



Transitional Council of the College of Traditional Chinese  
Medicine Practitioners and Acupuncturists of Ontario  
安省中醫師及針灸師管理局過渡委員會

## **Jurisprudence Course Handbook**

### **Important Legal Principles Practitioners Need to Know**

### **College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario**

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## Important Legal Principles Practitioners Need to Know

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### ***Introduction and Overview***

The purpose of this book and the jurisprudence course is to provide information on the ethical and legal framework within which TCM Practitioners and Acupuncturists practice in Ontario.

This book will first discuss the concepts of professionalism and self-regulation. The *Traditional Chinese Medicine Act* is based on these concepts. The book will then look at how proper communication with patients and colleagues is fundamental to a professional practice. For example, informed consent is not possible without communication. The book will then review the various laws that practitioners are most likely to have to deal with in their practice.

In this book there are a number of Acts that are referred to by their abbreviations including the following:

- AODA - *Accessibility for Ontarians with Disability Act*
- CFSA - *Child and Family Services Act*
- HCCA - *Health Care Consent Act*
- PHIPA – *Personal Health Information Protection Act*
- PIPEDA – *Personal Information Protection and Electronic Documents Act*
- RHPA – *Regulated Health Professions Act*
- TCMA - *Traditional Chinese Medicine Act*

## **1. Professionalism and Self-Regulation**

A profession is different from a business. Members of a profession believe that they help patients, not just make money from them. Practitioners have a number of duties to the patients they serve. For example, practitioners have the duty to be honest with patients. Practitioners have a duty to provide good service to patients. Practitioners have a duty to tell patients what they are going to do to the patient and to ask for the patient's consent before doing it.

Being a member of a profession also means that practitioners have a duty to other members of the profession. Practitioners have a duty to be polite to each other. Practitioners have a duty to work with fellow practitioners to serve the welfare of their patients. For example, practitioners need to try to coordinate the care of a patient they are both treating whenever possible (and the patient consents).

Practitioners also have a duty to work with their regulatory College to protect the public from dishonest or incompetent practitioners. For example, practitioners are required to cooperate in an investigation of a complaint.

Professionals must also obey the laws that apply to them. There are many different laws that apply to a practitioner. The purpose of this book is to describe some of these laws in a general way so that practitioners understand the basic principles. It does not cover all of the exceptions and special circumstances that arise in real life. If a practitioner has a specific legal question about their own circumstance, they should seek advice from a lawyer.

### ***a. The concept of self-regulation***

The "regulation" of an activity means that the law imposes restrictions on the activity to ensure that the public are not harmed, and actually benefit, from it. There are many ways in which an activity can be regulated. For example, the government could create offences for improperly doing the activity, or the government could have one of its Ministries overseeing the activity.

In Ontario, most professions are self-regulated. In many other parts of the world, professions are regulated directly by the government or through general consumer protection laws. Ontario has chosen this model so that those who best understand the profession are involved in its regulation.

Self-regulation means that the Ontario government has made a statute (often called an Act) giving the duty to regulate the profession to a separate body (called a College) the majority of whose Council is elected by the profession. The College is a regulatory body, not an educational institution. The Council is the Board of Directors of the College. The Council establishes the policies of the College (e.g., it makes the professional misconduct regulations) and oversees the administration of the regulatory activities of the College (e.g., it establishes the budget for the quality assurance program of the College). The College operates through committees (e.g., the

Registration Committee, the Discipline Committee) the majority of whose members are from the profession, with other members coming from the public.

The mandate of the College is to serve the public interest. It does this by regulating the profession in the public interest. Under its statute, the College “has a duty to serve and protect the public interest”. The College cannot serve the self-interest of the profession (e.g., the College cannot set fees to be charged to patients, nor can it advocate to the government on behalf of the interests of the profession); that is the role of a professional association, not a regulatory College. Self-regulation does not mean self-interest; in fact it means exactly the opposite. Self-regulation means serving the public interest. That is, the College ensures that the profession acts honestly and competently.

There are a number of safeguards that ensure that the College serves the public interest, including the following:

- i. The Council and the committees of the College also have public members on them (i.e., non-practitioners appointed by the government). The Act requires that public members comprise a sizeable minority of the Council and its committees.
- ii. Council meetings and discipline hearings are open to the public. Observers can attend and watch what happens.
- iii. The College must consult with members of the profession and the public before making a regulation or by-law affecting them. The College must circulate for comment the proposed wording of a proposed regulation and many by-laws for a period of at least 60 days.
- iv. Decisions of the committees of the College can be reviewed by other bodies. For example, decisions of the Registration Committee or the Inquiries, Complaints and Reports Committee can be reviewed by the affected individuals to the Health Professions Appeal and Review Board (HPARB). Decisions of the Discipline Committee or the Fitness to Practise Committee can be appealed to the Divisional Court.
- v. The government has appointed two bodies who ensure that the College acts in the public interest. The Office of the Fairness Commissioner makes sure that the College’s registration practices are transparent, objective, impartial and fair. In addition, the Minister of Health and Long-Term Care can refer concerns about the College’s regulations or programs to the Health Professions Regulatory Advisory Council (HPRAC) for review.
- vi. The College has to report to the Minister. It has to make an annual report and such other reports as the Minister requests. The Minister has the ability to make recommendations or even issue directions to the Council of the College. If there are serious concerns the Minister can audit the operations of the College and can appoint a supervisor to take over its operations. Thus, while the College is separate from the government, it is still accountable to the Minister of Health and Long-Term Care.

These safeguards help ensure that the College serves the public interest in a fair and open manner.

Given the public interest mandate of the College and the safeguards that are in place, professional members elected to the Council need to be careful about their role. As mentioned above, Council members are like directors of a corporation who have a duty of loyalty and good faith to the mandate of their organization. Council members are not like politicians who represent and serve those who elected them. The only role of Council members is to represent the public and the public interest

### *Sample Exam Question*

What sentence best describes the roles of the College and professional associations?

- i) The College serves the public interest; professional associations serve the interests of the profession.
- ii) The College and the professional associations both serve the public interest.
- iii) The College and the professional associations both serve the interests of the profession.
- iv) The professional associations direct the operations of the College.

*The best answer is i). The College's mandate is to regulate the profession in order to serve and protect the public interest. Answer ii) is not the best answer because professional associations are designed to serve the interests of their members. While professional associations care about the public interest and often take actions that assist the public interest, they are under no statutory duty to do so and are accountable only to their members. Answer iii) is not the best answer because the College is not permitted to serve the interests of its members under its statute. While it tries to ensure that it regulates its members sensitively and fairly, and consults with its members, the College's mandate is the public interest. Answer iv) is not correct. While the College consults with the professional associations and considers seriously their views and respects their expertise, the College is not under the control of any professional association.*

### ***b. Ethics, professional standards, professional misconduct, incompetence, incapacity***

A major part of the College's role is to develop and, sometimes, enforce a Code of Ethics and professional standards. The College takes action where there is professional misconduct, incompetence and incapacity. Each of these concepts is slightly different in its role and purpose.

This section of the book looks at each of them.

### *Code of Ethics*

Professions have ethical principles to guide their members. These ethical principles include being honest at all times, respecting the confidentiality of a patient, treating clients with sensitivity, maintaining one's competence and allowing patients to make informed choices as to their health care. Many professional associations have developed a Code of Ethics for their members.

The College is authorized under its statute to develop a Code of Ethics for its members. As such, the College's Code of Ethics takes priority over the Codes of Ethics of professional associations.

The purpose of the Code of Ethics is to set out the goals or ideals that practitioners try to reach. The principles are often set out as positive statements (e.g., a practitioner will be honest). This is different from a professional misconduct regulation which sets out the minimum practitioners must do to avoid discipline (e.g., a practitioner will not issue a false or misleading document). Many principles of the Code of Ethics also encourage practitioners to continually improve (e.g., one can always try to be more sensitive to the client).

The Code of Ethics is not enforced through the discipline process. Rather, their role is to guide and encourage the practitioner. If a practitioner follows the principles of the Code of Ethics (e.g., being honest) they will avoid engaging in professional misconduct (e.g., they will not issue a false or misleading document).

#### *Ethics Scenario*

*Practitioner X is always polite to his patients, in a formal way. He feels good about himself. However, he often says "God" to express surprise. The phrase means nothing to him and no one has ever expressed concerns about it. One of his patients, Paul, has shared that he is very religious. Whenever X says "God" Paul flinches a bit. X notices and asks Paul if the use of the word "God" bothers Paul. Paul says that, actually it does. X makes a point of not saying "God" anymore in front of Paul. After discussing the incident with a colleague, X decides that the ethical thing for him to do is to stop using the word "God" as an expression of surprise whenever he is with a patient because X cannot tell in advance who will be offended.*

#### *Professional Standards*

Professional standards describe the way in which practitioners practise their profession. For example, it is a professional standard to assess a patient before treating them.

Often the details of the professional standard are not written down anywhere by the College. For example, the College may not have a document describing exactly how a practitioner assesses a patient. Indeed, often how the standard is applied changes with the circumstances (e.g., the answers the patient gives to the practitioner's questions will change how the assessment is done). Professional standards are learned through one's education, professional

reading and learning, experience in practice and in discussions with other practitioners. Professional standards are always changing.

However, to assist members, the College develops written publications that discuss professional standards. These publications can have different names (e.g., Standards of Practice, Guidelines, Policies, Position Statements) depending on their context and purpose. The purpose of these publications is to remind practitioners about the factors that are required to practice safely, ethically and effectively. These publications are on the College's website and cover a wide variety of topics. While professional standards are not "law" in the same way that a statute or regulation is, failing to comply with a published standard will often lead to a violation of the law or will result in professional misconduct.

#### *Discontinuing Professional Services Scenario*

*Practitioner Y wants to stop treating a patient because the patient has stopped paying. She reads an article in the College's newsletter suggesting that patients should be given at least two weeks to find a new practitioner before one stops treating the patient. Y cannot see why she needs to see a patient who is not paying for her services and does not follow the newsletter suggestion. The patient experiences pain once the treatment stops and misses ten days of work before the patient can find another practitioner to treat him. The patient complains to the College. After investigating the complaint the College requires Y to appear before it to receive a verbal caution because Y abandoned a patient who was in pain without giving the patient adequate time to find another practitioner. The fact that Y was not paid did not remove her duty to the patient who was in pain.*

#### *Professional Misconduct*

Professional misconduct is conduct that falls below the minimum expectations of a safe and ethical practitioner. Professional misconduct is written in either the statute or the regulations that apply to practitioners. The provisions in the statute and regulations are described in more detail below on professional misconduct regulations. As noted above, many College publications will assist practitioners to recognize how to avoid engaging in professional misconduct.

Engaging in professional misconduct can lead to disciplinary proceedings that could result in serious orders (e.g., a fine, suspension or even revocation of one's certificate of registration). It is very serious for a practitioner to engage in professional misconduct.

#### *Permitting Illegal Conduct Scenario*

*Practitioner X is registered with the College. X's father is not registered with the College. Practitioner X's father sometimes drops into X's office to treat his long term patients. The office assistant refers to X's father as "Doctor" when booking patients. A patient complains to the College when her extended health insurance refused to pay for X's father's services because he was not registered with the College. Is Practitioner X responsible for his father's conduct?*

*The answer is yes. It is professional misconduct to permit a person to hold themselves out as practising the profession when they are not registered. Practitioner X condoned the conduct that occurred at his office. Practitioner X, by being registered, gave credibility and status to the illegal conduct of his father. X could face a discipline hearing.*

### *Incompetence*

Incompetence is where a practitioner shows a serious lack of knowledge, skill or judgment when assessing or treating a patient. It is defined in the statute. A concern that a practitioner is incompetent can be investigated by the College and can result in a discipline hearing. If the Discipline Committee finds that a practitioner is incompetent, it can impose restrictions on the practitioner's registration (e.g., the practitioner cannot practice in a certain way, such as with children), or it can suspend or revoke the practitioner's registration.

In any investigation of incompetence the College will usually look at the practitioner's records. The College will interview the patient and the practitioner and ask other practitioners if they think the conduct shows incompetence. Both of the College committees dealing with the case will have other practitioners on it who know the difference between good and bad practice.

### *Incompetence Scenario*

*Practitioner Y does not really assess her patients. She is in a hurry to treat as many patients as possible in a day. She just asks the patient what is wrong and then will proceed to give treatment. She does not bother to take patient history or review progress of the patient. A patient, Paula, came in with a serious condition. Y did not recognize it. Paula became unresponsive during her acupuncture treatment. Later that night, Paula ended up in the emergency department of the hospital with a stroke. Paula complained about Y's incompetence. The Inquiries, Complaints and Reports Committee looked at Y's patient records and heard Y's explanation for what she had done. It sent the case to discipline. The Discipline Committee agreed that Y showed a lack of knowledge, skill and judgment. It ordered Y to go back to school for a year.*

### *Incapacity*

A practitioner is incapable when he or she has a health condition that prevents him or her from practising safely. Usually the health condition is one that prevents the practitioner from thinking clearly. Even a severely disabled practitioner can practice safely so long as the practitioner understands his or her limits and gets the necessary help. Most practitioners who are found to be incapable are those who suffer from addictions or certain mental illnesses that impair the practitioner's professional judgment. For example, a practitioner who is addicted to alcohol or drugs may try to see patients when they are impaired.

Under the law, incapable practitioners are not treated in the same way as practitioners who have engaged in professional misconduct or are incompetent. The investigation looks at the practitioner's health condition and the treatment that they are receiving. The College can require the practitioner to go for a specialist examination to get more information about the practitioner's health. If the concern is justified, the practitioner is referred to the Fitness to Practise Committee for a hearing. The Fitness to Practise Committee can order the practitioner to undergo medical treatment, have medical monitoring and to restrict his or her practice. In an extreme case (e.g., where the practitioner continues to see patients while impaired) the Fitness to Practise Committee can suspend or revoke the practitioner's registration in order to protect the public.

#### *Incapacity Scenario*

*Practitioner Z has been drinking a lot more alcohol over the last few months. He has been coming to work with a hangover. More recently he has been drinking at lunch. One day Z comes back after lunch impaired. Paul, a patient, notices that Z smells of alcohol and that Z is stumbling around the office. Paul tells the College. At first Z denies he has a problem. However, on investigating, the College learns that some of Z's colleagues have noticed a significant change in Z's behaviour in recent months. The College also learned that Z has been charged with impaired driving. The College sends Z to a medical specialist who diagnoses Z with a serious substance abuse disorder. The College encourages Z to go for treatment at the Homewood Health Centre. Z agrees. The matter is referred to the Fitness to Practise Committee. Z and the College agree to an order requiring Z to stop drinking, attend Alcoholics Anonymous group meetings, see his new substance abuse specialist regularly and have a colleague watch Z at work and send regular reports to the College.*

#### *Conclusion*

Each of the above provisions looks at different aspects of professional practice. Each of these provisions also serves a different purpose. The Code of Ethics deals with the ideals which practitioners try to achieve. Professional standards deal with ways in which to practise safely, effectively and professionally. Professional misconduct deals with the minimum conduct necessary to avoid discipline. Incompetence deals with having an adequate level of knowledge,

skill and judgment in the assessment and treatment of a patient. Incapacity deals with health conditions that prevent a practitioner from thinking clearly.

### *Sample Exam Question*

The sentence “Practitioners are sensitive to the wishes of their patients” is most likely to be found in which of the following provisions?

- i. The definition of incapacity.
- ii. The definition of incompetence.
- iii. The definition of professional misconduct.
- iv. Professional standards published by the College.
- v. The Code of Ethics.

*The best answer is v). Being sensitive is an ideal that practitioners strive towards. Answer i) is not the best answer because incapacity deals with the practitioner’s health condition. Seriously insensitive behaviour may accompany some illnesses (e.g., addictions), but it is the illness that must be treated first. Answer ii) is not the best answer because incompetence deals with practitioners having an adequate level of knowledge, skill and judgment. Answer iii) is not the best answer because professional misconduct deals with the minimum conduct that is necessary to avoid discipline. The corresponding professional misconduct provision would likely be that practitioners shall not abuse their patients. Answer iv) is not the best answer because professional standards deal with ways in which to practice safely, effectively and professionally. A professional standard would likely provide practical suggestions about how to practice sensitively (e.g., advice on how to listen to the patient first before doing anything else).*

## **2. Communication**

### **a. Introduction**

Many complaints against practitioners could be avoided by good communication with patients, staff and colleagues. Good communication involves, first, listening to others. Understanding the person’s wishes, expectations and values before doing anything is important. Asking questions to clarify and expand on what the person is saying also helps. Repeating information back to a patient, in the practitioner’s own words, can help ensure understanding and reassures the patient that the practitioner has been listening. Good communication also involves making sure the other person knows what you are going to do, why you are going to do it and what is likely going to happen. When the other person is confused by what you are doing or why, there is miscommunication. Also, people do not like to be surprised (e.g., by pain, an unexpected side effect). Telling the person what will or may happen removes the surprise. The following section of this book deals with some of the areas in which good communication is legally particularly important.

## **b. Informed consent**

Patients have the right to control their bodies and their health care. Practitioners do not have the right to assess or treat a patient unless the patient agrees to it (i.e., consents). A practitioner who assesses or treats a patient without the patient's consent can face criminal (e.g., a charge of assault), civil (e.g., a lawsuit for damages) or professional (e.g., a discipline hearing) consequences. This section of the book deals with consent for the assessment and treatment of patients. Other parts of the book deal with the need for consent when dealing with a patient's personal health information or for billing them.

### *General Principles*

To be valid, a patient's consent must meet the following requirements:

- *Relate to the Treatment.* The practitioner cannot receive consent for one procedure (e.g., taking a history of the patient's health) and then use it to do a different procedure (e.g., physically examine the patient). The patient's consent must be for what is actually going to be done.
- *Be Specific.* The practitioner cannot ask for a vague consent. For example, one cannot ask for the patient to consent to any treatment the practitioner believes is appropriate. The actual assessment or treatment procedure must be explained. This means that the practitioner often has to obtain the patient's consent many times as new procedures become advisable. This also means that a practitioner cannot obtain a "blanket consent" when the patient first comes in to cover every procedure.
- *Be Informed.* It is necessary that the patient understands what they are agreeing to. The practitioner must explain to the patient everything the patient needs to know before asking the patient to give consent. For example, if someone asks for your consent to drive your car without telling you that they intend to use it to race over rocky fields, your consent was not informed. To be informed, consent must include the following:
  - *Nature of the Assessment or Treatment.* The patient must understand exactly what the practitioner is proposing to do. For example, does the practitioner intend to just ask questions or will the practitioner also be touching the patient? If the practitioner is going to be touching the patient, describe what the patient should expect.
  - *Who will be Doing the Procedure?* Will the practitioner be doing the procedure personally or will an assistant or colleague be doing it? If it is an assistant or colleague, is he or she registered with the College, another College, or not registered at all?
  - *Reasons for the Procedure.* The practitioner must explain why he or she is proposing that procedure. What are the expected benefits? How does the procedure fit in with the overall plan of the practitioner? How likely is it that the hoped for benefits will happen?

- *Material Risks and Side Effects.* The practitioner must explain any “material” risks and side effects. “Material” risks or side effects are those that a reasonable person would want to know about. For example, if there is a high risk of a modest side effect (e.g., sleeplessness), the patient should be told. Similarly, if there is low risk of a serious side effect (e.g., death or suicide), the patient needs to be told.
- *Alternatives to the Procedure.* If there are reasonable alternatives to the procedure (e.g., a more cautious approach), the patient must be told. Even if the practitioner does not recommend the option (e.g., it is too aggressive and has a higher risk), the practitioner should describe the option and tell the patient why the practitioner is not recommending it. Also, even if the practitioner does not provide the alternative procedure (e.g., it is provided by a member of a different profession, such as a physician), the practitioner must tell the patient if it is a reasonable option.
- *Consequences of Not Having the Procedure.* One option for a patient is do nothing. The practitioner should explain to the patient what is likely to happen if the patient does nothing. If it is not clear what will happen, the practitioner should say so and provide some likely consequences.
- *Particular Patient Concerns.* If the individual patient has a special interest in some aspect of the procedure (e.g., its nature, a side effect), the patient needs to be told (e.g., the procedure would violate the patient’s religious beliefs).
- *Voluntary.* The practitioner cannot force a patient into consenting to a procedure. This is particularly important when dealing with younger or older patients who may be overly influenced by family members or friends. This is also important where the assessment or treatment will have financial consequences for the patient (e.g., the patient will lose his or her job or will lose financial benefits if the patient refuses to consent). The practitioner should discuss with the patient that it is up to the patient whether to give consent and that the patient should not let anyone pressure them into doing something the patient does not want to do.
- *No Misrepresentation or Fraud.* The practitioner must not make claims about the assessment or treatment that are not true (e.g., telling the patient that a treatment will cure them when in fact the results are uncertain). This situation would not result in a true consent. Patients must be given accurate factual information and honest opinions.

Therefore, consent to an assessment or treatment must involve effective communication between the practitioner and the patient. The practitioner must make sure that the patient understands what he or she is agreeing to. While it may sound like a lot of work, most of the time informed consent can be obtained quickly and easily. It is only when dealing with complex or particularly risky matters that a lot of time is required.

### Consent Scenario No. 1

*Practitioner Y meets a new patient named Paula. Paula complains about feeling stressed and tired. Y says: "I would like to fully understand your personal and family background and your medical history. There could be a lot of things making you feel tired and stressed and this information will help me try to figure out why. If you are uncomfortable with any of my questions, please let me know. OK?" Y has probably just obtained informed consent.*

### Sample Exam Question

Obtaining a broad consent (often called a "blanket consent") in writing from the patient on his or her arrival at the office is probably a bad idea because:

- i. The patient does not know if they will need someone to drive them home afterwards.
- ii. The patient does not have confidence in the practitioner yet.
- iii. The patient does not understand to what they are being asked to agree.
- iv. The patient does not know how long the visit will be.

*The best answer is iii). Informed consent requires the patient to understand the nature, risks and side effects of the specific procedure proposed by the practitioner. It is impossible for the patient to know these things upon their arrival at the office. Answer i) is not the best answer because it focuses on a side issue and does not address the main issue. Answer ii) is not the best answer because having confidence in the practitioner is not enough for there to be informed consent. A patient may trust the practitioner and that may motivate the giving of consent, but the patient still needs to understand to what they are being asked to agree. Answer iv) is not the best answer because it focuses on a side issue and does not address the main issue.*

### Ways of Receiving Consent

There are three different ways in which a practitioner can receive consent. Each has its advantages and disadvantages.

- *Written Consent.* A patient can give consent by signing a written document agreeing to the procedure. A written consent provides some evidence that the patient did give consent. One disadvantage of written consent is that practitioners sometimes confuse a signature with consent. A patient who signs a form without actually understanding the nature, risks and side effects of the procedure has not given a true consent. Also, the use of written consent documents can discourage the asking of questions. In addition, the practitioner might not then check with the patient to make sure the patient understands the information and is in true agreement.

- *Verbal Consent.* A patient can give consent by a verbal statement. A verbal consent is the best way for the practitioner and the patient to discuss the information and ensure that the patient really understands it. Making a brief note in the patient record of the discussion can provide useful evidence later on if there is a complaint.
- *Implied Consent.* A patient can give consent by their actions. For example, in Consent Scenario No. 1, above, the patient Paula could just nod her head. That would be implied consent for Practitioner Y to begin asking her questions. The main disadvantage of implied consent is that the practitioner has no opportunity to check with the patient to make sure that the patient truly understands what is going to happen.

### *Consent Scenario No. 2*

*Practitioner X proposes that his patient Paul take a vitamin and mineral supplement. X says: "Try these: they will make you think more clearly". Paul takes one immediately and buys a bottle from the receptionist. When arriving at home Paul reads about the supplement on the internet and learns that it contains megadoses of Vitamin A<sup>1</sup> which, if taken for a long period of time, could lead to liver and other damage. Paul complains to the College. X tells the College that he was relying on Paul's implied consent by swallowing the first pill and buying a bottle from the receptionist. The Inquiries, Complaints and Reports Committee issue a decision critical of X for not obtaining informed consent because:*

- *X did not explain the nature of the "pill" including that it had megadoses of Vitamin A;*
- *X did not explain how the supplement would make Paul think more clearly;*
- *X misrepresented the hoped for benefit of the supplement as there was little evidence to support his very strong statement that it would make Paul think more clearly;*
- *X did not explain the way in which the supplement was to be used (how often to take the supplement and for what period of time);*
- *X did not explain the alternatives to taking the supplement including not taking anything; and, perhaps more importantly,*
- *X did not explain the risks of taking the supplement to Paul.*

### *Consent Where the Patient is Incapable*

A patient is not capable of giving consent if the patient either:

- Does not understand the information, or
- Does not appreciate the reasonably foreseeable consequences of the decision.

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<sup>1</sup> A megadose of Vitamin A probably results in the supplement being classed as a drug. Thus this scenario also raises issues about whether the practitioner is engaging in a controlled act. See the discussion of controlled acts below.

For example, if the practitioner recommends that a patient have a daily series of half-hour acupuncture treatments and the patient insists on receiving one six-hour session with longer needles instead, it is pretty clear that the patient does not appreciate the consequences of the decision.

A practitioner can assume a patient is capable unless there is evidence to the contrary. A practitioner does not need to conduct an assessment of the capacity of every patient. However, if the patient shows that they may not be capable (e.g., the patient simply cannot understand the explanation of the practitioner) the practitioner should assess the patient's capacity. The practitioner can assess the capacity of the patient by discussing the proposed procedure with the patient to see if the patient understands the information and appreciates its consequences.

The issue is whether the patient is capable of giving consent for the proposed procedure. A patient can be capable to give consent for one procedure but not capable for another. For example, a fifteen year old patient might be capable of consenting to nutritional counselling but not be capable of consenting to treatment for a major eating disorder. (There is no minimum age of consent for health care treatment.)

If a practitioner concludes that the patient is not capable of giving consent for a procedure, the practitioner should tell the patient. The practitioner should also tell the patient who will make decisions on their behalf – for example, a close relative. This person is called a “substitute decision maker”. The practitioner should still include the patient in the discussions as much as possible. Of course there are circumstances where involving the incapable patient in the discussions will not be possible (e.g., if it will be quite upsetting to the patient, where the patient is unconscious).

Unless it is an emergency, the practitioner must then obtain consent for the assessment or treatment from a substitute decision maker. A substitute decision maker must meet the following requirements:

- The substitute must be at least 16 years of age.<sup>2</sup> There is an exception where the substitute is the parent of the patient (for example, a 15 year old mother can be the substitute decision maker for the care of her child).
- The substitute must, themselves, be capable. In other words, the substitute must understand the information and appreciate the consequences of the decision.
- The substitute must be able and willing to act.
- There must be no higher ranked substitute who is able and willing to act. The ranking of the substitute decision maker is as follows (from highest ranked to lowest ranked):
  - A court appointed guardian of the person.

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<sup>2</sup> While there is no minimum age of consent for a capable patient, a substitute decision maker must normally be at least 16 years old.

- A person who has been appointed to be an attorney for personal care. The patient would have signed a document appointing the substitute to act on the patient's behalf in health care matters if the patient ever became incapable.
- A person appointed by the Consent and Capacity Board to make a health decision in a specific matter.
- The spouse or partner of the patient. A partner can include a same-sex partner. It can also include a non-sexual partner (e.g., two elderly sisters who live together).
- A child of the patient or a parent of the patient or the Children's Aid Society who has been given wardship of the patient.
- A parent of the patient who does not have custody of the patient.
- A brother or sister of the patient.
- Any other relative.
- The Public Guardian or Trustee if there is no one else.

Here is a scenario that shows how these rules work.

#### *Consent Scenario No. 3*

*Practitioner Y proposes a procedure for her patient Paula. Paula does not understand the proposed procedure at all. She is clearly incapable. Y knows that Paula appointed her friend Pat to be her power of attorney for personal care. However, Pat is travelling outside of the country and cannot be reached. Therefore Pat is not able to make the decision. Y contacts Paula's elderly mother, but Paula's mother is frail herself and does not feel confident in making the decision. Thus Paula's mother is not willing to act as a substitute decision maker. Paula's sister is willing and able to make the decision on Paula's behalf and appears to understand the information and its consequences for Paula. Paula's sister is able to give the consent even though she is not the highest ranked substitute.*

If there are two equally ranked substitute decision makers (e.g., two children of the patient), and they cannot agree, the Public Guardian and Trustee can then make the decision.

A substitute decision maker must comply with the following rules:

- The substitute must act in accordance with the last known capable wishes of the patient, if known. For example, if a patient clearly said, "Never send me to the hospital" before he became so ill that he could not think clearly, the substitute needs to obey those wishes.
- The substitute must act in the best interests of the patient if the substitute does not know of the last known capable wishes of the patient. For example, if a proposed treatment is simple and painless, would cause little risk of harm but would make the patient more comfortable through a difficult illness, the substitute decision maker should consent to it.

Where it becomes clear that a substitute decision maker is not following the above rules the practitioner should speak with the substitute decision maker about it. If the substitute decision maker is still clearly not following the above rules the practitioner should call the Office of the Public Guardian and Trustee. The contact information of the Public Guardian and Trustee of Ontario is available on the internet.

#### *Consent Scenario No. 4*

*Practitioner X proposes a procedure for his patient Paul. Paul does not understand the proposed procedure at all. He is clearly incapable. X knows that Paul appointed his friend Pat to be his power of attorney for personal care. Pat is going to inherit Paul's money when Paul dies. Paul has a lot of money. Paul is going to die within a few months. The proposed procedure is simple and painless, would make the patient more comfortable through a difficult illness and has little risk of harm. Pat refuses to give consent for Paul to undergo the proposed procedure. X is convinced that Pat is refusing to consent to the treatment in order to inherit more money (even though treatment is not very expensive). The rest of Paul's family is very upset because they want Paul to receive the treatment. X suggests that the family contact the Office of the Public Guardian and Trustee.*

The above rules on obtaining informed consent when a patient is incapable come from the *Health Care Consent Act*. Practitioners should be familiar with that statute. It is a difficult statute to read. Practitioners should check the College's website as the College will be developing policies on informed consent as it has time.

#### *Sample Exam Question*

Which of the following is the highest ranked substitute decision maker (assuming that everyone was willing and able to give consent):

- i. A power of attorney for personal care for the patient.
- ii. The patient's live-in boyfriend.
- iii. The patient's mother.
- iv. The patient's son.

*The best answer is i). Only a court appointed guardian is higher ranked than a power of attorney for personal care. Answer ii) is not the best answer because the patient's spouse or partner is a lower ranked substitute decision maker. In addition, it is not clear that the live-in boyfriend is a spouse (under the Health Care Consent Act, they must have been living together for at least one year, have had a child together or have a written cohabitation agreement to be spouses). Answers iii) and iv) are not the best answers because they are lower ranked than both a power of attorney for personal care or a patient's spouse. In addition, the patient's mother and son are equally ranked so either they would have to give the same consent or one would have to defer to the other.*

### *Emergencies*

One exception to the need for informed consent is in cases of emergencies. There are two kinds of emergencies:

- Where the patient is incapable and a delay in treatment would cause suffering or serious bodily harm to the patient.
- Where there is a communication barrier (e.g., language, disability) despite efforts to accommodate the barrier and a delay in treatment would cause suffering or serious bodily harm to the patient.

In either case the practitioner must attempt to obtain consent as soon as possible (either by finding a substitute decision maker in the first example or by finding a means of communication with the patient in the second example).

Emergencies are rare for practitioners of this profession, but can occur.

#### *Consent Scenario No. 5*

*Practitioner Y is seeing her patient Paula at the office. Paula suddenly collapses from an apparent heart attack. Y has a defibrillator in the office. Without trying to get consent from a substitute decision maker, Y uses the defibrillator. Y was able to act without consent in these circumstances.*

*Across the city, X, a practitioner, is seeing his patient Paul at the office. Paul has terminal cancer and has filled out a wallet card saying that he does not want any measures taken to resuscitate him should he have a cardio vascular accident. Paul has mentioned this to X. Paul suddenly collapses in an apparent heart attack. X has a defibrillator in the office. X is not able to act without consent in these circumstances. X already has a refusal from Paul that applies to these circumstances.*

#### **c. Boundaries and sexual abuse**

Practitioners must be careful to act as a professional health care provider, and not as a friend, to patients. Becoming too personal or too familiar with a patient is confusing to patients and will make them feel uncomfortable. Patients will be uncertain as to whether the professional advice or services are motivated by something else other than the best interests of the patient. It is also easier for a practitioner to provide professional services when there is a “professional distance” between them (e.g., telling the patient the truth about the patient’s condition).

Maintaining professional boundaries is about being reasonable in the circumstances. For example, one should be careful about accepting gifts from patients, but there are some circumstances in which it is appropriate to do so (e.g., a small New Year’s gift from a patient). In

other areas, however, crossing professional boundaries is never appropriate. For example, it is always professional misconduct to engage in any form of sexual behaviour with a patient.

The following are some of the areas where practitioners need to be very cautious to maintain professional boundaries.

### *Self-Disclosure*

When a practitioner shares personal details about his or her private life, it can confuse patients. Patients might assume that the practitioner wants to have more than a professional relationship. Self-disclosure suggests that the professional relationship is serving a personal need for the practitioner rather than serving the patient's best interests. Self-disclosure can result in the practitioner becoming dependent on the patient to serve the practitioner's own emotional needs, which is damaging to the relationship.

#### *Self-Disclosure Scenario*

*Practitioner Y is treating Paula for workplace stress-related illnesses. Paula is having difficulty deciding whether to marry her boyfriend and talks to Y about this issue a lot during treatment sessions. To help Paula make up her mind, Y decides to tell Paula details of her doubts in accepting the proposal from her first husband. Y tells of how those doubts gradually ruined her first marriage resulting in both her and her husband having affairs. Paula is offended by Y's behaviour and stops coming for treatment for the workplace stress-related illnesses. Y's self-disclosure was inappropriate and unprofessional.*

### *Giving or Receiving of Gifts*

Giving and receiving gifts is potentially dangerous to the professional relationship. A small token of appreciation by the patient purchased while on a holiday, around New Year's, or given at the end of treatment may be acceptable. In addition, one must be sensitive to the patient's culture where refusing a gift is considered to be a serious insult. However, anything beyond small gifts can indicate that the patient is developing a personal relationship with the practitioner. The patient may even expect something in return.

Gift-giving by a practitioner will often confuse a patient. Even small gifts of emotional value, such as a "friendship" card, can confuse the patient even though the financial value is small. While many patients would find a Christmas / holiday season card from a practitioner to be a kind gesture and good business sense, some patients might feel obliged to send one in return. So even here thought should be given to the type of patients in one's practice (e.g., some new Canadians might be unfamiliar with the tradition).

### *Gift-Giving Scenario*

*Practitioner X has a patient from an Asian culture who brings food for every visit. X thanks her, but tries not to treat it as an expectation. On one visit X happens to mention his special roast pig recipe. The patient insists that X bring it over to her house for New Year's. X politely declines, giving the patient a written recipe instead. The patient stops bringing in food, is less friendly during visits and starts missing appointments. X did not do anything wrong in this scenario, but it shows the confusion that can occur with a patient when the boundaries start to be crossed.*

### *Dual Relationships*

A dual relationship is where the patient has an additional connection to the practitioner other than just as a patient (e.g., where the patient is a relative of the practitioner). Any dual relationship has the potential for the other relationship to interfere with the professional one (e.g., being both the individual's practitioner and employer). It is best to avoid dual relationships whenever possible. Where the other relationship predates the professional one (e.g., a relative, a pre-existing friend), referring the patient to another practitioner is the preferred option. Where a referral is not possible (e.g., in a small town, where there is only one practitioner), special safeguards are essential (e.g., discussing the dual relationship with the patient and agreeing with the patient to be formal during visits and never talk about the issues outside of the office). It is never a good idea to treat a relative.

### *Dual Relationships Scenario*

*Practitioner X has Paula as a patient. Paula is a refugee with very little money. Paula works part-time as a house cleaner. X decides to hire Paula to clean his house. X also recommends Paula to some of his friends who also hire Paula. Paula is extremely grateful. Later X recommends a change in treatment that will not be covered by Paula's insurance. Paula wonders to herself if X is recommending this treatment in order to get back the money for cleaning his house. Paula also feels that she cannot say no or else she will lose her job cleaning the houses of X's friends. Did the dual relationship contribute to Paula's confusion?*

### *Ignoring Established Customs*

Established customs usually exist for a reason. Ignoring a custom confuses the nature of the professional relationship. For example, treatment sessions are usually held during regular business hours at the clinic rather than at a restaurant. By ignoring this custom, the patient might begin thinking that the meeting is a social visit. Or, the patient might feel that he or she has to pay for the meal. Treating patients as special, or different from other patients, can be easily misinterpreted.

### *Personal Opinions*

Everyone has personal opinions. Practitioners are no exception. However, practitioners should not use their position to push their personal opinions (e.g., religion, politics or even a vegan lifestyle) on patients. Similarly, strongly held personal reactions (e.g., that a patient is unpleasant and obnoxious) should not be shared. Disclosing personal reactions does not help the professional relationship.

### *Personal Opinions Scenario*

*Paul, a patient, discussing world events, pushes his practitioner Y for her views on immigration. At first Y resists, but eventually says she has some concerns about the abuses of the immigration system. Y says she has heard, often directly from patients, about how they have lied to the immigration authorities. Paul loudly criticizes the immigration authorities for allowing too many immigrants into the country. Paul is overheard by other patients in the clinic at the time, including some who are new Canadians. The other patients tell other staff at the clinic that they feel uncomfortable with either Y or Paul around.*

### *Becoming Friends*

Being a personal friend with a patient is a form of dual relationship. Patients should not be placed in the position where they feel they must become a friend of the practitioner in order to receive ongoing care. Practitioners bear the main responsibility to not allow a personal friendship to develop. It is difficult for all but the most assertive of patients to communicate to the practitioner that they do not want to be friends.

### *Touching and Disrobing*

Touching can be easily misinterpreted, particularly where disrobing is involved. A patient can view an act of encouragement by a practitioner (e.g., a hug) as an invasion of space or even a sexual gesture. Extreme care must be taken in any touching between practitioners and their patients. The nature and purpose of any clinical touching must always be explained first and the patient should always give consent before the touching begins. Patients should be asked to disrobe themselves wherever possible. Cultural sensitivities should be observed. The presence of a third party should be permitted and even offered where appropriate. The touching must always have a clinical relevance that is obvious to the patient.

Managing boundaries is important for both practitioners and patients.

## *Sexual Abuse*

The *Regulated Health Professions Act (RHPA)* is designed to eliminate any form of sexual contact between practitioners and patients. Because of the status and influence of practitioners, there is the potential for any such sexual contact to cause serious harm to the patient. Even if the patient consents to the sexual contact, it is prohibited for the practitioner.

The term “sexual abuse” is defined broadly in the *RHPA*. It includes the following:

- sexual intercourse or other forms of physical sexual relations between the practitioner and the patient;
- touching, of a sexual nature, of the patient by the practitioner; or
- behaviour or remarks of a sexual nature by the practitioner towards the patient.

For example, telling a patient a sexual joke is sexual abuse. Hanging a calendar on the wall with sexually suggestive pictures (e.g., women in bikinis, a “fire fighters” calendar) is sexual abuse. Non-clinical comments about a patient’s physical appearance (e.g., “you look sexy today”) is sexual abuse. Dating a client is sexual abuse.

This definition of sexual abuse includes treating one’s spouse. There have been a number of court decisions that have established that a practitioner cannot treat his or her spouse (with very limited exceptions, like an emergency). Practitioners need to transfer the care of their spouse or lover to other practitioners. It does not matter that the spousal relationship came first.<sup>3</sup>

Touching, behaviour or remarks of a clinical nature is not sexual abuse. For example, if it is necessary for the treatment of a patient to ask about the patient’s sexual history, it can be done. However, asking about a patient’s romantic life where this is unnecessary for treatment is sexual abuse. Similarly, touching of the chest or pelvic area of a patient must be clinically necessary (and, as discussed above, must be done only after receiving informed consent).

It is always the responsibility of the practitioner to prevent sexual abuse from happening. If a patient begins to tell a sexual joke, the practitioner must stop it. If the patient makes comments about the appearance or romantic life of the practitioner, the practitioner must stop it. If the patient asks for a date, the practitioner must say no (and explain why it would be inappropriate). If the patient touches the practitioner in a way that might be viewed as sexual (e.g., a kiss), the practitioner must stop it.

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<sup>3</sup> There has been some discussion about changing the requirement preventing practitioners from treating their spouses. However, at the time of writing, this change has not been made. Unless and until the change is made, practitioners cannot treat their spouses.

### *Sexual Abuse Scenario No. 1*

*Practitioner Y tells a colleague about her romantic weekend with her husband at Niagara-on-the-Lake for their anniversary. Y makes a joke about how wine has the opposite effect on the libido of men and women. Paula, a patient, is sitting in the reception area and overhears. When being treated by Y, Paula mentions that she overheard the remark and is curious as to what Y meant by this, as in her experience, wine helps the libido of both partners. Has Y engaged in sexual abuse? Y clearly has crossed boundaries by making the comment in a place where a patient could overhear it. However, the initial comment was not directed towards Paula and was not meant to be heard by her. It would certainly be sexual abuse for Y to answer Paula's question. Y should apologize for making the comment in a place where Paula could hear it. Y needs to state her focus is on Paula's treatment.*

Because sexual abuse is such an important issue, Colleges must take it very seriously. Each College must take steps to prevent sexual abuse from occurring. For example, the Patient Relations Committee of the College must develop a sexual abuse prevention plan that will educate practitioners, training programs, employers of practitioners and the public about avoiding sexual abuse.

In addition, practitioners are required to make a report where the practitioner has reasonable grounds to believe that another health provider has engaged in sexual abuse. The report is made to the Registrar of any health College where the other health provider is a member. For example, if a patient tells a practitioner that her physiotherapist fondled her, the practitioner must make a written report to the Registrar of the College of Physiotherapists of Ontario. This reporting obligation is discussed in more detail below, under the heading "Mandatory Reports".

There are also a number of special provisions dealing with the handling of sexual abuse matters in the complaints and discipline process. Such complaints are always taken seriously. If the complaint involves sexual touching and if there is evidence to support the complaint, a referral to discipline for a hearing is likely. At the discipline hearing the identity of the patient is protected. The patient may even be given a role at the discipline hearing (e.g., to make a statement on the impact of the sexual abuse on the patient if a finding is made). Where the sexual abuse involved sexual intercourse, or similar sexual acts, and a finding is made, the practitioner's registration will be revoked for a period of at least five years. In all cases where a finding of sexual abuse has been made, the practitioner will be reprimanded. If a finding of sexual abuse has been made, the practitioner can be ordered to pay for the costs of any counselling and therapy of the patient.

The College is also responsible to pay for the costs of any counselling or therapy needed by the patient if a finding of sexual abuse is made.

Practitioners should therefore consider ways of preventing sexual abuse (or even the perception of sexual abuse) arising. Experience indicates that most sexual abuse is not done by predators. Rather, in most cases the practitioner and the patient develop romantic feelings for each other and the practitioner fails to stop it.

Where any romantic feelings develop, the practitioner has two choices:

- put a stop to them immediately, or
- transfer the care of the patient to another practitioner immediately.

Other suggestions for preventing even the perception of sexual abuse include the following:

- Do not engage in any form of sexual behaviour.
- If a patient initiates sexual behaviour, put a stop to it. Be sensitive, but firm when doing so.
- Do not date patients.
- Avoid self-disclosure.
- Avoid comments that might be misinterpreted (“You are looking good today”).
- Do not take a sexual history unless there is a good clinical reason for doing so. If one must take a sexual history, explain why first and be very clinical in one’s approach.
- Do not touch a patient except when necessary for assessing or treating them. If one must touch a patient, explain the nature of the touching first, the reason for the touching and be very clinical in one’s approach (e.g., wear gloves). Consider having a third person in the room if examining or otherwise touching a disrobed patient.
- Do not comment on a patient’s appearance or romantic life.
- Document well any clinical actions of a sexual nature or any incidents of a sexual nature.

Dating former patients is a sensitive issue. Technically, it is not sexual abuse because the person is no longer the practitioner’s patient. However, it can still be unprofessional where the practitioner still has power over the patient. There should be an appropriate “cooling off” period. The length of the cooling off period will depend on the circumstances (e.g., how long the person was a patient, how intimate the professional relationship was).

### *Sexual Abuse Scenario No. 2*

*Practitioner X is attracted to his patient Paula. X notices that he is looking forward to working on the days when Paula will be there. X extends the sessions a few minutes in order to chat informally with Paula. X thinks Paula might be interested as well by the way that she makes eye contact. X notices that he is touching Paula on the back and the arm more often. X decides to ask Paula to join him for a coffee after her next visit to discuss whether Paula is interested in him. If Paula is interested, he will transfer Paula’s*

*care to a colleague. If Paula is not interested then he will make the relationship purely professional. X decides to ask a colleague, Y, for advice.*

*Y, correctly, tells X that he has already engaged in sexual abuse by letting the attraction develop while continuing to treat Paula. Y also says that it is important for X to transfer the care of Paula right away and certainly before they get together for coffee.*

#### *Sample Exam Question*

Which of the following is sexual abuse:

- i. Taking a sexual history when it is clinically necessary to do.
- ii. Using glamour shots of scantily dressed Hollywood stars as your interior design theme in order to attract younger patients.
- iii. Telling an employee a sexual joke when there are no patients around.
- iv. Dating a former patient.

*The best answer is ii). These pictures sexualize the atmosphere at the clinic which is inappropriate in a health care setting. Answer i) is not the best answer because taking a sexual history is appropriate when it is needed to assess the patient and it is done professionally. Answer iii) is not the best answer because the sexual abuse rules only apply to patients. Sexual behaviour with employees may, however, constitute sexual harassment under the Human Rights Code and could otherwise be unprofessional. Answer iv) is not the best answer because the person is not a patient at the time of dating. However, it might still be unprofessional to date a former patient soon after they stop being a patient (or, sometimes ever), particularly if the practitioner had an intense or intimate role in the treatment of the patient.*

#### **d. Interprofessional collaboration**

It is in the best interest of patients if all of their health care providers work with each other. Members of different professions working together to serve the same client is called interprofessional collaboration. Such collaboration would help ensure that treatments are coordinated and as effective as possible. Collaboration would also reduce the chances of there being conflicting or inconsistent treatment (e.g., drug and herb interactions, phasing out a patient's drug prescriptions as other forms of treatment begin to work). Collaboration could also reduce the chances of patients receiving inconsistent information and advice.

The *Regulated Health Professions Act* requires the College to promote interprofessional collaboration. The College tries to model this collaboration by working together with other health Colleges (e.g., sharing information on investigations, developing standards together to promote their consistency). In addition, the College attempts to help practitioners collaborate with members of other health care professions when treating the same patients.

The patient controls the extent of interprofessional collaboration. If a patient is uncomfortable with it, the patient can direct practitioners not to share the patient's personal health information with others. The practitioner must comply with such a direction unless one of the exceptions in the *Personal Health Information Protection Act* (it is discussed in more detail below) applies.

Practitioners should discuss any planned interprofessional collaboration with the patient when possible. However, there are circumstances where prior patient consent is not possible (e.g., when the patient goes to the hospital in an emergency and the hospital calls asking about what treatment the patient has received). Practitioners can disclose information needed for the treatment of the patient without consent so long as the patient has not prohibited the practitioner from doing so.

Interprofessional collaboration only succeeds if practitioners respect their colleagues. Even if the practitioner does not agree with the approaches taken by the other colleague, communications should be polite. Practitioners should share information and cooperate with their colleagues whenever possible. Reasonable attempts to coordinate treatment should be made. Compromises may sometimes need to be made (e.g., as to which treatment to try first). Interprofessional rivalries should be set aside; it is the patient's best interests that should come first. Attempts should be made to avoid forcing the patient to choose which health care provider to use (avoid saying: "either she goes or I go").

Where interprofessional collaboration involves working in a multi-disciplinary setting (i.e., a place where members of different professions work together and where patients are often seen by multiple health care providers), other issues arise, including the following:

- Will the setting have shared records or will each practitioner have separate records?
- If the records are shared, will the practitioner keep any private notes outside of the shared record? If so how will the practitioner make sure that the other health care providers have access to the information they need?
- How does the setting deal with the wording used in the records? For example, will everyone use the same abbreviations?
- What happens to the records if the practitioner leaves to practise elsewhere? Will the patient be told where the practitioner has gone? Will another practitioner from the setting take over the patient's care? Will the patient be given a choice? The patient really should be given a choice although some settings will only do so if the patient asks.
- Who is the health information custodian that owns the records?
- Will there be one person who has overall responsibility for the care of the patient? If so who? If not, how will the patient's care be coordinated?
- How will disagreements in the approach to the care of the patient be dealt with? If it is the practitioner who is in disagreement, when and how does the practitioner tell the patient?

- Is the patient aware of all of the above?

This is one of the many areas covered in this document in which a practitioner should consider consulting with his or her own lawyer.

While interprofessional collaboration will be more complicated and challenging for the practitioner, this is the way health care is now practised in Ontario. It is also in the best interest of most patients.

### *Interprofessional Collaboration Scenario*

*Practitioner X practises alone. He provides herbal and acupuncture therapies. His patient, Paula, also has a family MD. Paula's family MD calls unexpectedly to say that Paula is not responding to her medication as the MD had expected. The MD has just learned that X is also treating Paula. The MD wonders if anything that X is doing might interfere with Paula's medication. X remembers that he has hinted to Paula that he is not supportive of the medication that Paula is taking. X wonders if Paula has stopped taking the medication without telling the MD. What should X say?*

*In many respects, there has already been a failure of interprofessional collaboration in this case. X should have discussed the benefits of interprofessional collaboration with Paula. Rather than hinting at his concerns about the medication that Paula is on, X should have discussed the concerns openly with Paula and requested permission to speak with Paula's MD. At this point, however, X should probably speak to Paula first before talking to the MD. It is not clear that Paula would want such a discussion to take place and it is not an emergency. X should obtain Paula's permission to speak to the MD.*

#### **e. Billing**

The College does not set fees for practitioners to charge. Establishing fees is not part of the mandate of the College. In fact, the College does not regulate the amount a practitioner can bill the patient unless the fee is excessive. A fee is excessive when it takes advantage of a vulnerable patient or is so high that the profession would conclude that the practitioner is exploiting a patient.

However, the College does regulate the way in which practitioners bill patients. Billing must be open and honest. Patients must be told the amount of the practitioner's fees before the service is provided. This includes the cost of any products before they are sold to the patient. The best way to tell patients the amount of the fees is to give patients a written list or description of the fees of the practitioner. However, the patient can also be told verbally or there can be a sign clearly displaying the fees in the reception area of the practice. The problem with those methods of notification is that the patient might forget. The list or description of the fees must include all charges including any penalties for late payment.

A practitioner must provide an itemized bill for any patient who asks for it. The bill must describe the services that were provided and the products that were given. Any document relating to fees (e.g., a bill or a receipt) must be accurate. For example, it would be inaccurate for the document to do the following:

- Indicate that the practitioner was provided the service when someone else did.
- Indicate the wrong date for the service. For example, it is unprofessional to put in a date when the patient had insurance coverage rather than the actual date of service because the patient would not have insurance coverage.
- Indicate that one service was performed when, in fact, another service was provided. For example, it is unprofessional to indicate that acupuncture was performed when in fact a herbal remedy was provided.
- Bill for services at more than the practitioner's usual rate because the service is being paid for by an insurance company.
- Indicate that a service was performed when, in fact, no service was performed. For example, it is unprofessional to indicate that a patient visit occurred when, in fact, the patient missed the appointment and a late cancellation fee is being billed.
- Bill for a product for more than its actual cost. The actual cost can include a reasonable amount for the staff time for storage and handling.

No fee can be billed when no service was provided. The only exception is that a fee can be billed when a patient misses an appointment or cancels the appointment on very short notice.

Practitioners cannot offer a reduction in the amount of a bill if it is paid immediately. That would give wealthy patients an advantage over other patients. However, a practitioner can charge interest in overdue accounts because there is an actual cost to practitioners in collecting them.

Some practitioners offer "free" initial consultations. This is often more of an advertising issue than a billing issue. See the discussion of advertising below. The main point is that any such offers must be completely honest. The initial consultation must be complete and not just a partial service. There must be no requirement to attend a second time (e.g., to get the results). There must be no hidden charges. The offer must be open to everyone.

#### *Billing Scenario*

*Practitioner X, has a posted rate of \$120 per visit in the reception area of his office. In fact, if the patient is paying for the service personally and does not have extended health insurance coverage, X will provide a credit reducing the rate to \$99 per visit. If a patient has special financial needs, X will consider reducing his rate even further; in fact he has three regular patients who pay only \$5 per visit.*

*The above scenario is contrary to the professional misconduct regulation. In effect X's posted fees are not honest and accurate. X is, in effect, billing patients with insurance more than his actual regular rate.*

*It is acceptable, however, for X to lower his actual fee in individual cases of financial hardship. X has to do this on a case by case basis and not through a general policy intended to hide his true fee.*

### 3. Law

#### a. Types of law

There are a number of sources of law. They include the following:

- *Statutes.* Most often when one thinks of law, one thinks of statutes (also called Acts). There are overriding statutes that take priority over other statutes such as the *Canadian Charter of Rights and Freedoms*. The statutes that practitioners will need to be most aware of are the *Regulated Health Professions Act* and the *Traditional Chinese Medicine Act*. Statutes are made by the Legislative Assembly (in Ontario, the Legislative Assembly is often called Queen's Park).
- *Regulations.* Regulations are made by the government when a statute permits them to be made. Under the *Regulated Health Professions Act* regulations can be proposed by the College (e.g., registration, professional misconduct, quality assurance) or by the Minister of Health and Long-Term Care (e.g., controlled acts, professional corporations).
- *By-laws.* By-laws are made by the College. They deal primarily with the internal operations of the College. Some by-laws affect members (e.g., fees, professional liability insurance, information that must be provided by practitioners to the College, additional information that could be put on the public register, election of practitioners to the Council of the College).
- *Case Law.* Court decisions are used as a guide by lawyers and judges when similar issues arise in the future. Courts try to be consistent, so long as the result is not unfair. Court decisions are particularly important in guiding the procedure of College committees (e.g., investigations by the Inquiries, Complaints and Reports Committee, the Discipline Committee).
- *Guiding documents.* The College publishes official documents called Standards of Practice, Guidelines, Policy Statements and Position Statements. These documents are not actually "law". However, they help practitioners and College committees understand and interpret the law. As such these documents can be very useful for practitioners to read and understand. These documents are sometimes called "soft law".

Below is a discussion of the laws that are most applicable to the daily life of practitioners.

## **b. RHPA**

The *Regulated Health Professions Act* applies equally to all 26 health Colleges. It sets out the duties and responsibilities of the Minister of Health and Long-Term Care, the Colleges and each of its committees and of practitioners. The profession-specific statute of each College integrates the *Regulated Health Professions Act* into that statute so that they can be treated as one Act.

### **i. Controlled acts and delegation**

There are certain health care procedures that are potentially dangerous and should only be done by a properly qualified person. These potentially dangerous procedures have been listed in the *Regulated Health Professions Act*. They are called “controlled acts”. No one can perform controlled acts without legal authority.

The fourteen controlled acts are as follows:

1. Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.
2. Performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.
3. Setting or casting a fracture of a bone or a dislocation of a joint.
4. Moving the joints of the spine beyond the individual’s usual physiological range of motion using a fast, low amplitude thrust.
5. Administering a substance by injection or inhalation.
6. Putting an instrument, hand or finger,
  - i. beyond the external ear canal,
  - ii. beyond the point in the nasal passages where they normally narrow,
  - iii. beyond the larynx,
  - iv. beyond the opening of the urethra,
  - v. beyond the labia majora,
  - vi. beyond the anal verge, or
  - vii. into an artificial opening into the body.
7. Applying or ordering the application of a form of energy prescribed by the regulations under this Act.
8. Prescribing, dispensing, selling or compounding a drug as defined in the *Drug and Pharmacies Regulation Act*, or supervising the part of a pharmacy where such drugs are kept.
9. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.

10. Prescribing a hearing aid for a hearing impaired person.
11. Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or a device used inside the mouth to protect teeth from abnormal functioning.
12. Managing labour or conducting the delivery of a baby.
13. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response.
14. Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgment, insight, behaviour, communication or social functioning.<sup>4</sup>

The seventh controlled act refers to forms of energy set out in the Minister's regulation. That regulation lists the following forms of energy that cannot be used:

1. Electricity for,
  - i. aversive conditioning,
  - ii. cardiac pacemaker therapy,
  - iii. cardioversion,
  - iv. defibrillation,
  - v. electrocoagulation,
  - vi. electroconvulsive shock therapy,
  - vii. electromyography,
  - viii. fulguration,
  - ix. nerve conduction studies, or
  - x. transcutaneous cardiac pacing.
2. Electromagnetism for magnetic resonance imaging.
3. Soundwaves for,
  - i. diagnostic ultrasound, or
  - ii. lithotripsy.

Since only diagnostic ultrasound is prohibited, that means that therapeutic ultrasound is not a controlled act.

The eighth controlled act refers to the definition of a drug in the *Drug and Pharmacies Regulation Act*. That is an important definition for practitioners to know. It reads as follows:

“drug” means any substance or preparation containing any substance,  
 (a) manufactured, sold or represented for use in,

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<sup>4</sup> It is anticipated that the last controlled act, providing psychotherapy, will become law around the spring of 2013.

- (i) the diagnosis, treatment, mitigation or prevention of a disease, disorder, abnormal physical or mental state or the symptoms thereof, in humans, animals or fowl, or
  - (ii) restoring, correcting or modifying functions in humans, animals or fowl,
  - (b) referred to in Schedule I, II or III,
  - (c) listed in a publication named by the regulations, or
  - (d) named in the regulations,
- but does not include,
- (e) any substance or preparation referred to in clause (a), (b), (c) or (d) manufactured, offered for sale or sold as, or as part of, a food, drink or cosmetic,
  - (f) any “natural health product” as defined from time to time by the *Natural Health Products Regulations* under the *Food and Drugs Act* (Canada), unless the product is a substance that is identified in the regulations as being a drug for the purposes of this Act despite this clause, either specifically or by its membership in a class or its listing or identification in a publication,
  - (g) a substance or preparation named in Schedule U,
  - (h) a substance or preparation listed in a publication named by the regulations, or
  - (i) a substance or preparation that the regulations provide is not a drug;

Unfortunately, this definition refers to a number of other provisions. Practitioners may need to do some research or obtain advice when dealing with a specific substance. A general rule is that if a substance has a DIN (drug identification number) it is usually considered to be a drug.<sup>5</sup>

It is important for practitioners to be familiar with the above list of controlled acts.

#### *Controlled Acts Scenario No. 1*

*Practitioner X sees his patient Paul. Paul mentions an ear ache that he has had for two days. X takes a look and sees that a bug has gotten into his ear and has been jammed deep into the inner ear canal, perhaps with a cotton stick. X takes some tweezers and gently works his way into the inner ear canal and removes the bug. Paul is grateful. X mentions the incident to a colleague who advised X that he has just performed a controlled act that is not authorized to TCM practitioners. X checks the Regulated Health Professions Act and realizes that his colleague is correct.*

There are four ways in which a health care provider can receive legal authority to perform a controlled act:

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<sup>5</sup> Some non-drug substances have different kinds of drug numberings, for example, a Natural Product Number (NPN) or Homeopathic Medicine Number (DIN-HM).

- **Authorization.** Being authorized to perform the controlled act by the health care provider's enabling statute. The *Traditional Chinese Medicine Act* authorizes practitioners to perform the following controlled acts:
  - Performing a procedure on tissue below the dermis and below the surface of a mucous membrane for the purpose of performing acupuncture.
  - Communicating a traditional Chinese medicine diagnosis identifying a body system disorder as the cause of a person's symptoms using traditional Chinese medicine techniques
- **Exceptions.** The *Regulated Health Professions Act* creates a number of exceptions permitting people to perform controlled acts in certain circumstances. These exceptions include the following:
  - Helping someone in an emergency.
  - While in formal training to become a member of a College authorized to perform the controlled act.
  - Performing the controlled act under supervision.
  - Treatment by prayer or spiritual means pursuant to one's religion.
  - Administering a substance by injection or inhalation or entering a body opening or communicating diagnosis (e.g., telling one's child that she had a cold) when done for a member of one's household.
  - Helping a person with his or her routine activities of living where it includes administering a substance by injection or inhalation or entering a bodily orifice (e.g., on a home visit helping a patient with their insulin injection).
  - Counselling a person (so long as the counselling does not amount to communicating a diagnosis or providing psychotherapy). In many ways the counselling exception provision is simply intended to convey the point that counselling, itself, does not normally fall within any of the controlled acts. It is not really a true exception.
  - Providing aboriginal healing within the aboriginal community.
- **Exemptions.** In addition to the exceptions listed in the *Regulated Health Professions Act*, the Minister of Health and Long-Term Care has provided a number of exemptions in a Minister's regulation. Most of those exemptions are limited in scope (e.g., dentists are permitted to apply electricity for electro coagulation). A few of the exemptions have broader application, including the following:
  - Anyone can perform cosmetic body piercings and tattooing.
  - Anyone can perform electrolysis.
  - Members of seven health Colleges can perform acupuncture under exemption.<sup>6</sup>
  - Anyone can perform male circumcision.

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<sup>6</sup> They are: chiropody, chiropractic, massage therapy, nursing, occupational therapy, physiotherapy and dentistry. Naturopaths regulated under the *Drugless Practitioners Act* have their own exemption and will be added to the list when the new College is fully established. There are members of other Colleges, such as traditional Chinese medicine and physicians, who can perform acupuncture under the authorization of their profession-specific Acts.

- **Delegation.** A health care provider who is permitted to perform a controlled act can delegate the controlled act to others. For example, in the controlled act scenario described above, if X had called Paul's physician and the physician had delegated to X the removal of the bug from the internal ear canal, X would be authorized to perform the procedure. Delegation can be made to another health care provider or to an unregistered person. Delegation is subject to a number of rules, including the following:
  - The person giving the delegation is limited by any regulations or professional standards of his or her College. For example, the professional misconduct regulation of the College prohibits the delegation of a controlled act by practitioners unless the practitioner has taken steps to ensure that the person receiving the delegation has the knowledge, skills and judgment to perform the procedure and the practitioner has documented those steps.
  - The person receiving a delegation is limited by any regulations or professional standards of his or her College. For example, a practitioner would not be complying with professional standards by performing brain surgery on a patient even if that procedure had been delegated by a physician.
  - The person delegating the procedure is responsible for the actions of the person receiving the delegation. For example, if a practitioner delegated acupuncture to an assistant and the needle punctured a vital organ, the practitioner could be sued or disciplined for that event.

*Controlled Acts Scenario No. 2*

*Y, a traditional Chinese medicine practitioner, performs acupuncture on her patient Paula. Acupuncture is a controlled act authorized to practitioners under the Traditional Chinese Medicine Act. Y is authorized to perform that controlled act.*

*Controlled Acts Scenario No. 3*

*Practitioner X has a plate of cookies in his waiting room. Paul, a patient, eats one and goes into anaphylactic shock. X is called into the room. X recalls that Paul has a peanut allergy and realizes that the cookies may have peanuts in them. X looks in Paul's briefcase and finds an EpiPen containing a measured dose of epinephrine. X injects the epinephrine into Paul's muscle and calls 911. Paul recovers. While X did perform a controlled act not authorized to him (injecting a drug by injection), he did so under an emergency which is a recognized exception to the controlled acts rule.*

*Controlled Acts Scenario No. 4*

*Y, a practitioner, only works part time. Her other job is to perform artistic body piercings. Her professional training comes in handy when performing this procedure. Even though such piercings go beyond the dermis, this procedure is exempted under the Minister's regulation on controlled acts.*

### Controlled Acts Scenario No. 5

*X, a practitioner, works with a physician. Because of X's experience with acupuncture and knowledge of anatomy, the physician trusts X to perform injections on patients in a sterile manner at precise anatomical locations. The physician delegates intra-muscular injections of local anaesthesia to patients as part of their pain management treatments. X is authorized by the delegation to perform these injections. However, both X and the physician will be responsible if something goes wrong.*

#### Sample Exam Question

Which of the following is a controlled act:

- i. Removing broken glass that has been deeply embedded in a child's leg.
- ii. Cleaning a scrape on a child's elbow with soap and water.
- iii. Applying alcohol to that scrape on a child's elbow.
- iv. Wrapping the child's wounds.

*The best answer is i). Deeply embedded glass almost certainly has gone beyond the dermis and is sitting in deeper tissue. There may be an issue as to whether this is an emergency (likely not as in most cases it would be possible to take the child to a hospital or physician's clinic for treatment), but that does not change the fact that removing the glass is a controlled act. Similarly, the household exemption does not apply to these sorts of procedures. Answer ii) is not the best answer because a scrape on the skin implies that it has not gone beneath the dermis. Answer iii) is not the best answer because applying a substance to the skin is not administering a substance by inhalation or injection. Answer iv) is not the best answer because the procedure is above the skin and does not fall within any of the other controlled acts.*

#### ii. Scope of practice

Because the *Regulated Health Professions Act* uses controlled acts to protect the public from potentially dangerous health procedures, the scope of practice of each profession is not as significant. No profession has an exclusive scope of practice. Members of other professions can do the same things that practitioners can do. There are two exceptions:

- People cannot perform a controlled act unless they have legal authority to do so.
- There is a "risk of harm" provision that prevents people from performing potentially dangerous procedures even if they are not controlled acts.

### *Risk of Harm Provision*

The risk of harm provision prohibits a person from treating or advising a person “with respect to his or her health in circumstances in which it is reasonably foreseeable that serious bodily harm may result from the treatment or advice or from an omission from them”<sup>7</sup>. This provision is designed to prevent individuals from taking advantage of vulnerable patients, in ways other than performing a controlled act. For example, encouraging a cancer patient to try diet as the only means of treatment might fall within this risk of harm provision.

However, the risk of harm provision does not apply to practitioners practising within their scope of practice. Thus it is not an offence for a practitioner to provide treatment within the scope of practice of traditional Chinese medicine even if there is an inherent risk to the treatment. If there was incompetent care, the practitioner is accountable to the College (not to provincial offences court) for his or her conduct. However, if a practitioner provides treatment outside of the scope of practice of the profession, the risk of harm provision does apply. For example, if a practitioner treated a patient’s cancer by using procedures associated with Medical Doctors and which are not part of the scope of practice of traditional Chinese medicine, then the practitioner could face prosecution.

Thus it is important for practitioners to know their scope of practice.

### *Scope of Practice Statement*

A profession’s “scope of practice” is a description of what that profession does.

Under the *Traditional Chinese Medicine Act*, the scope of practice statement reads as follows:

3. The practice of traditional Chinese medicine is the assessment of body system disorders through traditional Chinese medicine techniques and treatment using traditional Chinese medicine therapies to promote, maintain or restore health.

While fairly broadly stated, this scope of practice statement does not allow a practitioner to provide treatments that are outside of the usual practices of practitioners. For example, any form of surgery is not included in this scope of practice.

Practitioners are permitted to perform procedures that are not inherently dangerous that lie outside of their scope of practice. For example, providing nutritional counselling and natural health products to patients would often be permissible. However, the College has a policy that patients need to know whether a practitioner is acting as a practitioner, or as another health care provider. This policy applies whether the practitioner is registered with another College or

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<sup>7</sup> Section 30 of the *Regulated Health Professions Act*.

not. The patient must be told which professional hat the practitioner is wearing. In fact, to ensure that a patient is not misled, separate appointments, records and billings should be made.

### *Scope of Practice Scenario*

*Y, a practitioner, is seeing Paula, a patient diagnosed with Stage IV cancer. Paula is scheduled for surgery next week to be followed by chemotherapy. Paula's physician says that the treatment has a 50% chance of success (i.e., meaning she will be alive and cancer free in five years time). Paula's physician also said that without treatment, Paula had a less than 5% chance of surviving for five years. After a careful assessment, Y advises the patient to cancel both the surgery and the chemotherapy. Y recommends a combination of relaxation tapes and a fasting cleansing program followed by an all fruit diet instead. Paula dies within two months and the family go to the police asking that Y be prosecuted under the risk of harm clause.*

*In this case, Y appears to have provided treatment that is outside of the scope of practice for practitioners. The treatment also appears to have no evidence to support it. There was an inherent risk of harm in advising the patient to reject the proposed medical treatment that had evidence of a reasonable chance of recovery for a treatment that had not been fully researched.*

### **iii. Use of titles**

There are a number of rules about the use of professional titles and designations by practitioners.

The first general rule is that only approved persons can use any form of the title "Doctor" when providing or offering to provide health care services in Ontario. If a person is not from one of the approved health professions, he or she cannot use the title in a clinical setting even if the person has an earned doctoral degree (i.e., the person holds a Ph.D). Allowing a staff person to call the health care practitioner "Doctor" would constitute an offence. Under this provision, people can use the title "Doctor" in other settings, such as socially or in a purely teaching setting, where there are no patients.

Practitioners are not allowed to use the title "Doctor" yet. Practitioners will be permitted to use the title "Doctor" once the class of registration for Doctors of Traditional Chinese Medicine is created. That class of registration will not be available when the *Traditional Chinese Medicine Act* is first proclaimed into law. It will likely be a few years before that class of registration becomes available.

The second rule is that each profession-specific statute regulates the use of titles relating to their profession. Each profession has specific titles that only persons registered with their

College can use as a professional title. For example, only practitioners can use the titles “traditional Chinese medicine practitioner” or “acupuncturist” or any variation of those titles. In addition, even if the person does not use the protected title, he or she cannot hold himself or herself out as a practitioner. This prevents people from pretending that they are practitioners when they are not.

Thus practitioners need to be careful not to use as a professional title a designation that is permitted to members of other Colleges. For example, unless a practitioner is registered with that College, they cannot call themselves a physiotherapist or a physical therapist.

The third set of rules is created by each College for its members in the registration and professional misconduct regulations. For example, each class of registration is given a specific designation for them to use (e.g., R. TCMP, or R. Ac). Practitioners with other classes of registration cannot use those designations unless specifically permitted to do so. In addition, since the profession does not have recognized specialties, practitioners cannot use titles or designations inferring specialist status or certification (e.g., paediatrician, gerontologist). However, practitioners are free to describe their areas of practice so long as it does not imply specialist status or certification (e.g., practice limited to children). Finally, there are general professional misconduct regulations preventing the use of misleading titles or designations or engaging in false or misleading advertising. For example, it would be professional misconduct for a practitioner to refer to an educational degree that had not been received.

#### *Use of Titles Scenario*

*X, a practitioner, teaches at a school that trains practitioners. There is no Doctor of Traditional Chinese Medicine class of registration in Ontario yet. The school has a clinic where it sees patients. X supervises the students at the clinic. The students refer to him as “Doctor X” at the clinic. The Dean of the school pulls X aside and tells him to ask his students to stop calling him “Doctor” in the clinic where there are patients. It is OK in the classroom, but not the clinic. X reviews the Regulated Health Professions Act and realizes that the Dean is correct. X is assisting in the treatment of patients there and thus is not permitted to call himself (or allow others to call him) “Doctor” there. X also recognizes that he was being a poor model for the students.*

#### **iv. Mandatory reports**

Part of being a member of a regulated health profession is that one cannot remain silent when another health care provider is harming a patient. A practitioner must speak up in those circumstances. In other words, making a report is mandatory. The *Regulated Health Professions Act* carefully balances the need to protect patients by requiring practitioners to make a report and disrupting the health care system with many unnecessary reports. The statute also recognizes that if practitioners unnecessarily report on their colleagues, it will harm the atmosphere necessary for interprofessional collaboration. This section of the book describes

the mandatory reporting provisions of the *Regulated Health Professions Act*. There are some mandatory reporting provisions in other statutes (e.g., the *Child and Family Services Act*) which are either dealt with below or are too uncommon for practitioners to warrant discussion in this book.

Both the *Regulated Health Protection Act* and case law provide immunity to practitioners who make a mandatory report in good faith.

The mandatory reporting requirements also create an exception to the practitioner's duty of confidentiality. In addition, the *Personal Health Information Protection Act* permits a report to the College to be made as an exception to the privacy duties under that statute.

### *Sexual Abuse*

A practitioner must report sexual abuse of a patient by another health care provider. The duty arises if the practitioner has reasonable grounds to believe the sexual abuse occurred in the course of practising the profession or while operating a health facility (which probably includes an office or clinic). The reasonable grounds could arise even if the practitioner did not personally observe the sexual abuse. For example, if a patient tells the practitioner details of the abuse, that would likely constitute reasonable grounds. A practitioner does not have to investigate the events first nor does the practitioner have to actually believe that the information is true (e.g., the practitioner might know the alleged abuser and cannot believe that he or she would do such a thing). If the information constitutes reasonable grounds, the report must be made. Reasonable grounds means information that a reasonable person who does not know the individual involved would conclude that it is more likely than not that the information is correct.

The report must be made in writing to the Registrar of the College to which the alleged sexual abuser belongs. The report has to contain the reporting practitioner's name and the grounds of the report. ***However, the report cannot contain the patient's name unless the patient agrees in writing that the name can be included.*** This limitation is intended to protect the privacy of patients who may be in a vulnerable position. The report must be made within thirty days of receiving the information. If it appears that patients are continuing to be harmed and there is an urgent need for intervention, the report must be made right away.

### Sexual Abuse Mandatory Report Scenario

*Y, a practitioner, is told by Paula, a patient, that she had an affair with her family doctor. Y asks Paula if her family doctor was treating her while the affair was ongoing. Paula says yes. Y tells Paula that she is required by law to report this information to the Registrar of the College of Physicians and Surgeons of Ontario (CPSO). Y explains that the CPSO will want to investigate the report. It will be very difficult for the CPSO to investigate the report if Paula's name and contact information is not included in the*

*report. The CPSO will likely want to interview Paula about the affair. The investigation could lead to a discipline hearing. However, the law is clear that Y cannot include Paula's name and contact information unless Paula is prepared to sign a written consent permitting Y to do so. Y says that they can call the CPSO right away, on an anonymous basis, to see what the process would be like. Paula agrees to the telephone call. After the call is completed Paula says that she will not give her consent to include her name and contact information. Y then provides the report in writing without identifying Paula.*

### *Incompetence, Incapacity and Professional Misconduct*

A practitioner must report if he or she ends a business relationship with another health care provider on the basis that the other health care provider is incompetent or incapacitated or engaged in professional misconduct. Examples of business relationships include employer-employee, partners, shareholders in a professional corporation or space sharing. If the practitioner was going to make a report, the report must be made even if the person quits or resigns first.

The report must be made in writing to the Registrar of the College that regulates the other health care provider. The report must be made within thirty days of ending (or proposing to end) the business relationship. Under this mandatory reporting obligation the name of the patient can be included without the patient's consent.

In addition, if a practitioner operates a health facility (which probably includes an office or clinic), the practitioner must report any reasonable grounds to believe that another health care provider is incompetent or incapacitated. This duty to report does not include just professional misconduct. This report must be made even if the business relationship with the other health care provider is not ended. For example, if a health care provider at the facility is found to have a drug addiction and goes into a treatment program while the job is kept for him or her, the report would still have to be made.

Again, the report must be made in writing to the Registrar of the College to whom the alleged health care provider belongs. The report has to contain the reporting practitioner's name and the grounds of the report. Under this mandatory reporting obligation the name of the patient can be included without the patient's consent, so long as it is not involving sexual abuse. The report must be made within thirty days of receiving the information. If it appears that patients are continuing to be harmed, the report must be made right away.

### *Incompetence, Incapacity and Professional Misconduct Mandatory Report Scenario*

*X, a practitioner, learns that his employer (a traditional Chinese medicine practitioner) is an alcoholic. X tries to help his employer get treatment, but the employer keeps relapsing. The day before, the employer came back after lunch totally impaired such that X had to call in his employer's wife to pick him up and take him home. X had to cover for*

*the patients. What scared X the most was that his employer treated three patients after lunch before X found out about his condition. X is preparing his letter of resignation. He consults a lawyer about what to do. X's lawyer advises him that X must make a written report to the Registrar of the College of X's employer.*

### *Offences – Self Report*

Practitioners have to report themselves when they have been found guilty of an offence. All offences are supposed to be reported. Thus criminal offences, offences under federal drug or other legislation and provincial offences (including highway traffic offences) need to be reported. Only courts can make offence findings. Thus any findings by a body that is not a court (called “tribunals”) are not reportable under this provision. All court findings are reportable regardless of whether or not they resulted in a conviction. A finding of guilt that leads to an absolute or conditional discharge must be reported even though they are not “convictions”.

Reports are to be made to the Registrar of the College as soon as possible after the finding and should contain the following information:

- the name of the practitioner filing the report;
- the nature of, and a description of the offence;
- the date the practitioner was found guilty of the offence;
- the name and location of the court that found the practitioner guilty of the offence; and
- the status of any appeal initiated respecting the finding of guilt.

The report will be reviewed by the College and may result in an investigation. However, the report does not automatically get put on the public register (see the discussion of the register below).

If there is an appeal that alters the information reported, an updated report must be made.

### Offence Mandatory Report Scenario

*Y, a practitioner, is found guilty of careless driving under the Highway Traffic Act. On the College's annual renewal form she sees a question asking if she has been found guilty of any offence. She cannot believe that this question is meant to including her careless driving charge. She calls the College for clarification. She is told that the Regulated Health Professions Act requires all offences to be reported. The intent of requiring such reports was to prevent practitioners from determining whether the findings were relevant or not. The statute wants that decision to be made by the College. In fact, Y should have reported the finding when it occurred and not waited six months for the annual renewal form. Y makes the report. A few weeks later she receives a letter from the College thanking her for her report, stating that the College does not believe that this*

*finding is worth investigating further and reminding her that in the future such findings need to be reported right away.*

### *Professional Negligence – Self-Report*

Practitioners have to report themselves when they have been found to have engaged in professional negligence or malpractice. Findings of professional negligence or malpractice are only made by the courts. Thus any findings by a tribunal are not reportable under this provision. Settlements of claims for professional negligence may not be included in the reporting requirement if they did not result in a court “finding”.

Reports are to be made to the Registrar of the College as soon as possible after the finding and should contain the following information:

- the name of the practitioner filing the report;
- the nature of, and a description of the finding;
- the date of the finding;
- the name and location of the court that made the finding; and
- the status of any appeal initiated respecting the finding.

The report will be reviewed by the College and may result in an investigation. The report is automatically put on the public register (see the discussion of the register below).

If there is an appeal that alters the information reported, an updated report must be made.

### Professional Negligence Mandatory Report Scenario

*X, a practitioner, is sued in Small Claims Court by a patient, Paul. Paul claims that he told X about pain in his lower abdomen but that X attributed those symptoms to stress. After two weeks of acupuncture for the stress, despite increasing pain, Paul went to the emergency department. Paul was rushed into surgery for appendicitis and stayed in the hospital for almost a week. Paul claims X should have referred him to another health care provider to rule out appendicitis before treating the symptoms as purely stress related. The Small Claims Court judge agreed and order X to pay Paul \$10,000 for the malpractice. X reported the finding to the College. The College placed a note about the finding on the public register.*

### *Duty to Warn*

Under case law, a practitioner who has reasonable grounds to believe that another person is likely going to cause severe bodily harm has to warn the appropriate people of the risk. The College has included a version of this duty to warn in its professional misconduct regulation. Where a practitioner learns of an incident of unsafe practice by another practitioner, the first

practitioner must report this to the Registrar. This duty to report does not include all forms of incompetence, incapacity or professional misconduct. It only applies where the practitioner risked the safety of a person (normally, but not always, a patient).

This provision does not apply where the provider engaging in risky behaviour is a member of another profession. However, in those circumstances there may be an ethical or even a case law duty to intervene in an appropriate way to prevent harm to a patient or other person.

The report must be made promptly to the College. It would be advisable to make the report in writing with all necessary details. Under this mandatory reporting obligation the name of the patient can be included without the patient's consent.

#### Duty to Warn Mandatory Report Scenario

*Y, a practitioner, learns from Paula, a patient, that another practitioner, X, strongly recommended that Paula undergo a month long cleanse. The cleanse involved no food and drinking only lemon juice and water. Paula is in her fifties and is underweight. Paula says that at least two other patients of X had been given similar advice. Y is concerned that such a cleanse is not safe for many people and certainly not someone like Paula. Y is also concerned that X likely does not have the expertise to oversee fasting for such a long time. Y makes a report to the Registrar of the College.*

#### Sample Exam Question

Is a mandatory report required where a practitioner overheard another practitioner telling two male patients a sexually explicit joke, who laugh loudly?

- i. No. Dirty jokes are not sexual abuse.
- ii. Yes. This is sexual harassment. The report should be made to the Human Rights Tribunal.
- iii. No. The patients liked the joke and would not have been harmed by it.
- iv. Yes. This constitutes sexual abuse.

*The best answer is iv). Sexual abuse includes comments of a sexual nature to a patient. Reporting sexual abuse is mandatory. While it is unlikely that significant action will be taken by the College (perhaps a sensitivity course), it is still important that practitioners learn that such conduct can be harmful to some patients. One never knows what experiences patients have had in their past that might make even a dirty joke harmful. Answer i) is incorrect because dirty jokes are sexual abuse as that term is defined in the Regulated Health Professions Act. Answer ii) is not the best answer because there are no mandatory reporting requirements under the Human Rights Code. Also, the Regulated Health Professions Act uses the term sexual abuse rather than sexual harassment and gives that term a much different meaning. Answer iii) is not the best answer because whether the patient was a willing participant or not is irrelevant. The comment still*

*should not have been made. Also, one never knows what experiences patients have had in their past that might make even a dirty joke harmful. In addition, sexualizing the practice of the profession is inherently confusing to patients who assume that there is no sexual aspect to their relationship with practitioners.*

#### **v. Public Register**

The *Regulated Health Professions Act* requires that the public be able to get certain information about practitioners. This information helps the public (e.g., patients, employers) to decide whether to choose a particular practitioner. This information also helps the public to see how well the College is regulating practitioners. The register also helps ensure that practitioners practise only as they are permitted by the College. For example, if a practitioner is suspended for three months, people can more easily report to the College if the practitioner is still working during the suspension period.

The register must contain the following information about each practitioner:

- Name;
- Business address and telephone number;
- Name, business address and telephone number of each professional corporation
- Class of registration;
- Any terms, conditions and limitations on the registration;
- Referrals to the Discipline Committee for a discipline hearing;
- A summary of every finding of professional misconduct, incompetence or incapacity;
- Findings by a court of professional negligence;
- Every suspension of registration;
- Every revocation of registration;
- Any agreement to resign and never reapply for registration; and
- Any other information that the by-laws say should go on the register.

There are very few circumstances where the College can choose not to put this information on the register or to remove information from the register. However, it can do so in the following circumstances:

- The information (e.g., contact information) would jeopardize the safety of a practitioner (e.g., if a practitioner is being stalked).
- The information is obsolete or no longer relevant (e.g., the finding of professional misconduct relates to conduct that is now acceptable, for example if the advertising rules happen to change).
- Unnecessary information about the personal health of a practitioner (e.g., in incapacity matters).

- After six years, where there was only a reprimand, a fine or a finding of incapacity and the Discipline Committee or Fitness to Practise Committee agrees that there is no public interest in keeping the information on the register.

The register is available to the public in a number of ways. It is on the College's website. It is available at the College's office. A paper copy can be requested. The College can also give information on the register over the telephone. Where a person asks about a practitioner, the College must help the person find whatever information that person wants that is on the register.

### ***Public Register Scenario***

*Y, a practitioner, has separated from her husband. Y's husband has hit her a few times. Since the separation, Y's husband has been following her. The police cannot seem to stop him. Y moves to another city. She asks the Registrar not to put her business address or telephone number on the public register so that her husband cannot find her. Y provides documents from the police and the courts about her husband's behaviour. The Registrar removes Y's contact information from the register.*

### **vi. Professional Corporations**

Practitioners can choose to practise personally (i.e., in their own names), through a partnership or through a professional corporation (i.e., a special type of corporation for regulated professionals). Practitioners cannot practice through regular business corporations; they can only practice through a professional corporation. Practitioners who have a regular business corporation will have to change that corporation to a professional corporation once they become registered with the College.

Professional corporations have a number of conditions and restrictions. These include the following:

- only practitioners can hold shares;
- the officers and directors of the professional corporation must be shareholders;
- the name of the corporation must include the words "Professional Corporation";
- the professional corporation cannot be a numbered company (e.g., 1234567 Ontario Inc.); and
- the professional corporation can only practise the profession, or provide related or ancillary services. It cannot, for example, practise another profession like massage therapy.

Practitioners cannot avoid professional liability through a professional corporation. Injured patients can sue the practitioner personally. However, practitioners working through a professional corporation do have protection against trade creditors. For example, if suppliers or

other creditors are not paid by the professional corporation, they cannot sue the practitioner personally.

A number of provisions have been made to prevent practitioners from hiding behind the professional corporation when facing questions from the College. These include the following:

- the RHPA applies to practitioners despite their practising through a professional corporation;
- a practitioner's fiduciary (i.e., loyalty and good faith) and ethical obligations to patients remain in place and now apply equally to the professional corporation as well;
- during investigations and other proceedings involving practitioners, the College has the same powers over the professional corporation (e.g., access to premises and documents) as it does against the practitioner;
- any monetary orders against practitioners are also payable by the professional corporation;
- any duty to a patient, the public or the College takes precedence over the duties of the practitioner as an officer or director of the professional corporation;
- any terms, conditions and limitations against a practitioner apply to the professional corporation as well; and
- any knowingly false representation made to obtain a certificate of authorization is an offence.

Professional corporations have to obtain from the College a "certificate of authorization", similar to a certificate of registration, for individual practitioners. To obtain a certificate of authorization, a health practitioner goes through the following process:

- Select a name for the professional corporation. Ministry regulations require that the name must contain the surname of at least one shareholder (as set out in the College register). The name can also include the person's given name and initials. The name of the corporation must also indicate the name of the practitioner's health profession. The name must also include the words "professional corporation". The name can include nothing else.
- The professional corporation must then be incorporated with the government. This involves preparing articles of incorporation, corporate by-laws, paying a fee and submitting an application form with the government. If the paperwork is acceptable, the government will issue a certificate of status and a certificate of incorporation.
- Within 30 days of obtaining one's certificate of status, the professional corporation must apply to the College for a certificate of authorization. Such an application will require the following:
  - Completing the application form that can be obtained from the College. The application form will require the name, registration numbers and addresses of each shareholder. The application form will require the applicants to specify

- which shareholders hold which positions with the corporation. The business premises or practice locations of the corporation will have to be identified.
- Paying the fee required by the College in its by-laws.
  - Enclosing the certificate of status issued by the Ministry that is no more than thirty days old.
  - Enclosing a certified copy (*i.e.*, sworn to be a true copy by a lawyer or notary public) of the certificate of incorporation issued by the government.
  - Providing a statutory declaration (*i.e.*, a sworn written statement) from a director of the corporation that was completed not more than fifteen days before the application date. The statutory declaration certifies the accuracy of the documents submitted with the application and that the corporation will only practice the profession or related or ancillary activities.

Once incorporated, the corporation must notify the College immediately if its name or articles of incorporation change. Also, the College needs to be notified promptly of any change in shareholder, officer or director of the professional corporation or if the corporation changes its location or locations of practice. Each year the professional corporation must renew its certificate of authorization. The renewal process involves completing the same sort of paperwork as was involved in the initial application. The renewal process updates the information about the corporation and its shareholders.

A certificate of authorization can be revoked if it does not follow the rules.

The College cannot give advice to practitioners as to whether a professional corporation is good for them. Practitioners will need to obtain advice from their own accountants or lawyers.

#### *Professional Corporation Scenario*

*X, a practitioner, has had a business corporation for many years before the College was created. His wife and children are shareholders. It is not a professional corporation. What are his options? X has to do something. He cannot continue to operate a regular business corporation once he becomes a registered member of the College because business corporations do not follow the rules for professional corporations. X has to either change his business corporation into a professional corporation, or give up the business corporation. X's wife and children cannot be shareholders of the professional corporation unless they are also registered with the College. If X gives up the business corporation, he cannot practice the profession through it. X should speak to his accountant or lawyer to get advice as to what is best for him.*

#### **c. TCMA, Regulations, By-laws**

The *Traditional Chinese Medicine Act* is the profession-specific statute of the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario. As mentioned

before, the *Traditional Chinese Medicine Act* works together with the *Regulated Health Professions Act* so that they can be treated as one Act. Together, these Acts authorize the College to develop regulations and by-laws to regulate the profession.

Regulations and by-laws are both forms of law. The major difference between a by-law and a regulation is that a by-law is made directly by the Council, while a regulation must be approved by the government of Ontario. By-laws typically relate to the administration and internal affairs of the College. Regulations generally deal with matters of broader public concern.

### **i. Registration Regulation**

Registration regulation sets out the requirements for obtaining and maintaining registration with the College. It is intended to make sure that members of the College are competent and have good character.

The registration regulation establishes five classes of members:

1. Grandparented Registration - intended for those who are currently practicing Traditional Chinese Medicine or TCM acupuncture in Ontario and who meet basic requirements to enter the profession;
2. General Registration – intended for members who are normally entitled to the independent practice of Traditional Chinese Medicine and TCM acupuncture;
3. Student Registration – intended for anyone in the process of qualifying to become a traditional Chinese medicine practitioner or TCM acupuncturist;
4. Inactive Registration – intended for existing members who for whatever reason are not currently practicing the profession but wish to remain members of the College; and
5. Temporary Registration – intended to permit recognized and skilled traditional Chinese medicine practitioners and TCM acupuncturists from other jurisdictions to practise in Ontario for a short period of time.

### *General Requirements*

There are certain requirements that must be met by all applicants for registration with the profession. All applicants must complete an application form fully and pay applicable fees. A police report is required to be provided to the College. The applicant must also inform the College of any criminal or regulatory proceedings or findings against them. The application form requires applicants to provide information regarding the applicant's training and experience, past professional experiences (including previous registration with another regulatory body). The applicant must also provide other information that may affect his or her ability to practise effectively and safely (i.e., professional liability insurance). The applicant must have immigration status to work in Canada. They must be able to speak, read and write in either English or French with reasonable fluency (there is an exception for Grandparented applicants – see below). The applicant must not be incapacitated (i.e., have an illness that prevents them

from practising safely, like a drug addiction that is not under control) unless adequate safeguards are in place.

All applicants other than for Student Registration must have completed a jurisprudence course on basic health regulation and law that applies to their practice.

An applicant who applies for Grandparented registration does not need to be able to speak, read or write English or French with reasonable fluency so long as the applicant provides a written plan on how he or she will communicate with others about his or her patients. The plan must deal with how to communicate with other practitioners and hospitals about patients (e.g., if there is an emergency or if the patient goes to another practitioner who only speaks English or French). For example, a Grandparented member could practise in association with another member who is fluent with English or French. There may be other ways to achieve this goal with the approval of the Registration Committee.

Applicants for Inactive registration do not need proof of professional liability insurance.

### *Specific Requirements*

There are specific requirements for each class of registration. For example, under the Grandparented registration category an applicant must complete a Safety program. Grandparented members then have five years to complete a prior learning assessment so that they can become General members.

Applicants for General membership (other than Grandparented members) must complete an acceptable education program, have supervised clinical experience, complete a Safety program and must pass the registration examination.

There are registration regulation provisions that allow for out-of-province registrants from elsewhere in Canada to transfer to Ontario with recognition of their qualifications. These are called mobility provisions. The Ontario College will not require qualified applicants registered elsewhere in Canada to once again prove that they have adequate education, experience and examination credentials.

### *General Conditions*

Once a person is registered with the College, he or she must continue to meet certain general terms, conditions and limitations. For example, if a member is found guilty of a criminal or other offence, the member must tell the College. If a member is disciplined by another professional regulator, the member must tell the College. If the member no longer has professional liability insurance coverage, the member must tell the College. Members of each class of registration are assigned a specific title that the members must use so that the public

can identify their registration status. Members must display their certificate of registration prominently where they practice.

### *Registration Regulations Scenario*

*X is a TCM acupuncturist who practices in BC and is registered with the College in BC. He has been invited by a colleague to come to Ontario to demonstrate a particular technique at a conference, and provide demonstrations with patients in Ontario. It has been suggested that he come over for three months and see patients under the supervision of a registered TCM acupuncturist in Ontario so that others can learn and benefit from his expertise. X does not want to take the registration examination. Can he be registered without doing it? The College has a Temporary class of registration that allows X to register for up to 6 months in Ontario so long as he is already registered and is holding a certificate in good standing in BC. In addition, if he wanted to, X could rely on the mobility provisions to register as a Full member to practice as an Acupuncturist.*

[NOTE: At the time of writing, the Registration Regulation is still undergoing review by the Ministry of Health and Long-Term Care.]

## **ii. Professional Misconduct Regulation**

As discussed above, some types of professional misconduct are contained in the *RHPA* itself. For instance, the *RHPA* makes breaking the law professional misconduct (e.g., to be found guilty of an offence relevant to a practitioner's suitability to practise the profession). Also, being found guilty of professional misconduct outside of Ontario can lead to disciplinary action in Ontario as well. Sexual abuse of a patient is also professional misconduct. So is failing to cooperate with the quality assurance program.

However, the College's professional misconduct regulation describes additional examples of professional misconduct. Some provisions found in the professional misconduct regulation are common to many of the professions under the *RHPA*, while others are more specific to this profession.

The following are the main topics found in the professional misconduct regulations.

### *Standards of Practice*

The professional misconduct regulation makes failing to meet the standard of practice of the profession professional misconduct. Usually, this relates to the assessment and treatment of patients by the practitioner. The standards of practice may be written, or unwritten. They reflect a shared understanding of the profession and how it should be practiced effectively and safely. This is based on what would be reasonably expected of the ordinary competent practitioner in his or her field of practice. Expert witnesses are often used to determine a standard of practice when it is unwritten, or under consideration.

One specific standard of practice in the professional misconduct regulation is that a practitioner must refer a patient to another health care provider where the patient has a condition that is beyond the knowledge, skill and judgment of the practitioner. For example, if a patient had symptoms that suggested advanced cardiac disease, the practitioner should not try to handle this alone. A referral to a medical doctor would be required.

#### *Inappropriate Behaviour towards Patients or the Public*

Many provisions in professional misconduct regulation relate to inappropriate behaviour towards patients or the public. For example, physical or verbal abuse of patients is professional misconduct. This includes rude or unbecoming behaviour towards patients, members of the public or other health professionals. In addition, if a patient has a concern about a practitioner's conduct and wishes to make a complaint, the practitioner has a professional obligation to advise the patient about the College's regulatory role and how to get in contact with the College.

#### *Record Keeping*

Failing to make and keep appropriate and adequate records is professional misconduct. This is an important area to understand for practitioners, so it is discussed in depth in its own section below.

#### *Informed Consent*

Informed consent has been discussed in more detail above in the section on communication, and is also mentioned in regards to record keeping. The regulation makes it professional misconduct to fail to obtain informed consent before assessing or treating a patient.

#### *Controlled Acts, Delegation and Supervision*

Delegation of controlled acts is discussed in detail above. To delegate a controlled act means to allow another person to perform a controlled act on one's behalf. The professional misconduct regulation says that members should not delegate a controlled act unless: a) it would be safe and effective to do so; b) the practitioner has ensured that the person performing it has the knowledge skills and judgment to perform the procedure; c) the practitioner has documented the person's knowledge, skill and judgment to perform the controlled act; and d) the practitioner has documented the conditions under which the procedure was delegated.

In addition to delegating, a member may also assign certain tasks which are not controlled acts to a person. The College expects that the practitioner supervises those doing any procedure on the practitioner's behalf.

#### *Confidentiality*

Practitioners must keep all patient information confidential. Failing to maintain confidentiality can be considered professional misconduct. There may be exceptions depending on the circumstances to this duty of confidentiality. For example, patients can consent to the

practitioner disclosing information. Also, where a practitioner is required (e.g., by a court summons) or permitted (e.g., when selling one's practice) by law to disclose patient information, it can then be disclosed. The concept of confidentiality is discussed further in the section below on *PHIPA*.

#### *Conflict of Interest*

Practitioners have a duty to act in the best interest of their patients. A conflict of interest arises when the practitioner appears to be acting in someone else's interest instead. For example, a practitioner has a duty to only refer patients to others where it is in the best interest of the patient. Where a health food store pays a practitioner to refer patients to them, the practitioner has a conflicting interest (i.e., getting paid by the store) that is unprofessional. This topic is discussed in its own section below.

#### *Improper Billing and Fees*

Practitioners must be honest in their billings. Because of this, the professional misconduct regulation prohibits improper billing. Billing has been discussed above.

#### *Misrepresentation*

It is professional misconduct to be dishonest in one's dealings with clients, colleagues, third party payers or the College. Dishonesty with third parties is also not acceptable (even if the intent is to help a patient). Third parties often assume that practitioners are honest because of their professional status and rely upon their integrity. For example, it would be professional misconduct to issue a letter or certificate saying that a patient was too sick to work when the practitioner does not know this to be true.

#### *Improper Use of Names, Title or Descriptions*

There are specific rules in the professional misconduct regulation that restrict use of certain names, titles or descriptions. For example, the title of the member will depend on their class of registration (classes of registration are discussed above in the registration regulation section). This is intended to ensure consistent, appropriate and clear use of titles that help the public know with whom they are dealing and to prevent confusion. Also, members of the College cannot use a term, title or designation indicating or implying that they have a specialization in an area or areas of practice (e.g., saying they are a paediatrician). Also, practising the profession under a name that is not registered with the College may be considered professional misconduct (e.g., if a practitioner uses a nickname when practising, the College must be told of that nickname first).

#### *Improper Advertising*

It is professional misconduct to engage in false or misleading advertising. There is a section below describing more details regarding improper advertising for practitioners.

*Conduct towards Colleagues*

Practitioners must treat their colleagues with courtesy and civility. For example, if a patient goes to another practitioner and that practitioner asks for a copy of the record (with patient consent), one cannot simply ignore the letter. If a practitioner disagrees with the treatment being provided by another health care provider, the practitioner must not make insulting comments about the other health care provider to the patient.

*Conduct towards the College*

Obligations come with the privileges of self-regulation. One obligation is that practitioners must accept the regulatory authority of the College. Examples of conduct towards one's College which can constitute professional misconduct include:

- Publicly challenging the integrity of the College's role or actions.
- Breaching an undertaking given to the College.
- Failing to co-operate in, or obstructing, an investigation by the College.
- Failing to participate in the quality assurance program.
- Failing to respond appropriately and promptly to correspondence from the College.
- Failing to report a practitioner to the College who has jeopardized the safety of a patient.

*Disregarding Restrictions on Certificate of Registration*

A practitioner must confine his or her practice to what is legally permissible. If the Act or a committee of the College restrict a practitioner in certain areas, it would be professional misconduct to exceed those restrictions. For example, a practitioner who is limited by the Registration Committee to TCM acupuncture cannot offer herbal remedies.

*General 'Catch-all' Provisions*

The College has two general catch-all provisions. These cover types of conduct that are not specifically dealt with elsewhere. One provision prohibits conduct that would be reasonably regarded as dishonourable, disgraceful or unprofessional. This provision assumes that there is a general consensus in the profession of conduct or behaviour that would be considered unacceptable. For example, there is no specific provision that says that a practitioner cannot abuse a patient's mother during a visit. However, no one doubts that this conduct would be unprofessional.

The second catch-all provision makes it professional misconduct to engage in conduct unbecoming a member of the profession. This provision refers to conduct in a practitioner's private life that brings discredit to the profession. For example, a practitioner who engaged in a fraud on the stock exchange could be disciplined for the dishonesty.

*Professional Misconduct Regulations Scenario*

*Y has recently been criticized by her colleague, W, who works in the same practice as her that sometimes Y is too loud with her patients. W mentions that in speaking loudly she is*

*disrupting other practitioners in the office. Y tells W that she is sorry for disrupting him, and any of his patients, and that she will try to keep her voice down or lower it out of respect for the rest of the practice. But W feels this is a serious problem, and that he should report Y to the College for professional misconduct. He cannot stand loud noise during his patients' visits. W wants the very best atmosphere created for his patients, and thinks talking loudly is completely unprofessional. Is W correct in saying this would be professional misconduct according to the regulations? Probably not. W holds a particular view about Y's level of voice that may not be consistent with the rest of the profession. Unless the conduct persists and unless it is so loud that most neutral observers would agree that Y is disrupting the rest of the office, it is not professional misconduct. While it was appropriate for W to raise the issue with Y so that they can come to a reasonable resolution, professional misconduct is not meant to apply to uniquely personal views of unacceptable behaviour. Instead, it is intended to be based on conduct that is considered unacceptable by a general consensus in the profession.*

#### Sample Exam Question

Which one of the following situations is (are) possible professional misconduct according to the professional misconduct regulation?

- i. Failing to maintain patient confidentiality.
- ii. Using verbal threats and insults to a patient in an email to them when they did not show up for an appointment.
- iii. Giving a patient a reduced rate for services if they do not have insurance.
- iv. All of the above.

*The best answer is iv). The regulation describes many types of professional misconduct. All of the situations described involve conduct that is specifically prohibited in professional misconduct regulation.*

#### **iii. Record-keeping**

One important aspect of the standard of practice is record-keeping. Keeping records is essential for providing good client care; even practitioners with excellent memories cannot recall all of the details of their patients' health status and treatment. Records permit the monitoring of changes in patients. Records assist other practitioners who may see the patient afterwards. Records also enable a practitioner to explain what they did for patients if any questions arise. Records help a practitioner defend themselves if a patient recalls things differently than the practitioner. Failure to make and keep adequate records can be a failure to maintain minimum professional standards and is professional misconduct.

College regulations and standards on record keeping deal with matters such as:

- The information that must be recorded;
- The form in which records can be kept (e.g., written, computerized);

- How long the information must be kept;
- Maintaining or transferring records upon leaving a practice or retiring;
- Confidentiality and privacy issues; and
- Patient access to records.

#### *The information that must be recorded*

The patient record is intended to record what was done and what was considered by the practitioner. It acts as a communication aid to ensure that there is continuity of care for the patient. Proper records also enhance patient safety. The following is a description of general requirements of the health record.

The record should always contain identifying information such as the name and date of birth of the patient. It should be on each document in the record so that a particular document may be returned to the record if separated.

The record should include all relevant subjective and objective information gathered regarding the patient. This includes all relevant information provided by the patient (or his or her authorized representative, or other health care professionals involved in the patient's care) to the practitioner regardless of the medium or format (e.g., communicated in person, on paper, email, fax, telephone, etc.). It also includes any records regarding findings from assessments or during observations (e.g., how the patient walked into the office).

Any results of testing done (including physical testing, laboratory results, etc.) by the practitioner should be recorded. If a patient discloses test results from another health professional it should be noted in the record. However, practitioners do not have to ask for copies of reports if they are not needed.

The treatment plan should be recorded. Then the actual treatment provided should be noted. The record should also include any progress notes of how the patient progressed during treatment, any changes in the patient's condition, or any reassessments or modifications of the treatment plan. It should be clear to any practitioner reading the record what happened.

If the patient was a referral, the person who made the referral and the reason for the referral should be in the record.

Any consent that is obtained should be included in the record. Please see the consent section above for specific guidelines surrounding consent.

#### *The form in which records can be kept*

Records must be legible. Failure to maintain a legible record would defeat the purpose of maintaining a complete and accurate record.

Records can be on paper or on computer. Computerized records should be printable and viewable and should have an audit trail of changes made. These requirements are discussed further in the section on the *Personal Health Information Protection Act (PHIPA)* section below.

It should be clear who made each entry into the health record, and when that entry was made. Any change or amendment to the record should be indicated, the date of which the change was made should be noted, and who made the change should be recorded. Importantly, any changes to the record should still permit the reader to read the original entry.

Practitioners cannot falsify records; this means that if an error is made in a previous entry it cannot be removed (e.g., 'whited-out', or deleted). The record should be maintained with correction to the error (usually a simple line through the error with the date and initial of the person correcting the error).

The record should be in English or French. The information can be recorded in other languages so long as all the information is also recorded in English or French. The generally accepted languages in the health care system in Ontario are English or French. This permits other health care providers on the patient's health care team (e.g., hospitals, other practitioners, other health care providers) to understand the record.

#### *How long the information must be maintained*

The practitioner (or health information custodian for whom the practitioner works) needs to keep the record for ten years from the last interaction with the patient, or the patient's eighteenth birthday, whichever is later. For example, if a patient is eight years of age the last time the practitioner sees the patient (i.e., last patient visit) then the practitioner would have to keep the record for twenty years since that last interaction. An interaction can involve any contact with the patient, including a phone call or an email.

The rule regarding keeping records for ten years includes financial records, appointment and attendance records, and where appropriate, equipment records, in addition to the health record.

#### *Maintaining or transferring records upon leaving a practice or retiring*

The entire original record should be kept by the practitioner (or the health information custodian for whom the practitioner works) and only copies are to be supplied to others.

Even when a practitioner retires or leaves the practice (i.e., resigns as a member of the College) the original record should be kept for the ten year retention period, unless the record has been transferred to another practitioner who will maintain the record. The patient must be notified

of the transfer. In those circumstances, the original record can be transferred to the new practitioner.

However, if the patient has just been referred to another health care professional and the patient record has not been transferred, then the retention period of the entire original record (i.e., ten years from last contact or the patient's eighteenth birthday) is still mandatory.

The only exception to this is if there is some legal compulsion to provide the original record (i.e., in a police, Coroner's or College investigation, or with a summons). If this circumstance occurs, the practitioner should keep a legible copy of the record for themselves.

When the time period for keeping the record has expired, the destruction of the records should be done in a secure manner that prevents anyone from accessing, discovering, or otherwise obtaining the information (i.e., shredding, complete electronic destruction). If a practitioner destroys any records, a good practice would be to keep a list or record of the names of which the file was destroyed and the date it was destroyed.

If transferring from paper records to electronic records, and the original paper record has been scanned into an electronic form, then the original may be destroyed. The electronic version of the document becomes the original.

#### *Confidentiality and privacy issues*

Practitioners should take reasonable steps to keep records safe and secure. In general, no one outside of the authorized circle of care of health professionals should be able to access the records. Privacy protections must be in place to ensure the records cannot be seen or taken by others. Paper records should be kept under lock and key. Computer records need to be password protected on computers that have firewall and virus protections and must be backed up regularly. Particular privacy issues are discussed later in the section on the *Personal Health Information Protection Act ("PHIPA")* below.

#### *Patient access to records*

Generally, a patient has the right to review and receive a copy of all clinical records kept by a practitioner unless access would significantly jeopardize the health or safety of a person. Although the practitioner may own the health care record and be responsible for it, patients are authorized by *PHIPA* to access the record. Also, the patient has the right to correct any errors in the health record. If a patient requests any relevant parts of the record, the practitioner should provide them with a copy and not the original. This topic is discussed later in the section on the *Personal Health Information Protection Act ("PHIPA")* below.

### Record Keeping Scenario

*X has been practising for 45 years in the same practice, and has built up a busy and successful practice. He decides he is ready for retirement but wonders what he is supposed to do with his patient records. Does he have to retain them himself? Ordinarily he would have to retain patient records for ten years from the last interaction with the patient, or the patient's eighteenth birthday, whichever is later. But, in this case X may be transferring his practice to another practitioner to take over the business and patients. If this is the case, he does not have to retain the records himself but needs to notify the patients of the transfer of their patient records. This can be done through a combination of telling patients on their next visit and placing a notice in the local newspaper.*

### Sample Exam Question

Which one of the following does not need to be recorded in the patient's record?

- i. The patient's birth date.
- ii. The person who recommended the patient to you.
- iii. The patient's health concerns.
- iv. The treatment plan for the patient.

*The best answer is ii). Only if the patient was referred by another health care provider must there be a record of who recommended the patient. If another patient referred the person or the person found out about your office through advertising, that does not have to be recorded (although in some cases it would be helpful to record this information). Answer i) is not the best answer because practitioners need to record the patient's birth date. It is relevant to many treatment decisions. Answer iii) is not the best answer because practitioners need to record the patient's health concerns (sometimes called chief complaints). It is relevant to many treatment decisions. Answer iv) is not the best answer because practitioners need to record the treatment plan for the patient. It is relevant to following through with the treatment on future visits and for justifying one's actions should questions be raised later.*

#### **iv. Conflicts of Interest**

A practitioner cannot engage in a conflict of interest. In order to avoid a conflict of interest, practitioners must put the interests of their patients first, and not allow personal or other interests to interfere. A conflict of interest arises where a practitioner does not take reasonable steps to separate his or her own personal interests from the interest of patients. Where the personal interest would reasonably affect the practitioner's professional judgment, a conflict of interest exists. For example, if a practitioner refers a patient to a health store owned by the practitioner's spouse to buy products, a reasonable person would question whether the

practitioner recommended that product because the patient needed it or in order to help his or her spouse.

There is no need for proof of an actual conflict of interest because this would require reading the practitioner's mind (to know if they were influenced by the conflicting interest). Instead, one looks to what a reasonable person might conclude from the circumstances regardless of what is actually going on in the mind of the practitioner. A conflict of interest can be actual, potential or perceived. In that way, the conflict of interest rules are intended to prevent concerns from arising.

A conflict of interest can be direct or indirect. For instance, it would be a conflict of interest for a close relative (i.e., parent, grandparent, child, spouse, or sibling) to receive a benefit on behalf of the practitioner.

Some common examples of conflicts of interest are as follows:

- Splitting fees with a person who has referred a patient;
- Receiving benefits from suppliers or persons receiving referrals from the practitioner;
- Giving gifts or other inducements to clients who use the members services where the service is paid for by a third party (e.g., insurance);
- Working for an unregistered person who can interfere with professional decisions (e.g., how much time is set aside for each appointment);
- Using or referring a patient to a business in which one has a financial interest; and
- Selling a product to a patient for a profit.

Many of the examples depend on the reasonableness of the circumstance in determining if a conflict of interest exists. The practitioner should always ask themselves – would another objective and reasonable person think that there is a conflict of interest, given this circumstance? For example, it probably would be appropriate to give a patient a small calendar to record their future appointments even if an insurance company pays for the treatment. However, giving the patient a new pair of expensive running shoes is unreasonable in the circumstances (even if the patient needs to exercise).

Most conflicts of interest are prohibited outright. But, there are certain circumstances where taking certain safeguards could remove the concern. In the example above about referring a patient to a health store owned by the practitioner's spouse to buy a product, such a referral would not raise concerns if the practitioner did the following:

- Disclose the nature of the relationship with the health store (e.g., "my spouse owns the store");
- Provide alternative options (e.g., "here are three other places you could get the product I am recommending for you"); and

- Reassure the patient that choosing another store will not affect the patient's care (e.g., "You are free to choose any of the places to get the product; you will still be welcome here as my patient").

Practitioners must provide the College with any documents, explanations or information regarding a suspected conflict of interest if requested. This is to enable the College to assess whether a conflict of interest is a concern. For example, if the College receives information that a practitioner is making unusual payments to a health food store whenever the store refers patients to the practitioner, then the College could ask for an explanation of those payments, and any financial records related to them, to determine whether there is a conflict of interest.

#### *Conflict of Interest Scenario No. 1*

*Y owns a practice down the street from a gym. She has been practicing there for less than a year. She is trying to build her practice and wants people to know she is new to the neighbourhood. Y offers to give the manager of the gym a free cruise to the Mediterranean in return for having him and his staff refer patients to her practice. The manager of the gym thinks this is a great idea, and offers Y a free membership to the gym and personal training if Y also refers patients to his gym. While this may seem like a good business decision, Y is in a conflict of interest for two reasons. Y cannot give a free trip to the manager of the fitness center in order to get referrals as this would constitute a collateral (or side) benefit. Patients should be referred to Y because they need her services and not because the referring person is getting a free cruise. Further, Y cannot accept free membership and free personal training at the gym as this would conflict with her duty to refer patients to a gym only if she honestly believed that this would be in their best interest. In addition, unless there was something special about the local gym, Y should recommend that the patient go to the gym that they are most likely to go to regularly. The referrals would be based on professional judgment and not on any 'kickbacks' she may receive.*

#### *Conflict of Interest Scenario No. 2*

*X is an acupuncturist who has a busy and successful practice. Recently, he began using new acupuncture needles that he has noticed reduce the pain of insertion for his patients. They have a new type of silicon coating that allows them to glide into the skin, unlike many other acupuncture needles without the coating. He calls the company to tell them his feedback from his patients and that he likes using the product, and to order more boxes of needles. The company asks him if he would like to be in a new advertising campaign they are going to put into some health and wellness magazines where he would provide statements similar to what he just gave to the company for promoting the product. They plan to put a picture of him within the advertisement and identify him by name and qualifications. They say they cannot pay him because they are still a small*

*company, and don't have the budget for it. He thinks, why not? He likes the product, and since he is not getting paid he is not inappropriately benefiting from the relationship.*

*Unfortunately, this would still likely be a conflict of interest and would be professional misconduct. An acupuncturist cannot use their professional status to promote a product commercially. This is so even though he has not been paid for the endorsement. It can be assumed that he will benefit from the advertisement in some indirect manner (for example, he may have increased patient influx from those people who see the advertisement). Also, without making any observations or assessments of an individual, the acupuncturist should not be making any sort of clinical recommendations. X can give advice on products and remedies, including in choosing what type of acupuncture needles to use, provided that it is based on professional judgment regarding a patient's individual needs through proper assessment.*

#### **v. Advertising**

Advertising is an appropriate way to provide information to potential new patients. Practitioners can use appropriate advertising to communicate the type and availability of services within their scope of practice to the public, or to other health professionals. The purpose of advertising should be to provide relevant information to the public in order for them to make informed choices in regards to their health care needs. However, advertising must not be dishonest, misleading or irresponsible.

Advertising is any message that communicates information about a practitioner, his or her practice and what services he or she may offer, under the practitioner's control. Advertising may be in any medium and may include (but is not limited to) the following:

- Radio
- Television
- Websites
- Print based notices – i.e., letterheads, newspapers, magazines, journals, flyers
- Contact listing services – i.e., yellow pages.

Advertising should be factual, accurate, objectively verifiable, independent of personal opinion, comprehensible and professionally appropriate. It should not include any information that is misleading by either leaving out relevant information, or including non-relevant, false, or unverifiable information. For example, providing before and after pictures of how one's services can enhance a patient's appearance is inherently misleading and unverifiable. Practitioners should also take reasonable steps to ensure that the advertisements placed by others (i.e., employees, marketing consultants) meet these standards.

In particular, references to qualifications in the advertisement should be consistent with the College's rules. For instance, the title the member can use will depend on their class of

registration. No practitioner can use the title of Doctor at the present time. Off-shore qualifications need to be clearly stated.

Important information such as office hours and days of operation, telephone or fax numbers, languages spoken, website address, location and methods of payment are acceptable inclusions in advertising. Fees or prices advertised should meet expectations for honesty and accuracy.

Further, advertisements are prohibited if they:

- promote a demand for any unnecessary services,
- make a claim or promise a result that cannot always be delivered (i.e., or be interpreted as a guarantee as to the success of a service provided),
- use comparative (e.g., “better”), superlatives (e.g., “best”), suggestion of uniqueness, or appeals to a person’s fears about any service quality, products or people (e.g., comparing one’s services to another’s, or claims that one’s service is superior to others, is not verifiable), and
- contain testimonials from a patient, former patient, or other person in respect of the member’s practice.

Advertising should also not involve the pressuring of vulnerable clients or patients. Soliciting or permitting the solicitation of an individual in person, by telephone, through electronic communications or by similar means, is unprofessional. However, it is not solicitation to remind existing patients of appointments, new developments or changes in the office.

#### *Advertising Scenario*

*Y has just started performing a new procedure with her patients that helps reduce redness and inflammation of the skin and is noticing great results. She wants to let other people know she now does this procedure so that patients can choose to come to her for it, or maybe even have another health care provider refer patients to her. She adds her weekly advertisement in the community paper with a description of the service. She makes sure the description only describes the procedure and does not offer any guaranteed outcomes, compare it to other procedures or provide reasons why she might be a better choice because she performs this procedure. However, she wants people to know the great results she has been seeing with her patients. So, with the consent of a few of her patients, she takes some before and after pictures and publishes them in the local paper. She feels that people can decide for themselves based on the pictures if they want to try the procedure. Unfortunately, in doing so Y has violated the advertising standards of her profession. Before and after pictures are inherently misleading as they cannot be verified for authenticity, and involve comparisons in order to promote a specific procedure. Also, before and after pictures may be construed as suggesting an outcome, or a guarantee, that cannot always be expected.*

### Sample Exam Question

1. Advertising needs to be:
  - i. Accurate.
  - ii. Verifiable.
  - iii. Not contain personal opinions.
  - iv. All of the above

*Answer iv) is the best answer. All of the qualities are those that are required of advertising. There are more qualities that advertisements should be such as factual, objective, comprehensible, and appropriate. Answer i) is not the best answer because all of the qualities listed in the question are fine. Answer ii) is not the best answer because all of the qualities listed in the question are fine. Answer iii) is not the best answer because all of the qualities listed in the question are fine.*

#### **d. The College**

The College does a number of things in order to protect the public. Under its Act, the College has to set up various committees and operate various programs. The following are some of the most important processes the College carries out in the regulation of the profession.

##### **i. Registration process**

As mentioned above, registration is the way for a person to enter into the profession and become a member of the College if they meet the requirements set out in the registration regulation. The process of registration itself is fairly structured.

To become a member of the College a person files an application form with the Registrar, and pays the applicable fees. The form is available on the College website. Through the application form the applicant provides the College with information about his or her training and experience, his or her past conduct, and other information that may affect his or her ability to practise effectively (e.g., language skills, professional liability insurance, current experience, etc.). The applicant should provide enough information to demonstrate that he or she meets the requirements for registration. The applicant must not make any false statements on the application.

Where the applicant meets the requirements, the Registrar's office will simply accept the application. In this case, a certificate of registration is issued to the new member of the College.

However, if it appears that the applicant does not meet the registration requirements (or even if the Registrar is not sure) the Registrar will refer the application to the Registration Committee. The applicant will be told of the concern and will be given an opportunity to provide a written response to the concerns. The Registration Committee will consider the

application further and determine suitability to become a member. If the Registration Committee concludes that the applicant meets the requirements, a certificate of registration will be issued. If the Registration Committee concludes that the applicant does not meet the requirements it can make a number of decisions including:

1. Directing the applicant to complete further training or examinations.
2. Register the applicant with terms, conditions and limitations (for example, if the missing requirement is exemptible and the public can be protected in the circumstances).
3. Refuse the application.

If a certificate is not granted by the Registration Committee the applicant has further options. The decision may be appealed to the Health Professions Appeal and Review Board (HPARB). HPARB is appointed by the government and is independent of the College. HPARB will review the file and, if the applicant wishes, hear from witnesses. HPARB can determine that an applicant meets the registration requirements or requires the Registration Committee to obtain additional information and make a new decision. HPARB's decision can be appealed to the courts.

To ensure that a College's registration process is fair, the registration system itself is audited and reviewed through the Office of the Fairness Commissioner of Ontario. Further, the *RHPA* has provisions to ensure that the registration process of Colleges is transparent, objective, impartial and fair.

Where an applicant is registered in another part of Canada, the College must, with rare exceptions, accept the applicant's education, experience and examination credentials without further inquiry. The College can still review the other registration requirements (e.g., good character, professional liability insurance, jurisprudence, and, if not previously determined, language requirements).

#### *Registration Process Scenario 1 – Making False Statements*

*X filled out his application form for registration, but when asked if he had any previous criminal findings he did not want to put down the shoplifting conviction he received twenty years ago. He was worried it would affect his application. So, on his application he reported that he did not have any previous criminal findings. On the basis of the application form, the College registers X. A few years later the College is told about X's previous conviction. The College realizes that X made a false statement. The College can revoke X's registration because he made the false statement on the application form. Ironically, if X had disclosed the conviction, the Registration Committee would probably have accepted X for registration since he had had no difficulties in twenty years. However, making a false statement on the application form is so serious and reflects current dishonesty, such that now he will be removed from the profession.*

An applicant who has received a pardon or who has received a conditional or absolute discharge from court must still report the offence.

## ii. Complaints and discipline process

In order to protect the public, investigating concerns about a practitioner's professional conduct or competence is an essential element of self-regulation. Where a concern appears serious, disciplinary action must be taken. The College deals with professional misconduct and incompetence in an educational manner as often as possible. If a matter is referred for discipline, the College provides a fair procedure to the practitioner.

The following outlines how the complaints and discipline process works.

### *The ICRC*

The Inquiries, Complaints and Reports Committee (ICRC) is the statutory committee of the College that handles member-specific concerns (e.g., professional misconduct, incompetence and incapacity).

The ICRC can only handle concerns regarding members and some former members of the College. Further, the ICRC is only involved in allegations regarding professional misconduct, incompetence or incapacity. It does not handle claims about professional negligence (i.e., civil lawsuits), criminal or quasi-criminal offences of a member.

For professional misconduct and incompetence issues there are two main sources for concerns:

1. Formal complaints; and
2. Formal investigative reports (called Registrar's Reports).

Incapacity concerns are also handled by the ICRC but will be discussed in a later section because they are handled in a different way than complaints that bring a practitioner's conduct or competence into question.

### *Intake of Complaints*

For a complaint to be a formal complaint the following requirements must be met:

- the complaint must be in writing or recorded on tape, film, disk or other medium (as set out in the *Health Professions Procedural Code*);
- the complainant must be identified;
- the member must be identifiable (the ICRC may be able to assist in identifying the member based on the information provided by the complainant);
- the complaint must identify some conduct or actions that are of concern (i.e., not just the complaint that a member is "unprofessional", "incompetent" or "incapable" but instead including some level of detail to demonstrate those complaints); and
- the complainant must intend the matter to be a complaint.

The Registrar must give the member notice of the complaint. This must be done within fourteen days of the receipt of the formal complaint.

### *Intake of Registrar's Reports Investigations*

As mentioned before, the discipline process can be initiated by a Registrar's Report. In this method the following occurs:

- a concern arises that the Registrar believes warrants investigation and it is brought to the ICRC with the request for the ICRC to approve appointment of an investigator;
- an investigator is appointed;
- the investigation is conducted and the investigator makes a report to the Registrar; and
- the Registrar then makes a Registrar's Report to the ICRC.

Once a Registrar's Report is made to the ICRC, the matter proceeds very similar to the way it does with a complaint.

### *Investigations*

The investigations by the ICRC should be thorough but neutral, objective and fair.

#### 1. Complaints Investigations:

- **Frivolous or Vexatious Complaints:** There is one exception to the ICRC investigating every complaint. When it is 'frivolous or vexatious', made in bad faith, moot or is otherwise an abuse of process the ICRC can choose not to investigate it. This happens rarely. Generally, it must be fairly obvious that there is little merit to the complaint and the processing of the complaint is unfair in the circumstances. For example, a complainant repeating a complaint without any new evidence would be frivolous and vexatious. Notice is given to the member and complainant if the ICRC intends to take no action in these cases.
- **Investigative Steps:** Both complainant and member are usually first asked to provide all documentation available to them. The ICRC staff gathers additional information until they determine it is likely that all reasonable and available evidence has been obtained. Information is gathered from a variety of sources including College files, public databases (i.e., court files), other regulators, witnesses and other practitioners.
- **ICRC Decision:** At the completion of the investigation the ICRC makes its decision about the complaint.
- **Time Limits:** A complaint is filed when it is delivered in written form to the Registrar of the College. A complaint is supposed to be completed within 150 days of it being filed with the College. After that the parties must be notified regularly about the

progress of the complaint. If the College takes too long, the complainant or the member can ask the Health Professions Appeal and Review Board to take action.

## 2. Registrar's Reports on Investigations:

- There are three types of appointment of investigators that can occur from this method: 1) Concerns that come to the attention of the Registrar; 2) Request made by the ICRC to help investigate a complaint, and; 3) Information from the Quality Assurance Committee.
- Any concern that is about the conduct or actions of a member that is not a formal complaint is generally brought to the attention of the Registrar. If a Registrar is of the view that there are reasonable and probable grounds that the member engaged in significant professional misconduct or is incompetent, the Registrar brings the concerns to the attention of the ICRC. The ICRC is asked to approve appointment of an investigator.
- Complaints Investigations: If the ICRC cannot obtain important information about a complaint on its own (e.g., a person refuses to provide it), the ICRC can ask the Registrar to use his or her special powers to help.
- Appointments based on Quality Assurance Committee Information: Where a member does not co-operate with the quality assurance process, or the process has revealed significant concerns regarding professional misconduct, incompetence or incapacity, the Quality Assurance Committee can bring the concern to the ICRC. The ICRC can decide whether to appoint an investigator.
- The Investigation: The investigator appointed by the Registrar has special powers. For example, he or she can enter the office of the practitioner and examine files, can summons documents and can compel witnesses to answer questions.
- Time limits: There is no set deadline to complete a Registrar's Report on Investigation and render a decision. However, they should be completed within a reasonable time.

### *ICRC Disposition (Decision)*

Once the investigation is completed the ICRC makes a decision on the issues. There are many options for the ICRC. Discipline is not the only option. The ICRC is a 'screening' body. The ICRC cannot make findings of credibility on disputed facts, find wrongdoing (i.e., professional misconduct, incompetence), or impose a disciplinary sanction (i.e., fine or suspension). Only the Discipline Committee can do these things. The following are some of the dispositions that can take place.

- **Withdrawal of Complaint:** If a complainant wishes to withdraw a complaint, the ICRC can still decide to proceed with the investigation. The ICRC has to decide whether to accept a withdrawal of a complaint.

- **Disposition by Undertaking:** This means that a member promises to do certain things (or refrain from doing certain things). An undertaking then results in the ICRC taking no further action because the undertaking addresses the concern.
- **Referral to Discipline:** Discipline is intended for serious concerns (e.g., dishonesty, breach of trust, wilful disregard of professional values, inability to practice competently). Even then the ICRC must ensure that there is reasonable evidence to support the concern.
- **Referral for Incapacity Proceedings:** This is where the conduct may be due to an illness or health condition. The procedure is described separately below.
- **Appearance for a Caution:** The member can be required to appear before the ICRC for a verbal caution. Usually this is accompanied with the statement that, if the circumstances do not change, the member will face more formal action.
- **Other Actions:** The ICRC can be creative in their decisions and solutions. For example the ICRC can require the member to undergo a specified continuing education and remediation program (e.g., a record keeping course).
- **Taking No Action:** If there is no basis for concern the ICRC can close (or dismiss) the complaint. Reasons must be given for taking no action.

### *Review Before HPARB*

In a complaint matter, either party (i.e., the complainant or the practitioner) may seek a review of an ICRC decision before the Health Professions Appeal and Review Board (HPARB) (unless the decision was referred to discipline proceedings or for incapacity proceedings). HPARB may confirm a decision of the ICRC or return the matter to the ICRC to make a new decision. HPARB can also make recommendations to the ICRC.

### *Discipline Proceedings*

All discipline matters are referred to discipline by the ICRC. Formal complaints and other matters first go through the ICRC, and are investigated by the ICRC. The ICRC refers specified allegations to the discipline process, and the discipline process is confined to evaluating those allegations.

In very serious cases the ICRC may make an interim order (for example, the suspension of the member's certificate of registration) to protect the public while awaiting a discipline hearing. It is only used when absolutely necessary to protect patients from harm.

### *Procedure before the Hearing Starts*

- Notice of the hearing officially initiates proceedings before the Discipline Committee. The notice contains information necessary to ensure that the member can participate effectively in the hearing. It usually is accompanied by a statement of allegations

outlining the facts, and legal conclusions to be drawn from the facts (i.e., incompetence, or category of professional misconduct).

- Disclosure of all relevant information in the College's files is made to the practitioner. Disclosure will enable the practitioner to present the best possible defence.
- The Chair of the Discipline Committee selects a panel from among the members of the Discipline Committee to hold the hearing for any allegations referred to it. It is usually five people (two must be public members, and three are usually professional members). These decision makers must be disinterested and unbiased.
- Prehearing conferences may be held before the discipline hearings. This is to reach an agreement on as many issues as possible, and to plan the hearing. Discussions at pre-hearing conference are 'off the record'. If a resolution is agreed upon (e.g., settlement) it is presented to the panel of the Discipline Committee for acceptance.

#### *Procedure at the Discipline Hearing*

- The procedure of a discipline hearing is formal. It is similar to a court case in that there are two sides that each present their arguments and evidence to the panel. Usually both the College and the practitioner are represented by lawyers. The Discipline Committee panel ensures that the cases are presented fairly, they listen impartially to the evidence and arguments, and after both parties have completed their presentations the panel decides on the issues.
- The hearing is open to the public unless there is some compelling reason for privacy in order to uphold transparency and fairness in the process. There are only a few limited exceptions where the hearing may be closed (e.g., a person's health privacy interests might be disclosed and outweigh the interests in a public hearing).
- The College presents its witnesses first. Then the practitioner is permitted to call his or her witnesses. The practitioner may choose to testify. The College can then call witnesses to reply to what the practitioner's witnesses said.

#### *Evidence at the Discipline hearing*

- Generally, rules of evidence that apply to civil court trials apply to discipline hearings.
- Decisions are to be based exclusively on the evidence admitted before it. The Committee cannot rely on any knowledge to make a finding that was not presented as evidence.
- A record is kept compiling all the exhibits of evidence.

#### *Findings of Professional Misconduct*

- Once a Discipline Committee determines what a practitioner has done, it must then decide whether or not that behaviour constitutes professional misconduct as is outlined in the *RHPA* and the regulations (as described above).

### *Findings of Incompetence*

- Incompetence is different from professional misconduct. It generally does not involve unethical or dishonest conduct, but rather that the practitioner does not have the knowledge, skill and judgment to practise safely. It is assessed based on the care of one or more of the practitioner's patients.
- A finding of incompetence can either be that the practitioner is unfit to continue to practice, or that the member's practice should be restricted.

### *Decisions and Orders in Discipline Cases*

If a practitioner has been found to have engaged in professional misconduct, the Discipline Committee can make one or more of the following orders:

- Revocation – the removal of the member from the profession (lasts at least a year, then the practitioner must satisfy the Discipline Committee that he or she ought to be permitted back into the profession).
- Suspension – the temporary removal of a member from the profession. It can be fixed or flexible, or dependent on an event occurring (e.g., successful completion of a course).
- Terms, conditions or limitations – can either be for a specified period (e.g., until the practitioner successfully completes certain remedial training) or for an indefinite period (e.g., the practitioner cannot consume any alcohol). The terms, conditions or limitations must be related to the finding made by the Discipline Committee. For example, if the practitioner was dishonest because of a substance abuse problem, the condition cannot be to take remedial education courses because there was no finding that the practitioner lacked any basic knowledge.
- Reprimand – conversation between the Discipline Committee and the practitioner where the Committee tells the practitioner its views of his or her conduct and how to avoid similar problems in the future.
- Fine – the Discipline Committee can impose a fine of up to \$35,000.
- Reimbursement for funding in sexual abuse cases – in a finding of sexual abuse the Discipline Committee can require a practitioner to reimburse the College for any funding provided to the patient.
- Minimum order in sexual abuse cases – cases involving frank sexual acts have a mandatory minimum order of both a reprimand and revocation. No reinstatement can be made for five years after revocation on these grounds.
- Costs can be ordered by the Discipline Committee to cover a portion of the expenses associated with the hearing.

In incompetence cases, the Discipline Committee can order revocation, suspension or terms conditions and limitations.

The Discipline Committee must issue both a written decision and written reasons.

### *Appeals*

There is an option for appeal to the Divisional Court by any party at the discipline hearing. The Divisional Court has the power to confirm, amend or reverse a decision of the Discipline Committee if it acted unreasonably or made an error of law.

### *Complaints and Discipline Scenario – The Typical Complaint*

*A patient sends a letter of complaint to the College saying that X, a practitioner, was rude to her. The patient says that X became angry when she expressed concern that the treatment was not working. The patient says that X “threw her out of the office”. The Registrar sends a letter notifying X of the complaint and asking for a response. X responds that the patient was extremely challenging and after doing all that he could for the patient the patient became verbally abusive and X had to terminate the professional relationship. X’s letter is sent to the patient who replies that she was never verbally abusive to X and that X is making this up to defend himself. The Inquiries Reports and Complaints Committee (ICRC) obtains statements from the patient’s husband, X’s receptionist and a couple of patients who were around at the time. It is difficult to reconcile the stories but the picture that emerges is that there was a verbal confrontation in which both parties may have used intemperate language. The ICRC decides that this is not a case for discipline, particularly since there have been no previous complaints about X. However, the ICRC sends X a letter of caution reminding him of the need to be professional in his dealing with patients even in challenging circumstances.*

### **iii. Incapacity process**

As noted above, incapacity has a particular definition when it refers to a practitioner under the *Regulated Health Professions Act*. It relates to a practitioner having a physical or mental condition which may warrant some restrictions on his or her practice. This section focuses on what happens when incapacity becomes a concern.

The intent of the incapacity provisions is not to punish a practitioner who is ill. The goal of the incapacity process is to ensure that the member receives appropriate treatment and is supervised and monitored sufficiently closely so that he or she can continue to practice without undue risk to the public. Only on rare occasions will the practitioner have his or her certificate of registration suspended or revoked by the Fitness to Practise Committee.

### *Concern of Incapacity Initiated*

When incapacity becomes a problem for a practitioner, the concern is brought to the Inquiries, Complaints and Reports Committee (ICRC) either by the Registrar, or by another panel of the ICRC. The information of possible incapacity can come from a number of sources including a law enforcement agency, a mandatory report by an employer, or an expression of concern by a member of the profession or the public.

### *ICRC Inquiry*

Once an ICRC panel is selected, notice is given to the member that the ICRC panel intends to inquire into whether the member is incapacitated. The ICRC inquiries panel is an investigative body. Its role is to gather information and then determine if formal proceedings should be initiated. The inquiry may involve any (or all) of the following:

- an interview with the practitioner;
- a review of any relevant information that might be contained in other College files;
- obtaining witness statements from patients, co-workers, colleagues, family members, and others who have observed the practitioner's behaviour recently, particularly any unusual behaviour;
- obtaining hospital and office charts of relevant treatment of the practitioner;
- obtaining a report from health practitioners who have treated the member; and
- ordering a specialist examination of the practitioner.

The ICRC must prepare a report of its inquiries, and a copy must be sent to the practitioner. The ICRC determines if the matter should be referred to the Fitness to Practise Committee for a hearing.

### *ICRC Decision to refer to Fitness to Practice Committee for hearing (or not)*

The matter is only referred when the practitioner's problem is serious. The decision to refer to the Fitness to Practice Committee for a hearing is not taken lightly and there must be sufficient evidence of, and a reasonable prospect of finding, incapacity. This is usually when there is some concern that the member's illness will, now or in the future, affect his or her professional practice negatively. Typically, it involves a lack of insight by the practitioner into the extent of his or her condition.

The ICRC can make an order that directs the Registrar to suspend the certificate of registration of the member, or to impose terms, conditions, or limitations on the member, temporarily until the Fitness to Practice Committee addresses the matter.

### *Hearing before the Fitness to Practice Committee*

The hearings before the Fitness to Practice Committee share many similarities with the hearings before the Discipline Committee. Generally, the procedure at a Fitness to Practice hearing is as follows:

- Panel is selected by the chair of the Fitness to Practice Committee – consists of at least three people, at least one of whom is public member of College Council.
- Disclosure of evidence – the College has the same disclosure obligations as in discipline hearings.
- Closed hearing – ordinarily fitness to practice hearings are closed to the public (as set out by the *RHPA*) because of the personal nature of such a hearing (and because the hearing is not meant to be punishment to the practitioner). Only the practitioner can request that the hearing be opened to the public.
- Order of hearing – similar to discipline hearing. The burden of proving the practitioner is incapacitated lies upon the College. The College presents its case first.

### *Decisions of Fitness to Practice Hearing*

The Fitness to Practice Committee must determine if the practitioner is indeed incapacitated. As mentioned, this requires that the member has a physical or mental condition and that the condition warrants in the public interest some restrictions on the member's practice (e.g., supervision or treatment). This will be based upon evidence presented at the hearing, usually involving expert evidence on the member's health status. It is determined with consideration of the present status of the member's health, and not in the past (which is different from a discipline hearing).

If the Fitness to Practice Committee finds the member to be incapacitated, it must also decide what restriction to place on the member's certificate of registration. It can revoke a member's certificate, suspend a member's certificate, or impose terms, conditions or limitations on the member's certificate of registration. Usually terms, conditions or limitations on the certificate are made. For example, an order for treatment followed by monitoring and supervision.

The Committee can vary their orders, meaning they can adjust the decision to suit the situation more as it changes over time. A party can bring a motion for the Committee to vary an order. For instance, if a practitioner establishes a period of time that his or her illness has been in remission (i.e., sobriety) there can be a loosening of the restrictions on his or her certificate of registration.

### *Appeals*

There is an option for appeal to the Divisional Court by any party at the hearing before the Fitness to Practice Committee. Despite an appeal being made, any order from the Fitness to Practice Committee takes effect while the appeal is pending.

### *Fitness to Practise Scenario – The Typical Case*

*X is a practitioner working with J, another practitioner. J reports to the College that he is terminating his partnership with X because X's drinking is beginning to affect his work. J is tired of covering for X when he comes to the office two hours late after a binge. The Registrar makes some inquiries that tend to confirm J's report. X, however, denies he has any problems. The Registrar reports the matter to the ICRC. The ICRC asks X for consent to obtain a copy of his medical records, which X provides. Those records indicate that X has separated from his wife who accuses him of drinking and that X has recently been charged with impaired driving. The ICRC directs that X attend an assessment with a specialist in substance abuse disorders. The report from the specialist indicates that X clearly has a substance abuse disorder. The ICRC refers X to the Fitness to Practise Committee for a hearing and suspends X's certificate of registration until the hearing can be completed. X enters and successfully completes a thirty-day in-patient treatment program for substance abuse and is an active participant in the recommended after-care program. At the Fitness to Practise Hearing X's lawyer and the College's lawyer present a joint submission asking the Committee to find that X is incapacitated, as defined in the statute, and ordering that X's certificate of registration be restored on the condition that he continues in regular treatment; that he works with another practitioner who will monitor his performance at work and make regular reports to the College on his progress.*

#### **iv. Quality Assurance Program**

##### *(a) Purposes of the program*

Every College must have a quality assurance program. The quality assurance program is intended to assist practitioners improve and enhance their practice by participating in professional development activities and receiving constructive feedback.

The quality assurance program is not a form of discipline. No information about a practitioner that the College obtains through the quality assurance program may be used by the College to discipline a practitioner or by any person in any legal proceeding. At most the Quality Assurance Committee can report the practitioner's name and alleged misconduct to the Inquiries, Complaints and Reports Committee. The only exception is where the member makes a false statement to the College or fails to cooperate with the program.

The quality assurance program is administered by the Quality Assurance Committee of the College (the "Committee"). The quality assurance has the following components:

- Professional development,
- Self, peer and practice assessments, and
- Monitoring of members' participation in and compliance with the program.

*(b) Self-assessment and professional development*

Practitioners must participate in self-assessment and professional development activities. For example, practitioners may be asked to fill out a form prepared by the College that describes the nature of his or her practice, the skills needed to practice well and a description of what the practitioner could do to improve those skills. The practitioner could then take a course or otherwise improve those skills. Practitioners are required to record these activities so that the College can monitor them. A practitioner must produce his or her record upon the request of the College.

Professional development activities allow practitioners to remain informed about changes and innovations in practice standards and techniques, and develop skills and knowledge of inter-professional collaboration.

*(c) Peer and practice assessment and remediation*

Every year, the Committee selects practitioners to participate in peer and practice assessments. This allows the Committee to assess practitioners' skill, knowledge and judgment.

*Selection of members*

Practitioners may be randomly selected for a peer and practice assessment. A practitioner may also be selected if the College asks to see the practitioner's record of self-assessment and professional development activities, and the record is incomplete or inadequate. The College may also develop other criteria for selecting practitioners for peer and practice assessments (e.g., practitioners who have not practised much for a few years and whose knowledge, skill and judgment may not be quite up to date). These criteria will be published on the College's website.

*Practice assessors*

A peer and practice assessment is conducted by an independent practice assessor appointed by the Quality Assurance Committee. Often those assessors will be practitioners. A practice assessor may review a practitioner's education, professional development and self-assessment records. A practice assessor can also obtain information about a practitioner's practice by various methods including visiting the practitioner's office.

Practitioners must cooperate with an assessment. In particular, during a peer and practice assessment, practitioners must:

- Permit the assessor to enter and inspect the premises where the practitioner practices; however, assessors may not enter a practitioner's home;

- Permit the assessor to inspect the practitioner's records of the care of clients, even if they are confidential;
- Give the assessor any information requested regarding the care of clients or the practitioner's records, and
- Meet with the assessor upon request.

At the time of writing, the College has not yet decided how it will conduct its practice assessments.

#### *Role of the Committee*

Following a peer and practice assessment, the practice assessor will prepare a report for the Committee. The practice assessor's role is simply to review and report on a practitioner's practice, and not to make any rulings about the practitioner's practice.

The Committee's role is to determine if the practitioner's knowledge, skills or judgment are satisfactory. If the Committee is of the opinion that the practitioner's knowledge, skills or judgment are not satisfactory, the Committee may do any of the following:

- Require a practitioner to participate in continuing education or remediation programs;
- Direct the Registrar to impose terms, conditions or limitations on the practitioner's certificate of registration for a specified period of time; or
- If the Committee believes the practitioner may have committed an act of professional misconduct, or may be incompetent or incapacitated, the Committee may disclose only the name of the practitioner and the allegations against the practitioner to the Inquiries, Complaints and Reports Committee.

Since the quality assurance program is educational and supportive in nature, it will be rare for the Committee to direct anything other than upgrading (e.g., courses or seeing a mentor) even in cases where there are significant gaps in the practitioner's knowledge, skill and judgment.

The Committee must consider any written submissions by the practitioner before taking any action.

#### *Quality Assurance Scenario No. 1*

*Y, a practitioner, is asked by the College to provide her record of professional development and self-assessment activities. Y has not kept any record of professional development activities. A practice assessor is appointed. The practice assessor meets with Y, and reviews her professional development and self-assessment activities. The practice assessor prepares a report for the Committee that describes the professional development activities that Y participated in. The Committee may decide that there is no*

*reason to take any action because Y has learned from this experience about the importance of keeping records of professional development activities.*

### *Quality Assurance Scenario No. 2*

*X, a practitioner, is randomly selected for a peer and practice assessment. A practice assessor is appointed. X cooperates with the practice assessor's review of his records and inspection of his office. The practice assessor provides a report to the Committee, who reviews the report and finds that X has not been keeping adequate clinical records. The Committee gives X an opportunity to respond in writing. After reviewing X's response, the Committee decides that X must take a record keeping course. The Committee also directs that X's practice be reassessed in one year's time to see if there has been an improvement.*

### *Sample Examination Question*

- If a practitioner is selected for a peer and practice assessment, the practitioner should:
- i. Cooperate with the practice assessor's review, including permitting the assessor to inspect his or her office and upon request provide any requested records.
  - ii. Permit the practice assessor to inspect his or her home.
  - iii. Give the assessor all records except those that are confidential.
  - iv. Complete all required professional development records and fill in gaps in client records before sending them to the practice assessor.

*The best answer is i). Practitioners have a duty to cooperate with peer and practice assessments. Answer ii) is the not best answer because practice assessors are not permitted to enter private homes. Answer iii) is not the best answer because the practice assessor's right to access premises and records overrides patient confidentiality. Answer iv) is not the best answer because while a practice assessment is a good opportunity to improve record keeping and other practices, a practitioner should always update client records immediately so that they are accurate. Practitioners should never wait until they are selected for an assessment to update their records. Additionally, if records are falsified, the Committee may report the practitioner's name and this allegation to the Inquiries, Complaints and Reports Committee.*

#### **e. Other laws**

##### **i. PHIPA**

###### *(a) Personal health information*

Practitioners have a legal and professional duty to protect the privacy of patients' personal health information. The *Personal Health Information Protection Act* ("PHIPA") governs

practitioners' use of personal health information, including its collection, use, disclosure and access. This Act helps guide the general duty of confidentiality described above.

Personal health information refers to almost anything that would be in a practitioner's files on a patient. It is defined in PHIPA as written or oral identifying information about a person, if the information:

- (a) Relates to the person's physical or mental health, including the person's family health history;
- (b) Relates to the providing of health care to the person, including the identification of a person as someone who provided health care to the person;
- (c) Is a plan of service within the meaning of the *Home Care and Community Services Act, 1994* for the person;
- (d) Relates to the person's payments or eligibility for health care, or eligibility for coverage for health care;
- (e) Relates to the donation by the individual of any body part or bodily substance of the person or is derived from the testing or examination of any such body part or bodily substance;
- (f) Is the person's health number; or
- (g) Identifies a person's substitute decision-maker.

*(b) Health Information Custodians*

A Health Information Custodian ("Custodian") is the person or organization responsible for all health records. The Custodian must create, implement and oversee a privacy policy that meets the requirements of PHIPA.

A sole practitioner is the Custodian over any health information and records that the practitioner collects.

If a practitioner works for a health services organization such as a hospital or long-term care home, the organization is the Custodian of health records.

Two or more practitioners who work together may decide to act as a single organization for the purposes of PHIPA. This may be helpful because the practitioners can create a single privacy policy. This would allow for consistent health record keeping practices. In this case the practitioners will have shared responsibility for complying with PHIPA.

*(c) Information Officers*

PHIPA requires every practitioner and organization to appoint a contact person (often called an Information Officer). An Information Officer is the person who ensures compliance with the privacy policy and requirements of PHIPA. The Information Officer's duties include reviewing

the organization's privacy practices, providing training, and monitoring compliance. The Information Officer is also the contact person for public information requests.

A sole practitioner has to act as Information Officer himself or herself. A health services organization may appoint a person within the organization, or may hire a person outside of the organization to be its Information Officer.

#### *PHIPA Scenario*

*Three practitioners work together in an office. They decide they will act as an organization for privacy purposes. Their organization is the Health Information Custodian. The practitioners create a privacy policy together. The practitioners decide to appoint the most senior practitioner to be the Information Officer. The Information Officer creates a procedure to protect personal information, develops a privacy complaints procedure, and ensures that all practitioners comply with the privacy policy.*

#### *(d) Protecting personal health information*

Custodians must put in place practices to protect personal health information in their custody or control.

Practitioners or organizations must take appropriate measures to protect personal health information from unauthorized access, disclosure, use or tampering. The nature of those safeguards will vary depending on the sensitivity of the information and the circumstances. Personal health information is generally considered highly sensitive. Those safeguards must include the following components:

- physical measures (e.g., restricted access areas, locked filing cabinets),
- organizational measures (e.g., need-to-know and other employee policies, security clearances), and
- technological measures (e.g., passwords, encryption, virus protection, firewalls).

Practitioners or organizations need to systematically review all of the places where they may temporarily or permanently hold personal health information and assess the adequacy of the safeguards. Almost every organization will find that it needs to make changes.

Practitioners or organizations also need to securely retain, transfer and dispose of records in accordance with the College's requirements. For example, the College requires that patient records be kept for ten years from the last contact with the patient (or if the patient was not an adult at the last contact, ten years from when the patient turned 18).

A practitioner or organization's privacy policy should explain how health information will be protected.

*(e) Collection, use and disclosure of personal health information*

A practitioner or organization must only collect, use, or disclose a person's personal information if the person consents and the information is necessary, or if the collection, use or disclosure is otherwise permitted or required by law. A practitioner should collect, use or disclose no more information than is reasonably required in the circumstances.

A practitioner's or an organization's privacy policy should clearly explain how and when personal health information will be collected, used and disclosed.

Under PHIPA, collection, use and disclosure of personal health information is permitted without consent in limited circumstances.

*Circle of Care*

A practitioner can share personal health information with other individuals within a patient's "circle of care" for the purposes of providing health care, without the patient's express consent. A circle of care may include other health professionals who provide care to the same patient. A practitioner may assume that he or she has a patient's implied consent to disclose personal health information to other health providers in the patient's circle of care.

A practitioner who is working in a multidisciplinary setting may share personal health information with other health care professionals who are providing care to the same patient, because these other health care professionals are within the patient's circle of care.

A practitioner who refers a patient to another health professional may consider that health professional to be within the patient's circle of care.

The circle of care of a sole practitioner's patient may also include other health care providers in other institutions, if it is necessary for providing health care to the individual, and it is not reasonably possible for consent to be obtained in a timely manner. However, many practitioners do not share information with others in the health care team without the patient's explicit consent unless it is an emergency so as to avoid misunderstandings. This caution is particularly important where the information is sensitive.

The exception to this principle is that if a patient or patient's substitute decision maker says that he or she does not want the information to be shared. The information must then be put in a "lock box" and cannot be shared unless another provision in PHIPA permits it.

### *Circle of Care Scenario*

*Y, a practitioner, receives a telephone call from a registered nurse at a local hospital. The nurse advises Y that her patient has just been admitted to the hospital. The nurse reports that she has been unable to contact the patient's substitute decision-maker (SDM). The nurse wants to know about what treatment Y has been providing to the patient. Y recalls that the SDM told her never to share the patient's personal health information with any other health care provider. In this case, the "circle of care" principle does not allow Y to disclose her patient's personal health information. However, an exception, noted below, applies if Y believes on reasonable grounds that the disclosure would reduce a risk of serious harm to the patient (or any other person). Thus Y tells the registered nurse about the patient's treatment so that the patient can receive emergency care.*

#### *Family and friends*

Generally speaking, consent should be obtained before sharing personal health information with members of a person's family.

However, personal health information may be disclosed for the purposes of contacting family members, friends, or other persons who may be potential substitute decision-makers, if the individual is injured, incapacitated, or ill, and cannot provide consent. This may be particularly relevant for practitioners working in acute care settings.

#### *Disclosure related to risk*

A practitioner may disclose a person's personal health information if the practitioner believes on reasonable grounds that the disclosure is necessary to eliminate or reduce a significant risk of serious bodily harm to the person or anyone else.

For example, if a patient has threatened to kill someone, the practitioner can warn the person being threatened and the police. The practitioner could share information about the patient that will help the police to deal with the threat.

#### *Other laws*

PHIPA permits disclosure of personal health information that is permitted or required by many other Acts, including the following:

- The *Health Care Consent Act* or *Substitute Decisions Act* for the purposes of determining, assessing or confirming capacity;
- Disclosure to a College acting under the *Regulated Health Professions Act*; and
- Disclosure to an investigator or inspector who is authorized by a warrant or by any provincial or federal law, for the purposes of complying with the warrant or facilitating the investigation or inspection.

Additionally, as discussed above in the section of the book on Mandatory Reports, there are some circumstances in which disclosure of personal health information is mandatory.

*(f) Access to personal health information*

Every patient has a right to access his or her own personal health information. One important exception is if granting access would likely result in a risk of serious harm to the patient's treatment or recovery, or a risk of serious bodily harm to the patient or another person. Many students of privacy law believe that "bodily harm" includes mental or emotional harm.

If a person makes a request to access personal health information, the practitioner or organization must:

- permit the person to see the record and provide a copy at the person's request;
- determine after a reasonable search that the record is unavailable, and notify the person of this as well as his or her right to complain to the Information and Privacy Commissioner; or
- determine that the person does not have a right of access, and notify the person of this as well as his or her right to complain to the Information and Privacy Commissioner.

The Information and Privacy Commissioner may review the practitioner's or organization's refusal to provide a record, and may overrule the decision.

If the law does not permit disclosure for any reason, a practitioner should black out those parts that should not be disclosed if it is reasonable to do so, so that the patient may access the rest of the record.

*Sample Exam Question*

Which of the following best describes a patient's right to access personal health information contained in a practitioner's records?

- i. A patient has an unrestricted right to access his or her personal health information.
- ii. A patient generally has a right to access his or her health information, and has a right to complain to the Information and Privacy Commissioner if access is refused for any reason.
- iii. A patient has a right to access his or her health information unless the practitioner believes it is not in the patient's best interests to see the information.
- iv. A patient can request a copy of a record containing his or her personal health information, but a practitioner does not have to provide it.

*The best answer is answer ii). A patient's right to access his or her health information is broad but has some legal limits. However, even if access is refused for an appropriate reason, the patient is entitled to bring a complaint to the Information and Privacy Commission. Answer i) is not the best answer because the right to access personal health information may be restricted in some circumstances (e.g., where there is a serious risk of significant bodily harm). Answer iii) is not the best answer because a practitioner's opinion about whether it is good for the patient to see the record is irrelevant. Only if the practitioner believes on reasonable grounds that viewing the information would seriously harm the patient's treatment, may access be refused. Answer iv) is not the best answer because a practitioner does not have a general right to refuse a person access to personal health information.*

### *Correction of personal health information*

Individuals generally have a right to request corrections to their own personal health information. A practitioner or organization receiving a written request must respond to it by either granting or refusing the request within thirty days. It is wise to respond to verbal requests as soon as possible as well. If the request cannot be fulfilled within thirty days the person should be advised of this in writing.

Corrections to records must always be made in a way that allows the original record to be traced. The original record should never be destroyed, deleted, or blacked out. If the record cannot be corrected on its face, it should be possible for another person accessing the record to be informed of the correction and where to find the correct information. The person should also be notified of how the correction was made.

At the person's request, the practitioner should notify anyone to whom the practitioner has disclosed the information of the correction. The exception to this is if the correction will not impact the person's health care or otherwise benefit the person.

The practitioner or organization may refuse the request if the practitioner or organization believes the request is frivolous or vexatious ; if the practitioner did not create the record and does not have the knowledge, expertise and authority to correct it; or if the information consists of a professional opinion made in good faith. In other words, corrections are limited to factual information, not professional opinions.

A practitioner who refuses to make a correction must notify the person in writing, with reasons, and advise the person that he or she may:

- prepare a concise statement of disagreement that sets out the correction that the practitioner refused to make;

- require the practitioner to attach the statement of disagreement to his or her clinical records, and disclose the statement of disagreement whenever the practitioner discloses related information;
- require the practitioner to make all reasonable efforts to disclose the statement of disagreement to anyone to whom the practitioner has previously disclosed the record; or
- make a complaint about the refusal to the Information and Privacy Commissioner.

### *Complaints*

Every organization must have a system in place to deal with complaints regarding personal health information. Patients should also be aware of their right to complain to the College and/or to the Information and Privacy Commissioner.

## **ii. PIPEDA**

Another privacy law that practitioners should be aware of is the Personal Information Protection and Electronic Documents Act (PIPEDA). PIPEDA is a federal law that governs the collection, use, and disclosure of personal information in relation to commercial activity other than health care.

PIPEDA applies only to commercial activities of practitioners, such as the sale of products at practitioners' offices, and the offering of educational sessions. Unlike PHIPA, which governs personal health information, PIPEDA governs all types of non-health personal information. Examples of personal information include the person's name, date of birth, and home address.

The following ten privacy principles apply to practitioner's commercial activities:

1. **Accountability**: Someone in an organization (the "privacy officer", sometimes called an "information officer") must be accountable for the collection, use, and disclosure of personal information. The privacy officer must develop privacy policies and procedures, and ensure that staff receives privacy training.
2. **Identifying Purposes**: An organization must identify the purposes for which personal information will be used at the time that the information is collected.
3. **Consent**: Informed consent is required to collect, use, and disclose personal information except in limited circumstances (e.g., in emergencies or where the law otherwise permits this).
4. **Limiting Collection**: An organization must only collect the information that is necessary to collect for the identified purposes.
5. **Limiting Use, Disclosure, and Retention**: An organization must only use, disclose and retain personal information that is necessary, for the identified purposes and is obtained with consent. It should be retained no longer than necessary.
6. **Accuracy**: An organization must make reasonable efforts to ensure that any personal information collected is accurate, complete, and up-to-date.

7. Safeguards: An organization must protect personal information with appropriate safeguards in order to protect against loss, theft, unauthorized access, disclosure, copying, use, or modification.
8. Openness: An organization must make its privacy policies readily available.
9. Individual Access: Upon request, an individual must be informed of the existence, use, and disclosure of his or her personal information, and be given access to it. An individual can request corrections to the information. Access may be prohibited in limited circumstances such as the privacy of other persons, prohibitive cost to provide it, or other legal reasons.
10. Challenging Compliance: An organization must have a complaints procedure relating to personal information and must investigate all complaints.

As you can see, PHIPA and PIPEDA are based on the same principles. PHIPA simply provides more details about how to achieve those principles in the health care context.

### iii. **Health Care Consent Act**

The Health Care Consent Act (“HCCA”) sets out rules about consent to treatment especially where there is concern about the capacity of the patient to consent to treatment. The topic of informed consent is dealt with in detail above. In brief, except in cases of emergency, informed consent for any assessment or treatment must be obtained from either the patient. If the patient is incapable, informed consent is obtained from the patient’s substitute decision maker.

Where there is a dispute about the care of incapable patients, the decision-making body responsible for making decisions regarding consent and capacity in Ontario is the Consent and Capacity Board (“CCB”). A practitioner, patient, or substitute decision-maker may apply to the CCB when a decision relating to a patient’s consent or capacity needs to be made. The powers of the CCB include the following:

- The CCB can consider a patient’s challenge to a decision by a practitioner that he or she is incapable with respect to a treatment. The CCB may agree with the health practitioner, or may overrule the practitioner and find that the patient is capable with respect to the treatment. If the CCB overrules the practitioner, the practitioner cannot administer the treatment unless the patient consents.
- The CCB can provide direction to a substitute decision-maker with respect to an incapable person’s wishes (e.g., whether the wish applies to the circumstances, or whether or not the wish was expressed when the person was capable).
- The CCB can also consider a request from a substitute decision-maker to depart from a person’s wish that was expressed while the person was capable.
- The CCB can review decisions regarding a person’s capacity to consent to treatment, admission to care facilities, or the use of a personal assistive service.

- The CCB can appoint a substitute decision-maker to make decisions for an incapable person with respect to treatment, admission to a care facility or use of a personal assistance service.
- The CCB can amend or terminate the appointment of a representative.
- The CCB can review a decision to admit an incapable person to a hospital, psychiatric facility, nursing home or home for the aged for the purpose of treatment.
- The CCB can review a substitute decision maker's compliance with the rules for substitute decision-making.

A patient may challenge a decision of the CCB by appealing to the courts.

#### *Health Care Consent Act Scenario*

*X, a practitioner, is of the opinion that a patient is not capable with respect to a proposed treatment. The patient does not agree with this decision, and decides to challenge it at the CCB. The CCB holds a hearing. It receives testimony from both X and the patient, and concludes that the patient is capable of consenting to the treatment. The patient tells X he is refusing to consent to the treatment. In this situation, X cannot administer the treatment, even if X believes the treatment is in the patient's best interests.*

#### **iv. Child and Family Services Act**

A practitioner who suspects that any child is in need of protection must report this to a children's aid society (CAS). This duty overrides all privacy and confidentiality duties and laws, including PHIPA. No legal action can be taken against a practitioner for making a report, unless the report is made maliciously or without reasonable grounds. The College cannot discipline a practitioner for making such a report in good faith and with reasonable grounds.

As a result of a report, a CAS worker may investigate the report further, and where action is needed, in many cases a CAS will offer a family such services as counseling and parenting. A report to a CAS will not usually result in a child being taken away from a family.

A practitioner has a duty to report with respect to any child under the age of 16 (or who is 16 or 17 years old and under a child protection order). This includes all children, including a child of a patient, or a child who is a patient, or any other child. However, a practitioner has a special responsibility to report information about a child who is a patient or client if the information was obtained while providing treatment or services to the child. A practitioner may be fined up to \$1000 for failing to make a report in this circumstance.

The duty to report is ongoing even if a previous report has been made respecting a child. A practitioner must make a report personally.

A practitioner must make a report if he or she has reasonable grounds to suspect any of the following:

*The child has been or is at risk of harm*

A report is required if a child has been or is at risk of likely being physically harmed by a person having charge of the child (e.g., a parent or guardian), either directly or as a result of neglect or a pattern of neglect.

A report is also required if a child has been or is at risk of being sexually molested or sexually exploited, either by a person having charge of the child, or by another person, if the person having charge of the child knows or should know of the risk of this happening and fails to protect the child.

*Failure to provide or consent to services or treatment*

There are numerous circumstances where a report is required because the person having charge of a child does not or cannot provide services or treatment to a child, or does not or cannot consent to services or treatment for a child.

A report is required where a child is not receiving services or treatment, and:

- the child requires medical treatment to cure, prevent or alleviate physical harm or suffering;
- the child has suffered or is likely at risk of suffering emotional harm, demonstrated by serious anxiety, depression, withdrawal, self-destructive or aggressive behaviour, or delayed development believed to be caused by action or inaction of the person having charge of the child;
- the child has a mental, emotional or developmental condition that, if not remedied, could seriously impair the child's development; or if
- the child is under the age of 12, has killed or seriously injured another person or has caused serious damage to another person's property, and services or treatment are needed to prevent a recurrence.

*Abandonment*

A report is required if a child has been abandoned by a parent or guardian, or is otherwise left without a caregiver. This includes the death of a child's parents.

*Failure to supervise a child*

A report is also required if a child has injured another person or damaged another person's property more than once because a person having charge of a child has not or cannot supervise a child adequately.

### *Mandatory Reporting Scenario 1*

*Y, a practitioner, has a patient who discloses that she has physically harmed her son. Y has a duty to make a report, even if the patient reported this in confidence or in the course of assessment or treatment. If two months later the patient says something that makes Y suspect that the patient has physically harmed her son again, Y has a duty to make another report.*

### *Mandatory Reporting Scenario 2*

*X, a practitioner, has an 11 year old patient who has been displaying signs of erratic and violent behaviour, and reports that he violently attacked his friend last week. X believes that specialized health care services are necessary to prevent the patient from causing serious injury to other people again, and recommends a referral to another health care practitioner. The patient's parents do not believe that their 11 year old son would hurt anybody, and refuse to consent to any further treatment. In this case X has a duty to make a report. This duty to report exists even if the child does not want anyone to know about the incident and the parents refuse to believe it and are angry with the practitioner.*

## **v. Long-Term Care Homes Act**

The Long-Term Care Homes Act regulates long-term care homes in Ontario, which are facilities that provide 24-hour nursing care and supervision.

### *Resident care and rights*

The Long-Term Care Homes Act sets out a Resident's Bill of Rights requiring long-term care homes to ensure residents are treated fairly and with dignity and respect. This includes the right to participate in decision-making about the resident's care, the right to privacy in treatment and care, and the right to receive care and assistance that is aimed at maximizing the resident's independence as much as possible.

A long-term care home must have a zero-tolerance policy with respect to abuse and neglect of residents. Abuse includes physical, sexual, emotional, verbal or financial abuse.

### *Complaints*

Practitioners have a duty to report abuse and neglect of residents and certain other conduct to the Ministry of Health and Long-Term Care. A report is required if a practitioner (or any other person) suspects on reasonable grounds that any of the following have occurred:

- Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident;
- Abuse of a resident by anyone;
- Neglect of a resident by staff, including management, that resulted in harm or a risk of harm to the resident;

- Unlawful conduct that resulted in harm or a risk of harm to a resident;
- Misuse or misappropriation of a resident's money; or
- Misuse or misappropriation of funding provided to a long-term care home.

It is an offence for a practitioner to fail to make a report in any the above circumstances if the practitioner provides care or services in a long-term care home. A practitioner may be fined up to \$25,000 for failing to make such a report.

Complaints and reports about the care of a resident or the operation of a long-term care home must be investigated by the Ministry of Health and Long-Term Care if they involve certain matters including abuse of a resident by anyone, and neglect of a resident by staff.

Every person including a practitioner is protected from retaliation for making a report or for cooperating with an investigation. This includes protection from being fired, disciplined or suspended.

#### *Sample Exam Question*

A practitioner is not required to report the following:

- A resident's son frequently yells and swears at the resident.
- A staff member is borrowing money from a resident with memory difficulties.
- A nurse has not been monitoring a resident over the past several shifts.
- A resident's daughter has stopped visiting the resident.

*The best answer is iv). All of the above except iv) must be both reported and investigated. While a resident's family member may neglect that person, this does not have to be investigated unless the neglect is to the point of emotional abuse. Answer i) is not the best answer because this may constitute emotional abuse, and emotional abuse by any person must be reported and investigated. Answer ii) is not the best answer because this may be considered financial abuse, and any person who financially abuses a resident must be reported and investigated. Answer iii) is not the best answer because a nurse who has not been monitoring a resident may be neglecting that patient. Neglect of a patient by a staff member must be reported.*

Similar provisions have also been enacted for residents of retirement homes under the Retirement Homes Act. Retirement homes typically are for residents who require less care.

## **vi. Human Rights Code**

### *(a) Human Rights Code*

Every person is entitled to access and receive health care services in a manner that respects his or her human rights. The Ontario Human Rights Code requires every practitioner to treat patients, potential patients, employees and others equally, regardless of the person's race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status or disability.

If a person feels that a practitioner or organization has violated the Human Rights Code, the person can complain to the Human Rights Tribunal of Ontario. If the Human Rights Tribunal finds that a practitioner has violated the Human Rights Code, it may order the practitioner or organization to pay damages and require a practitioner or organization to take action, such as, undergo training or implement a human rights policy. However, the Human Rights Tribunal does not have the power to suspend or revoke a practitioner's certificate of registration. For that reason, a person who believes his or her human rights have been violated may also bring a complaint to the College.

### *Duty not to discriminate*

A practitioner must not discriminate against any person on any prohibited ground. Examples of discrimination may include the following:

- Refusing to accept a new patient for a prohibited reason;
- Refusing to continue treating a patient for a prohibited reason;
- Making a treatment decision for a prohibited reason;
- Insulting a patient in relation to a prohibited reason;
- Refusing to permit a patient with a disability to meet with the practitioner with a support person; and
- Making assumptions, not based on clinical observation or professional knowledge and experience, about a person's health or abilities because of his or her age or another prohibited reason.

It is not discrimination to make clinical decisions or to accept or refuse to continue seeing a patient for reasons other than prohibited grounds. For example, if a practitioner does not have the competency to treat or continue to treat a person, or if the treatment required is not within the practitioner's scope of practice, a practitioner should not accept or continue to treat a patient.

In order to meet the obligations of the College and to avoid a misunderstanding that could lead to a human rights complaint, practitioners should always clearly communicate their reasons for making clinical treatments, referrals and other decisions. Practitioners should always make decisions to refuse or end treatment in good faith, and should not use their own lack of

competency as an excuse to refuse to provide services to a person if there is no real competency issue.

Practitioners are similarly entitled to rely on professional knowledge, judgment and experience to make comments upon clinically relevant matters that relate to a person's age or gender.

It is discrimination to treat someone unequally even if the practitioner did not intend to do so. For example, a policy that does not permit any animals in a building discriminates against persons who rely on a seeing-eye dog, even if the policy was not intended to discriminate against anyone. The policy would have to make exceptions for "service animals".

### *Duty to accommodate*

The Human Rights Code requires that persons with disabilities be accommodated unless the accommodation would result in undue hardship (e.g., because of a real risk to health or safety or because of undue cost).

Accommodation must be individualized. Not all persons with the same disability will require or request the same accommodation. Individual accommodations should be discussed with the person where possible, and must be provided in a manner that respects the person's dignity and autonomy. However, a practitioner is not required to provide the exact accommodation that a person requests, if another form of accommodation is reasonable and acceptable.

Examples of accommodation may include the following:

- Permitting a patient who uses a wheelchair to reschedule an appointment with less than 24 hours notice if the elevator in the practitioner's office is temporarily out of service;
- Offering an extended appointment time to a patient with an intellectual, learning, or mental health disability who may need a longer time to explain his or her symptoms;
- Permitting a person with a disability to enter your premises with a support person, service animal, or assistive device; and
- Communicating in writing if a person with a hearing impairment or other disability requests this.

The duty to accommodate also applies to other prohibited grounds of discrimination.

### *Human Rights Code Scenario No. 1*

*Y, a practitioner, determines she is not competent to continue to treat her patient because the patient's health condition has become increasingly more complex. The patient is unhappy about Y's decision, and believes that Y has always had a problem with him because of his race and religion. Y should carefully communicate her reasons for terminating the practitioner-client relationship, so that the patient is not left with a misunderstanding such as that the decision was for a prohibited reason such as the*

*patient's race or religion. Y should also provide an appropriate referral if possible and in a timely manner.*

#### *Human Rights Code Scenario 2*

*X, a practitioner, has a potential new patient who has an intellectual disability. X finds it difficult to communicate with the potential patient. X should ask how he can help communicate better with the patient. If the patient has a support person who sometimes provides assistance, the patient may ask to bring her support person to X's office. X is required by law to permit a support person to accompany a patient. However, X should not assume that the patient needs a support person. Additionally, if the patient does not have the capacity to make treatment decisions, the patient may need a substitute decision maker. In any of these circumstances, X cannot refuse to accept the patient because of her disability even if it will take X more time for those visits.*

#### *Human Rights Code Scenario No. 3*

*Y has a patient who has been diagnosed with a mental illness. Y has been having increasing difficulties interacting with her patient. The patient has also been rude towards Y and staff. While no patient has a right to be abusive towards practitioners and staff, Y may consider whether the behaviour is caused or exacerbated by the person's mental illness. Y cannot stop providing treatment or health services because of the patient's mental illness, unless Y concludes she is not competent to continue treating the patient. If Y believes a referral to another health care provider with the appropriate competencies to manage the patient's health care needs is necessary, Y should clearly explain the reasons for the decision. Y also should consider whether any accommodations are possible. For example, a patient who is uncomfortable in a crowded waiting room because of his or her mental health disability might be offered an alternative space to wait. There may be other practical measures that the patient may be able to suggest that will help the patient manage his disability-related symptoms.*

#### *(b) Accessibility for Ontarians with Disabilities Act*

The Accessibility for Ontarians with Disabilities Act ("AODA") provides for accessible customer service, information and communications, transportation, employment, and built environment (i.e., physical facilities). The AODA applies to every person and organization in Ontario. The intention of the standards is to achieve accessibility for Ontarians with disabilities by 2025. A practitioner or organization may be fined for not complying with the AODA.

The standards currently apply only to persons and organizations with at least one employee in Ontario. Different standards apply depending on the number of employees an organization has. A sole proprietor or a group of persons in a partnership are not considered "employees", and therefore the AODA standards currently do not apply to some practitioners.

### *Interaction between AODA and other laws*

Accessibility standards are regulations and legally must be obeyed. If a standard provided in the AODA is different from a standard required under a different law, the higher standard always prevails. However, the AODA will not necessarily prevail over other legal requirements such as occupational health and safety laws.

A breach of an AODA standard is not necessarily a breach of the Human Rights Code. However, it is possible that the AODA standards will be used as a reference point in Human Rights Tribunal hearings.

### *Customer Service Standard*

Practitioners with at least one employee in Ontario must comply with the accessible customer service standard by January 2012. For organizations with fewer than 20 employees, the AODA requires the following:

- Implement policies, practices and procedures regarding the provision of goods and services to persons with disabilities,
  - that are consistent with the principles of dignity, independence, integration, and equal opportunity, and
  - that deal with the use of assistive devices and the availability of any measures that make services accessible (e.g., TTY, elevator).
- Permit service animals and support persons in public areas of premises.
- Provide reasonable notice of any temporary disruptions to any accessibility features or services, including the reason for the disruption, the anticipated duration, and a description of any alternate services.
- Provide training to all employees and anyone else who deals with members of the public or third parties (i.e., anyone outside of a practitioner's organization), or participates in the development of policies, practices and procedures regarding accessible customer service, which must include the following:
  - Review of purposes of the Act and requirements of Customer Service standard;
  - How to interact with persons with disabilities who use assistive devices, use a service animal, or are assisted by a support person;
  - How to use available accessibility equipment and devices on premises or that are otherwise provided to the public; and
  - What to do if someone with a particular type of disability is having difficulty accessing the providers' goods or services.
- Establish a process for receiving and responding to feedback about accessibility and make information about the process readily available to the public,
  - People must be permitted to provide feedback in person, by telephone, in writing, or electronically, and

- Process must specify actions that will be taken if complaint is received.

For organizations with 20 or more employees, there are additional requirements including putting its policies, practices and procedures in writing and making them available upon request, filing publically-available accessibility reports, and keeping records of the training that has been provided.

#### *Information and Communication Standard*

The Information and Communication Standard requires organizations to ensure that information available to the public and the organization's communications with the public are accessible, or can be made accessible. This includes making any feedback system accessible upon request, ensuring that any emergency or public safety information that is available to the public is made accessible upon request, and providing accessible information formats and communication supports upon request.

This standard may require practitioners with at least one employee to provide intake forms, charts, and other health information in an accessible format (e.g., large print, audio, or Braille). It may also require practitioners to provide a person with sign language interpretation. The practitioner must consult with the person making the request regarding the form of accessible format or communication support. The practitioner must provide a requested accessible format or communication support in a timely manner, and may charge no more than the regular cost that is charged to other persons.

For organizations with 50 or more employees, additional steps will be required, including ensuring that websites are compliant with web accessibility standards, and filing accessibility reports.

This standard will be phased in and will apply to organizations with fewer than 50 employees in 2017.

#### *Employment Standard*

The employment standard requires employers to provide an accessible workplace. This includes the following:

- Providing public notice regarding accessibility practices in hiring employees;
- Providing accessible workplace information; and
- Providing, on request, any individualized emergency response information to employees who require this individualized information because of a disability.

For organizations with fewer than 50 employees, the employment standard will generally come into force on January 1, 2017. The exception is that the deadline for providing individualized workplace emergency response information is January 1, 2012.

### *Built Environment Standard*

The standard on built environment has not yet been developed. However, it will apply to the construction of new buildings and to major renovations.

#### *AODA Scenario*

*X, a sole practitioner has an office with one employee who provides administrative support. X must create an accessibility plan for providing accessible customer service and accessible information and communications. X is not required to put its policies, practices and procedures in writing, but must ensure that they are followed, including by his employee. X is also responsible for ensuring that training is provided to the employee regarding the accessibility standards (e.g., that support persons, animals or devices are allowed on the premises). X should also be aware of how the information and communications and employment standards will apply to his or her practice.*

#### **vii. Municipal licensing**

In addition to being registered with the College, practitioners may require a municipal licence. A municipal licence, such as a business licence, is granted and regulated by the municipality, and not by the provincial government. A municipal licence does not give a practitioner the right to be registered with the College. However, a practitioner may be registered with the College and also hold a municipal licence.

Generally speaking, the purpose of municipal licensing is to set conditions for a practitioner's premises in which a practitioner operates, as well as public health matters such as sanitation. For example, a municipal inspector may inspect a practitioner's office and ensure that protocols are in place to avoid the spread of disease. A municipal licensing body is generally not focused on professional qualifications or professional conduct.

If the College requires a higher standard or different standard than the municipality does, the College's standard must always be followed. The *Regulated Health Professions Act* is a provincial statute; it takes priority over a municipal by-law.

#### *Municipal licensing scenario*

*Y, a practitioner, has a municipal licence to practice in her city and pays a fee every year to renew her licence. The municipal authority recently inspected Y's practice and found no violations. Y now wishes to register with the College. Y must meet all registration requirements of the College in order to become a member. While the municipal licensing authority did not require Y to maintain accurate clinical records, and did not look at Y's*

*records during its inspection, the College does require this. Y must understand and abide by the College's record keeping expectations.*

**Conclusion**

If a legal issue arises, practitioners are encouraged to discuss them with colleagues and one's professional association and to check with the College as to its expectations. The College cannot provide legal advice (neither can one's colleagues or professional association). Thus on many issues a practitioner may need to consult with his or her own lawyer.