlying Principles in the Patient-Practitioner Relationship

1. Avoidance, as much as possible, of any professional relationship with a patient when the professional's objectivity or competence could reasonably be expected to be impaired because of the professional's present or previous familial, social, sexual, emotional, financial, supervisory, political, administrative, or legal relationship with the patient or with another relevant person associated with or related to the patient.

2. If a dual relationship or conflict of interest is unavoidable, the professional should document the specific circumstance, an account of why the duality or conflict is unavoidable and document the informed consent of the patient(s) for all services.

3. Obtaining informed consent at the beginning of professional relationships and understanding that informed consent is an ongoing process, rather than a onetime event.

7. What Constitutes Informed Consent

The BC *Health Care (Consent) and Care Facility (Admission) Act* defines "*Informed Consent"* as follows**:**

4 Every adult who is capable of giving or refusing consent to health care has

(a) the right to give consent or to refuse consent on any grounds, including moral or religious grounds, even if the refusal will result in death,

(b) the right to select a particular form of available health care on any grounds, including moral or religious grounds,

(c) the right to revoke consent,

(d) the right to expect that a decision to give, refuse or revoke consent will be respected, and

(e) the right to be involved to the greatest degree possible in all case planning and decision making.

5 (1) A health care provider must not provide any health care to an adult without the adult's consent except under sections 11 to 15.

(2) A health care provider must not seek a decision about whether to give or refuse substitute consent to health care under section 11, 14 or 15 unless he or she has made every reasonable effort to obtain a decision from the adult.

6 An adult consents to health care if

(a) the consent relates to the proposed health care,

(b) the consent is given voluntarily,

(c) the consent is not obtained by fraud or misrepresentation,

(d) the adult is capable of making a decision about whether to give or refuse consent to the proposed health care,

(e) the health care provider gives the adult the information a reasonable person would require to understand the proposed health care and to make a decision, including information about

(i) the condition for which the health care is proposed,

(ii) the nature of the proposed health care,

(iii) the risks and benefits of the proposed health care that a reasonable person would expect to be told about, and

(iv) alternative courses of health care, and

(f) the adult has an opportunity to ask questions and receive answers about the proposed health care.

Appendix 2 – HPA Provisions

Duty and objects of a college
16 (1) It is the duty of a college at all times

(a) to serve and protect the public, and
(b) to exercise its powers and discharge its responsibilities under all enactments in the public interest.

(2) A college has the following objects:
(a) to superintend the practice of the profession;
(b) to govern its registrants according to this Act, the regulations and the bylaws of the college;
(c) to establish the conditions or requirements for registration of a person as a member of the college;
(d) to establish, monitor and enforce standards of practice to enhance the quality of practice and reduce incompetent, impaired or unethical practice amongst registrants;
(e) to establish and maintain a continuing competency program to promote high practice standards amongst registrants;
(f) to establish, for a college designated under section 12 (2) (h), a patient relations program to seek to prevent professional misconduct of a sexual nature;
(g) to establish, monitor and enforce standards of professional ethics amongst registrants;
(h) to require registrants to provide to an individual access to the individual's health care records in appropriate circumstances;
(i) to inform individuals of their rights under this Act and the Freedom of Information and Protection of Privacy Act;
(i.1) to establish and employ registration, inquiry and discipline procedures that are transparent, objective, impartial and fair;
(j) to administer the affairs of the college and perform its duties and exercise its powers under this Act or other enactments;
(k) in the course of performing its duties and exercising its powers under this Act or other enactments, to promote and enhance the following:
(i) collaborative relations with other colleges established under this Act, regional health boards designated under the Health Authorities Act and other entities in the Provincial health system, post-secondary education institutions and the government;
(ii) interprofessional collaborative practice between its registrants and persons practising another health profession;
(iii) the ability of its registrants to respond and adapt to changes in practice environments, advances in technology and other emerging issues.

Definitions for Part
26 In this Part:

"professional misconduct" includes sexual misconduct, unethical conduct, infamous conduct and conduct unbecoming a member of the health profession;

"registrant" includes a former registrant, and a certified non-registrant or former certified non-registrant to whom this Part applies;

"serious matter" means a matter which, if admitted or proven following an investigation under this Part, would ordinarily result in an order being made under section 39 (2) (b) to (e);

"unprofessional conduct" includes professional misconduct.

Duty to report sexual misconduct
32.4 (1) If a registrant has reasonable and probable grounds to believe that another registrant has engaged in sexual misconduct, the registrant must report the circumstances in writing to the registrar of the other registrant's college.

(2) Despite subsection (1), if a registrant's belief concerning sexual misconduct is based on information given in writing, or stated, by the registrant's patient, the registrant must obtain, before making the report, the consent of

(a) the patient, or

(b) a parent, guardian or committee of the patient, if the patient is not competent to consent to treatment.

(3) On receiving a report under subsection (1), the registrar must act under section 32 (2) as though the registrar had received a complaint under section 32 (1).

Immunity

32.5 No action for damages lies or may be brought against a person for making a report in good faith as required under section 32.2, 32.3 or 32.4.