College of Dietitians of Ontario

The Jurisprudence Handbook for Dietitians in Ontario

Richard Steinecke, LL.B., BA, and
College of Dietitians of Ontario

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Contents

Figures

Introduction

The College of Dietitians of Ontario exists to regulate and support all Registered Dietitians in the interest of the public of Ontario.

We are dedicated to the ongoing enhancement of safe, ethical and competent nutrition services provided by Registered Dietitians in their changing practice environments.

The *Jurisprudence Handbook for Dietitians in Ontario* is offered as a rich and comprehensive resource for the application of ethics and laws to support dietetic practice in Ontario. This online version is updated regularly to reflect changes in laws which have an impact on dietetic practice, for example, amendments to the *Regulated Health Professions Act* and the *Laboratory and Specimen Collection Centre Licensing Act,* which now allow dietitians to perform the controlled act of skin pricking in their practice.

Since the application of law in day-to-day practice can be complex, the *Jurisprudence Handbook* has been organized to help Registered Dietitians, students in foods and nutrition programs, and dietetic interns gain clarity about what the law requires, its effect on professional practice, duty to clients, and accountability. The handbook covers a wide range of topics including professionalism, scope of practice, communication and boundary issues. The purpose is to encourage dietitians to explore practices and policies that maximize their ability to work effectively within the dietetic scope of practice.

Updated versions of the *Jurisprudence Handbook for Dietitians in Ontario* will only be published online. We do not publish hard copies. This allows us to update the handbook promptly following changes in law and regulation to ensure that dietitians in Ontario always have access to the most current information about the regulations, ethics and the law for their practice.

We hope you will benefit from this handbook and we encourage you to contact our Practice Advisory Service if you have further questions or comments.

Mary Lou Gignac
Registrar & Executive Director

Acknowledgements

This book represents a collaborative effort between the College of Dietitians of Ontario and the principle author of this book, Richard Steinecke, LL.B., B.A., a renowned lawyer in the field of health professional regulation. Mr. Steinecke is counsel to many professional regulatory bodies including the College of Dietitians of Ontario and is known province-wide for his educational writings and workshops about different aspects of health professional laws and procedures.

Many of the College's previous publications and guidelines have been used as sources or quoted directly to complement Mr. Steinecke's information. Of note, are the *Code of Ethics Interpretive Guide* (1999) and various guidelines about topics such as mandatory reporting, filing complaints, controlled acts and the *Health Care Consent Act.* All are available on our website at: www.collegeofdietitians.org

The College extends its gratitude to everyone who contributed to creating this book. We are particularly grateful to our members, Registered Dietitians who offered their valued feedback through surveys, emails, letters and phone calls. Thank you for participating in our surveys. Your comments were valuable for this new edition.

The College would also like to extend its appreciation to the staff who have contributed to this edition: Mary Lou Gignac, *Registrar & Executive Director*, who conceived the idea of a jurisprudence handbook as a resource for dietitians and contributed to its format and editing. For reviewing the text and contributing scenarios, we express our gratitude to Sue Behari McGinty, RD, *Quality Assurance Program Manager*, Deborah Cohen, RD, Practice Advisor and Policy Analyst; and Carolyn Lordon, RD, Registration Program Manager. We also thank Monique Poirier, Project Editor, for her painstaking review and editing of the draft.

How to use this Book

The *Jurisprudence Handbook for Dietitians in Ontario* begins with two documents that are at the heart of jurisprudence for dietitians: the *Code of Ethics for the Dietetic Profession in Canada* and the College's *Professional Misconduct Regulation*. Each document offers a different perspective on a dietitian's duties: the first sets out the ideals that guide dietitians and the other sets out the minimum legal requirements for dietetic practice. Be familiar with these key documents.

KEY PRINCIPLES

Every chapter introduces key principles in a *Need to Know* section. Their relationship to practice is illustrated with topical scenarios.

SCENARIOS

Scenarios in every chapter illustrate key concepts. Generally, there is more than one acceptable approach that appropriately addresses the underlying issues illustrated in the scenarios.

QUIZZES

In a quiz at the end of each chapter, you are asked to apply the principles discussed in the chapter. The quiz not only tests factual knowledge, but also gives you an opportunity to apply and expand upon the concepts covered in each chapter. Compare your answer to the "model" provided in Appendix 1, (p. 119) .

REFERENCES

"Law" is expressed in different formats: acts, regulations and case law. These change over time. The *Jurisprudence Handbook* makes it easier to find the right resources with handy references, many with live links, at the end of each chapter and in the reference sections at the back (*Appendix II*, p. 130 and the *Bibliography,* p 131).

Code of Ethics

For the Dietetic Profession in Canada

Professional Oath:

As a professional dietitian/nutritionist I pledge to practice the art and science of dietetics to the best of my abilities:

- to maintain integrity and empathy in my professional practice;
- to strive for objectivity of judgment in such matters as confidentiality and conflict of interest;
- to maintain a high standard of personal competence through continuing education and an ongoing critical evaluation of professional experience;
- to work co-operatively with colleagues, other professionals, and laypersons;
- to protect members of society against the unethical or incompetent behaviour of colleagues or other fellow health professionals;
- to ensure that our publics are informed of the nature of any nutritional treatment or advice and its possible effects;
- to obtain informed consent for our invasive or experimental procedures.

I further pledge to promote excellence in the dietetic profession:

- to support others in the pursuit of professional goals;
- to support the training and education of future members of the profession;
- to support the advancement and dissemination of nutritional and related knowledge and skills;
- to involve myself in activities that promote a vital and progressive profession.

The Code of Ethics was developed by Dietitians of Canada and officially adopted by the provincial dietetic associations and regulatory bodies.

Back to Table of Contents

Professional Misconduct Regulation

Dietetics Act, 1991, ONTARIO REGULATION 680/93

1. The following are acts of professional misconduct for the purposes of clause 51 (1) (c) of the *Health Professions Procedural Code:*

THE PRACTICE OF THE PROFESSION AND CARE OF, AND THE RELATIONSHIP WITH, CLIENTS

1. Practising the profession while the member's certificate of registration has been suspended by the Registration Committee for non-payment of fees.
2. Contravening a term, condition or limitation imposed on the member's certificate of registration.
3. Failing to comply with an order of a panel of the Complaints Committee, Discipline Committee or Fitness to Practise Committee.
4. Failing to carry out an undertaking given by the member to the College or an agreement entered into with the College.
5. Failing to maintain a standard of practice of the profession.
6. Doing anything to a client for a therapeutic, preventative, palliative, diagnostic, cosmetic, research or other health related purpose in a situation in which a consent is required by law, without such a consent.
7. Abusing a client verbally, physically or emotionally.
8. Practising the profession while the member's ability to do so is impaired by any substance.
9. Discontinuing professional services that are needed unless,
    i. the client requests the discontinuation,
    ii. alternative services are arranged, or
    iii. the client is given reasonable notice to arrange alternative services.
10. Discontinuing professional services without reasonable cause contrary to the terms of an agreement between the member and the member's employer.
11. Practising the profession while the member is in a conflict of interest.
12. Giving information about a client to a person other than the client or his or her authorized representative except with the consent of the client or his or her authorized representative or as required or allowed by law.
13. Breaching an agreement with a client relating to professional services for the client or fees for such services.
14. Recommending vitamins, minerals or nutritional supplements for improper use.
15. Failing to reveal the exact nature of a treatment used by the member following a client's request to do so.
16. Failing to report incidents of unsafe practice or unethical conduct of dietitians.
17. Assigning members, dietetic interns, food service supervisors, dietetic technicians or other health care providers to perform dietetic functions for which they are not adequately trained or that they are not competent to perform.
18. Failing to inform the member's employer of the member's inability to accept specific responsibility in areas where specific training is required or where the member does not feel competent to function without supervision.
19. Treating or attempting to treat a condition that the member knew or ought to have known was beyond his or her expertise or competence.

REPRESENTATIONS ABOUT MEMBERS AND THEIR QUALIFICATIONS

20. Inappropriately using a term, title or designation in respect of the member's practice.
21. Using a name other than the member's name, as set out in the register, in the course of providing or offering to provide services within the scope of practice of the profession.

RECORD KEEPING AND REPORTS

22. Failing to keep records as required.
23. Falsifying a record relating to the member's practice.
24. Failing, without reasonable cause, to provide a report or certificate relating to an assessment or treatment performed by the member, within a reasonable time after a client or his or her authorized representative has requested such a report or certificate.

25. Signing or issuing, in the member's professional capacity, a document that the member knows contains a false or misleading statement.

26. Failing to take reasonable steps before terminating services to a client or resigning as a member, to ensure that, for each client health record for which the member has primary responsibility,
    i. the record is transferred to another member, or
    ii. the client is notified that the member intends to resign and that the client can obtain copies of the client health record.

BUSINESS PRACTICES

27. Submitting an account or charge for services that the member knows is false or misleading.

28. Charging a fee that is excessive in relation to the service charged for.

29. Failing to itemize an account for professional services if requested to do so by the client or the person or agency who is to pay, in whole or in part, for the services.

30. Offering or giving a reduction for prompt payment of an account.

MISCELLANEOUS ITEMS

32. Contravening the Act, the *Regulated Health Professions Act*, 1991 or the regulations under either of them.

33. Influencing a client to change his or her will or other testamentary instrument.

34. Contravening a federal, provincial or territorial law, a municipal by-law or a by-law or rule of a facility where a member practices if,
    i. the purpose of the law, by-law or rule is to protect the public health, or
    ii. the contravention is relevant to the member's suitability to practise.

35. Failing to co-operate in a College investigation.

35.1 Failing to provide the Registrar with accurate information respecting any information required to be contained in the College's register.

35.2 Failing to inform the Registrar of a change of any information required to be contained in the College's register within 30 days after the change occurring.

35.3 Failing to inform the Registrar of a change in citizenship or immigration status within 30 days after the change occurring.

36. Engaging in conduct or performing an act that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

37. Failing to co-operate with the Quality Assurance Committee or with a panel of that committee or with any assessor it appoints and failing to carry out a self-assessment in accordance with guidelines and policies established by the College and distributed to members.

38. Failing to carry out any requirement or order of the Quality Assurance Committee or a panel of that committee, including refusing to undergo remediation or a practice assessment required by the committee or panel or failing to complete remediation within the time required by the committee or panel. O.Reg. 680/93, s. 1; O. Reg. 203/00, s. 1; O. Reg. 302/01, s. 1

NOTE: This definition of professional misconduct is in addition to section 51 of the *Health Professions Procedural Code*, which applies to all health professionals and reads as follows:

Professional misconduct

51. (1) A panel shall find that a member has committed an act of professional misconduct if,

(a) the member has been found guilty of an offence that is relevant to the member's suitability to practise;

(b) the governing body of a health profession in a jurisdiction other than Ontario has found that the member committed an act of professional misconduct that would, in the opinion of the panel, be an act of professional misconduct as defined in the regulations;

(b.0.1) the member has failed to co-operate with the Quality Assurance Committee or any assessor appointed by that committee;

(b.1) the member has sexually abused a patient; or

(c) the member has committed an act of professional misconduct as defined in the regulations. 1991, c. 18, Sched. 2, s. 51 (1); 1993, c. 37, s. 14 (1); 2007, c. 10, Sched. M, s. 39 (1).

Back to Table of Contents

ONE

College of Dietitians of Ontario

Introduction to Professionalism

AT A GLANCE

SCENARIOS

NEED TO KNOW

1.
Professionalism means being competent, honest and fair.

2.
Professionalism forms the basis of the *Code of Ethics* and the legal definition of professional misconduct.

3.
The challenge for dietitians is to balance competing interests appropriately.

What is Professionalism?

Professionalism is a value that puts ethical and high quality services before self-interest. All codes of professionalism can be summarized in one phrase: "competent, honest and fair". Competence refers to providing high quality services every time. Alistair Cooke said "A professional is a man (sic) who can do his best at a time when he doesn't particularly feel like it."[1] Honesty requires being truthful and open in your statements, and not misleading by omission. Fairness refers to appropriately balancing competing interests.

Most professions have developed a sophisticated sense of how their members should act in recurring situations because ethical dilemmas tend to follow patterns. However, it is difficult to express a firm rule that applies to every circumstance because each situation adds new twists. True professionalism does not just come from obeying written professional codes; it is a mind-set, informed by training, experience and professional relationships.

Code of Ethics vs. the Professional Misconduct Regulation

Like most professions, dietitians have both a written *Code of Ethics* [2] and a *Professional Misconduct Regulation* under the *Dietetics Act* [3] (both documents are presented before Chapter 1, pages x and xi, for easy reference). While covering many of the same topics, these documents have different perspectives. The *Code of Ethics* sets out the ideals that dietitians should strive to achieve, focusing on the values needed to reach excellence. It uses words such as "principle" and "pledge" to describe the precepts underlying the law. The *Professional Misconduct Regulation*, by contrast, sets out the minimum legal requirements that a dietitian must practice. Failure to meet this bare minimum can result in disciplinary proceedings by the College and legal liability for professional negligence. It uses words such as "shall" and "must" to describe a dietitian's duties.

Thus, the *Code of Ethics* and the *Professional Misconduct Regulation* have different goals. These different goals can be illustrated by looking at one of the principles found in the Code of Ethics, "to work co-operatively with colleagues, other professionals and laypersons". The *Code of Ethics Interpretative Guide* [4] published by the College shows how this goal can be achieved by:

- seeking consultations when appropriate;
- reporting to the referring practitioner when acting as a consultant;
- respecting and acting constructively in a client's interest when working as part of a professional team; and
- working collaboratively with an employer so that, where possible, a client's needs can be met in a manner that is acceptable to the employer.

From the legal perspective of professional misconduct, the concept of working "cooperatively" is a somewhat vague basis for a discipline hearing. Normally, the disciplinary function kicks in only when poor attitude or lack of cooperation affects client care. Engaging in care beyond your competence, for example, is a disservice to both your clients and your employers. This aspect is captured in the *Professional Misconduct Regulation* :

> "18. Failing to inform the member's employer of the member's inability to accept specific responsibility in areas where specific training is required or where the member does not feel competent to function without supervision."

Aspects of Professionalism

There are three fundamental aspects defining a professional practitioner: competence, honesty and fairness.

COMPETENCE

Competence is a basic principle of the *Code of Ethics*. It states that an ethical dietitian pledges "to maintain a high standard of personal competence through continuing education and

an ongoing critical evaluation of professional experience". Incompetence is a basis for discipline under the *Regulated Health Professions Act*, which states:

> 52 (1) A panel shall find a member to be incompetent if the member's professional care of a patient displayed a lack of knowledge, skill or judgment of a nature or to an extent that demonstrates that the member is unfit to continue to practise or that the member's practice should be restricted."[5] [Many statutes use the word "patient" where dietitians might use "client".]

Competence has three components:

1. Appropriate knowledge, skills and judgment;
2. A professional attitude focused on client welfare; and
3. Continuously upgrading knowledge, skills and judgment.

1. Knowledge, skills and judgment

SCENARIO 1-1
Stretching the Limits of Competence

You have worked in an academic setting for most of your career as a dietitian and your position has been downsized. After a long search, you have been hired by an agency that primarily serves children. For three months, you have been dealing with Type 1 diabetes cases and feel comfortable in what you are doing. Your probationary period is coming to a close and your supervisor has indicated that you need to work more independently. You have a new client who is 16 and is 175 cm tall. She weighed 50 kg on her second visit (down from 60 kg). On her third visit, she weighs 48.5 kg and shows some signs that she may have anorexia nervosa. You have read up on eating disorders and diabetes and feel that you know the theory of what to do. What should you do?

All dietitians need to demonstrate minimal knowledge, skills and judgment in order to be registered with the College. They need to successfully complete an educational program related to dietetics; demonstrate minimal knowledge, skills and judgment in various settings (e.g., clinical, food service, community, industry); and pass an examination that involves the application of knowledge and critical thinking.

An integral part of competence is being able to recognize when you need more knowledge and skills to treat a client. Scenario 1-1, *Stretching the Limits of Competence*, raises the issue of using your professional judgment to recognize the limits of your competence. You would need to be aware that this client's life might be at risk and that, despite your readings, you may not have the skills necessary to treat anorexia safely. Considering your lack of experience and having the client's welfare in mind, the best course of action would be to consult with your supervisor to ensure the best possible care for this teenager.

The foundation for competence is present in all dietitians. The question is whether knowledge, skills or judgment grow or dissipate over time. The answer to that question depends on the other two components of competence: attitude and upgrading.

2. Attitude

Key to competence is attitude. Knowing what needs to be done but declining to do so because of time pressures, personal problems or sheer laziness, is incompetence and subject to discipline. On this point, there is a distinction between existing and prospective clients. When unable to provide high quality services because of workload, a dietitian is demonstrating a professional attitude by refusing to take on new clients. The dietitian might advocate for more services or apply triage principles to screening clients, but does not have to accept every client (especially where lack of time and resources will affect client care). However, once a client is accepted, the dietitian has a professional responsibility to promptly assess and, where appropriate, address the client's dietetic needs until their care is transferred or discharged.

The *Code of Ethics Interpretative Guide* identifies the additional negative behaviours that affect competence, and indicate a lack of respect for

clients who expect competent services. They are:

- Practising while impaired by a substance or illness;
- Refusing to consider concerns expressed by others or not seeking feedback when appropriate;
- Choosing to practise in an area where you are not skilled;
- Avoiding disclosure to an employer of limitations in your knowledge, skills and judgment;
- Declining to engage in continuing education;
- Failing to reflect on your practice interests, strengths and weaknesses;
- Refusing to acknowledge mistakes so that they can be corrected and not repeated; and
- Shunning accountability processes at work.

It is rare for someone to be disciplined by a college for a simple mistake. Slip-ups are almost always dealt with through other means. An ingrained unprofessional attitude that causes or aggravates errors, however, can sometimes only be dealt with through discipline.

3. Upgrading

The process of continuing education or upgrading maintains and enhances competence. Traditionally, this was simply an ethical precept with no guidance or accountability. However, one of the innovative features of the *Regulated Health Professions Act* (RHPA) requires all health professionals to participate in a quality assurance program., which addresses changes in practice environments and "incorporates standards of practice, advances in technology and changes made to entry to practice competencies and other relevant issues in the discretion of the Council". [6] Typically, these programs involve a process of professional self-reflection, self-learning and peer review.

In keeping with the RHPA, the College has developed the *Self-Directed Learning Tool* to assist members with continuing education and upgrading of competence. The College's Quality Assurance Committee monitors and guides members in this exercise. A professional dietitian will welcome this initiative even if it is somewhat structured.

SCENARIO 1-2
Food Poisoning

You work in a long-term care facility. Two weeks ago, three suspected cases of food poisoning occurred. Everyone has now recovered although the exact cause has never been determined. You overhear a conversation by the kitchen staff at the service entrance that a jug of gravy had accidentally been left out overnight. You are pretty sure that they were talking about the incidence of food poisoning by the sudden hush and their body language of discomfort when you come around the corner. By coincidence, you are at a management meeting later that day and the Administrator asks if anyone knows what happened two weeks ago to cause the food poisoning. She is looking principally at the senior nurse. What do you do?

HONESTY

Honesty can sometimes be rationalized away. Scenario 1-2, *Food Poisoning*, highlights issues at the core of honesty:

- the competing duties of loyalty;
- being sensitive when expressing honest statements; and
- remaining silent when that can amount to dishonesty.

For instance, in the situation above, you could easily justify saying nothing for any of these reasons:

- You don't know for sure what happened - you just have a bit of information and a pretty good hunch;
- There is no mandatory reporting requirement in this case (see the discussion in Chapter 3);
- You are not saying anything that is untrue, you are simply not saying anything;
- It is unfair to report what you heard in an open forum before mentioning it to the direct supervisor of those employees;
- It is defamatory to make those allegations and you could be sued; and
- No permanent harm occurred.

However, saying nothing is not completely honest either. You are misleading the administrator by being silent, preventing management from taking appropriate measures to avoid a recurrence, and failing to look after the best interests of your "clients" — the residents of the facility.

There is often more than one ethical and honest approach to dealing with a difficult issue. If you are concerned about the fairness of reporting what might be unfounded gossip, consider the following options:

- Make clear in your report the uncertain quality of the information you received;
- Report that you heard some gossip earlier but need to follow-up on it first before making a report;
- Keep silent for the moment, but determine to speak with the supervisor after some further investigation and then make a report in a less open forum.

Honest Billing

Billing is another common test of honesty, especially as more dietitians work in private practice. A failure to maintain honest and informed billing is professional misconduct. More than 10% of the paragraphs defining misconduct in the *Professional Misconduct Regulation* deal with billing issues.[7] More than 10% of all disciplinary proceedings of health practitioners in Ontario relate, at least in part, to billing concerns. An honest account must comply with the following:

- The account must accurately describe the service provided. For example, it is improper to;
  - portray a missed visit as a treatment service;
  - bill for an assessment when what really occurred was a treatment.
- The account must not be misleading by omission. For example, it is misleading to:
  - bill for a disbursement with a mark-up (e.g. supplies consumed, equipment dispensed), while implying that only the actual cost of the item is being charged;
  - bill a service provided by an unregistered assistant as your own, if you were not involved.
- Charging a higher fee for insured clients than for those who pay directly is not honest. This does not prevent a dietitian from giving a discount to an individual who cannot afford the service. However, discounts must be done on a case-by-case basis for a person in need, and not as a practice or policy. Similarly, volume discounts, while not absolutely prohibited, need to be approached with care to ensure integrity.
- Dietitians must be familiar with the insurance requirements of their clients' policies so that they do not submit an account that will be misinterpreted by the insurer. For example, if the policy requires payment of a deductible, it is improper to bill the insurer for the initial services without mentioning that a client still needs to be billed for and pay the deductible.
- Charging a fee that is excessive for the service provided is a form of dishonesty. While there are no fixed charges or specified maximum fees for dietetic services, at some point a high fee becomes excessive. Charging a very high fee becomes particularly concerning where a client is financially vulnerable or incapacitated, or where a third party payer has little knowledge of the service provided.
- Dietitians are prohibited from offering a reduction for prompt payment. This rule is based on the notion that those with financial means will be able to take advantage of the reduction, while those with modest means will end up paying more for the same service. This rule does not prevent a dietitian from charging interest on overdue accounts.

Responsibility for Billing

Dietitians are not absolved from their professional responsibility for honest and informed billing simply because someone else submits their accounts. While still rare, billing issues might occur for some services provided under extended

health care plans, for a Community Care Access Centre (CCAC) or other government or quasi-government agency, for a gym or spa or other private business, or for services provided directly to the public. Dietitians must take responsibility for any billing going out in their name or with their registration number to ensure that it is honest and informed. While this does not mean that they must personally sign every account, which would be impractical in some settings, dietitians must be satisfied that the billing system is accurate and appropriate. At the very least, they should review the billing procedures and do periodic spot checks to ensure continued accuracy.

This is especially true when an unregulated individual employs a dietitian. Great care should be taken to discuss accounting methods and to include billing practices as part of the contract of employment. By doing this, the dietitian helps achieve a balance between an employer's right to run a business their way and the dietitian's duty to maintain professionalism.

FAIRNESS

SCENARIO 1-3
Rationing of Services

Working under contract for a Community Care Access Centre, you assess an elderly man and determine that he will need at least six visits to learn about managing the nutrition aspects of his Type 2 diabetes. The client is mentally challenged and has some longstanding eating habits that need to be modified in a substantial way. The case manager says that there is no way the CCAC can approve more than three visits, and even that exceeds current policy. What do you do?

Scenario 1-3, above, "Rationing of Services", illustrates one of the most challenging aspects of being a professional - balancing competing interests, particularly in the area of managed resources. Challenges in this area can occur in many contexts, from a direct pay client who has limited funds, to the CCAC situation described in this scenario. How can dietitians put clients first and maintain professional standards in the context of externally managed resources?

How far should you go in advocating for clients when legitimate external pressures affect client interests?

Despite the absence of resources, dietitians must meet the standards of practice. The starting point in balancing competing interests is to understand your role as a dietitian. As an assessing and/or treating practitioner, you have a fundamental obligation to clients. You cannot place third party interests above that of clients. As a professional, you must advocate on behalf of your clients and maintain professional standards, regardless of the resources available. It is not your role to pay for the service or, with some rare exceptions, to provide services without prospect of payment.

In a managed care environment, where an insurer or other third party needs to approve the service in advance of payment, it is important for dietitians to communicate the administrative processes thoroughly and clearly to the client. A direction by a third party payer that it will not pay for a reassessment or the making of records does not excuse the dietitian from performing those tasks as indicated. If certain appropriate treatment options are not funded (e.g., a machine to monitor glucose levels at home), the dietitian must advise the client of the options available and permit the client to choose a desired option.

Dietitians must always beware of crossing the thin line between a third party restricting resources or interfering with clinical decisions. If there is a real attempt to interfere with clinical decisions, the issue may be resolved by educating the third party about the professional role of the dietitian. If educational measures do not work, then the dietitian must explain the options to the client. Of course, all of this must be done professionally, without making critical or demeaning comments about a third party in discussions with the client.

As the professional dietitian in Scenario 1-3, you would advocate for the treatment the client needs and would respect the CCAC's final funding decision. You would explain to the client and, if

necessary, the substitute decision-maker, that:

- the assessment is provided through the CCAC;
- the report of the assessment would be made to the CCAC
- the CCAC would have to approve your recommendations;
- you would advise the client or substitute decision-maker of the results of the assessment;
- the client is free to purchase the service elsewhere if the CCAC did not fully fund the recommended service;
- you would discuss alternative sources of services if the CCAC did not provide the treatment plan.

Before the start of a treatment program (after an assessment is completed), a dietitian generally has no professional obligation to initiate the treatment program except in an emergency. If there are insufficient resources to complete the treatment program, and no benefit would be achieved by starting it, the dietitian should not initiate treatment without some assurance that alternative resources are available. If there were some benefit in completing a portion of the program, hold a full and frank discussion with the client to discuss options such as:

- initiating the program;
- seeking other resources; or
- choosing not to start the program at all.

After a treatment program has started, the dietitian has an obligation not to terminate it abruptly. Where the services are necessary, the dietitian must continue them unless:

- the client requests that they be terminated;
- alternative services are arranged; or
- the client is given reasonable notice to arrange alternative services.[8]

The length of a "reasonable notice" depends on the nature and frequency of treatment and the availability of services in the community. However, usually 10 to 30 days notice would be appropriate. Even where the treatment is not urgent, the dietitian should make every effort to either arrange alternative services or give appropriate notice.

Conclusion

Professionalism requires a fundamental sense of how competence, honesty and fairness are balanced in the unique circumstances of a dietitian's practice.

As a dietitian, you are advised to review the *Code of Ethics*, which sets out what you must strive to achieve as a professional in Ontario, and the definition of professional misconduct in the *Professional Misconduct Regulation,* which describes your obligations in legal language. Analyzing these two documents, dietitians will see certain themes

- being competent, i.e. having appropriate knowledge, skills and judgment;
- having an attitude focused on client welfare;
- being committed to a process of continuous upgrading;
- being scrupulously honest, even when that's not in your immediate interest; and
- being fair in balancing the competing and, sometimes, contradictory interests

The remainder of this book will further illustrate how the principles of professionalism apply to specific situations encountered by dietitians in their practice.

1 Alistair Cooke as quoted at http://www.quotationspage.com.

2 The *Code of Ethics* was developed by Dietitians of Canada in 1987 (then Canadian Dietetic Association) and officially adopted by the College of Dietitians of Ontario in 1996.

3 *Professional Misconduct, Dietetics Act,* 1991, Ontario Regulation 680/93, Amended to O Reg. 302/01.

4 College of Dietitians of Ontario, *Code of Ethics Interpretive Guide*. Toronto: 1999.

5 *Regulated Health Professions Act,* 1991, S.O. 1991, Chapter 18, Schedule 2: *Health Professions Procedural Code*, Section 52(1).

6 *Regulated Health Professions Act,* 1991, S.O. 1991, Chapter 18, Schedule 2: *Health Professions Procedural Code*, Section 80.

7 *Professional Misconduct Regulation, Ibid,* paragraphs 27 to 31.

8 *Professional Misconduct Regulation, Ibid,* paragraph 9.

Quiz

Provide the best answer to each of the following questions. Some questions may have more than one appropriate answer. Explain the reason for your choice. See *Appendix 1* for answers.

1. **In Scenario 1-1, *Stretching the Limits of Competence*, what should you do?**
   a. Get help from a colleague outside of the agency; this is a life-and-death situation.
   b. Get help from your supervisor; this is a life-and-death situation.
   c. Being a professional means that you have sufficient ability to find the answer on your own. Besides, your employer has told you to be independent.
   d. Nothing; anorexia is a diagnosis and you are not able to diagnose.

2. **In Scenario 1-2, *Food Poisoning*, to whom are you primarily accountable?**
   a. The residents.
   b. The administrator.
   c. The supervisor of the employees you heard gossiping.
   d. The employees you heard gossiping, because there is no one to speak up for them and you should not have been listening to their conversation.

3. **Which of the following best describes the differences between a *Code of Ethics* and the *Professional Misconduct Regulation*?**
   a. Should not vs. must not.
   b. Goals vs. bare minimum.
   c. Ideals vs. law.
   d. All of the above.

4. **A client asks you not to record anything about her HIV-positive status because a friend works as a nurse at your workplace and has access to the records. The nurse works in another department and is unlikely to have professional contact with your client during the course of treatment. What should you do?**
   a. Because of your duty of honesty, tell the client that anything she says will be recorded.
   b. Tell the client that only relevant information will be recorded, including this diagnosis. Discuss how access to your records is on a need-to-know basis and those who read them are bound by confidentiality.
   c. Tell the client that this diagnosis is relevant and needs to be recorded, but you will keep it separate from the chart.
   d. Say nothing, but record the information.

5. **You work in industry. Your company wants to promote the health value of its vegetable products. Which of the following best describes your role in this process?**
   a. Find the most current and reliable evidence on the health benefits of a diet high in vegetables, and present it in a clear and accurate manner to the project team.
   b. Research and report on the labelling laws.
   c. Provide a letter of endorsement, so long as it does not tie in to a specific product.
   d. Research which diseases are more likely to be prevented or assisted by a diet high in vegetables.

Resources

COLLEGE OF DIETITIANS OF ONTARIO

Code of Ethics Interpretive Guide. Toronto, 1999.

résumé articles

- "Professional Responsibilities of CDO Members During a Work Stoppage". Summer 2000, p. 2.
- "Fitness to Practice", Spring 2002, p. 6.
- "Coping with Stress at Work", Fall 2005, p. 2.
- "When Stress Leads to Incapacity", Winter 2006, p. 2.
- "Are you considering a leave of absence?", Summer 2006, 2-3.
- "Extra Workload Responsibilities", Spring 2008, 10-11.

PUBLICATIONS

Dietitians of Canada. *Code of Ethics***.** Toronto, 1987.

LEGISLATION

Dietetics Act, 1991, *Professional Misconduct Regulation,* Ontario Regulation 680/93, amended to O Reg. 302/01.

Regulated Health Professions Act, 1991, S.O. 1991, Chapter 18.

Back to Table of Contents

TWO

College of Dietitians of Ontario

Communication Skills

AT A GLANCE

SCENARIOS

FIGURES

NEED TO KNOW

1. Good communication skills are the foundation of an ethical, effective and legal practice.

2. Dietitians should recognize that there are inherent barriers to effective communication with clients, including the special knowledge and status of dietitians which can create an imbalance of power in the professional/client relationship.

3. There are numerous strategies for good communication available for dietitians, such as planning sufficient time with clients and being an active listener.

Importance of Communication Skills

SCENARIO 2-1
Non-Progressing Client

An adult client in your clinical practice, Kim, has had sporadic attendance and a spotty ability to implement agreed upon goals. As she arrives for a visit, you say, "Look, Kim, we are having a compliance problem here and now we need to talk about it." Kim bursts into tears.

You are very apologetic for the frustration contained in the tone of your comment. Kim tells you that it just made her think of her live-in boyfriend's threat the previous evening to set her straight. You notice both recent and fading bruising on Kim's wrist and upper shoulders, which she acknowledges were made by her boyfriend.

Good communication skills are the foundation of a good dietetic practice. Consider all that can be achieved by effective communication; a sense of professionalism; compliance with mandatory reporting obligations; conveying the results of an assessment without communicating a diagnosis; maintaining confidentiality; obtaining consent to treatment; providing meaningful client access to records; avoiding conflicts of interest; and preventing boundary complications or violations.

Skilled communicators build a rapport and trust with their clients and colleagues, which is necessary for information to be transmitted. Clients who feel involved in the process are more likely to make the effort to achieve the goals that have been set. Sensitive communication also reduces misunderstandings and avoids conflicts. Conversely, poor communications figures prominently in the vast majority of complaints made about health practitioners to their regulatory Colleges, and in many lawsuits against practitioners.

The first principle of the *Code of Ethics* is that to "maintain integrity and empathy in professional practice, I will…make every effort to communicate effectively with clients." Most definitions in the *Professional Misconduct Regulation* relate to poor communication in one form or another. Without good communication with clients, dietitians:

- cannot conduct a proper assessment;
- cannot obtain informed consent;
- cannot implement a treatment plan;
- cannot resolve real or perceived concerns; and
- may provoke complaints.

Two distinct communication issues are raised in Scenario 2.1, *Non-Progressing Client:*

1) How the dietitian dealt with the concerns about lack of progress; and
2) How the dietitian should deal with the client's revelation of abuse.

1. HOW THE DIETITIAN DEALT WITH LACK OF PROGRESS

With respect to the first issue, the dietitian was legitimately concerned about the lack of progress, and was understandably frustrated that it was reducing chances for a successful outcome. However, the communication strategy selected by the dietitian did not achieve the desired response, perhaps because:

- The statement by the dietitian was made without any preliminary discussion to gauge the readiness of the client to receive the message.
- The statement was accusatory, demanding and slightly sarcastic. Such statements to clients are unlikely to provoke a constructive response.
- The statement appears to meet the dietitian's need to cope with his or her own feelings of frustration, rather than the needs of the client.
- The statement uses language that may not be understood by the client. "Compliance

concerns" is almost a professional term, and an arcane one at that, which to a dietitian means that a client is not carefully following the treatment plan. A client with little familiarity with the health care system might not understand that term, and be put off by the suggestion of a duty to "comply" with recommendations from a practitioner.

- While the scenario obviously has omissions, there is no indication that the dietitian first explored, in a sensitive and cautious way, the cause underlying the lack of progress. The dietitian simply assumed that the client was wilfully choosing to give the treatment a low priority. As it turns out, personal problems may have been preventing the client from focusing on the treatment.
- There is no indication that the dietitian explained the rationale for and importance of full participation in the treatment program at the beginning of the process. Similarly, there is no indication that the dietitian obtained the client's genuine commitment to follow the treatment plan.

The dietitian may still be able to salvage the situation. Apologizing for the tone of the statement would be a good start.

2. HOW THE DIETITIAN SHOULD DEAL WITH THE CLIENT'S REVELATION OF ABUSE

The key to salvaging the situation, however, may well be how the dietitian deals with the second communication issue—the revelation of abuse by the client. Again, there are a number of considerations:

- **Avoid compensating for earlier comments.** First, the dietitian needs to ensure that any guilt feelings about the earlier statement do not cause her or him to overcompensate in dealing with the client's abuse revelation. As noted in Chapter 10, proper boundaries must still be maintained; the dietitian must approach this information as a dietitian, not as a personal friend. Be aware of training limitations and the scope of practice.
- **Remain aware of training limitations.** Dietitians are not qualified sexual or physical abuse counsellors unless they have received additional training; even then, the dietitian needs to clarify which professional role they're serving. The dietitian is probably not capable of providing ongoing abuse counselling and probably does not have the time to do so. Similarly, assessing the nature and significance of the bruising on the client's body is outside of the dietetic scope of practice.
- **Listen with empathy.** Perhaps the most important initial response to a revelation of this nature is to listen empathetically, without criticism or judgment, letting the client express her feelings in a safe environment.
- **Explore Options.** The dietitian should explore with the client her immediate options, whether seeking a professional counsellor with expertise in this area, disclosure to friends or family members, leaving the unsafe environment she lives in, or going to the police. The dietitian should make clear that the choice is the client's, and that the dietitian will provide resources to assist the client, such as names, telephone numbers, and possibly a referral.
- **Avoid putting pressure on the client to make a hasty decision.** In all likelihood, the dietetic treatment planned for the day is now a low priority and should be postponed. When resuming dietetic treatment, the dietitian should recognize and deal with the client's readiness to change and with the barriers to implementing goals.

Why Effective Client Communication is So Difficult

Wayne McKerrow, in his article, "Improving Patient Care and Reducing Risk through Effective Communication", [1] identifies the following complications inherent in communications between health practitioners and their clients:

SCENARIO 2-2
Dress Code

Cher was named after a singer who became famous in the 1960s. Cher has taken after her namesake and likes to wear interesting and even exotic outfits. Recently, her public health employer has transferred her to a neighbourhood with a significant Muslim population.

Despite her outgoing personality, Cher has found for the first time in her career that she has difficulty developing a rapport with clients. In fact, some of them seem almost to dislike her, and many seem hesitant to bring their children to the office. Cher mentions this observation to Marvin at lunch one day. Marvin responds, "Don't get me wrong, I love what you wear, but just take a look at yourself and compare that to what your last client wore." Cher looks at the mirror and notices that her outfit has no sleeves, reveals a small bit of midriff, and displays purple bra straps. Her last client wore a traditional Muslim dress.

- **Relative Knowledge.** To become registered, a dietitian must complete rigorous university and practical training. Dietitians know a lot about dietetics and have for a long time. It takes effort and sensitivity for dietitians to put themselves in the place of their clients and remember what it was like to know nothing about dietetics. If a dietitian's explanation becomes too technical, it may not satisfy clients who need lay terms to better understand their treatment options. They may feel put down or inadequate and reluctant to ask questions.
- **Relationship of the Parties.** The dietitian and the client are not on an equal footing. On one "side" is the knowledgeable dietitian who is being consulted because of her or his expertise. On the other "side" is the client, who lacks knowledge and is asking for help. This relative circumstance is sometimes called an "imbalance of power". Given this inherent imbalance within the relationship, it takes great sensitivity and hard work to ensure that the client becomes a relatively equal partner and is able to take responsibility in the process of making decisions.
- **Non-Verbal Communications.** Clients take in not just the words spoken, but also the non-verbal aspects of communication. If the words are difficult to understand, the body language might be easier for some clients to read. If there is an inconsistency between gestures and words, clients will be confused or, worse, insulted. Ontario is a multicultural community. This diversity of communication styles increases the chances that non-verbal cues may be misinterpreted.

  The challenges of non-verbal communications in a multicultural society are illustrated in Scenario 2-2. Cher is tolerant of the choices made by others, and assumes others are tolerant of her choices. However, even though Cher may well be professional and appropriate in her speech, her approach to clothes is unconventional and bothers some people from other cultures. Cher needs to consider the impact that her outfits have on clients. The reality is that her clothes diminish her effectiveness as a dietitian. While she has rights too, and should not let others control her life, she may have to make compromises if she hopes to make a professional impact on her clientele.
- **Nature of the Information.** Often the message being conveyed by a dietitian has an emotional impact as well as a factual content. Discussing obesity, a chronic condition, a life-threatening illness, or what a person can and should eat will often generate a passionate response from clients. Dietitians have to balance their duty to provide information with sensitivity towards their client's emotional needs and beliefs.

Communication during Assessment and Treatment

Communicating effectively with clients and avoiding misunderstandings involves different considerations at all four stages of the assessment and treatment process.

BEFORE OR DURING THE FIRST VISIT

- Describe your qualifications clearly and accurately. This includes using appropriate titles and professional designations. Advertisements should be comprehensible and not misleading, even by omission. Clarify the nature of the dietetic services that you offer as appropriate for the client.
- Describe the nature of the practice adequately. If a dietitian has a restricted practice, it is better to make this known before the client arrives.
- Show excellent client-service skills. To make a good first impression dietitians and their staff (if any) should:
  - Possess basic friendliness skills;
  - Give their qualifications;
  - Follow a checklist of points to cover;
  - Confirm appointment information with the client to avoid misunderstanding;
  - Help clients complete questionnaires;
  - Explain to clients the reason for each request of information.

ON THE FIRST VISIT

- **Be punctual.** If there is a delay, apologize to the client. Some health practitioners who will not put up with waiting in line at the bank for five minutes expect their clients to wait patiently for 30 or more minutes for a pre-scheduled appointment. What message does that convey about the role of the client in the relationship?
- **Introduce yourself and talk about your professional qualifications.** It is useful to ensure that the client knows what a dietitian is. If the client seems unfamiliar with the health care system, explain that dietitians are regulated by a college under the *Dietetics Act.* In some cases, give written material about dietitians to clients to take away. Consider wearing a name tag that contains both your name and professional status. In an institutional setting, particularly where the client is sick, inquire if this would be a good time to have a discussion.
- **Listen first.** Use active listening techniques such as nodding your head where appropriate, making eye contact, asking clarifying questions and summarizing in your own words the key points of what you are hearing. Do not take notes for the first few minutes of the meeting. Understand why the client has come. Be sensitive to whether there are multiple purposes for the visit.
- **Conduct an initial assessment.** Explain the overall purpose of the assessment beforehand and the precise nature and reasons for particular aspects of the assessment. Obtain informed consent throughout. Explain the results of the assessment afterwards.
- **Develop treatment options, if you can, and describe them.** Review the advantages and disadvantages of each. Obtain feedback to ensure that the client understands them and appreciates their consequences. Obtain informed consent (see Chapter 7). Explain each step and the importance of the client's participation. The assessment and development of treatment options may take more than one visit.
- **Discuss confidentiality issues.** Explain that ordinarily the information collected is not available to anyone without the client's consent or some other legal authority. Explain who would usually have access to the information in the practice (e.g. others on the treatment team interacting with the client) and for what purposes. Obtain the client's consent (See Chapter 6).
- **Discuss the financial aspects of the relationship if the service is not publicly funded.** Who will pay, how much and when? Be clear about terms of payment, as clients often complain about this area in private practice. Also, discuss what client information may be disclosed for financial purposes to a payer such as an insurance company.

  Scenario 2-3, *Block Billing Boondoggle*, on the next page, identifies the unique difficulties created by the financial aspects of private practice. Good communications strategies require that the financial aspects of the

relationship be clearly explained and understood before assessment and treatment begin. Simply describing the arrangements on a brochure or a consent form is not sufficient. You need to have an explicit discussion to ensure a meeting of minds.

Whenever unusual or unfamiliar billings models are used, like block fees, the explanation needs to be even clearer. For example, the dietitian needs to obtain feedback from the client on what happens if the follow-up visits are not used, to ensure the client understands it.

- **Discharge planning is an important part of good client communication.** As much as possible, explain how and when the treatment sessions will likely end.

DURING ONGOING VISITS

- **Continuously maintain informed consent.** Check that the client knows what is happening and why. Discuss any proposed changes in advance, ensure the client is in agreement and that nothing has happened to the client that might alter treatment or recommendations.
- **Anticipate misunderstandings.** Being alert to miscommunications ensures that they are caught early and remedied. Diligence in this area greatly reduces the disruption that misunderstandings can cause.
- **Continue to plan for discharge.** In this way, the client is not surprised and can prepare effectively for the transition. This approach also serves as a reminder of what must be arranged before discharge (e.g., home services, necessary equipment or prescriptions, home instruction sheets, and a list of contact and referral information).

WHEN DISCHARGING A CLIENT

- **Review with the client whether their treatment goals were achieved.** If not, review the reasons why and the options available to the client.
- **Ensure that the client and their family agree with the discharge.** If not, communicate the reasons for discharge and the implications for the client and the family.
- **Make sure that any post-discharge supports are in place.**
- **Obtain feedback on your service.** This can be an effective part of the continuous quality improvement (CQI) of your practice. Upon discharge, clients are most likely to provide candid feedback.

SCENARIO 2-3
Block Billing Boondoggle

June has a successful private dietetics practice centred on weight gain and related illnesses such as diabetes. Typically she offers a complete assessment and treatment plan and five follow-up visits for $500. This is set out in the office brochure. If the services were purchased individually they would cost over $600. Every couple of months, she has to spend time dealing with a client who did not use all of the follow-up visits and wants a partial refund. Is June doing something wrong?

Communication Style and Techniques

There is no universal approach to communication. Everyone has to develop a communication style that fits with their personality. Whatever techniques you choose, consider some factors that can support or detract from your communications.

ENVIRONMENT

Dietitians can often block out their environment because of their ability to focus in familiar surroundings. However, clients may find that having other people around, frequent interruptions and a high noise level can interfere with their ability to concentrate on their dietitian's message. Consider, too, any communications obstacles a client might have, such as hearing difficulties, and adjust for them.

CULTURAL SENSITIVITY

Ontario is a multicultural society, and different cultures respond in different ways to authority (as dietitians are perceived by some) and to various communications styles. For instance, some cultures discourage questioning a health practitioner. In such a case, acquiescence might not constitute true consent.

In other cultures, it is inappropriate to shake hands upon introduction. And in cultures where males traditionally dominate, the dietitian needs to consider the expectations of a father, husband or other senior male family member in the counselling of a female client. Failing to do so may result in ineffective communication.

Becoming familiar with the "do's and don'ts" of a culture can significantly improve the effectiveness of communication (see Scenario 2-2 *Dress Code*). Language barriers also require special measures, including obtaining an interpreter (family member, colleague or an official translator), demonstrating some matters physically, or asking the client to demonstrate what they have learned.

SENSITIVITY TO LEVELS OF LITERACY AND EDUCATION

Dietitians need to be aware that a client's literacy level may also affect comprehension. People who have limited reading and writing skills may find it difficult to understand technical dietetic terms. Make sure that you explain treatment processes in a way that can be easily understood by your clients.

TIME

Good communication takes time, particularly at the beginning of the professional relationship. Rushing through each visit is a prescription for miscommunication. However, most dietitians are busy professionals who have to use their time wisely. Consider developing checklists, handouts and diagrams to ensure that time spent with clients is efficient.

REPEATING KEY POINTS

Repeating important points and essential messages in multiple formats (oral, written, video) helps to reinforce messages. If a dietitian has staff who can go over significant items, clients are much more likely to retain key points. On subsequent visits, the dietitian may want to review them again.

ACCESSIBILITY

Some clients are hard to reach. Make sure you have as much contact information as possible (home, work and cell numbers, email addresses, fax numbers, contact people, and a mailing address) should you need to communicate outside formal visits. Clarify the degree of privacy for many of these forms of communication and have consent for leaving messages where privacy is not assured.

In addition, should the client need to reach you, provide guidance as to what works best, such as leaving a detailed voice message or sending an e-mail. If you are not able to access one of the methods of communication frequently, advise clients that there may be delays and suggest an alternative. However, once you provide a contact route, you have a professional responsibility for checking it regularly.

HANDLING DISAGREEMENTS.

Dietitians cannot expect to have full agreement in every case. Conflicts or differences of opinion can develop with clients, a member of their family, or members of a client's care team. Being a professional means trying to understand the full reasons for the concern, clarifying intentions and expectations, and working on a resolution if possible. If all else fails, refer the issue or the client appropriately and courteously to someone else.[2]

Strategies for Effective Communication

Fundamentally, dietitians need to understand their clients. How much information can they absorb? What type of information do they need to take away with them? What resources do they need? Make everything real for them. For example, do not just tell clients they need more calcium; tell them about the calcium-rich foods they need to buy when they go shopping, and focus on foods that they like to eat. Words, body language and ability to listen will tell clients that their dietitian cares for them and their well-being.

WORDS

How we speak is as important as our choice of vocabulary. When speaking with clients, recognize and practise these strategies:

(a) Use tact and consideration when explaining procedures to clients to avoid causing anxiety;

(b) Meet the client's health care needs. Undertake all interactions with clients with this in mind. If self-disclosure meets the needs of the client, and not merely the personal needs of the dietitian, then such disclosure may be appropriate (as discussed in Chapter 10, *Boundary Issues,* self-disclosure has to be managed with extreme care);

(c) Be honest and straightforward to demonstrate respect and concern for clients;

(d) Legitimize the client's fear and embarrassment (natural emotions when submitting to an assessment or procedures);

(e) Reassure clients by demonstrating respect and empathy;

(f) Provide clients with an opportunity to ask questions;

(g) Provide clients with answers within the scope of a dietitian's responsibility; and

(h) Talk directly to clients when working with interpreters or members of their support networks. Be mindful that an interpreter may not accurately translate what the dietitian or client has said.

BODY LANGUAGE

Body language, the nonverbal component of language, conveys as much as words. Remember to:

(a) Maintain appropriate eye contact, depending on the cultural environment;

(b) Adopt appropriate facial expression to convey concern, understanding and attention;

(c) Be careful when using physical gestures;

(d) Respect each client's personal sense of space;

(e) Position yourself appropriately so that clients can easily see everyone present.

LISTENING SKILLS

Since the goal of communication is mutual understanding, listening is just as important as speaking. Communicate with your entire being, to listen and carefully observe clients. By listening effectively, you can modify your speech to match the needs of the clients.

(a) Observe a client's own non-verbal communication signals; and

(b) Verify understanding of the intended message, and clarify or re-phrase the message if necessary.

Communication with Other Professionals

The *Regulated Health Professions Act* makes interprofessional collaboration an express duty for both the College and dietitians. The College's mandate by law is to collaborate with other health colleges and to promote interprofessional collaboration between dietitians and other health practitioners. Interprofessional collaboration between dietitians and other

SCENARIO 2-4
Disagreement with Colleagues

You work in a hospital. A physician orders a diet and refers the client to you to implement the order. You conclude after your assessment that the diet is not appropriate for this client. You try to raise the issue with the doctor, who cuts you off and insists that you teach the recommended diet to the client. What do you do?

practitioners is also a component of the quality assurance program.[3]

Sometimes communication with colleagues, employers, government agencies, and third party payers can be more difficult than speaking with clients. However, in the scenario above, dietitians do not have full responsibility for successful communication, as they would with their own clients. Other people and organizations have a mutual or shared duty to communicate effectively and sometimes one or both parties are not prepared to meet halfway. Under the *Code of Ethics*, dietitians have a duty to be collegial. Dietitians also have an obligation, in serving their clients' interests, to make these ancillary relationships work. They must put their duty to client care first.

When there is a difference of opinion between a dietitian and physician, dietitians have a duty to ensure good communications and maintain client trust in the professionals who care for them. Many of the same strategies and styles discussed above apply to these communications as well. Here are other suggestions that may help:

- **Know the facts.** Do your own assessment. Review as much of the record as possible. Have the literature references handy.
- **Approach the practitioner in a collaborative way.** Instead of criticizing the recommendation, engage the colleague in a discussion of what options might best serve the client's interests and wishes. Try to give additional information that might provide a basis for the colleague to change his or her view.
- **Try not to put clients in the middle, or to "lobby" clients for your own position.** Of course, do not exclude clients from making informed choices. This can be appropriately handled without unnecessarily involving clients in a treatment-team dispute.
- **Document the discussion and its results.**
- **Adhere to the facility regulations and policies related to authority to write orders** (see Chapter 4).

The IPC Charter and Communication

Client-centred care places patients and families at the apex of the health care system and the collaborative efforts of health care providers. It is a highly held value and a cornerstone of dietetic practice. It is also central to improving interprofessional care (IPC). In November 2009, *HeathForceOntario* released a report and accompanying *Resource Guide for IPC Competence* presenting ideas and a tool kit to support patients, caregivers and leaders in the health sector to collaborate and communicate effectively with each other. The IPC Charter (see next page) was developed to foster a shared vision of collaborative care and a common language to advance IPC competence and communication.[4]

Conclusion

Effective communication is the foundation of a dietitian's practice. In recognition of the many barriers to good communication, dietitians must continually assess their skills, and be deliberate in their efforts to minimize misunderstandings. Consider environmental and cultural factors. Developing strategies for enhanced communication can make a difference in your effectiveness in treating clients.

1 *Health Law in Canada*, 1997: Vol. 18, No. 1, pp.30-32.

2 For more detailed examples, see Chapter 10, "Boundary Issues", and Chapter 1, "Introduction to Professionalism".

3 College of Dietitians of Ontario, "New Regulated Health Professions & Interprofessional Collaboration." *résumé*: Summer 2009, p. 5.

4. Oandasan. I., Robinson, J., Bosco, C., Carol, A., Casimiro, L., Dorschner, D., Gignac, M. L., McBride, J., Nicholson, I., Rukholm, E., & Schwartz, L. (2009). *Resource Guide for IPC Competence*. Toronto: University of Toronto. www.healthforceontario.ca/upload/en/whatishfo/ipcproject/ccwg%20resource%20guide%20_nov%2020%20-%20final%202010_.pdf

Figure 2-1

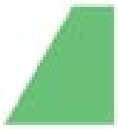
ADVANCING COMPETENCE IN INTERPROFESSIONAL CARE: A CHARTER ON EXPECTATION AND COMMITMENTS

Patient Expectation

As a patient in Ontario, I expect my health care to be provided by various health caregivers who respect me and the health care choices I make. My caregivers seek to know my health experience and are prepared to work with me across settings to combine their knowledge and skills to meet my health goals.

IPC Blueprint

Interprofessional care (IPC) is the provision of comprehensive health services to patients by multiple health caregivers who work collaboratively to deliver quality care within and across settings.



Caregiver Commitments

As a health caregiver in Ontario, in supporting the IPC vision,

1. I will seek to know the experience of those I care for, respect and strive to understand their needs, and work with them to develop their care plans that acknowledge their choices,
2. I will understand my role and understand the role and expertise of other health caregivers,
3. I will inform those who are caring for patients with me about the care I am providing with them,
4. I will ask questions, communicate to be understood, seek input and listen respectfully to generate options for care,
5. I will be aware of how my own behaviour and attitudes impact interprofessional care and how I actively foster a culture of collaboration, and
6. I will acknowledge that there are limits to what I know and will continue to learn from others so that care can be better integrated and led by the best possible ideas.

Leader Commitments

To meet patient expectation(s) and enable caregiver commitments in Ontario, as health system leaders,

1. We will align our language, processes, structures and resources to foster an IPC culture,
2. We will create opportunities to collaborate within and across sectors to integrate IPC into practice, education, policy and research,
3. We will measure and evaluate our IPC initiatives to know what is being achieved, and
4. We will continuously improve IPC in the health care system by identifying, promoting and implementing practices that make a difference to patient care.

IPC Charter

Chart From: Oandasan. I., Robinson, J., Bosco, C., Carol, A., Casimiro, L., Dorschner, D., Gignac, M. L., McBride, J., Nicholson, I., Rukholm, E., & Schwartz, L. (2009). *Final Report of the IPC Core Competency Working Group to the Interprofessional Care Strategic Implementation Committee: Resource Guide for IPC Competence.* Toronto: University of Toronto, p. 8.

Quiz

Provide the best answer to each of the following questions. Some questions may have more than one appropriate answer. Explain the reason for your choice. See *Appendix 1* for answers.

1. **In Scenario 2-1, *Non-Progressing Client*, what should the dietitian do about the abuse revelation?**
   a. Counsel the client on assault syndromes.
   b. Refer the client to an assault counsellor.
   c. Refer the client to a physician to examine her bruises.
   d. Encourage the client to move out of her current living arrangement with her boyfriend.

2. **In Scenario 2-4, "Disagreement with Colleagues", what should you do?**
   a. Refuse to teach the diet.
   b. Teach the diet but tell the client you do not agree with it.
   c. Pursue additional communication strategies such as involving your team leader.
   d. Tell the client about your disagreement with the doctor, including how the doctor responded to your concerns.

3. **Poor communication can lead to which of the following?**
   a. Less than ideal results.
   b. A complaint to the College.
   c. A lawsuit.
   d. Losing clients.

4. **A hiring freeze results in a 40% reduction in your staff at a time when referrals increase by 25%. Your waiting list has reached six months. What should you do first?**
   a. Explain the situation and its consequences to your supervisor both verbally and in writing.
   b. Provide only mini-assessments on a first visit, and then deal with all clients through group work.
   c. Write a letter to the board of the organization and, if that fails, quit.
   d. Write a letter explaining the situation to your referral sources.

5. **What is the most significant barrier to effective communication with clients?**
   a. Dietitians are too knowledgeable.
   b. Dietitians' expertise makes it easy to overlook a client's perspective.
   c. Ontario is multicultural.
   d. Dietitians are pressed for time.

Resources

COLLEGE OF DIETITIANS OF ONTARIO

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DIETITIANS OF CANADA AND COLLEGE OF DIETITIANS OF ONTARIO

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LEGISLATION
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PUBLICATIONS

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Back to Table of Contents

THREE

College of Dietitians of Ontario

Requirements under the *Regulated Health Professions Act* & Other Statutes

AT A GLANCE

SCENARIOS

FIGURES

NEED TO KNOW

1. The *Regulated Health Professions Act* and other legislation create obligations for dietitians that they need to learn, like mandatory reporting.

2. Dietitians have a duty to cooperate with the College of Dietitians of Ontario in investigations, inquiries and assessments.

3. The challenge for dietitians is to balance competing interests appropriately.

The Structure of the RHPA

Laws originate from two main sources: case law and statutes. The courts decide case law, often called "common law". For example, the case of McInerney v. MacDonald (1992), 93 D.L.R. (4th) 415, is a decision of the Supreme Court of Canada, which indicates that clients generally have a right to look at and obtain a copy of their chart from their health practitioner. Although not directly aimed at dietetic practice, this law also applies to clients of dietitians. This case law existed long before the *Personal Health Information Protection Act*, 2004 (PHIPA) was enacted. In many respects, PHIPA consolidates and then extends the case law.

Either the Federal or the Provincial Legislature can make a "statute", often called an "act". A number of statutes, not directly related to the regulation of the profession, affect the practice of dietetics. The *Public Hospitals Act*, for example, affects dietitians who work in public hospitals. Sometimes, the province enacts more than one statute to form a unified set of laws relating to one topic. The following legislation directly relates to how dietitians are regulated:

- The ***Regulated Health Professions Act*** sets out the framework for the regulation of the entire health profession sector and the role of the Minister of Health and Long-Term Care.
- The ***Health Professions Procedural Code*** is an attachment, or schedule, to the RHPA. It sets out the common duties and procedures for individual health Colleges, including the College of Dietitians of Ontario. For example, it specifies the responsibilities of the Council and the seven statutory committees of each College.
- The ***Dietetics Act*** is a distinct statute. It deals specifically with issues pertaining to the regulation of dietitians, such as the dietetic scope of practice and the protection of dietetic titles.

Many statutes authorize the making of further law through regulations or by-laws without having to go to the legislature again. Regulations appear under both the RHPA and the *Dietetics Act*. Those under the RHPA are general in nature, applying to all health professions, while regulations under the *Dietetics Act* specifically address the regulation of dietitians including:

- Registration ;
- Professional misconduct;
- Quality Assurance Program;
- Notice to the public of open meetings and hearings; and
- Funding for therapy and counselling for clients who have been sexually abused.

The College also has by-laws that deal with internal administrative matters, such as elections to the Council, composition of committees, fees, the content of the register of members, and the reporting of information by members to the College.

In addition to this legislation, the College has created a number of guidelines, policies and standards. Strictly speaking, these are not laws, but tools that assist members to comply with their legal and professional obligations.

Duties of the College Under the RHPA and the *Dietetics Act*

Under the RHPA and the *Dietetics Act*, the College has the mandate to regulate the dietetics profession. Its duty is to serve and protect the public interest. The College does not exist to advance the interests of the dietetic profession; this is the role of professional associations. Still, there is no doubt that a well-regulated profession preserves its reputation and stature.

Further, the College has a duty to act fairly when dealing with its members. Legal "fairness" means that before the College takes any action that might harm a dietitian's rights, such as making a finding of professional misconduct, or imposing a fine or suspension, the College must notify the member of the concern, and hear and consider the member's explanation.

The RHPA requires regulated health colleges to carry out seven core functions to achieve public protection:

1. Registration
2. Public Register
3. Complaints, Reports and Investigations
4. Discipline
5. Incapacity
6. Quality Assurance
7. Patient Relations

1. REGISTRATION

The College has a duty to ensure that only qualified applicants are given a *Certificate of Registration* to practice as a dietitian. If the College does not accept an applicant's qualifications, it must give reasons for the decision, and provide the applicant with a right of review before the independent *Health Professions Appeal and Review Board*.[1]

2. PUBLIC REGISTER

The College is obliged to maintain a register of all members containing basic information about their registration status (e.g., category of registration, whether there are any terms, conditions or limitations), business contact information, discipline history and other information (e.g., findings of professional negligence). The register must be available on the College's website. This enables members of the public to make informed choices about using the services of a dietitian.[2]

3. COMPLAINTS, REPORTS AND INVESTIGATIONS

The College must operate a public complaints system, and investigate every complaint received about dietitians. When a complaint is received, the dietitian must be notified of the complaint and get an opportunity to respond in writing. Both the dietitian and the complainant have a right of review before the independent *Health Professions Appeal and Review Board*, unless the matter results in further action by the College. The College has published a detailed description of the complaints process in an articles in *résumé* entitled, *Investigations of Members – how they get started* (Spring 2008) and *Inquiries, Complaints and Reports Committee* (Spring 2009).[3]

In addition to public complaints, the College has a duty to investigate concerns about members that arise from other sources such as mandatory reports (Table 3-1, p. 33).

4. DISCIPLINE

If concerns from a complaint or a report are serious and are supported by sufficient evidence, the Discipline Committee will hold a formal discipline hearing. Any finding of misconduct or incompetence, and any penalty ordered, may be appealed to the courts.

5. INCAPACITY

If there is a concern that a member has an illness that is likely to interfere with their ability to practice or their professional judgment (e.g. certain chronic and severe mental illnesses or substance abuse), the College can inquire into the matter. Should medical evidence substantiate a concern, the College will attempt to negotiate a treatment and monitoring plan with the member. If no agreement can be reached, a formal hearing is held in private before the Fitness to Practise Committee. The committee can order, among other things, ongoing treatment and monitoring. Any decision can be appealed to the courts. The College has published two useful resources in the *résumé* newsletter:

1. "Fitness to Practice", *résumé* , Spring 2002, p. 6;
2. "When Stress Leads to Incapacity What Can I Do", *résumé*, Winter 2006, p. 2.

6. QUALITY ASSURANCE

The College is required to establish and operate a Quality Assurance Program for its members to encourage and assist members in being the best dietitians possible. The program is non-punitive and participation is mandatory.[4]

7. PATIENT RELATIONS

Another non-punitive program, the Patient Relations Program, tries to provide education, guidelines and tools for both dietitians and members of the public to support constructive, collaborative and non-exploitative interactions with clients. While preventing or dealing with sexual abuse of clients is a mandatory component of the Patient Relations Program, it is far from being its exclusive focus. It also provides funding for therapy and counselling for abused clients. Reports about abuse are dealt with in a respectful and timely manner.

Duties of Dietitians Under the RHPA and the *Dietetics Act*

This section explains the essential aspects of a dietitian's most important obligations as set out in the *Regulated Health Professions Act*, (includes the *Health Professions Procedural Code)* and the *Dietetics Act.* Here are the fundamental duties of every dietitian.

RESPECT OF THE SYSTEM OF CONTROLLED ACTS

Controlled acts are higher risk procedures. No one, including dietitians, is permitted to perform them without legal authority. This duty is discussed in detail in Chapter 4.

RESPECT LEGAL RESTRICTIONS FOR THE DIETITIAN TITLE

The *Dietetics Act* prohibits the use of the title "dietitian" by anyone who is not a member of the College. The prohibition includes using variations or abbreviations of "dietitian" in any language. The College takes steps to ensure that the "dietitian" title is protected by pursuing complaints about the misuse of the title. Dietitians are encouraged to report to the College anyone suspected of misusing the title.

Dietitians are not permitted to use the title "doctor" or an abbreviation or variation of that title in the course of providing or offering to provide health care to individuals in Ontario. Even dietitians who have a doctoral degree cannot use that title in the context of their practice. Dietitians with a doctoral degree can use the title socially or in non-clinical contexts, where they would not be taken to be offering to provide health care. In addition, the professional misconduct regulations prohibit the inappropriate use of a term, title or designation in respect of a dietitian's practice. An inappropriate use would likely include:

- Using a false or misleading term such as Medical Dietitian when the person is not a physician; or
- Implying specialization or certification such as Paediatric Dietitian, since there are no recognized and certified specialties in dietetics.

It is generally acceptable, however, to indicate that a practice is restricted to a particular area, such as children. It is also acceptable to use the title Public Health Nutritionist, where appropriate, because the term implies an area of practice rather than a specialty, and is recognized under the *Health Protection and Promotion Act.*

COOPERATE

The issue of cooperation is raised in Scenario 3-1, *Cooperation with the College* (next page). All dietitians have an obligation to cooperate with the College in an investigation, inquiry or assessment conducted under the RHPA. Failing to cooperate with the College is in itself professional misconduct, even if the behaviour initially being investigated is blameless. Cooperation with the College is part of the accountability expected of dietitians, including:

- Responding to College communications in a timely manner;

- Providing access to facilities and records for College investigators or assessors;
- Fully cooperating with College investigators including answering questions related to the investigation;
- Not withholding, concealing or destroying documents or things relevant to an investigation or assessment;
- Attending for cautions (formal warnings) directed by the Inquiries, Complaints and Reports Committee, or reprimands ordered by the Discipline Committee;
- Complying with a summons issued by a committee or an investigator appointed by the College;
- Providing required information to the College, including changes of information contained in the public register of the College (e.g., business address and telephone number);
- Fulfilling an undertaking or promise to the College; and
- Practising within the restrictions placed on your Certificate of Registration.

PARTICIPATE IN THE QUALITY ASSURANCE PROGRAM

Dietitians are required to participate in the Quality Assurance Program. This includes completing and returning, when requested, the *Jurisprudence Knowledge and Assessment Tool* and the *Self-directed Learning Tool*, which facilitate professional development. It also requires cooperating with any practice assessment directed by the Quality Assurance Committee or any remediation that might flow from an assessment.

AVOID SEXUAL AND OTHER ABUSE

A major theme of the RHPA is the eradication of sexual abuse of clients by registered health practitioners. Any sexual behaviour, including making a ribald comment, constitutes sexual abuse. See Chapter 10 for more details on boundary issues.

SCENARIO 3-1
Cooperation with the College

A letter arrives from the College informing you of a complaint by a client who says you were rude. The College asks you to respond to the complaint within 30 days. In fact, you believe that it was the other way around, and can barely contain your frustration at having to deal with yet another problem. You are already working 60-hour weeks, have a mother who can barely cope in her home, and as the only child in the city, are trying to persuade her to go to a retirement home.

Six weeks go by, and you receive a reminder letter from the College. On a visit to your family physician for a recurring cough, she diagnoses you with exhaustion and tells you to stop all work related activity for a month. What do you do?

AVOID TREATING CLIENTS WHILE INCAPACITATED

A dietitian must not treat a client while being impaired by any substance or illness. This means avoiding situations that can lead to trouble, such as booking client visits after a Christmas luncheon or party where alcohol might be consumed, or skipping necessary medication.

Special provisions exist to deal with situations where the illness itself so impairs judgment that a dietitian may not know that they are incapacitated. Typically, this occurs with addiction to alcohol or drugs, or with some severe and chronic mental illnesses. If these conditions are confirmed upon a full inquiry — which can include an independent medical or other examination — the College will usually require the dietitian to go through treatment and monitoring to ensure client safety.

REPORT FINDINGS OF OFFENCES OR PROFESSIONAL NEGLIGENCE

Dietitians must report to the Registrar of the College if they have been found guilty of any criminal code or provincial offence, or if a court has made a finding of professional negligence or malpractice. The College will then assess

whether the particular finding is relevant to the dietitian's suitability to practise. If the finding raises no apparent concerns (e.g., a traffic offence that does not involve dishonesty or impairment), the College will simply file the report. If the finding raises concerns relevant to the dietitian's suitability to practice dietetics (e.g., a criminal conviction for fraud or professional negligence involving serious breaches of standards of practice) the College will investigate the matter to determine if some regulatory action should be taken, such as, remediation or discipline). The College is required by the RHPA to place any finding of professional negligence on the public register. Offence findings are not, however, placed on the public register.

This new provision is a self-reporting obligation only. Other dietitians do not have to make a report if they become aware of a finding made against someone else (although in some circumstances a dietitian may conclude that he or she has an ethical obligation to notify the College of a serious court finding).

CARRY LIABILITY INSURANCE

Dietitians practising dietetics as defined by the College must carry professional liability insurance as set out in the College's By-law 5, *Professional Liability Insurance Coverage Requirements for Members,* below. (See Figure 4.1: *CDO`s Definition of Practicing Dietetics*, p. 38.)

A dietitian can rely on their employer's professional liability insurance coverage only where the dietitian is an "added insured", i.e., the insurer agrees to defend the dietitian even if the employer is not sued. The College may ask dietitians to provide proof of this liability insurance coverage.

OTHER DUTIES

Numerous other duties are set out in the legislation, particularly in the *Professional Misconduct Regulation*. They include:

- competence (Chapter 1);
- honesty (Chapter 1);
- appropriate assignment of tasks and supervision (Chapter 4);
- privacy obligations (Chapter 5)
- respecting client confidentiality (Chapter 6);
- obtaining informed client consent (Chapter 7);
- record keeping (Chapter 8);
- appropriately managing conflicts of interest (Chapter 9);
- maintaining proper boundaries (Chapter 10);
- effective communication (Chapter 2);
- mandatory reporting (next page).

FIGURE 3-1
CDO BY-LAW 5

Professional Liability Insurance Coverage Requirements for Members

1.01 A member engaging in the practice of dietetics shall maintain professional liability insurance coverage with the following characteristics:

a. The minimum coverage shall be no less than $2,000,000 per occurrence.

b. The aggregate coverage shall be no less than $5,000,000.

c. The deductible shall be no more than $1,000.

Mandatory Reporting for Dietitians

A special duty under the RHPA, and indeed other statutes, is to make mandatory reports to the proper authority when certain events occur, such as sexual abuse of a client, child abuse, abuse of an elderly person in a long-term care or nursing home, or unprofessional behaviour of another dietitian. If it appears that one of these situations exists, a dietitian should obtain specific legal advice. Figure 3-2, *Mandatory Reporting Requirements for Dietitians* (p. 33), identifies the reporting requirements, what must be reported, and to which authority.

Generally, failing to make a mandatory report is professional misconduct, and carries significant consequences. In some cases, dietitians can be prosecuted and fined up to $50,000 in Provincial Offences Court. A dietitian could also be sued for any harm that results. Some years ago, a physician was successfully sued for more than half a million dollars for failing to report a client who was a danger to others, and who then harmed someone in a motor vehicle accident.

A mandatory report is not a breach of confidentiality, even where a client does not want a report to be made. A dietitian's duty of confidentiality is subject to other requirements or authority of law.

REASONABLE GROUNDS

Many of the mandatory reporting criteria refer to "reasonable grounds to believe". That phrase has two components:

1. **Reasonable grounds refer to objective information, not personal belief.** If the facts are present, a report must be made even though you might not believe the facts to be true. A dietitian does not have to make a detailed evaluation of whether the person providing the information is credible -- so long as there is some objective basis for making the report.

2. **Reasonable grounds describe the type of information needed to make a report.** Mere rumour or gossip does not constitute reasonable grounds; for example, a nurse saying over coffee that everyone knows that a certain doctor in the hospital sleeps with his patients. However, hard evidence or clear proof is not needed either. Information from someone who did not personally observe the event is fine, so long as it contains some specifics.

For a report under the *Child and Family Services Act,* only reasonable grounds to "suspect", not "believe", is needed. This means that the degree of information suggesting that a child is in need of protection can be quite low.

Mandatory Report of Sexual Abuse

SCENARIO 3-2
Sexual Abuse

You have been working with your client, Maria, for some time and have developed a fairly cordial professional relationship. On one visit, Maria seems quite subdued. After your attempts to engage her don't work, you ask her what is wrong. Maria bursts into tears. After regaining her composure, she tells you that her family physician conducted an improper breast examination. She describes what occurred, which certainly sounds like an unusual breast examining technique. You know the identity of the physician from her file. What are your legal obligations?

When dealing with revelations of sexual abuse, it is important for dietitians to manage them sensitively and not cause further harm. In addition, dietitians need to be aware of their professional legal obligations. Scenario 3-2, *Sexual Abuse*, raises the issue of mandatory reporting obligations and when they apply. According to law:

- A report of sexual abuse under the RHPA must be made if a dietitian has reasonable grounds, obtained in the course of practising dietetics, to believe that a regulated health professional has sexually abused a patient.

- A report of sexual abuse under the RHPA cannot include the identity of the client unless the client gives written consent to including his or her name.
- A report of sexual abuse under the RHPA must be made within 30 days unless there are reasonable grounds to believe that additional abuse may occur, in which case the report must be made immediately.

Mandatory Report of Child Abuse

Any person who has a reasonable suspicion that a child is in need of protection needs to report that suspicion to the local *Children's Aid Society*. While everyone has this duty, it is an offence for a dietitian not to make a report when the information is obtained in the course of practising dietetics.

The definition of a child in need of protection, under the *Child and Family Services Act*, is quite lengthy and complex. For example, one part of the definition states: "The child requires medical treatment to cure, prevent or alleviate physical harm or suffering and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, the treatment." Obviously, there can be some debate as to the precise meaning of that definition. If in doubt, get advice.

Duty to Warn

The duty to warn is the professional obligation for dietitians to notify appropriate third parties and/or authorities when a clear threat of harm or death is made by a client to another identifiable individual or group. The duty to warn may also apply when a client is at significant risk of seriously harming themselves. The duty to warn created by case law is not defined very clearly and permits some variation in interpretation.

The *Personal Health Information Protection Act* provides legislative support for making a report without client consent in order to protect a third party from a significant risk of serious bodily harm or a client from serious self-inflicted harm (see Chapter 6).

Mandatory Reports about the Conduct of Another Registered Health Practitioner

One of the more frequent mandatory reports is for terminating an employee or an association with another registered health practitioner, including other dietitians, for professional misconduct, incompetence or incapacity. A dietitian might make a report to the Registrar of a college, for example, when ending a group practice because they could no longer tolerate a practitioner's drinking or repetitive rudeness to clients.

Another reporting obligation for dietitians who operate a facility, such as a long-term care home, is where they have reasonable grounds to believe that another registered health practitioner is incompetent or incapacitated. Incompetence refers to a significant demonstration of a lack of knowledge, skill or judgment towards a patient. Incapacity generally refers to a mental or substance abuse illness that impairs the practitioner's judgment. This reporting obligation is in addition to "termination" reports. The two work together as follows:

- If the association (e.g., employment) with a registered health practitioner is terminated, the facility and/or the Registered Dietitian must report the matter in all cases, including professional misconduct, incompetence or incapacity.
- If the association with a registered health practitioner is not terminated, the facility and/or the Registered Dietitian must report incidents of unsafe practice or unethical conduct, incompetence and incapacity.

Employers and facility operators generally have a sense as to what incompetence or incapacity are, but may not always appreciate what constitutes professional misconduct for a

dietitian. The starting point is to read the definition of professional misconduct found at the beginning of this book. Generally, misconduct involves any breach of honesty or trust. In addition failure to comply with any fundamental standards of practice (e.g., confidentiality, informed consent, etc.) would also qualify. Where in doubt the employer or the facility operator can contact the College.

Scenario 3-3 illustrates the issue of when a

SCENARIO 3-3
Breach of Employer Rules

George has been fired for repeated personal use of facility phones during work hours and for failing to re-assess residents of the facility every three months. Should the employer report the matter to the College?

breach of employment rules is reportable. Even though George was fired, a report is only necessary if the conduct constitutes professional misconduct. Not all breach of employer rules constitute professional misconduct. One has to look at whether the breach compromised safety, created a risk to clients or jeopardized patient care or amounted to a serious departure from the honesty or trust that the public can expect from dietitians. Further guidance is provided by the 34th definition of professional misconduct with reads as follows:

> "34. Contravening a federal, provincial or territorial law, a municipal by-law or a by-law or rule of a facility where a member practices if,
>
> i. the purpose of the law, by-law or rule is to protect the public health, or
>
> ii. the contravention is relevant to the member's suitability to practise."

In Scenario 3-3, the personal use of facility phones during business hours is more of an employment management issue than one of professional misconduct. While it is true that there may have been some brief absences from client care when making the calls, those absences likely were not material to client care. The failure to re-assess residents may be another matter, particularly if it occurred over several months, not just a few days, and the clients were high risk. Depending on the circumstances a mandatory report may well be required for that matter.

Writing a Mandatory Report

A report should either be made or confirmed in writing. Here are some key elements for writing a report:

- Provide a summary of the concern. Be clear about the concern. Do not make the reader guess, particularly if the matter is technical or clinical.
- Provide details. This will assist the recipient to respond appropriately. It may also reduce your subsequent involvement in answering obvious questions. It is usually acceptable to attach pertinent documents.
- Include a list of witnesses the authority may wish to contact. Remember, for reports of sexual abuse under the RHPA, the identity of the client cannot be included unless he or she consents in writing.
- Include any response or explanation from the subject of the report. Fairness would suggest that it be mentioned in the report. This demonstrates good faith. In addition, including the response helps everyone understand the complete situation. You are not taking sides by making a report, but providing important information to an authority.
- Outline any action that has been taken to date on the allegation. It is important for the authority to know, for example, that the person has been placed on workplace suspension.

The Formal Investigation

Once the mandatory report is made, the authority will first consider if there is enough information to conduct a formal investigation. If there is any doubt, the reporting dietitian will probably be contacted again. If a formal investigation is initiated, the investigator will focus on locating and interviewing firsthand

witnesses of the actual events, and obtaining documents that might bear on the allegations. Most authorities try not to reveal the name of the person making a mandatory report. However, it sometimes is necessary to disclose the name in order to properly investigate or prosecute the matter.

Should dietitians conduct their own investigation if a mandatory report is going to be or has been made? There is no clear answer to this question. Some worry that this could interfere with or even jeopardize the official investigation. Nonetheless, proceed with great caution and consider these factors:

- In every case, try not to disturb the evidence. Make sure that documents are not altered by your inquiries. Ensure that the recollection of witnesses is not affected by asking leading questions, or interviewing them in the presence of other witnesses or people who may, by their mere presence, influence the answers.
- Only make inquiries if there is an important reason for doing so, for example, to ensure that sufficient facts have been collected in order to make the report, establish whether anyone is at immediate risk or take necessary internal disciplinary action.
- If it is reasonably possible, wait until the authorities have completed their investigations.

Protection from Retaliation

When a dietitian makes a mandatory report, there is some legal protection from retaliation. Unless acting in bad faith, the reporting dietitian cannot be successfully sued for making a mandatory report. Making a false report in order to get someone into trouble would be an illustration of bad faith.

A dietitian making a report that later turns out to be groundless would still be protected if there was information to support the report, even though that information was incorrect. Some statutes provide additional protection as well. The RHPA for example, protects people who submit reports from retaliation in their employment or their contract to provide services.

Even where the criteria for making a mandatory report are not present, courts tend to offer similar protections for voluntary reports made to an appropriate authority in good faith. For instance, if you learned at a party about a health practitioner having sexual relations with a client, a report would not be mandatory (Table 3-1, next page). However, you might feel compelled to report the matter in order to protect the public, and could expect legal protection.

Conclusion

For reasons of public protection, the *Regulated Health Professions Act* and other laws specify the obligations of dietitians. For those who are unaware of their professional responsibilities, failure to comply could mean a course of remedial action by the College, legal action or potential fines. Dietitians need to learn and understand how these laws apply to their professional practice. In an effort to guide dietitians, the following chapters examine the complexities of jurisprudence issues in detail and their application to dietetic practice.

1 The *Health Professions Appeal and Review Board* is appointed by the government and is made up of lay people. Depending on what the applicant requests, the Board will either conduct a paper review or conduct a full hearing with witnesses to assess whether the Registration Committee made a reasonable decision. If the Board believes that the Registration Committee made an unreasonable decision, it can make a number of orders including referring the matter back to the Registration Committee for reconsideration, or even directing that the Registration Committee register the applicant. The Board also reviews decisions made by the Inquiries, Complaints and Reports Committee of the College.

2 Richard Steinecke. Transparency and Privacy What the World Will Know About You. *résumé:* Spring 2009, p. 4.

3 Dean Benard, RN., LL.M., C.Med, "Investigations of Members — How they get started", *résumé*, Spring 2008, p. 6. And, Richard Steinecke, LLB. "Inquiries, Complaints and Reports Committee", *résumé*, Spring 2009, p. 6. Also see, *What Happens When you make a Complaint.* on the College website.

4 The College's website has an entire section explaining its Quality Assurance Program: www.collegeofdietitians.org > Members: Quality Assurance Program

Figure 3-2: Mandatory Reporting Requirements for Dietitians

WHAT MUST BE REPORTED	LEGISLATION / LEGAL AUTHORITY	TRIGGER FOR REPORT	WHO IS RESPONSIBLE FOR THE REPORT	REPORT TO
Sexual relations, touching, behaviour or remarks of a sexual nature between a registered health practitioner and a client where you know the name of the alleged abuser.	*Regulated Health Professions Act*	Reasonable grounds obtained either in: 1. The course of practising your profession; or 2. Operating a health facility.	1. Dietitian; or 2. Facility Operator (e.g., CEO, administrator, or their delegate).	The Registrar of the College to which the person belongs.
Professional misconduct, incompetence or incapacity of a registered health practitioner.	*Regulated Health Professions Act*	1. You are terminating employment; 2. You are revoking, suspending or imposing restrictions on privileges; 3. You are dissolving a partnership or association; or 4. You intended to terminate or revoke, and the person quits first.	Any person who meets the trigger must make the report.	The Registrar of the College to which the person belongs.
Incompetence or incapacity of a registered health practitioner.	*Regulated Health Professions Act*	You operate a facility and have reasonable grounds to believe that a registered practitioner is incompetent or has an incapacity.	Facility Operator (e.g., CEO, administrator, or their delegate).	The Registrar of the College to which the person belongs.
Offence details, professional negligence or malpractice details in a finding by a court.	*Regulated Health Professions Act*	A dietitian is the subject of a finding by a court.	Self–report must be made by the dietitian who has been the subject of the finding by the court.	The Registrar of the College of Dietitians of Ontario.
Incidents of unsafe practice or unethical conduct by another dietitian.	*Professional Misconduct Regulation for Dietitians*	Not stated. Probably reasonable grounds.	Dietitian	Any appropriate authority.
That a child (under 16) is in need of protection as defined in the Child and Family Services Act (e.g., suffering abuse or neglect).	*Child and Family Services Act*	Reasonable grounds to suspect.	Any person who meets the trigger must make the report.	Children's Aid Society The report must be personal; cannot delegated.
That a resident of a long-term care or retirement home has suffered or may suffer harm as a result of unlawful conduct, improper or incompetent treatment or care, neglect, or misuse or misappropriation of a resident's money or of funding provided, among other events.	*Long-Term Care Homes Act,* and the *Retirement Homes Act*	Reasonable grounds to suspect.	Any person who meets the trigger must make the report, other than another resident.	The Director at the Ministry of Health and Long-Term Care (for long-term care homes or nursing homes), and the Registrar of the *Retirement Home Regulatory Authority* (for retirement homes).
That an identifiable person or group is at substantial risk of serious harm or death from another person.	Case law "duty to warn"	Reasonable grounds to suspect.	Dietitian	To an appropriate authority such as the police, the Public Guardian and Trustee or, in some circumstances, the primary care physician and, possibly, the intended victim.

Quiz

Provide the best answer to each of the following questions. Some questions may have more than one appropriate answer. Explain the reason for your choice. See *Appendix 1* for answers.

1. **In Scenario 3-1, "Cooperation with the College", what should you do?**
   a. Follow doctor's orders and do not respond to the complaint.
   b. Call or write the College explaining the situation and requesting an extension.
   c. Write a brief response because you must cooperate with the College.
   d. Call the client, apologize, explain your condition and ask her to withdraw the complaint.

2. **In Scenario 3-2, "Sexual Abuse", what do you do?**
   a. Report the physician to the Registrar of the College of Physicians and Surgeons of Ontario, with all the details including the client file.
   b. If you get the client's written consent,report the physician to the Registrar of the College of Physicians and Surgeons of Ontario.
   c. Report the physician to the Registrar of the College of Physicians and Surgeons of Ontario, with all the details except the client's identity (unless you have the client's written consent).
   d. Report the physician to the Registrar of the College of Dietitians of Ontario.

3. **You have reasonable grounds to suspect that a 17-year-old mentally challenged potential client needs an assessment for possible Type 1 diabetes. The person is clearly incapable of consenting. You have discussed the situation with the parents. The parents won't act because of their personal beliefs and have told you to drop the matter. What should you do?**
   a. Report the matter to the *Children's Aid Society* under the *Child and Family Services Act.*
   b. Contact the family physician anyway because you have implied consent to discuss the case with the client's health care team.
   c. Report the matter to the *Public Guardian and Trustee's* office (who looks after the affairs of incapable persons where there is no one else) under the common law (case law) duty of care.
   d. Search for another substitute decision-maker.

4. **You have reasonable grounds to believe that a health care aide is physically abusing a resident of a long-term care or nursing home. The resident is mentally capable but fearfully denies any suggestion that someone might be hurting her. You understand that you must make a mandatory report under the *Long-Term Care Homes Act* (2007). Should you advise the resident that you are making the report?**
   a. While not required to do so, it is a good idea.
   b. Yes, the *Long-Term Care Homes Act* requires it.
   c. No, the *Long-Term Care Homes Act* prohibits it.
   d. No, it might interfere with the investigation.

5. **On the facts raised by question 4, should you tell the administration *Long-Term Care Homes Act* of the home that you are making the report?**
   a. Yes, before you make the report, so that the administration can conduct its own investigation.
   b. Yes, after you make the report, so that the administration does not try to talk you out of it.
   c. No, it might interfere with the investigation.
   d. Yes, as soon as possible, so that the administration can take steps to protect this and other residents.

Resources

COLLEGE OF DIETITIANS OF ONTARIO

résumé

- "Fitness to Practise", Summer 2002, 6-7.
- "When Stress Leads to Incapacity What Can I Do", Winter 2006, 2-4.
- "Coping with Stress at Work", Fall 2005, 1-4.
- "Liability Issues & Collaborative Practice: Part 1 - Negligence & Seven Principles of Team-Based Care, Summer 2007, p. 4-7.
- "Liability Issues & Collaborative Practice: Part 2 - Professional Liability Insurance - What you should know. Fall 2007, p. 5-8.
- "Liability Issues & Collaborative Practice: Part 3 - Understanding legal actions against healthcare teams. Winter 2008, p. 5-8.
- "Investigations of Members — how they get started", Spring 2008, 6-8.
- "Inquiries, Complaints and Reports Committee", Spring 2009, 6-7.
- "Transparency and Privacy: What the world will know about you", Spring 2009, 4-5.
- "Mandatory Reports —New Requirements", Summer 2009, 9-10.
- "RD Responsibilities for Mandatory Reporting in a Facility." Fall 2009, 4-5.
- "RD Liability Insurance FAQs", Spring 2011, p. 10.

Guidelines at www.collegeofdietitians.org >

- *Making a Complaint*
- *Responsibilities of Employers*

PUBLICATIONS

Richard Steinecke, « Mandatory reporting Obligations », Grey Areas, January 2006, www.smllaw.com/publications/newsletters-detail.asp?DocID=5472.

McInerney v. MacDonald (1992), 93 D.L.R. (4e) 415.

Federation of Health Regulatory Colleges of Ontario. A*n Interprofessional Guide on the Use of Orders, Directives and Delegation for Regulated Health Professionals in Ontario* (2007). Online guide at: www.regulatedhealthprofessions.on.ca/EVENTSRESOURCES/medical.asp

LEGISLATION

Dietetics Act, 1991, "Professional Misconduct", Ontario Regulation 680/93. Amended to O.Reg. 302/01.

Dietetics Act, 1991, "Quality Assurance", Ontario Regulation 593/94. Amended to O. Reg. 301/01, Part III.2.

Regulated Health Professional Act, 1991, S.O. 1991, Chapter 18, Prohibitions 27 (2).

Back to Table of Contents

FOUR

College of Dietitians of Ontario

Scope of Practice, Controlled Acts, Delegation and Orders

AT A GLANCE

SCENARIOS

TABLES

NEED TO KNOW

1. Controlled acts cannot be performed without proper legal authority.

2. Know each of the controlled acts as it applies to dietetics.

3. Dietitians who act outside of their scope of practice can be prosecuted for performing dangerous acts, even if they are not controlled acts.

4. Other statutes, employers and the standards of practice of the profession may impose additional limitations on a dietitian's ability to provide certain services.

Scope of Practice

Each profession under the *Regulated Health Professions Act* has a scope of practice statement that describes in broad terms the focus of the profession. For dietitians, the statement is set out in the *Dietetics Act*, Section 3, as follows:

> "The practice of dietetics is the assessment of nutrition and nutritional conditions and the treatment and prevention of nutrition related disorders by nutritional means."

There is no exclusivity to this statement. People who are not dietitians can provide these services unless they contravene a provision of the *Dietetics Act*. Specifically, they must not use the title "dietitian". Dietitians should also be aware that when they are acting outside of the scope of practice, they are not practising dietetics. They are practising something else and should not call it dietetics.

Scope of Practice and Practising Dietetics

The primary purpose of the scope of practice statement is to educate dietitians and the public about the focus of the dietetic profession. The College uses the scope of practice statement to define parameters for developing standards of practice. However, to monitor competence in dietetic practise and to help with the administration of regulations, by-laws, programs and policies, the College elaborated on the scope of practice statement with a definition of practising dietetics as follows:

> "Practising Dietetics is paid or unpaid activities for which members use food & nutrition-specific knowledge, skills and judgment while engaging in:
>
> - the assessment of nutrition related to health status and conditions for individuals and populations;
> - the management and delivery of nutrition therapy to treat disease;
> - the management of food services systems; building thee capacity of individuals and populations to promote, maintain or restore health and prevent disease through nutrition and related means;
> - and management, education or leadership that contributes to the enhancement and quality of dietetic and health services." (see Figure 4.1, next page, for more examples of practising dietetics).

The College does not consider the following activities as practising dietetics:

- Holding a position solely in non-dietetic management (e.g., Vice President or Administrator of a hospital or other organization).
- Holding a position solely in the area of human resources (HR), information technology (IT), or risk management.
- Engaging in sales or marketing of pharmaceuticals that are not related to nutrition.
- Assessing facility processes to meet accreditation standards.

Circumstances determine whether a dietitian is practising dietetics or not. For instance, a dietitian who works at a gym might provide some personal training services with no nutrition component and, in that context, would not be seen as practising dietetics. However, if the dietitian were to offer diabetes management to a client that included exercise at a gym, he or she would be practising dietetics.

Generally, the College's interest lies in regulating actions performed within the scope of practice. There are times, however, where the College can regulate aspects of a dietitian's private life that are outside the dietetic scope of practice but within its public protection mandate. This would apply where a dietitian's actions have an impact on professional ethics or public safety, such as cheating on income tax, abusing one's own child or driving while impaired. A dietitian who drinks and drives places others at risk. Would that dietitian also risk coming to work and treating patients while under the influence of alcohol? Even though the dietitian may not yet have come to work impaired, the College would have a legitimate public protection interest in regulating the behaviour.

Figure 4.1 CDO`s Definition of Practising Dietetics

"Dietetic Practise is paid or unpaid activities for which members use food & nutrition-specific knowledge, skills and judgment while engaging in:

- the assessment of nutrition related to health status and conditions for individuals and populations;
- the management and delivery of nutrition therapy to treat disease;
- the management of food services systems; building the capacity of individuals and populations to promote, maintain or restore health and prevent disease through nutrition and related means; and
- the management, education or leadership that contributes to the enhancement and quality of dietetic and health services."

For greater clarity, dietetic practice includes the following activities:

- Assessing nutrition status in clinical settings to provide meal plans, nutrition guidance or advice and/or formulating therapeutic diets to manage and/or treat diseases or nutrition-related disorders.
- Assessing, promoting, protecting and enhancing health and the prevention of nutrition-related diseases in populations using population health and health promotion approaches, as well as strategies focusing on the interactions among the determinants of health, food security and overall health.
- Managing food and management services and developing food services processes in hospitals and other health care facilities, schools, universities, and businesses.
- Conducting research, product development, product marketing, and consumer education to develop, promote and market food and nutritional products and pharmaceuticals related to nutrition disorders or nutritional health.
- Assessing compliance of long-term care homes to meet the Ministry of Health and Long-Term Care standards related to nutrition and hydration of residents.
- Developing or advocating for food and nutrition policy.
- Teaching nutrition, food chemistry or food service administration to students in dietetics, the food and hospitality industry and/or to other health care providers.
- Planning and engaging in direct food & nutrition research.
- Communicating food & nutrition information in any print, radio, television, video, Internet or multi-media format.
- Directly managing, supervising or assuring quality of front-line employees who are engaged in any of the previously-mentioned dietetic practice circumstances.

Members are not considered to be practicing dietetics when engaged in the following activities:

- Holding a position solely in non-dietetic management (e.g., Vice President or Administrator of a hospital or other organization).
- Holding a position solely in the area of human resources (HR), information technology (IT), or risk management.
- Engaging in sales or marketing of pharmaceuticals that are not related to nutrition.
- Assessing facility processes to meet accreditation standards.

Scope of Practice & the "Harm Clause"

SCENARIO 4-1
Cancer Nutritionist

You work in a community setting. A client's husband, Jorge, tells you about an experience suffered by his late wife, Michelle. A year ago, she was diagnosed with breast cancer. The prognosis had been reasonably optimistic if Michelle had surgery followed by radiation and chemotherapy. Michelle hated surgery and drugs, so she investigated alternative care options. She found a "nutritionist" who performed tests with a crystal and assured Michelle that she would be fine if she strictly followed a fruit, mushroom and nut diet, and purchased a special brand of multiplex vitamins from her.

Did the "nutritionist" do anything illegal? Does it matter whether the "nutritionist" is a dietitian?

The RHPA gives Ontario health colleges the authority to regulate health professions to ensure that the public gets competent and ethical care from qualified professions. Also in the public interest, the RHPA has a provision, the "Harm Clause", which applies to non-regulated health care practitioners and regulated health practitioners acting outside their scope of practice. The "Harm Clause" prohibits anyone from engaging in health care practices that would reasonably cause harm, unless the activity is within the scope of practice of a regulated health professional. It states:

> 30. (1) No person, **other than a member treating or advising within the scope of practice of his or her profession,** shall treat or advise 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."[1] (Bold emphasis added.)

By definition, no Registered Dietitian, either a general or temporary member, acting within their scope of practice, could breach the harm clause. Dietitians causing harm while engaging in health care activities within their scope of practice are subject to College discipline for incompetence or misconduct. However, a dietitian causing harm while engaging in health care activities outside of the dietetic scope of practice, would be in breach of the harm clause, and could be prosecuted.

In the "Cancer Nutritionist" scenario above, there obviously was a reasonably foreseeable risk of serious physical harm if Michelle did not receive appropriate treatment. In this case, the nutritionist was not a dietitian and:

- could be prosecuted by the Attorney General of Ontario for breach of the "Harm Clause" under the RHPA, because she was not a regulated member of the College of Dietitians of Ontario, and it was reasonably foreseeable that serious physical harm might result from the advice she gave;
- could be prosecuted under the *Criminal Code of Canada* for criminal negligence; or
- could be subject to a civil action.

If the nutritionist had been a dietitian and the recommended treatment was within the dietetic scope of practice, she:

- would be subject to College discipline proceedings for professional misconduct and incompetence;
- could be prosecuted for criminal negligence under the *Criminal Code of Canada*; or
- could be subject to a civil action.

If the nutritionist had been a dietitian, and the recommended treatment was not within the dietetic scope of practice, she

- would be subject to College discipline proceedings for professional misconduct and incompetence;
- could be prosecuted by the Attorney General of Ontario for breach of the "Harm Clause" under the RHPA, because she was not acting within her scope of practice and it was reasonably foreseeable that serious physical harm might result from the advice she gave;

- could be prosecuted for criminal negligence under the *Criminal Code of Canada*; or
- could be subject to a civil action.

Restrictions on a Dietitian's Practice

There are a number of restrictions on a dietitian's ability to perform certain kinds of assessments or provide certain kinds of treatment. Dietitians must be sure that none apply before initiating any assessment or treatment. The restrictions are stipulated through:

A. Statutes applying to dietitians other than the RHPA or the *Dietetics Act;*

B. Controlled acts stipulated in the RHPA, which dietitians cannot perform without legal authority;

C. Employer or facility restrictions;

D. Regulations; and

E. Standards of practice.

A. Statutes Applying to Dietitians other than the RHPA or the Dietetics Act

Other statutes have restrictions on dietetic practice. The *Criminal Code of Canada* has a number of provisions that would apply to dietitians engaging in dangerous or dishonest activities. For example, criminal negligence would apply to some dangerous actions or omissions. Federal drug legislation such as the *Controlled Drugs and Substances Act* and the *Natural Health Product Regulation* made under the *Food and Drug Ac*t also apply to dietitians.

Where federal legislation is more restrictive than provincial legislation, the federal legislation takes priority. For example, under the *Food and Drug Act*, there are restrictions on the distribution of free drug samples (e.g. only physicians, dentists, veterinarians and pharmacists are allowed to distribute samples under certain conditions).

Those restrictions would take priority over the provisions in the RHPA permitting dietitians to receive delegation of the controlled act of dispensing drugs.

The *Patient Restraint Minimization Act* applies to both public and private hospitals. It prevents the use of any sort of restraint on the freedom of a client unless:

- It enhances freedom, e.g. locking doors of a unit or using a monitoring device so that a client can have greater privacy;
- It prevents harm; or
- Immediate action is necessary.

Many forms of restraint would not be controlled acts.

B. Controlled Acts

Controlled acts are health care actions that are considered potentially harmful if performed by unqualified persons. The RHPA sets out 13 (soon to be 14) acts that should only be performed by someone with the legal authority to do so (Figure 4-2, p. 41). Dietitians have been granted the legal authority under the *Dietetics Act* to perform only one controlled act, skin pricking, which falls within the controlled act of performing a procedure below the dermis. this authority for RDs to take blood samples by skin pricking for the purpose of monitoring capillary blood readings while practicing dietetics:

> **Authorized act**
>
> 3.1 In the course of engaging in the practice of dietetics, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to take blood samples by skin pricking for the purpose of monitoring capillary blood readings. 2009, c. 26, s. 7. [2]

When can dietitians perform other controlled acts?

Dietitians can perform a controlled act if they have a delegation, which means they have

FIGURE 4-2

The Fourteen Controlled Acts under the *Regulated Health Professions Act.* [2]

A "controlled act" is any one of the following done with respect to an individual:

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. 1991, c. 18, s. 27 (2); 2007, c. 10, Sched. L, s. 32.

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (2) is amended by the Statutes of Ontario, 2007, chapter 10, Schedule R, subsection 19 (1) by adding the following paragraph:

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 judgement, insight, behaviour, communication or social functioning.

obtained the authority to do so from someone who is authorized to perform the act by their profession-specific act, such as a physician, or if one of the established exceptions applies. If a procedure is not a controlled act, it is said to be in the public domain, meaning that anyone can do it. However, it would be subject to the "Harm Clause" under the RHPA or criminal negligence under the *Criminal Code of Canada.* Below is a review of seven controlled acts faced by dietitians in their practice.

1. COMMUNICATING A DIAGNOSIS

The first controlled act, communicating a diagnosis, does not stop dietitians from formulating a diagnosis, but prevents them from communicating it to clients in certain circumstances. Nor does it prevent a dietitian from communicating the results of an assessment, so long as this does not amount to communicating a formal diagnosis.

The scope of practice statement for dietitians makes clear that they can assess and treat clients. Indeed, given their obligation to obtain an informed consent from clients, dietitians must be able to assess and clearly inform their clients about assessment results — so long as they do not communicate a formal diagnosis. Communicating a formal diagnosis has a number of characteristics:

- It is a communication to a client or a client's representative.
- It is a formal, medical label of a disease, disorder or dysfunction. Describing or giving proper names to symptoms, e.g. weight loss, is not a diagnosis.
- The medical label is a conclusion. A list of possible conditions under consideration is not usually considered a diagnosis.
- The medical label is not one previously given to the client. Repeating or expanding on the nature and implications of a previously given diagnosis is permissible.
- There must be a reasonable expectation that the client will rely on the communication to make health decisions.

Communicating a diagnosis is telling a client that he or she has anorexia nervosa and should see a psychiatrist. Conversely, it is not communicating a diagnosis to tell a client that your assessment indicates a number of potentially dangerous eating and behavioural habits, and advising them to see a physician to rule out a serious condition such as anorexia nervosa.

Laboratory results are not usually the same as a diagnosis. Discussing a blood glucose level with a client is not communicating a diagnosis. Invariably, questions are asked about the meaning of the result, which a dietitian often cannot answer without giving a diagnosis. It is wise, therefore, to be cautious about releasing test results to clients who are not already aware of their condition. In addition, some laboratory tests are almost diagnostic in themselves (e.g. observation of cancer cells from some biopsies) and should not be communicated to clients who have not previously been advised of their diagnosis.

Often, the best strategy for dietitians is to set up a first meeting only after clients have been advised of their diagnosis. Confirm at the beginning of the meeting that they have already received it. Once clients have been given their diagnosis, it is acceptable to discuss it and their dietetic treatment options with them. For example, retinal screening at a diabetes education centre would not appear to be an invasive procedure. In and of itself, it is not a controlled act unless it is combined with other acts, such as issuing a prescription for a vision device. However, if you were to perform the test, you would want to ensure that you had the skill to do so in accordance with acceptable standards, and that you did not communicate a diagnosis when giving the client the results of the test. If in doubt, advise the client to speak about the test results with the centre's physician or optometrist.

2. PROCEDURE BELOW THE DERMIS

The second controlled act, performing a procedure below the dermis includes skin pricking. Scenario 4-2, *Skin-Prick Testing*, on the next page, raises the issue of whether a dietitian

SCENARIO 4-2
Skin-Prick Testing

You are working in long-term care and providing meal planning services for Harvey, a resident who has diabetes. You wish to perform capillary blood glucose monitoring on Harvey to assist in meal planning. This involves pricking his fingers and drawing a small amount of blood. Your colleague, Susan, sees you performing the test and tells you that you have just broken the law. Is Susan right?

would be allowed to perform the skin-prick test. Until 2009 the answer was no. Up until then, you would have required a delegation from a practitioner authorized to perform skin pricking, like a physician. However, amendments to the *Dietitians Act* and the *Laboratory and Specimen Collection Centre Licensing Act* now authorize dietitians to perform the controlled act of taking blood samples by skin-pricking for the purpose of monitoring capillary in the course of their practice. Section 3.1 of the *Dietetics Acts* reads as follows:

> **Authorized act**
>
> 3.1 In the course of engaging in the practice of dietetics, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to take blood samples by skin pricking for the purpose of monitoring capillary blood readings. 2009, c. 26, s. 7.

This amendment was part of a broader initiative to facilitate interprofessional collaboration and enhance the efficiency of the health care system.

However, being authorized to perform a controlled act is not the end of the story. RDs still have a professional obligation to ensure that they are competent to perform the procedure in accordance with the principle of client-centred care and that they perform the procedure in a safe manner (e.g., with proper infection control procedures, waste management disposal guidelines).

3. INJECTION OR INHALATION

The fifth controlled act, administrating a substance by injection or inhalation, would include adding a substance to a saline solution line that has already been established.

4. ENTERING OPENINGS INTO THE BODY

The sixth controlled act relates to entering openings into the body, an internal act.[3] An attempt has been made to give anatomical precision to the provision. Introducing a feeding tube into a client is a controlled act.

5. PRESCRIBED FORM OF ENERGY

The seventh controlled act, applying a prescribed form of energy, refers to electricity, electromagnetic energy, or sound waves. Electrical impedance testing, while electrical in nature, is not prohibited in the regulations made by the Minster of Health and Long-Term Care. Moreover, this controlled act does not apply to the energy level of diets, enteral nutrition or TPN. Food energy is also not part of this controlled act.

6. PRESCRIBING, DISPENSING, SELLING OR COMPOUNDING A DRUG

The eighth controlled act, prescribing, dispensing, selling or compounding a drug, covers many over-the-counter or publicly available substances. Dietitians must ask themselves two questions before acting in this area:

1. Is it a drug?
2. Am I prescribing, dispensing, selling or compounding?

The word "drug" is given a broad meaning under the *Drug and Pharmacies Regulation Act*.[4] It is not restricted to prescription drugs but is defined as meaning;

> "any substance or preparation containing any substance,
>
> (a) manufactured, sold or represented for use in,
>
> (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...

It is important to know what is meant by "Schedule I, II or III" in the definition of a drug. "Schedule I,II, or III" are categories of drugs under the *National Association of Pharmacy Regulatory Authorities* (NAPRA) national drug scheduling model, which specifies the condition of sale for the different categories of drugs. Schedule I drugs require a prescription for sale and are provided to the public by the pharmacist following the diagnosis and professional intervention of a practitioner.

Schedule II drugs require professional intervention from the pharmacist at the point of sale and possibly referral to a practitioner. While a prescription is not required, the drugs are available only from the pharmacist and must be retained within an area of the pharmacy where there is no public access and no opportunity for patient self-selection (behind the counter).

Schedule III are available without a prescription and are to be sold from the self-selection area of the pharmacy which is operated under the direct supervision of the pharmacist (over the counter).

Unscheduled drugs can be sold (or given out in the form of samples) without professional supervision, because adequate information is available for the client to make a safe and effective choice.

The *Natural Health Products Regulations*, under the federal *Food and Drugs Act,* were developed to regulate the manufacture, clinical trials, labeling, packaging, and reporting with respect to natural health products. The products under these regulations include vitamins, minerals, herbal remedies, homeopathic medicines, probiotics, amino acids and essential fatty acids. As noted above, the definition of drug in the *Drug and Pharmacies Regulation Act* specifically excludes natural health products. This means that the controlled act related to prescribing, dispensing, selling or compounding a drug would not apply to any of these products, unless they appeared on one of the NAPRA schedules.

Some vitamins and minerals are only considered scheduled drugs above a certain dose. For example iron is considered a Schedule II drug in doses over 30 mg (as a result many prenatal vitamins now contain only 27 mg of iron allowing dietitians to provide samples of them to clients).

To determine whether a particular product is listed under one of the national drug schedules, consult the NAPRA website at: http://www.napra.org/pages/Schedules/Search.asp. The search feature allows you to search by drug name (e.g., Iron) or by the name of the product (e.g., "Materna"). The NAPRA schedules are updated regularly. For the most current information regarding any product, it is best to consult the NAPRA website rather than relying on print articles or resources which may be out of date. For example, Materna was listed as a Schedule II drug. It is now unscheduled. [5]

Even if the substance is a drug, there is a difference between recommending and prescribing it. If a substance is a drug, dietitians can still recommend it but cannot prescribe it. Recommending is advising a client about a drug that they can obtain on their own and explaining how it might be of assistance. Prescribing means authorizing the dispensing of a drug, usually with specific doses and frequency, to a client who would not normally be able to obtain it on their own. For instance, recommending that a pregnant client purchase a nonprescription prenatal multivitamin and mineral supplement is acceptable. Giving a document addressed to a pharmacist with instructions to dispense the specific supplement, with itemized directions for its use, is prescribing.[6]

7. PSYCHOTHERAPY

A fourteenth controlled act relating to psychotherapy will likely be proclaimed into force sometime in the future . It will read as follows:

> 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.

The contours of this new controlled act are still uncertain, and it is hoped that some practical guidance will be issued before then. However, the provision is not intended to cover the usual types of advice and counselling generally provided by dietitians in day-to-day practice. Those developing a significant therapeutic relationship to help change dangerous behaviours, such as significant eating disorders, might wish to consider advocating for a medical directive to support their activities.

EXCEPTIONS TO THE CONTROLLED ACTS

There are a number of exceptions to the rules, permitting controlled acts to be performed in certain circumstances:

- Any controlled act can be performed during an emergency. This would include applying a defibrillator where someone appears to be having a heart attack or administering a glucagon injection when someone is suffering from a severe hypoglycemic reaction rendering them unconscious.
- Assisting a person with "routine activities of living" may involve administering a substance by injection or inhalation or performing an internal act. For example, a dietitian on a home visit could, if they were competent to do so, assist clients with their regular insulin injection.
- Treating a member of your own household can properly involve communicating a diagnosis, administering a substance by injection or inhalation or performing an internal act.
- Students training for a profession that has controlled acts can do them under the supervision of a registered member of the profession. This would apply to dietitians training students on techniques for skin pricking.
- Spiritual or religious healing can involve the performance of a controlled act if it is a tenet of the religion.
- Aboriginal healers can provide traditional healing services.

AUTHORITY MECHANISMS FOR DIETITIANS PERFORMING CONTROLLED ACTS

Dietitians can perform controlled acts delegated to them by the registered members of the professions authorized to perform them. For example, a physician may authorize a dietitian to dispense a drug such as a multivitamin. The delegation can be either specific or general. For instance, it can be made specifically for a client whose treatment has been discussed with the physician. Conversely, a medical directive is a form of direction that is not restricted to a specific client and usually sets criteria as to when it can be relied upon. An example would be that all expectant mothers at a particular

clinic serving low income clients, and meeting certain criteria, should be given a multivitamin and mineral supplement by a dietitian.

There is significant confusion about the differences between delegations, orders, medical directives, and Assignments. Table 4-2, on the next page, *Comparing Delegations, Orders and Assignments*, illustrates the differences between them.

Delegations

Accordingly, it is reasonable for the delegating practitioner to set certain criteria for the performance of the controlled act and to monitor its performance. Authorizers are responsible for ensuring that:

- they are capable of performing the procedure correctly, themselves;
- the person to whom the procedure is assigned (the implementer) has the competence to perform it
- they provide any order or documentation required to substantiate that the delegation has been given.

The person receiving the delegation, the implementer, is responsible for its performance. Implementers are responsible for:

- demonstrating that they are competent and having this documented where required;
- assessing appropriateness to initiate the procedure even if an order exists;
- ensuring legal responsibilities are met, e.g. if an order is required, to obtain it.

Orders

Another act restricting the practice of dietitians is the *Public Hospitals Act*. It requires orders in hospitals for controlled acts and many otherwise public domain acts. For example, prescribing a therapeutic diet is not a controlled act. However, most public hospitals would expect a dietitian to obtain an order from a physician and to ensure it was recorded in the chart before issuing a therapeutic diet. This onus of responsibility is the major distinction between a delegation and an order. If an order is given, the ordering practitioner is not generally responsible for its actual performance, unless the person

FIGURE 4.3 Comparing Delegation, Order and Assignment

TERM	APPLIES TO	AUTHORIZER CO-RESPONSIBLE FOR PERFORMANCE?	EXAMPLE
Delegation	Controlled acts	Yes	Physician delegates to a dietitian the prescribing (including adjusting the dose) of *Oral Hypoglycemic Agents* within a predetermined limit for clients with poor glycemic control.
Order	1. Controlled acts where recipient is authorized to perform only with an order 2. Public domain acts where other legislation or facility rules require an order.	No, unless person giving order is employer of person performing procedure.	1. Physician orders nurse to insert IV line. 2. In hospital, physician orders a therapeutic diet.
Assignment	Public domain acts that are part of the authorizer's practice.	Yes, as the act is a part of the authorizer's practice.	Dietitian asks the dietetic assistant to teach a diabetic diet.

giving the order is the employer of the person receiving the order.

A verbal order can be relied upon as long as the hospital has an approved protocol setting out how this is to be done. The section requiring orders under the *Public Hospitals Act* reads as follows:

> 24. (1) Every order for treatment or for a diagnostic procedure of a patient shall, except as provided in subsection (2), be in writing and shall be dated and authenticated by the physician, dentist, midwife or registered nurse in the extended class giving the order. O. Reg. 64/03, s. 10.
>
> (2) A physician, dentist, midwife or registered nurse in the extended class may dictate an order for treatment or for a diagnostic procedure by telephone to a person designated by the administrator to take such orders. O. Reg. 64/03, s. 10.
>
> (3) Where an order for treatment or for a diagnostic procedure has been dictated by telephone:
>
> (a) the person to whom the order was dictated shall transcribe the order, the name of the physician, dentist, midwife or registered nurse in the extended class who dictated the order, the date and the time of receiving the order and shall authenticate the transcription; and
>
> (b) the physician, dentist, midwife or registered nurse in the extended class who dictated the order shall authenticate the order on the first visit to the hospital after dictating the order. O. Reg. 761/93, s. 11; O. Reg. 45/98, s. 3.

Medical Directives

Medical directives have become a useful method of making the health system function at a time when limited resources are requiring physicians to focus on diagnosing and treating serious conditions. The College has gathered and published information about how dietitians have successfully obtained and used medical directives to provide competent, effective and prompt care to clients, while protecting client safety and ensuring that appropriate practitioners (e.g. physicians) are brought in to deal with complicated cases.[7] Medical directives are also consistent with the trend to collaborative care.

A growing number of hospitals have adopted policies or medical directives that authorize dietitians to order therapeutic diets and/or implement them without obtaining a physician signature on each occasion. In some hospitals (although not supported by policy or medical directive), dietitians do write orders for therapeutic diets and have them implemented before a physician or person authorized to do so cosigns the order. However, it is best to have this practice supported by a hospital policy or a directive.

Some medical directives permit the implementation of a dietitian's order before the order is co-signed. In this case, the medical directive as signed by a physician is itself the order. It fulfills the requirements for a physician order. As such, the implementation of the order by another person does not require a further cosignature, unless the facility chooses to require it as a matter of policy. Typical medical directives deal with matters such as dispensing certain drugs directly related to dietetic practice (e.g., certain prenatal supplements) and performing related tests or procedures (e.g., venipuncture). They most commonly apply to a single organization (e.g. a public health unit) or setting.

Following an appropriate process is the key to success in obtaining a medical directive. Research by the College suggests the following tips:

- Start with a specific dietetic problem. Don't go for too much at once. Try to choose an issue that only involves two or three professions (e.g. dietitians and physicians).
- Word the directive so that it is clear as to when it applies, what can be done by whom, and what safeguards are needed to ensure that the client's care is not compromised.
- Communicate the medical directive clearly

to everyone who will be affected.

- Ensure there are enough dietitians with the necessary training and qualifications to implement the medical directive.
- Recruit an appropriate manager(s) (e.g. Professional Practice Leader, Clinical Manager) to help navigate the organization's approval process.
- Solicit support from other professions and stakeholders.
- Have an existing organizational process for developing medical directives.

A medical directive can be either an order or a delegation depending on the context. The distinctive feature of a medical directive is that it applies to any client who meets the criteria, not just one client. The *Federation of Health Regulatory Colleges of Ontario* has developed a useful guide to assist all professions in developing appropriate medical directives, *An Interprofessional Guide on the Use of Orders, Directives and Delegation for Regulated Health Professionals in Ontario.* [8]

Assignments

An assignment is a direction by a health practitioner to another person to perform a public domain procedure, i.e. procedures that are not controlled acts, such as teaching a diet. Dietitians are still responsible for ensuring that they assign activities within their scope of practice appropriately, even if they are not controlled acts. Not doing so is an act of misconduct according to Paragraph 17 of the *Professional Misconduct Regulation*:

> 17. Assigning members, dietetic interns, food service supervisors, dietetic technicians or other health care providers to perform dietetic functions for which they are not adequately trained or that they are not competent to perform.

Health practitioners operating an office or facility may set some rules or criteria for the performance of public domain procedures in their capacity as a manager. Managers can set these rules or criteria even though the assignees could perform the procedure without restriction outside of the office or facility.

C. Employer or Facility Restrictions

Employment contracts may contain some restrictions in the practice of a dietitian. For example, an office may confine itself to paediatric or geriatric care. Similarly, an employer may choose to refer certain types of cases (e.g. anorexia nervosa) out of the office even though a dietitian might wish to treat them. Even if the dietitian were authorized to perform the acts, the contract would generally apply.

Similarly, facilities have the right to impose limitations on what their staff does. Although the *Long-Term Care Act* has no such requirement, a long-term care or nursing home could, for example, require an order from a physician for implementing individual therapeutic diets through an organizational policy. As long as a dietitian is associated with that facility, appropriate restrictions should be honoured, unless there are concerns about a breach of professional standards. Employer or facility rules are not a justification for failing to maintain dietetic standards or professionalism.

Legislation covering long term care facilities does not require physicians to give orders for dietetic care. In fact, many such facilities have protocols permitting dietitians to give orders without co-signatures by physicians. In such cases, limitations are imposed by facility policy, not statute. Failure to comply with a valid contractual term or facility rule can constitute grounds for termination without notice or compensation.

D. College Regulations

The College has the authority to develop regulations that pose restrictions on a dietitian's practice. The *Professional Misconduct Regulation*

specifies acts of professional misconduct, for example, "Treating or attempting to treat a condition that the member knew or ought to have known was beyond his or her expertise or competence."

E. Standards of Practice

Being legally authorized to perform a procedure covers the legal aspect of an activity. A dietitian must still act ethically and competently, always ensuring that professional standards are met. If the standard of practice dictates certain actions in a particular circumstance, then disregarding the standard can result in disciplinary action and civil liability to pay for resulting damages.

Standards of practice refer to the shared understanding of what is proper within a profession. These standards need not be in writing, however, general principles usually are. You may want to consult the College's Practice Advisory Service, respected textbooks and periodical literature for current information about standards of practice. If in doubt about your actions in any situation, ask yourself: Would the vast majority of right thinking members of the profession think that this action was appropriate? If the answer is no, then do not do it.

Conclusion

Several statutes define the scope of practice and set limits to dietetic practice. Dietitians must be aware of these statutes and understand how they affect their practice. The system of controlled acts, for example, is fundamental to the health regulatory system and the ideals of public protection in Ontario health care. The statutes, limiting the practice of controlled acts to authorized regulated professionals only, applies to everyone including laypersons. All are forbidden to practice controlled acts without being authorized to do so by law. Every dietitian must be aware of the complex issues involving the interpretation of controlled acts in relation to dietetics. This understanding is critical, because dietitians would not want to violate the law, and yet would not want to unnecessarily limit their health care activities ~~and efficient de~~livery of client-centred health care. The College has published several excellent articles about scope of practice, controlled acts and dietetic practice.

1 Section 30 of the *Regulated Health Professions Act.*.

2 Regulated Health Professions Act, 1991, S.O. 1991, Chapter 18, Prohibitions 27 (2).

3 i.e., 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.

4 Drug and Pharmacies Regulation Act, R.S.O. 1990, Chapter H.4, Part IV, Pharmacy, Interpretation, Part VI: Section 117.

5 For more information see: "Vitamins & Minerals & the RD Scope of Practice." *résumé*: Summer 2008, p. 8.

6 Dr. Len Piché, "Natural Health Products and Your Practice", *résumé*, Summer 2002, p. 6. This article identifies resources for dietitians relating to natural health products. See also: "Vitamins and Minerals - Prescribing or Recommending? Scheduled? DIN or NPN?", *résumé*, Summer 2004, 4-6.

7 "A Primer for Developing Medical Directives", *résumé*, Winter 2004, 5-6.

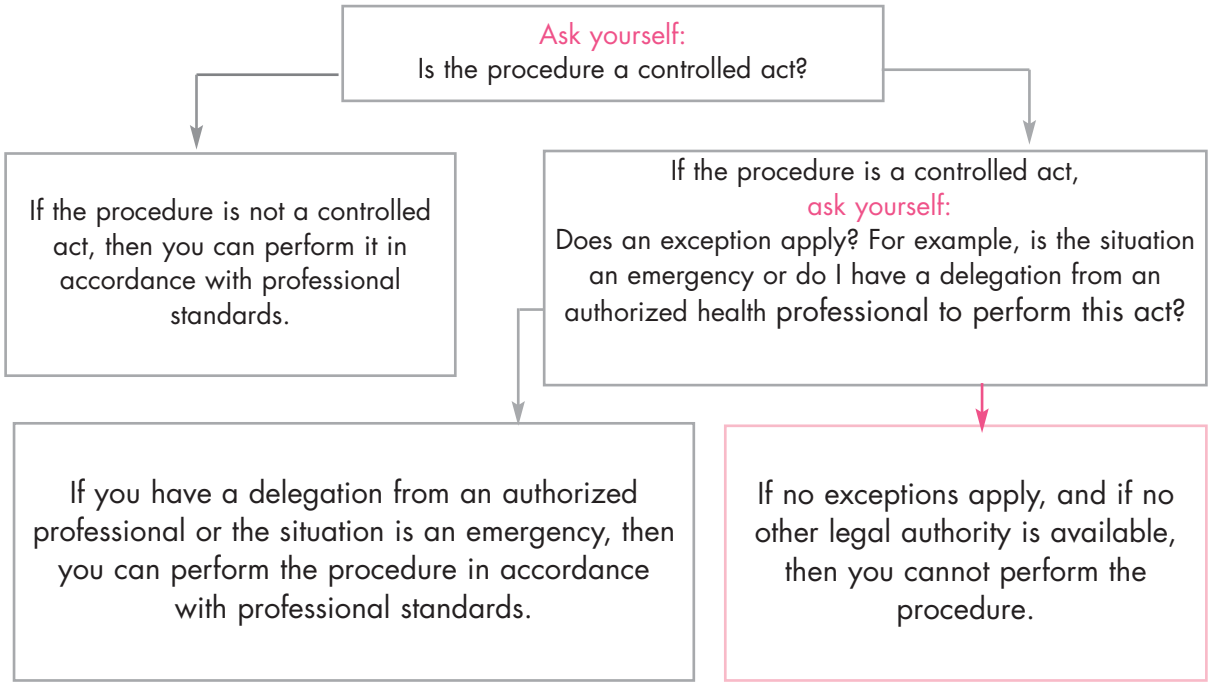
"Therapeutic Diet Orders and Medical Directives", résumé, Summer 2003, 6-7.

"Insulin Adjustments", *résumé*, Fall 2002, p. 5;

Also, see Deborah Ellen (Boyko) Wildish, BHEc, MA, RD, "Medical Directive: Authorizing Dietitians to Write Diet and Tube Feeding Orders", Canadian Journal of Dietetic Practice and Research, Vol. 62, No. 4, Winter 2001, 204-206.

8 Federation of Health Regulatory Colleges, A Guide to Medical Directives and Delegation, http://www.regulatedhealthprofessions.on.ca/EVENTSRESOURCES/medical.asp

FIGURE 4-4 CAN I PERFORM THIS PROCEDURE?



Quiz

Provide the best answer to each of the following questions. Some questions may have more than one appropriate answer. Explain the reason for your choice. See *Appendix 1* for answers.

1. **In Scenario 4-1, "Cancer Nutritionist", assuming that the nutritionist is not a Registered Dietitian, what law has the nutritionist probably broken?**
   a. The "Harm Clause" under the *Regulated Health Professions Act*.
   b. The criminal negligence portion of the *Criminal Code of Canada*.
   c. Dispensing and selling a drug, which is a controlled act under the *Regulated Health Professions Act.*
   d. All of the above.

2. **Assume in Scenario 4-1, "Cancer Nutritionist", that the nutritionist said, "I don't accept the diagnosis of medical doctors", and did a full assessment. Following the assessment, the nutritionist said: "You have a 'condition' that can be managed by nutritional means". Did the nutritionist perform the first controlled act relating to communicating a diagnosis?**
   a. Yes, the client relied on the communication for making treatment decisions.
   b. Yes, the nutritionist identified diet as the cause of the client's symptoms. The diagnosis was wrong, but it was still a diagnosis.
   c. No, because dietary insufficiency is not a disease or disorder.
   d. No, because the nutritionist did not identify a condition or disease as the underlying cause but simply recommended treatment.

3. **In Scenario 4-2, "Skin-Prick Testing", which of the following statements is not true?**
   a. Skin-pricking is the same as acupuncture, and acupuncture is not a controlled act.
   b. Collecting blood samples by skin-pricking for the purpose of monitoring capillary blood readings.
   c. Dietitians can now perform that controlled act on their own authority.
   d. In performing the procedure, Harvey still needs to meet all applicable professional standards.

4. **A therapeutic diet:**
   a. Is an acceptable dietetic treatment.
   b. Is a controlled act.
   c. Requires an order.
   d. Is a treatment assigned to dietitians by physicians.

5. **A dietitian could inject insulin into a client where:**
   a. The dietitian creates a religion where that is a tenet in faith healing.
   b. The dietitian is aboriginal.
   c. The client receives regular injections every day and the usual helper is unavailable.
   d. The client's registered practical nurse gives an order for it.

Resources

COLLEGE OF DIETITIANS OF ONTARIO

résumé *at www. cdo.on.ca > Resources > Practice Standards & Resources > Scope of Practice, Controlled Acts & Authority Mechanisms*

résumé *at www. cdo.on.ca > Resources > Publications > résumé.*

- "Members Share Their Experience In Developing a Policy and Procedure for Prescription of Therapeutic Diets", Winter 2000, p. 3.
- "Members Share Ideas about Diet Orders", Spring 2003, 6-7.
- "Therapeutic Diet Orders and Medical Directives", Summer 2003, 6-7.
- "Insulin Adjustments", Fall 2002, p. 5.
- "A Primer for Developing Medical Directives", Winter 2004, p. 5.
- "Vitamins and Minerals - Prescribing or Recommending? Scheduled? DIN or NPN?", Winter 2004, p. 5.
- "Test Your Knowledge - Venipuncture", Spring 2004, p. 3.
- "Swallowing Assessments & Dysphagia - Understanding Scope of Practice", Summer 2005, p. 1.
- "Communicating a Diagnosis", Summer 2006, p. 11-12.
- "Vitamins and minerals and the RD scope of practice?, Summer 2008, p. 8-10.
- "Vitamin and mineral update", Winter 2009, p. 9-10.
- "Are RDs allowed to transcribe verbal nutrition care orders in hospitals?", Spring 2009, p. 8.
- "The Dietetic Scope of Practice Enhanced", Winter 2010, 8-9.
- "Managing Changes to RD Job Responsibilities", Winter 2010, 9-10.

Workshop 2006. *Controlled Acts and Authority Mechanisms.*

PUBLICATIONS

Bohnen, Linda. *Regulated Health Professions Act: A Practical Guide*. Aurora: Canada, Law Book, 1994.

Steinecke, Richard. *A Complete Guide to the Regulated Health Professions Act*. Aurora, Canada Law Book, updated annually.

Deborah Ellen (Boyko) Wildish, BHEc, MA, RD, "Medical Directive: Authorizing Dietitians to Write Diet and Tube Feeding Orders", *Canadian Journal of Dietetic Practice and Research*, vol. 62, no 4, Winter 2001, 204-206.

Federation of Health Regulatory Colleges of Ontario, *The Interprofessional Guide on the Use of Orders, Directives and Delegation for Regulated Health Professionals in Ontario.* http://www.regulatedhealthprofessions.on.ca/EVENTSRESOURCES/medical.asp

Jacinthe Boudreau. "Controlled Acts and Delegation: An Overview of the RHPA". Conference December 2003 : *Medical Directives and the Delegation of Controlled Acts.*

Randy Zettle. "The Use of Medical Directives: Why, When & How?". Conference December 2003 : Medical Directives and the Delegation of Controlled Acts.

LEGISLATION

Drug and Pharmacies Regulation Act, R.S.O. 1990, Chapter H.4, Part IV, Pharmacy, Interpretation, Part VI: Section 117. http://www.search.e- laws.gov.on.ca/en/isysquery/5a49a3ef-654d-430e-8858-8e59b3703e16/1/frame/?search=browseStatutes&context=

Regulated Health Professions Act and other provincial statutes can be found at www.elaws.gov.on.ca. and on the CDO website under Resources.

Federal statutes:
http://laws.justice.gc.ca/en/index.html

- *Criminal Code of Canada: http://laws.justice.gc.ca/en/C-46/*
- *Controlled Drugs and Substances Act«; http://laws.justice.gc.ca/en/C-38.8/*
- *Natural Health Product Regulation, under the Food and Drug Act: http://laws.justice.gc.ca/en/F-27/SOR-2003-196/*

Back to Table of Contents

FIVE

College of Dietitians of Ontario

Privacy Obligations

AT A GLANCE

SCENARIOS

FIGURE

NEED TO KNOW

1. Privacy obligations are much broader than confidentiality duties. They are based on the principle that clients own the information that practitioners hold on them.

2. Privacy legislation covers personal health information.

3. Every organization should have a comprehensive privacy policy.

Privacy and Access Legislation

Privacy and access legislation has been a feature of the public sector for decades, and has recently expanded into the private sector. For example, the federal government enacted the *Personal Information Protection and Electronic Documents Act* (PIPEDA). It came into force on the provincial level on January 1, 2004 and applies to all organizations collecting, using or disclosing personal information while engaged in a commercial activity.

On November 1, 2004, Ontario passed the *Personal Health Information Protection Act*, 2004 (PHIPA). This statute is most relevant to personal health information in Ontario and supplants the federal act, PIPEDA, for most purposes. PIPEDA is most relevant for non-health aspects of a dietitian's business (e.g. a dietitian who has a business conducting speaking tours).

Both the provincial act, PHIPA, and the federal act, PIPEDA, require practitioners or their employers to develop a *Privacy and Access Code* describing how they collect, use and disclose personal information. The *Privacy and Access Cod*e must adhere to the 10 principles that have been adopted internationally to describe privacy duties (Figure 5-1, p. 61). There is flexibility in how to achieve the intent of the 10 principles. However, failing to reasonably achieve them will leave the practitioner open to investigation and sanction by either the Ontario or federal information and privacy commissioners.

Dietitians who work for government (e.g. Public Health) may be covered by government privacy legislation. The *Freedom of Information and Protection of Privacy Act* and the *Municipal Freedom of Information and Protection of Privacy Act* are the most likely statutes to apply. These statutes generally follow the same 10 principles but with necessary modifications because they apply to government (e.g., some exceptions to the right of access apply in order to protect government policy development processes).

Differences Between Confidentiality and Privacy

Privacy is a much broader concept than confidentiality. Privacy involves not only disclosing personal information, but also limiting when and how it is collected and used. Privacy includes:

a. knowing why the information is being collected from the client;
b. only collecting the amount of information needed to achieve that purpose;
c. collecting the information directly from the client, if possible, to achieve the purpose;
d. destroying the information as soon as it is no longer necessary;
e. not using the information for other purposes unless a new consent is obtained from the client (or the law permits);
f. taking steps to ensure that the information is accurate before using it;
g. focusing on preventing inadvertent disclosure of the information through proper safeguards, as much as on deliberate disclosures;
h. advising clients and the public about your policies for collecting, using, safeguarding and disclosing personal information;
i. permitting clients to freely access their information and request corrections for any errors contained in it;
j. permitting clients to challenge an organization's privacy practices through a clearly defined and accessible internal complaints process and through an external review body.

Privacy principles reinforce the concept that personal health information belongs to the client, not the practitioner. The practitioner acts as a trustee, holding the information only for the benefit of the client.

Complying With Privacy Requirements

SCENARIO 5.1
Compulsive Record Keeping

You work in public health. You keep detailed records on what information clients request and the names and addresses where information is sent. This record includes information about specific health conditions, some of which may be considered sensitive. You wonder whether new privacy legislation has an impact on what you document.

Is it necessary to maintain all of this information? Consider whether you would ever need a record of what was sent to a client (e.g. if a concern was later expressed that you had not responded to an issue). You would also ask if recording the address where it was mailed was necessary (especially if another record already had the address).

Unless there is a College, institutional or legal requirement to record information, a dietitian should only record what is reasonably necessary to create an accurate and effective client health record. Dietitians, or their employers, can comply with their privacy obligations by following the seven-step plan below.

STEP 1- IDENTIFY THE CUSTODIAN

A Health Information Custodian (HIC) is responsible for each health record held in an organization — overseeing, approving, maintaining and implementing policies and procedures to ensure the privacy and the security of these records. The HIC can be a sole practitioner, an employer or a facility, while an organization can be the business of a sole practitioner, or a health or non-health facility.

Sole Practitioner

Dietitians who are the sole practitioners in their practice have all of the responsibilities of the HIC, including establishing a written privacy policy.

Dietitians in private practice must also have a business plan and/or will in place in the event of their sudden incapacity or death to designate who would be responsible for their client health records. The privacy obligations and practices of the designated HIC should be clearly described in the business plan and/or will.

Obviously the dietitian will be the Information Officer (discussed below) in this context, and will handle all inquiries and concerns directly. As an independent contractor, for example, in a Community Care Access Centre (CCAC), the dietitian may still be the custodian. The dietitian should confirm if the organization views itself as responsible for the privacy practices of the dietitian. If so, *Health Services Facility,* below, applies. Often, such contracting agencies do not wish to be responsible for the privacy practices of a large pool of independent contractors.

Health Services Facility

Where there is a health services organization, the organization is the "health information custodian". This would include a public hospital, a long-term care or nursing home, or public health department. An office containing a number of dietitians would also be a HIC with the "owner(s)" of the business responsible for privacy matters. Most multidisciplinary clinics would also be HICs.

Non-Health Facility

For non-health organizations, the question of who constitutes the HIC is more complex, and may require specific legal advice. First, you have to ensure that health services are offered by the organization. If so, either the organization or those providing health services have to accept responsibility for health information privacy. For example, a summer camp, spa or industrial plant may have a health office. The employer will either have to designate the health office as the HIC, or indicate that those who work there are considered independent contractors who carry the responsibilities for the privacy obligations of the health office.

Under PHIPA, "persons providing fitness or weight-management services" are excluded from the concept of custodians. Thus, dietitians who provide only such services would not be covered by PHIPA. However, if a dietitian offered any additional health services, then he or she would have to negotiate whether the facility would be the HIC for those services or whether the dietitian would assume those responsibilities.

Dietitians working for a health information custodian are called "agents" of the custodian. Agents are expected to comply with the privacy policies of their custodian, unless doing so would result in a breach of the PHIPA. Dietitians are expected to advocate within their organization to ensure that the custodian's practices meet dietetic standards of practice and College requirements.

STEP 2 - DESIGNATE THE INFORMATION OFFICER

The "Information Officer" (sometimes called a Privacy Officer"), is accountable for the organization's compliance with the privacy obligations. In a case where the HIC is the sole owner of a health practice, then this owner is both the custodian and the Information Officer. In the example of the camp, the dietitian or the nurse might be designated as the Information Officer.

The Information Officer need not be an employee of the organization. It can be the organization's lawyer or an outside privacy consultant. However, for many small offices, it makes sense for the Information Officer to be the owner or the senior practitioner.

Information officers are responsible for:

- reviewing the organization's collection, use and disclosure of personal information;
- implementing procedures to protect personal information;
- being the contact person for client or public inquiries about information handling;
- establishing (and, in a small organization, operating) a complaints procedure;
- training and continually updating staff on the information privacy policy;
- monitoring compliance;
- publishing the organization's information handling policies for the public.

STEP 3 - TAKE AN INVENTORY OF PERSONAL INFORMATION COLLECTED

A critical step in creating a privacy policy is to take an inventory of the personal information the organization handles. This involves identifying every category of personal information that the organization collects. Personal information is any information about an identifiable individual other than business title and business contact information, and typically falls into the following categories:

- personal characteristics such as name, home contact information, gender, age, etc.;
- health information including health history, condition and treatment; and
- activities and views including occupation, notes on the individual, religion and financial data.

Part of this inventory might identify categories of individuals for which you collect different types of information (e.g. clients, prospective clients, and suppliers).

STEP 4 - IDENTIFY PURPOSES FOR COLLECTING THE PERSONAL

SCENARIO 5.2
Marketing Scheme

You work for a weight loss clinic and an RD from a food distribution company calls about marketing a weight loss product. She offers to pay your organization $10 for each client address and telephone number that you provide, so the company can send information on the product and make follow up telephone calls. What do you do?

INFORMATION

This scenario confirms the importance of having

an organizational privacy policy that is clear about why client information is collected, how it will be used, and under what circumstances personal information will be disclosed to anyone. Organizations need to conduct an inventory of the types of personal information they handle and the categories of individuals for which it collects the information. Once the inventory is done, organizations have to ensure that information handling is consistent with privacy principles.

For any type of personal information collected, the organization must identify and justify the following:

- the purposes for which it collects the information, including
  - the primary purpose
  - related purposes
  - secondary purposes;
- whether it could limit its collection; and
- by what authority it is collected (e.g. consent of the individual, legal exception to the consent requirement).

Primary Purpose

The primary purpose for collecting personal information from clients is generally the provision of the goods or services sought by them. The purpose must be documented by the organization, and be one that a reasonable person would consider appropriate in the circumstances. The primary purpose for collecting personal information from non-clients (e.g. members of the public) is not always as obvious and will need to be stated.

Related Purpose

A related purpose for collecting personal information is to support the primary purpose, for example, billing the client or providing follow-up services. The purpose for collecting the information should be clearly identified in the consent process and identified in the privacy policy.

Secondary Purposes

Most organizations also have secondary purposes for collecting personal information, such as quality control (a supervisor reviewing the information to ensure that the employee is performing his or her job well), marketing future special offers to the client, and regulatory accountability. These should also be identified in any consent obtained or in the organization's privacy policy. Where possible (e.g. marketing future special offers) the client should have a choice to refuse the secondary use.

Sample Disclosure to Clients

In disclosing the purpose for the collection and use of client information, a dietitian might say:

> "Our primary purpose for collecting personal information about you is to provide you with dietetic services."

The description of that purpose might be:

> "We collect information about your health history, your dietary habits and function, and your social situation to help us assess your needs, to advise you of your options, and then to provide the dietetic intervention you select."

A second primary purpose might be:

> "to obtain a baseline of health and social information so that in providing ongoing dietetic services we can identify changes that are occurring".

Consent Forms

As a HIC, an organization should develop consent forms to obtain permission from clients to collect and use their personal information for organizational purposes. The consent form should refer to the organization's privacy policy, with clear indications of why personal client information is collected, how it will be used and under which circumstances it might be disclosed to another party, if at all.

STEP 5 - SAFEGUARDS, RETENTION AND DESTRUCTION POLICIES

Organizations must take appropriate measures to safeguard personal information from unauthorized access, disclosure, use or tampering. In Scenario 5-3, *Transporting Client Information*, next page, client information is at risk of exposure or theft in the cloakroom. The nature of the safeguards would vary depending on the sensitivity of the information and the circumstances. Generally, safeguards must include the following components:

- **Physical measures**
  - Keeping such information in restricted access areas;
  - locked filing cabinets and offices; and
  - possibly employing security cameras.
- **Organizational measures**
  - Staff training in privacy; internal policies (e.g. staff can only access client information on a need-to-know basis);
  - security clearances; and
  - policies about transmitting or discarding paper or electronic information.
- **Technological measures**
  - Passwords to access any computer;
  - screen saver passwords; encryption;
  - virus protection; and
  - firewalls.

In one real-life example, a researcher took health data home on his laptop to do some work. On the way, he left the laptop in his van (concealed from view) at a parking lot while he went to an event. Upon his return the passenger window was broken and the laptop was gone.

Thousands of clients had to be notified that their personal health information was compromised. The Information and Privacy Commissioner of Ontario was critical of the fact that the information was not encrypted when taken out of the office (in fact she questioned whether it was necessary to remove the information from the hospital at all). Password protections were insufficient. The case prompted the Commissioner to issue a fact sheet entitled, *Encrypting Personal Health Information on Mobile Devices* (www.ipc.on.ca).

SCENARIO 5.3
Transporting Client Information

Shelley is a dietetic student on placement at your facility. You take her to a seminar and you both leave your coats and cases in the cloakroom. After, while driving her home, you talk about an interesting case she is working on. She opens her case and refers to her file during the discussion. Do you need to address anything here?

Organizations need to systematically review all of the places where they may temporarily or permanently hold personal information and assess the adequacy of the safeguards. Almost every organization will find that it needs to make changes to their privacy policy. See Figure 8-2: *Checklist for Securing Personal Information*.

Retention and Destruction Policy

The organization is also required to have a retention and destruction policy. Personal information should be retained long enough to achieve the purpose, and permit the client to make reasonable follow up inquiries about goods/services provided. However, the information should not be kept longer than reasonably necessary, as that provides greater opportunity for it to be misused or misappropriated.

Organizations can have different retention periods for different categories of personal information. The minimum and maximum retention time must be established by policy, and should be consistent with the requirements established by the College (see Chapter 8).

Personal information must be destroyed in a secure fashion. Typically, this involves shredding paper, deleting electronic information, and destroying or completely reformatting any computer hard drives or electronic data storage containers when they are discarded.

STEP 6 - ACCESS, CORRECTION, COMPLAINTS AND OPENNESS

Access

A consequence of the concept that the information belongs to the client is that the client has the right of access to the chart. That right includes portions of the chart provided by others, such as consultation reports and lab results. Generally, the dietitian can only decline access to information when:

- it is quality of care information, or information generated for the College's quality assurance program;
- the information is raw data from standardized psychological tests or assessments;
- there is a risk of serious harm to the treatment or recovery of the client, or of serious bodily harm to another person; or
- access would reveal the identity of a confidential source of information (assuming that it was a suitable to collect information this way, e.g. for a medicolegal report).

A refusal to provide access can be challenged before the Information and Privacy Commissioner. Where the dietitian works in a facility or for an employer, the existing procedures for handling such requests may have to be followed as long as they do not pose a barrier to reasonable access.

Information Correction

An individual has the right to request a correction of erroneous personal information held by the organization. If the organization agrees that an error has been made, it must correct the information and, where appropriate, notify any third parties who have received the wrong information of the correction.

Where the individual and the organization cannot agree, the organization must note the disagreement in its file. Again, the organization should notify any third parties who have received the disputed information of the disagreement, where appropriate.

Some grounds for refusing to correct information include situations where:

- the request is frivolous, vexatious or made in bad faith;
- the custodian did not create the record, and does not have sufficient knowledge, expertise or authority to make the correction; or
- the information consists of a professional opinion or observation made in good faith.

Complaints

The organization is required to develop an internal complaints system, and make the details of that system, and other external recourses, publicly available. The internal complaints system should have the following features:

- a designated individual in the organization (perhaps the Information Officer) to receive, and ensure the prompt investigation and response to all complaints;
- an easily accessible and simple to use procedure that includes acknowledging receipt, investigating the complaint, and providing a decision with reasons;
- the ability to respond appropriately to complaints that are justified including making changes to information handling policies and practices; and
- notifying the public of external recourses, including any regulatory body and the provincial or federal Information and Privacy Commissioner.

Open Privacy Policy

The organization must make its privacy policy available to the public. Individuals should be able to obtain this policy with reasonable effort, and it should be generally understandable.

A smaller organization might use one privacy

policy document, while a large organization might have three:

- a brochure summarizing the organization's privacy policy document;
- a comprehensive privacy policy document;
- an internal operational guide to assist staff in implementing the policy document.

STEP 7 - IMPLEMENTING THE PRIVACY POLICY

Implementing the privacy policy will have two stages. The first stage will be to complete a review of how the organization handles personal information, and to prepare and roll out the privacy policy. The second stage is to periodically monitor, review and update the policy, something that should be fairly frequent in the first year as issues will arise.

Information and Privacy Commissioners have criticized organizations for having a policy in writing that does not reflect what is actually happening. At a minimum, organizations should set a specific date each year to monitor, review and update the privacy policy, and document that review.

Accountability

The *Personal Health Information Protection Act* (PHIPA), 2004, provides detailed requirements for an external complaints system involving the Information and Privacy Commissioner of Ontario. This complaint system is stronger than that for the *Personal Information Protection and Electronic Documents Act*. For example, the Commissioner can directly issue a compliance order without having to go to court. A copy of any compliance order must be given to the custodian's regulator (e.g. the College). Where an order is made, the individual can sue in court for actual damages and up to $10,000 of mental anguish.

PHIPA also provides comprehensive whistle-blowing protections, and broad protections for persons who disregard their employer's (or other's) wishes in order to comply with the Act.

PHIPA also creates a number of offences for deliberately breaching the Act. For example, wilfully collecting, using or disclosing personal health information contrary to the Act is an offence. So is the insecure disposal of such information (e.g. throwing documents into the "blue box" without first shredding them).

Conclusion

Privacy is a much broader concept than confidentiality. It provides dietitians with broader duties to:

- identify why personal information is collected;
- obtain consent to collect, use and disclose the information in most cases;
- develop a comprehensive privacy policy;
- safeguard the information effectively; and
- give clients the right to access and correct any errors in their information.

The *Personal Health Information Protection Act, 2004*, is the key statute for Ontario dietitians. The philosophy behind it is that personal information belongs to and should be controlled by the individual to whom it relates.

FIGURE 5-1

The Ten Principles for Privacy of Personal Information

PRINCIPLE 1 - ACCOUNTABILITY

- Appointment of a designated information officer is required.

PRINCIPLE 2 - IDENTIFY PURPOSES FOR COLLECTING THE INFORMATION

- Any use must be identified.
- Uses should be summarized in the organization's privacy policies.
- Other than for assessment and treatment of the client, any use should be recorded (e.g. promotional mailings, sale of information).

PRINCIPLE 3 - CONSENT

- Consent will be required, with some exceptions, for every collection, use or disclosure of personal information.
- Implied consent might be possible for access to files for supervision, risk management or quality assurance.

PRINCIPLE 4 - LIMIT COLLECTION TO WHAT IS NECESSARY FOR IDENTIFIED PURPOSES BY FAIR AND LAWFUL MEANS

- Consider what information is necessary for proper service, and what information is going too far (e.g., social insurance number, financial information).

PRINCIPLE 5 - LIMIT USE, DISCLOSURE AND RETENTION TO ORIGINAL PURPOSE UNLESS FURTHER CONSENT IS OBTAINED OF LAW REQUIRES OTHERWISE

- Destroy the file as early as reasonably possible. Retention period should consider issues such as keeping file for return visits and College retention period guidelines.
- To use clinical files for a subsequent research project requires compliance with the *Personal Health Information Protection Act,* 2004, research requirements.

PRINCIPLE 6 - ACCURACY

- Probably already an existing standard of practice.

PRINCIPLE 7 - SAFEGUARDS

- Health information is relatively sensitive, so higher level of safeguards is needed.
- Files must be in secure area when not in use.
- Special safeguards are required when transmitting client information over the internet or outside of the office.

PRINCIPLE 8 - TRANSPARENCY

- Need policies and procedures in writing.
- Need to publish those policies, at least to clients and potential clients and should be available to others upon request.

PRINCIPLE 9 - INDIVIDUAL ACCESS TO PERSONAL INFORMATION

- Will have to give access of their files to clients.
- Grounds for refusal are limited (e.g. risk of harm).
- Duty to correct erroneous information.

PRINCIPLE 10 - ACCOUNTABILITY FOR INFORMATION PRACTICES

- Need a process to handle complaints about the information handling practices of the organization.
- May be subject to the Information and Privacy Commissioner's investigations of particular cases or general information handling practices.

Quiz

Provide the best answer to each of the following questions. Some questions may have more than one appropriate answer. Explain the reason for your choice. See *Appendix 1* for answers.

1. **You are doing an initial interview of a client in a multi-disciplinary setting. Your standard history form contains questions about a client's social and sexual history. What should you do?**
   a. Only ask the questions if they appear to be relevant to the client's presenting complaint, or if you are taking the history for the entire team and this information is needed by them.
   b. Have the questions removed from the form.
   c. Ask the client if it is OK to get into these areas.
   d. Ask the questions, as the answers may become relevant at some point in the client's care and you may be criticized for not taking a complete history.

2. **In Scenario 5-2, "Marketing Scheme", if you chose to honour the request;**
   a. There is no problem because weight loss clinics are not HICs and, thus, are exempt from the *Personal Health Information Protection Act*, 2004.
   b. You could put an "opt out" box on the initial new client documentation, so that the information can be given out unless the box is ticked off.
   c. Prepare a brochure to use when clients first come to the centre, indicating that you might sell this information to other companies.
   d. Verbally ask each client for permission.

3. **In Scenario 5-3, "Transporting Client Information", what should be done?**
   a. Nothing, because you don't know that Shelley recorded the client's name in her notes.
   b. Review safe transportation and storage practices with Shelley. Leaving the case in the cloakroom was unsafe.
   c. Tell Shelley never to take client information home again.
   d. Report Shelley to her school.

4. **You inadvertently left a purse containing three client files on a counter at the local sandwich shop. The purse was stolen. What should you do?**
   a. Report the matter to the police.
   b. Wait and see if the purse is returned with the files in it.
   c. Change your privacy policy so that files are not put into purses.
   d. Advise the three clients of the privacy breach.

5. **Your client asks to see his/her chart. It contains a number of consultation reports, including some that comment on his lack of effort towards treatment recommendations. You worry that revealing these consultation reports might damage his (not to mention your own) relationship with those practitioners.**
   a. Provide access to the entire chart; it is the client's right.
   b. Provide access to everything except the consultation reports, and direct the client to those practitioners for copies of their charts.
   c. Ask the consultants for permission to share the consultation reports with the client.
   d. Set a $250 administrative fee for looking at the chart. You know that your client cannot afford it.

Resources

COLLEGE OF DIETITIANS OF ONTARIO

résumé at www. cdo.on.ca > Resources > Publications

- "What the New *Personal Health Information Protection Act*, 2004, Means for Practitioners", Fall 2004, 8-9.
- "The Circle of Care & Consent to Treatment", Winter 2005, 9-11.
- "Here's what health professionals are asking about Ontario's new health privacy legislation", Spring 2005, p. 10.
- "What is the 'lock-box provision'?", Spring 2006, 3 & 6.
- "Privacy by Design", Spring 2010, p. 2.

PUBLICATIONS

Cavoukian, Ann, Ontario Information and Privacy Commissioner, Encrypting Personal Health Information on Mobile Devices, Information Sheet, www.ipc.on.ca.

Sharpe, Gilbert. "Regulating Health Information: The Ontario Approach", *Health Law in Canada*, 2000: vol. 20, No. 4, .69-76.

LEGISLATION

Freedom of Information and Protection of Privacy Act *at www.elaws.gov.on.ca*

Municipal Freedom of Information and Protection of Privacy Act *at www.e-laws.gov.on.ca*

Personal Health Information Protection Act, 2004 *at www.e-laws.gov.on.ca*

Personal Health Information Protection and Electronic Documents Act
http://laws.justice.gc.ca/en/index.html

Back to Table of Contents

SIX

College of Dietitians of Ontario

Confidentiality & Disclosure of Client Information

AT A GLANCE

SCENARIOS

CHECKLIST

NEED TO KNOW

1. All client information is confidential.

2. Disclosure of client information is normally made only with client consent.

3. Some legal provisions and obligations permit or require dietitians to disclose client information without consent.

Duty of Confidentiality

SCENARIO 6.1
Curling Team

You are organizing a women's curling team to compete against your husband's team. You recall a former client of yours who spoke about enjoying curling when she was a youth. You look up her telephone number in the closed records file drawer. You are about to call her when you hesitate, because you recall the staff at another hospital getting into trouble for looking up the Prime Minister's file. Is this the same thing?

This chapter describes the duty of confidentiality and the rationale for the duty. It identifies the complexities of obtaining consent for releasing client health information and provides some practical suggestions to achieving valid consent. Some exceptions to the confidentiality requirement are also examined. One of the highest obligations required of a dietitian is to maintain client information in confidence. Without confidentiality, clients will not be forthcoming or trust their health care providers with the very private and personal information necessary for their care.

The trouble with confidentiality is not the general concept, but applying the duty in a variety of difficult circumstances. What information is confidential? When is there consent to disclose it? When is it legally possible or required to disclose confidential information without consent?

Revealing confidential information about a client is viewed as unethical and professional misconduct, and could result in a lawsuit for damages. The definition of professional misconduct that requires confidentiality is worded as follows in the *Professional Misconduct Regulation:*

> "12. Giving information about a client to a person other than the client or his or her authorized representative, except with the consent of the client or his or her authorized representative or as required or allowed by law."

Scenario 6-1, *Curling Team*, is about the extent of the duty of confidentiality, and whether it includes using client information for other purposes. A dietitian should consider first that all medical and non-medical information provided by a client is confidential, including addresses, telephone numbers and information provided in an informal conversation at a social event where, for instance, a client may reveal details about an impending divorce. Even the fact that a person is your client is confidential.

Entertaining the notion that certain client information is confidential and that other client information may not be, could lead to inadvertent disclosure. Therefore, all client information obtained through a professional relationship is considered confidential; authority to disclose it—in writing, in speaking, in emails, or any other form — must be acquired from somewhere, if only by implied consent. Consent is always needed to disclose information in any form.

This approach to confidential information places a duty on dietitians to be clear about their role. For example, when speaking with a client at a social function, a dietitian must be aware that the client might consider the conversation as being covered by the duty of confidentiality, even though it is not a professional encounter. In that context, the dietitian should be sure that the client consents, or that there is some other legal authority before disclosing such information. Dietitians should also avoid discussing their clients in social situations.

The case of Shulman v. College of Physicians and Surgeons of Ontario (1980), 29 O.R. (2d) 40 (Div.Ct.), illustrates the breadth of the duty of confidentiality. Dr. Morton P. Shulman, a famous coroner, wrote for a Toronto newspaper. He received an anonymous envelope containing a patient file, which revealed a blood transfusion error in a hospital that resulted in the death of a patient. Dr. Shulman wrote about the incident, identifying the hospital and the patient. Even though Dr. Shulman had no

involvement in the treatment of the patient, was acting in his capacity as a journalist, not as a physician, and the patient was deceased, he was disciplined for breach of confidentiality.

In addition to the misconduct definition under the *Dietetics Act*, some statutes have specific provisions dealing with confidentiality. For example, the *Public Hospitals Act* has rules as to when client information can be revealed externally. Similarly, for dietitians who work for a government body, the *Freedom of Information and Protection of Privacy Act* or the *Municipal Freedom of Information and Protection of Privacy Act* might apply. The *Mental Health Act* covers dietitians working in a mental health facility. The *Personal Health Information Protection Act,* 2004, (PHIPA) also has some relevance to a dietitian's duty of confidentiality (see Chapter 5). Dietitians need to be aware of those provisions, which generally start with the assumption of complete confidentiality, and then describe circumstances in which the information can be used or disclosed.

Consent to Disclose Health Information

SCENARIO 6-2
Anorexia Nervosa

You are a private practice dietitian. You have received a referral from Dr. Malik to provide nutrition counselling to Beatrice, who suffers from anorexia nervosa. Beatrice, 17, was accompanied by her mother at her first appointments with you.

Two months after the referral, Beatrice informed you that she had stopped seeing Dr. Malik, and requested that you stop disclosing her health information to Dr. Malik or her mother. After providing nutrition counselling to Beatrice for six months, you become concerned because she has continued to lose weight and her BMI has dropped significantly. Based on your experience, you believe that Beatrice is at significant risk and is in need of medical attention. Should you report Beatrice's condition to Dr. Malik or her mother?

This section explains how to obtain client consent to disclose health information, and under what circumstances it may be necessary to reveal client health information without client consent.

Client consent authorizes the disclosure of client information. Consent can be formal (in writing), verbal or implied. If informed and genuine, each type of consent is equally valid. However, Scenario 6-2, *Anorexia Nervosa*, raises the issue of whether there are limits to the ability of clients to control their information, which would have an effect on a dietitian's duty of confidentiality. Assuming that all client information is confidential and requires a client's consent to disclose it, the real debate begins when other considerations — such as the duty to warn about client self-harm — have an effect on the general duty of confidentiality.

FORMAL, WRITTEN CONSENT

A formal, written consent is often obtained when it involves providing a copy of a chart or formal report to a third party. This is particularly recommended in situations where the information might be used against the client, for example, giving client information to an insurance company for a matter relating to a car accident, or to a lawyer for a legal proceeding.

However, as will be discussed in more detail in Chapter 7, a signature on a piece of paper does not constitute formal consent. The client must understand:

- what information will be disclosed;
- to whom it will be disclosed;
- for what purpose it will be used; and
- the likely consequences that will flow from that disclosure.

VERBAL CONSENT

Verbal consent is appropriate for most cases where a formal written consent is not necessary. Again, this involves explaining to the client the nature, purpose and implications of the disclosure, and obtaining explicit permission to do so.

Verbal consent can be made easier in circumstances where the dietitian has a handout or a notice in the clinic describing common or recurring disclosure issues (e.g. disclosures to students in a teaching facility). It is a simple matter, then, to discuss the information to make sure that the client understands and consents to disclosure. The consent should be documented in the client's file especially when the disclosure may become controversial (e.g., to the mother or Dr. Malik in Scenario 6-2).

IMPLIED CONSENT

SCENARIO 6.3
Circle of Care

Rose was transferred from Central Hospital to Quiet Acres Manor, a long term care facility. Barbara, a dietitian from Quiet Acres, has to prepare a dietetic treatment plan to address Rose's medical and nutritional needs. Rose is no longer capable and her substitute decisionmaker, a niece, is unavailable for a month. While not an emergency, Barbara wants to implement a dietetic plan within days, not weeks. Barbara needs more information and notices that her classmate, Jennifer, was the dietitian on record at Central Hospital. Barbara calls Jennifer to see if she can provide a more detailed history and any suggestions for managing Rose's nutritional needs. Can Jennifer help?

Implied consent is the riskiest type. It is difficult to be certain that the consent is fully informed and voluntary, when matters are not even discussed with the client. Misunderstandings are too easy, particularly in cases where the dietitian believes that the client has consented and the client does not agree.

In many circumstances, implied consent is routine. There is implied consent to discuss a client's condition directly with the client. Another example exists in a facility or clinic where a team is involved in caring for a client. It can often be inferred that the client consents to sharing information within the team.

In Scenario 6.3, *Circle of Care*, prior to PHIPA, Jennifer may not have shared any client information with Barbara without explicit consent from the client's substitute decision-maker. As this was not an emergency and there was no expressed consent, such a disclosure would not have fallen within any established exception to Jennifer's general duty of confidentiality. Practitioners like Jennifer were hesitant to imply consent for disclosure of information between institutions, without some prior discussion with their client or their client's substitute. This has changed. PHIPA has adopted the principle of implied consent to promote the concept of the "circle of care". While the term does not actually appear in the Act, Dr. Ann Cavoukian, the *Information and Privacy Commissioner* when the Act was enacted, explained the rationale as follows:

> "The 'circle of care' is not a defined term under PHIPA. It is a term of reference used to describe health information custodians and their authorized agents, who are permitted to rely on an individual's implied consent when collecting, using, disclosing or handling personal health information for the purpose of providing direct health care. In a physician's office, the circle of care would include:
>
> - the physician;
> - the nurse;
> - a specialist or other health care provider referred by the physician; and
> - any other health care professional selected by the patient, such as a dietitian, pharmacist or physiotherapist.
>
> In a hospital, the circle of care would include:
>
> - the attending physician; and
> - the health care team (e.g. residents, nurses, dietitians, technicians, clinical clerks and employees assigned to the patient) who have direct responsibilities of providing care to the individual."[1]

In September 2009 the *Information and Privacy*

Commissioner published a booklet providing guidance on the concept. It is called: *Circle of Care, Sharing Personal Health Information for Health-Care Purposes* and can be downloaded from: www.ipc.on.ca .

Under the circle of care concept, a custodian (or their agent) is able to share personal health information with another custodian (or their agent) for the purpose of providing health care, even without express consent. Disclosure for treatment purposes would be barred only if the client, or the client's substitute, had indicated that the information not be shared.

The circle of care can, like in Scenario 6-3, cross institutional boundaries. Where it is not reasonably possible to obtain the client's consent in a timely manner, a representative Health Information Custodian (HIC) can share personal health information about a client with another HIC to facilitate treatment without client consent.

Express client consent is required to disclose personal health information to a non-custodian, but is not necessary for disclosure within the circle of care for treatment purposes. However, because of past practices and the heightened importance of privacy of personal health information, Jennifer might want assurances from Barbara about the legitimacy of her need for the information. She might ask Barbara to put her request in writing and to confirm that Barbara's facility is, in fact, a health information custodian. Since Jennifer also has an obligation to comply with her own employer's privacy policies, she may wish to review them and to confer with her privacy officer to ensure that there are no applicable internal rules.

Dietitians need to be aware that some facilities do not yet accept the application of the circle of care concept outside of their own facility. Once custodians become comfortable with the concept, disclosure in treating clients like Rose should flow more easily than in the past.

Implied Consent & Hospital Administration

Consent may often be implied for practice settings, with norms that are widely followed and understood. For example, it is generally understood that in the absence of direction by a client to the contrary, a person calling a hospital will be told that a patient has been admitted and given their room number (which can indicate the nature and seriousness of the patient's condition).

Similarly, there is a broad recognition of the need for normal administrative access to client information. For example, there is usually implied consent for administration to have access to information for routine filing or billing purposes. In addition, implied consent would generally cover supervisory access to client information for quality control purposes (e.g. for an audit or as a part of a facility accreditation process).

Implied Consent and the Community Care Access Centre (CCAC)

A dietitian providing home care through a CCAC needs to be sensitive to a client's understanding of what information will be shared with the CCAC and their physicians. Usually, the case manager obtains consent from clients to have home care professionals provide reports back to the case manager. However, a prudent dietitian will check to make sure that the client has in fact given consent.

Unless the dietitian is certain that the client understands what information will be reported to the CCAC, she or he should explain what will happen and ensure that the client agrees to this type of disclosure.

Implied Consent and Publicly Available Information

Implied consent may also apply to publicly available information. For example, if a client proudly describes a child's achievements and the dietitian hears the client tell other non-practitioners about it, the dietitian can probably infer consent and tell mutual friends about it. However, even where the information is public, care must be taken because of the credibility attached to statements made by a treating practitioner. For example, if the local paper

reports that the Mayor is being treated for diabetes, it may still be inappropriate for the dietitian, as a treating practitioner, to say anything about it without the Mayor's consent.

SHARING INFORMATION WITH FAMILY MEMBERS

Great care must be taken when discussing client information with family members of a client. For example, a spouse calling with a concern about a client's eating habits may not necessarily justify a discussion of treatment recommendations. It would be prudent to first obtain the client's consent to involve family members in the treatment process.

Another tricky area is discussing client information with parents of teenagers. If a client is capable, then she or he should consent to any discussions with the parents first. Even when a parent accompanies a teenager on a visit, it does not necessarily mean that the teenager is consenting to disclosure of information to that parent. Sometimes parents do not accept this restriction. Dietitians need to be sensitive to the dynamic between the teenager and the parent and, where appropriate, arrange to speak with the teenager alone.

RESTRICTED CONSENT

Relying on implied consent becomes more difficult when a client wishes to maintain confidentiality in some circumstances, such as refusing consent to send a report to another hospital. The refusal of consent in that circumstance raises a concern that the client does not always want his or her health information shared with others on the health care team. The dietitian would then want to clarify when the client is comfortable with the sharing of information, to avoid any incorrect assumptions. Dietitians must also comply with the College`s *Record Keeping Guidelines for Registered Dietitians* (2014).

Clients Withdrawing Consent

Consent can be withdrawn. A dietitian must be sensitive to and respect any wishes from a client to withdraw consent. This may occur if the client better appreciates the consequences of a disclosure. An example would be where a parent uses information to interfere with a teenage client's treatment choices, and the teenager now wants disclosure to cease. If the dietitian has reason to doubt that a previous consent is still active, discuss the issue with the client. A withdrawal of consent does not reverse disclosure that has already been made, but applies to any future disclosure. A dietitian does not have to retrieve the records or reports that have already been sent out.

In some circumstances, courts would view the withdrawal of consent as unfair. For example, if a client makes a complaint to the College about the actions of a dietitian, there is implied consent for the dietitian to reveal client information in response to the complaint. It would be unfair for the client to make a complaint and then tell the dietitian that, in defence to the complaint, all consent to reveal information about the matter to the College is withdrawn.

Clients Incapable of Consent

Where a client is incapable, consent can be obtained from a substitute decision-maker. A client is incapable of giving consent when he or she does not understand the nature or the purpose of the matters proposed to be disclosed, or does not appreciate reasonably foreseeable consequences of the disclosure. For example, a long-term care resident with early dementia may not appreciate that failure to disclose to staff his treatment plan for diabetes management may result in hypoglycemic events. Therefore, this resident may not be capable of granting or withholding consent.

The approach to obtaining substitute consent to disclosure of information is set out in the

Personal Health Information Protection Act, 2004. These rules are very similar to that for obtaining substitute consent for treatment in the *Health Care Consent Act.* The major differences are:

- a capable person can authorize someone in writing to act on his or her behalf while still capable.
- a custodial parent can authorize decisions affecting the personal health information of a 15 years or younger unless:
  - the child disagrees;
  - the child consented to the original treatment on his or her own (i.e. without the assistance of the parent); or
  - for some family counselling situations. This rule tries to avoid having to obtain express consent from children 15 years or younger when dealing with the child's parents, while still leaving the child the option of preserving confidentiality.
- a guardian or attorney for property can act as a substitute decision-maker for consent.[2] (See Chapter 7 for more details about substitute consent for treatment.)

These rules for consent are based on the concept that the information belongs to the client, not the dietitian. The dietitian may own the paper or computer system in which the information is stored, but holds the information in trust for the benefit of the client.

Disclosure without Consent

A dietitian may disclose client information without consent when permitted or required to do so by law. However, before disclosing the information without consent, a dietitian should consider whether discussing the matter with the client is appropriate. Prior notice to the client, as uncomfortable as it may be, may reduce the anger of the client when learning of the disclosure. Yet in some circumstances, particularly where third parties are at risk, prior notice to the client may not be appropriate.

MANDATORY REPORTS

The most obvious example of disclosure without consent is when the dietitian is required to make a mandatory report. Mandatory reports typically required of dietitians include:

- reasonable grounds of sexual abuse by health practitioners;
- child abuse;
- elder abuse;
- professional misconduct, incompetence or incapacity as a grounds for termination of employment or an association with a dietitian;
- the endangering of safety by dietitians; and
- the "duty to warn" (see Chapter 3 about mandatory reporting).

Duty to Warn

The "duty to warn" is the most difficult of these mandatory reports because it arises from case law. It has now received some statutory support from ss. 40(1) of *Personal Health Information Protection Act*, 2004, which reads as follows:

> 40. (1) A health information custodian may disclose personal health information about an individual if the custodian believes on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons.

However, this provision only permits the disclosure of information in order to warn others of a serious risk of significant third party or self-inflicted harm. The common law duty goes further; it is a legal obligation to warn where others would otherwise face a significant risk of serious bodily harm, or if a client is at risk of serious self-inflicted harm.

The duty to warn typically arises where a client has confided to a practitioner a threat to harm another person or identifiable group (e.g. "That is the last straw, I am going to blow him away"). If the threat is clear and immediate, and it appears that the client might have the ability to

carry it out, there is a duty to warn those threatened. Usually reporting the matter to the police is sufficient.

A threat by a client to harm himself or herself is even more difficult to assess. Our society places a high value on self-determination. A client generally has the right to refuse treatment, even if the result might be permanent damage or even death. However, a threat of self-harm may reflect a lack of capacity or appreciation that such actions may harm others (e.g. a suicide attempt while driving), creating a duty to warn. If there is time, the dietitian should consult with legal counsel. Even if a dietitian turns out to be wrong, warning of a risk of harm will generally be supported by law where it is reasonably based on genuine concern.

CHECKLIST 6-1

Duty to Warn Considerations

MOST DUTY TO WARN CONSIDERATIONS ARE MADE THROUGH A COMBINATION OF THESE FACTORS:

- ☐ Is the threat specific?
- ☐ Is the threat to a specific individual or identifiable group?
- ☐ Is the threat imminent?
- ☐ Is the client capable of carrying out the threat (e.g., does the client have the means to carry it out. For example, does the client have a gun if the threat is to shoot someone)?
- ☐ Can the threat be appropriately dealt with through direct intervention?
- ☐ Do you have the skill and confidence of the client to do so?
- ☐ Should another person on the client's health care team more appropriately deal with the threat? Do you have actual or implied consent to discuss it with them? If not, is the threat such that this step should be taken without consent?
- ☐ Who should be warned? If criminal behaviour is threatened, it may be the police.
- ☐ Should you discuss the disclosure with the client before making the warning?
- ☐ Can you discuss the situation with a colleague on a no-names basis?
- ☐ Is it possible to obtain prior legal advice?

Duty to Disclose Information to Government Agencies

In addition to mandatory reports, there may be a duty to disclose information to government agencies funding treatment. Both the *Workers Safety and Insurance Act* and the *Health Insurance Act* require practitioners to provide information when requested to support payment for insured services, even if the client does not consent. Under the *Long-Term Care Act* and the *Retirement Homes Act,* the consent of the client is generally (but not always) required to disclose client information to anyone except other service providers. Dietitians would be wise to obtain consent at the beginning of the relationship, even for disclosing client information to a CCAC.

COURT SUMMONS

A dietitian may be summonsed as a witness in a court or tribunal proceeding and be compelled to provide written or verbal information about their clients. However, read any court or tribunal order or summons carefully. Normally, the disclosure is only to be made at the hearing itself. It would often be improper to discuss the information with the person summoning the dietitian prior to the start of the hearing. In addition, if the dietitian is not the health information custodian, the dietitian may not have the authority to bring the client's chart to the hearing unless the custodian is also summonsed. It is prudent for the dietitian to consult with legal counsel if summonsed.

Conclusion

The duty of confidentiality applies to all information obtained about a client in the course of a dietitian's professional duties. Ordinarily, a dietitian will require a client's consent, whether express, verbal or implied, to disclose

information to others. Only in rare cases, will a dietitian have a legal obligation to disclose client information, even without consent (e.g. mandatory reporting obligations and where there is a duty to warn). The *Personal Health Information Protection Act*, 2004, further ~~reinforces a die~~titian's duty of confidentiality.

1 Ann Cavoukian, Ontario Information and Privacy Commissioner, What is the "circle of care?, June 12, 2006 at: http://www.ipc.on.ca/index.asp?navid=63&fid1=43

2 The list of substitute decision-makers in ss. 26(1) of the *Personal Health Information Protection Act*, 2004 reads as follows:

"26. (1) If an individual is determined to be incapable of consenting to the collection, use or disclosure of personal health information by a health information custodian, a person described in one of the following paragraphs may, on the individual's behalf and in the place of the individual, give, withhold or withdraw the consent:

1. The individual's guardian of the person or guardian of property, if the consent relates to the guardian's authority to make a decision on behalf of the individual.
2. The individual's attorney for personal care or attorney for property, if the consent relates to the attorney's authority to make a decision on behalf of the individual.
3. The individual's representative appointed by the Board under section 27, if the representative has authority to give the consent.
4. The individual's spouse or partner.
5. A child or parent of the individual, or a children's aid society or other person who is lawfully entitled to give or refuse consent in the place of the parent. This paragraph does not include a parent who has only a right of access to the individual. If a children's aid society or other person is lawfully entitled to consent in the place of the parent, this paragraph does not include the parent.
6. A parent of the individual with only a right of access to the individual.
7. A brother or sister of the individual.
8. Any other relative of the individual."

Quiz

Provide the best answer to each of the following questions. Some questions may have more than one appropriate answer. Explain the reason for your choice. See *Appendix 1* for answers.

1. **In Scenario 6-1, "Curling Team", what should you do?**
   a. Call the former client; the information is not confidential.
   b. See if you can find the former client's contact information through a public source, like the phone book. If not, don't make the call.
   c. Write to the client asking about the curling team. Ask the client to call you. A letter is less intrusive than a phone call, and the client is in control of whether to talk to you.
   d. Call the client at the business number recorded on the chart, because that is not personal information.

2. **In Scenario 6-2, "Anorexia Nervosa", what should you do?**
   a. Tell Dr. Malik as he is part of the health care team.
   b. Tell the mother because you have implied consent since she attended early visits.
   c. If on your assessment Beatrice is at imminent risk of serious harm, tell either Dr. Malik or the mother or both, whichever seems best.
   d. Tell no one because clients have the right to self-determine their fate.

3. **Which of the following client information details, provided to you by the client, is least likely to be confidential?**
   a. His sharing at the grocery store of his successful completion of a marathon run.
   b. His guided tour of his house on a home visit.
   c. His "celebration" on a visit when he lost 30 pounds.
   d. His report to you during a visit of a successful business deal.

4. **Your client is being discharged and is moving to a long term care facility. She asks that when you transfer the chart to the facility, omit any information related to her past history of binge eating. Discussions with the client on the point are fruitless. What do you do?**
   a. Make the deletions, but advise the facility that portions of the chart you are sending have been removed at the client's request.
   b. Provide nothing to the facility, and advise them that full consent has not been provided and it would be misleading to provide part of the chart.
   c. Provide nothing to the facility, without explanation, because the explanation is itself confidential.
   d. Provide everything to the facility, because the client must be incapable if she gave you those instructions.

5. **Your client's parent is suing for custody in a *Children's Aid Society* matter. The client is 15 years old and is capable of instructing you. You are summoned to bring your chart and testify at a hearing by the client's parent. The lawyer for the client's parent, who issued the summons, leaves a message asking you to call her. What should you do?**
   a. Tell your client that you have been summoned.
   b. Book time off for the court date and organize and copy the file.
   c. Return the call to the lawyer in case it is about administrative matters (e.g. when and where to appear), but advise the lawyer that, without written consent from your client, you cannot discuss any client information until you are on the witness stand.
   d. All of the above.

Resources

COLLEGE OF DIETITIANS OF ONTARIO

résumé at www. cdo.on.ca > Resources > Publications

- "Disclosure of Client Information by Dietitians", Spring 2000, p. 3.
- "The Circle of Care & Consent to Treatment", Winter 2005, 9-11.
- "What is the 'lock-box provision'?", Spring 2006, 3 & 6.
- "Changes in the Plan of Treatment & Client Consent", Winter 2007, 4-5.
- "Documenting Consent", Summer 2009, 12-13.
- "Do you have a duty to warn?", Summer 2011, 4-6.

Record Keeping Guidelines for Registered Dietitians in Ontario, 2014.

LEGISLATION

Cavoukian, Ann, *Ontario Information and Privacy Commissioner*, "FAQ: What is the "circle of care?", June 12, 2006, http://www.ipc.on.ca/index.asp?navid=63&fid1=43

Gilbert Sharpe, "Regulating Health Information: The Ontario Approach", *Health Law in Canada*, 2000: vol. 20, No. 4, 69-76. This article reviews the implications on health practitioners of the *Personal Information Protection and Electronic Documents Act.*

A.E. Grant and A.A. Ashman, *A Nurse's Practical Guide to the Law***.** Aurora: Canada Law Book Inc., 1997. See chapter about confidentiality.

J.J. Morris, M.J. Ferguson and M.J. Dykeman, *Canadian Nurses and the Law***,** 2nd ed. Toronto: Butterworths Canada Ltd., 1999. See chapter about confidentiality.

D.R. Evans, *The Law, Standards of Practice, and Ethics in the Practice of Psychology***.** Toronto: Emond Montgomery Publications Limited, 1997. See chapter about confidentiality.

Michael Carey, "The Limits of Doctor-Patient Confidentiality in Canada", *Health Law in Canada*, 1998: vol. 19, No. 2, 52-63. Discusses the duty to warn.

Lorraine E. Ferris, "In the Public Interest: Disclosing Confidential Patient Information for the Health or Safety of Others", *Health Law in Canada*, 1998: vol. 18, No. 4, 119-126. Discusses the duty to warn.

Shulman v. College of Physicians and Surgeons of Ontario (1980), 29 O.R. (2d) 40 (Div.Ct.).

PUBLICATIONS

Dietetics Act, 1991, "Professional Misconduct", Ontario Regulation 680/93, Amended to O Reg. 302/01.

Personal Health Information Protection and Electronic Documents Act: http://laws.justice.gc.ca/en/index.html.

The Regulated Health Professions Act, and the Personal Health Information Protection Act, 2004, and other provincial statutes can be found at www.elaws.gov.on.ca.

Back to Table of Contents

SEVEN

College of Dietitians of Ontario

Consent to Treatment

AT A GLANCE

SCENARIOS

FIGURES

NEED TO KNOW

1. Consent for treatment is always required, except in an emergency.

2. Consent is generally obtained from a client directly and can be verbal, in writing or, in some cases, by implication.

3. Where a client is incapable, the dietitian must obtain consent from a substitute decisionmaker.

4. There is no minimum age for consent; it is based on the capacity of the client.

Informed Consent to Treatment

SCENARIO 7-1
Energy Supplementation

You work at a long-term care facility. A number of residents are identified as requiring additional energy in their meal plan. You are asked if it would be a good idea to put the energy supplement in mashed potatoes for 17 residents. The cook tells you that the residents won't even be able to taste the difference and will never know. You think the addition to their diet would make sense. What kind of consent would you need from the residents?

The requirement for informed consent rests on the principle that clients make their own treatment decisions. The role of the practitioner is to provide information and make recommendations that will enable clients to make informed decisions. Consent can be obtained in a number of ways, and can even be implied, and must be obtained (except in cases of emergency) for any therapeutic intervention. If a client is not capable of giving consent, a substitute decision-maker must be found.

In the scenario above, the first question is whether adding the energy supplement is treatment. Providing a balanced food diet might not be viewed as treatment; the facility would be performing the same role as a restaurant. However, adding a specific substance to food for a therapeutic purpose would be considered treatment. "Treatment" means any clinical intervention with a client and, for the purposes of informed consent, includes assessments.

Thus, some consent is needed, whether from the general consent obtained at the time of admission to the facility, or otherwise. Scenario 7-1, *Energy Supplementation*, illustrates the need to obtain consent in every case where one intervenes with a client. The fact that an intervention is positive is no reason to assume that consent is not needed. The principle that clients should make their own treatment decisions is based on a number of rationales.

- Individuals have control over their bodies. A health practitioner should not touch, examine or otherwise interfere with another person's body without true consent. Of course, meaningful consent requires that the client knows everything needed to make an informed choice.
- Health practitioners must provide high quality services to clients. In part, these include advising them of their options and partnering with them. The "best possible service" means just that for each particular client.[1]
- Health practitioners owe a fiduciary duty of good faith and loyalty to their clients. Often, health practitioners have a high status in our society. Health practitioners also have specialized knowledge and expertise. Clients often approach health practitioners such as dietitians at a time of need. For all of these reasons, clients are vulnerable in relation to the health practitioner, which places a corresponding duty on the health practitioner to act only in the client's best interests.

Scenario 7-2, *Refusal to Eat*, next page, illustrates the difficulties in accepting a client's wish when it's contrary to your own treatment orientated practice and personal values, particularly when relatives and colleagues take a different view. The issue here, however, is whether Veronica is able to give informed consent. Does she understand and appreciate the consequences of her decision? Is she depressed? If Veronica is fully capable, then her wishes need to be respected.

It is sometimes difficult to reconcile the principle of client autonomy, including the right to refuse treatment, with the duty to warn others about a client's intent to harm themselves discussed in Chapter 6. There are two main distinctions:

- First, where there is a concern that a client does not truly understand and appreciate what they are proposing, the duty to warn about client self-harm is more likely to apply. The decision is not an informed, autonomous choice.
- Second, the duty to warn results only in advising those who need to know about the contemplated self-harm. However, the people advised about the client's intent to

harm themselves usually still need informed consent to intervene; from the client, if capable, and from a substitute if the client is not capable.

WHY INFORMED CONSENT IS NOT ALWAYS OBTAINED

Often there is a discrepancy between a health professional's belief that informed consent has been obtained and what actually happens in reality. Dietitians know that they are supposed to obtain informed consent, and generally believe that they do. However, some objective observers might question this assumption. There are several reasons for this discrepancy in perception:

- **Health care professionals assume a level of sophistication in their clients that often does not exist.** In Scenario 7-1, *Energy Supplementation* (p. 76), the dietitian might assume that the residents are familiar with dining room operations, and would know that additions are often made to food to address specific nutrition insufficiencies. However, dietitians must recognize that they live day in and day out with dietary matters, and that many other people never think twice about the nutrients contained in the foods they eat.
- **Health care professionals are rushed.** In today's environment of cutbacks and downsizing, there is tremendous pressure to provide nutrition care for an increasingly higher volume of clients, often combined with more complex assessment and treatment needs.
- **Poor communication skills.** Making assumptions or even making a statement is not communication. Communication involves feedback and understanding.
- **Ignorance of the requirements of informed consent.** While all dietitians know that they need informed consent, they often do not appreciate all aspects and responsibilities of this duty. Some wrongly assume that it only applies to invasive procedures such as surgery and the administration of drugs. Appropriately, these invasive activities are generally the focus of published standards and guidelines. However, all treatment decisions and many other matters, such as client assessments and the release of information, require informed consent.

SCENARIO 7-2
Refusal to Eat

Veronica is sharp as a whip. But she is severely and painfully disabled. Recently the pain has been getting worse, and Veronica is having trouble taking the pain medication. In the last few days she has refused to eat. You have discussed the issue with Veronica a few times. While she has not been completely forthcoming, you are convinced that she is capable and is possibly choosing to end her life. Veronica's family is upset at her declining condition, and insist that she receive tube feeding. Veronica's physician agrees and provides the order. In discussing tube feeding with her, Veronica is adamant that she does not want it. What do you do?

ELEMENTS OF INFORMED CONSENT

Often, consent can be quite informal. For example, when a dietitian asks a client questions about his or her medical history, a client generally demonstrates consent by answering them. However, whenever a dietitian touches a client, or orders or administers a treatment, a more formal approach should be taken. A client is entitled to know the following before any assessment or treatment is performed:

- **The nature of the treatment or assessment.** Don't assume that clients know what will happen next. It is generally prudent to explain exactly what you'll be doing and the manner or mechanism by which the nutrition intervention works.
- **Who will be providing the intervention.** Unless a client is unconscious, he or she will generally see who is administering a treatment. Some clients, dealing with professionals they have never met, may feel uncomfortable telling them to stop a treatment and asking for someone else to do it. Therefore, clients should be given some information about the professionals who will be treating them, e.g. whether the person is registered. For some procedures, it is also

prudent to communicate the gender of the person providing the treatment. If treatment will be provided at another time, it would be sensible to tell the client who will be administering it in advance.

- **Reasons for the intervention.** The client should understand the expected benefits of the procedure.
- **Material effects, risks and side-effects of the intervention.** One court has described it this way: "A risk is thus material when a reasonable person in what the [practitioner] knows or ought to know to be the patient's position would be likely to attach significance to the risk or cluster of risks in determining whether or not to undergo the proposed therapy." [2] In other words, a risk is material if a client would want to know about it.
- **Alternatives to the intervention.** Often, more than one treatment option may be available for a client. Some options have an influence on a client's choice because they may be more intrusive, painful or expensive than others. Although a dietitian may prefer a certain option, it is up to the client to decide on the best course of treatment. It is acceptable, however, for a dietitian to explain why certain options are not recommended and, in a general way, to explain the material effects, risks and side effects of alternative options. It is not acceptable to provide only the options that the treating dietitian is able to offer; all reasonable options should be presented, including those that other dietitians or even other health practitioners can provide.
- **Consequences of declining the intervention.** All clients should have an opportunity to consider the advantages and disadvantages of refusing treatment as well. This discussion should not create the impression, however, that the practitioner is attempting to coerce clients to agree to the intervention.
- **Specific questions or concerns of the individual client.** In addition to the general aspects of informed consent, dietitians should be sensitive to any particular concerns of individual clients. If the practitioner knows that an intervention could offend any religious, ethical or personal belief held by a client, then that issue should be discussed. In addition, any specific questions asked by the client need to be answered.

To give informed consent for treatment, a client must not only understand the information, but must also appreciate reasonably foreseeable consequences of the decision. For example, a client may understand that a modified texture diet would include pureed foods, but may not understand that favorite liquids such as tea or juice must be thickened to decrease the risk of aspiration.

Consent may be given for a course of treatment (e.g. the ongoing adjustment of a diet for clients with renal disorders) or a plan of treatment (e.g. a diabetes management program involving a health care team). Once given, the consent applies to the entire course or plan of treatment, unless there is a significant change in circumstances or consent is withdrawn.

Normally, it is the responsibility of the person proposing the course or plan of treatment to obtain consent. However, if the person proposing the treatment is not able to obtain the consent (e.g. because they do not know all of the material risks and benefits, etc.), someone else may have to do it. Even where a member of the health care team has obtained consent for the course or plan of treatment, it is prudent to check with the client before implementing one's own intervention to ensure that the consent was informed and has not been withdrawn.

For repetitive matters, it is acceptable to give a written description of the information that the client needs to know. This will often save considerable time. However, there should always be some individual discussion with clients after they have read the treatment description, to ensure they understand the information, appreciate the implications, and have all their questions answered. Some clients are functionally illiterate and hesitant to disclose this fact. So, simply asking, "Did you understand what you read?" is often not enough.

Implied Consent to Treatment

Consent to treatment need not always be obtained in writing or even verbally from a client. In many circumstances, such as a routine assessment, a written consent is impractical. While formal, documented consent is not always required, dietitians need to be sensitive and confident that they have actually obtained consent.

An express written consent offers proof should a subsequent challenge arise. Yet as Scenario 7-3, *Implied Consent* illustrates, consent is often obtained informally. An express statement from the client was not necessary for the consent to be valid, and the risk involved in a client receiving a reduced fat diet was minimal. While not a "best practice", relying on the client's implied consent was probably sufficient in this scenario.

If a particularly risky intervention is recommended, or if a client appears unreliable, then a written consent can help a dietitian prove that a proper consent was obtained. The consent form should be simple and easy to understand. A sample consent form is set out in Figure 7.2. Dietitians need to carefully fill in the blanks, using language that is easy to understand. If desired, they can add an explicit acknowledgement of understanding for a particular risk or side-effect; for example, introducing fibre in large amounts too quickly may result in abdominal cramping and bloating.

Written consent forms are not a complete defence to an allegation of failing to obtain consent. Dietitians sometimes confuse a signed consent form with obtaining informed consent. A written consent form is simply a piece of paper, unless it is read, understood and appreciated. Obtaining informed consent is a process that involves the meeting of minds.

The client can still claim that the form was not clearly explained before his or her signature was obtained, or that he or she did not understand or appreciate what was signed. Therefore, the written consent form should not be obtained in a rushed or routine fashion. It should never be obtained with the client's initial registration with the office, facility or clinic, unless it is already known what intervention will occur. What, then, is the benefit of a written consent?

SCENARIO 7-3
Implied Consent

You work in a public hospital and speak with a client about a reduced fat meal plan. You have a good discussion about the goals and methods of reducing fat consumption, and have found a means to achieve the meal plan agreeable to him. At the end of the meeting, you say, "I will initiate a low fat meal plan for you starting tomorrow. You should know that you won't be getting ice cream for desert." As you leave, you realize that the client never actually said yes. However, you are sure that he was with you on the point and was not objecting. Do you need to go back and get an express consent?

Should a problem occur, a clear and simple signed consent form, witnessed by the attending dietitian or another person, places a heavy onus on the client to explain why he or she signed the form without fully understanding it. If a written consent is not obtained for particularly risky procedures, practitioners should document in the client's chart that an informed consent was given verbally. A note in the chart is also prudent when the client appears to be unreliable. A useful tip is to document the reason why a client chose one treatment option over another. Such a note is valuable supportive evidence that the dietitian actually obtained informed consent.

Withdrawal of Consent to Treatment

Consent can be withdrawn. If a client consents to a course of treatment but then changes their mind, the dietitian can no longer rely on an earlier consent. This new decision must be respected.

A written consent can also be verbally withdrawn. However, the dietitian may ask the client to confirm the withdrawal of consent in writing so that there is a record. Also, the risks and benefits of the decision to withdraw consent should be reviewed to ensure that the withdrawal of consent is informed.

Consent for Incapable Clients

SCENARIO 7-4
Developmentally Challenged Client[4]

A family physician refers you, a home care dietitian, to teach a 29-year-old developmentally challenged female, who lives alone, nutrition management of her newly diagnosed insulin-dependent diabetes. The client is able to provide what seems like an accurate record of her daily food intake.

When you explain the relationship of food intake to insulin, the need for regular meals and snacks, and the need to follow a daily meal plan, the client becomes quite agitated. She repeats several times that she had no idea that "the diet would be forever" and that she wants to eat like a regular person. When you try to reassure her that you will work with her to set up a meal plan that she will be able to follow, she begins to cry. At this point, you suggest that you will come back again to talk again about her diet.

The next day, using food models, you try to show her how the meal plan will work. Again, the client is distressed and states that she doesn't believe that the meal plan is important and she doesn't think anything will happen if she skips meals. After the visit, you contact the referring physician, who says that he feels the client is capable of understanding her diabetes and the treatment implications. He reiterates that the diet is an essential component of her treatment. You call the home care nurse, who says that the client is able to draw and inject her insulin independently. She does tell you, however, that the client lives close to her parents and that her mother is involved in some aspects of her care. What do you do?

Scenario 7-4, *Developmentally Challenged Client*, illustrates the complexity of determining whether a client is capable of giving informed consent for a particular treatment. Sometimes clients can be capable for some decisions and not others.

If you determine that a client is not capable, then you must obtain consent from the appropriate substitute decision-maker. The key issue in this scenario is whether the client understands and appreciates the consequences of her decision. Her statement at the second visit, that she doesn't believe that the meal plan is important and she doesn't think anything will happen if she skips meals, raises serious doubts about whether the client appreciates the consequences of her decision. The dietitian, while considering the views of the referring physician and the home care nurse, has to make his or her own assessment of whether the client is capable of making this particular decision.

Sometimes, there is confusion about the role of the Consent and Capacity Board in making findings of incapacity. It is rare for the Board to become involved in individual treatment decisions (where they do, it is usually after the fact, i.e., in an appeal of a finding that a person is not capable of making decisions). Unless the Board has made a general finding of incapacity about the client, it is the responsibility of the front line practitioner to determine the client's capacity for the individual treatment proposed. In this case, the dietitian would not determine the client's general capacity, but rather whether the client was capable of making a decision about the specific dietary changes being recommended.

The *Health Care Consent Ac*t (HCCA) provides a useful model for obtaining consent from a substitute decision-maker, which can be applied in all cases. While it provides detailed guidance for obtaining consent from a substitute decision-maker, where a client is incapable, it does not expressly cover all forms of intervention. Case law, however, does require that consent be obtained for all interventions (other than emergencies). Therefore, prudent practitioners should follow the procedures set out in the HCCA for all matters.

DETERMINATION OF CAPACITY

Clients are assumed to be capable. An assessment of a client's capacity may be made only when there is reason to doubt it. However, a specific set of rules does not exist for determining the capacity of a client. When reservations about a client's capacity exist, a dietitian can perform an assessment to determine capacity based on the condition of the client and the nature of the proposed service. As noted above, the assessment is only of the client's capacity to make a particular treatment decision, not the client's general capacity.

For the purposes of a dietitian's interactions with a client, a general assessment of the capacity or incapacity is not required. The assessment should simply determine whether a client is capable of giving informed consent to a proposed treatment or service. A client may be capable of consenting to some treatments or services that are simple to understand, but not for those that require the analysis of complex considerations (for example, Scenario 7-4). In addition, a client may be capable during some periods but not others. For example, with some forms of dementia, a client may have "good days" and "bad days".

In each case, the dietitian must assess whether the client understands and appreciates the reasonably foreseeable consequences of a decision. The assessment of capacity must be based on observations about the client (apparent confusion) rather than on presumptions, generalizations or stereotypes (age, diagnosis, disability).

There is no minimum age for consent. As a general guideline, a dietitian may often find that:

- Children under 7 are incapable of consent for almost any treatment;
- Children between 7 and 12 can rarely consent to treatment; and
- Youth over 12 need to be carefully assessed as to their capacity on a case-by-case basis.

SUBSTITUTE DECISION-MAKERS

When a client is incapable of giving consent, it must be obtained from a substitute decision-maker (unless there is an emergency). The substitute decision-maker must:

- be at least 16 years old (unless the substitute is the parent of the client);
- be capable;
- be able and willing to make the decision; and
- act in accordance with either the last capable wishes of the client, if any, or in the best interests of the client.

A dietitian has some obligation to intervene if it is clear that the substitute is not fulfilling his or her obligations. In some cases, explaining the obligations to the substitute is sufficient. In other cases, for example if the substitute is culpable of misconduct, the dietitian would be required to make a report to the Public Guardian and Trustee.

For certain decisions, an opinion from an independent evaluator may be required. For example, under the *Health Care Consent Act*, an evaluator's opinion may be required for the admission of an incapable person to a care facility. Dietitians may act as an evaluator for this purpose. [4]

THE PRIORITY DECISION-MAKER

SCENARIO 7-5
Non-Custodial Parent

Robert calls wanting to see you right away about his 8-year-old daughter Olivia. Olivia is with him for the day and has to be returned to her mother the next morning. Robert is concerned that Olivia is not being adequately fed by her mother, and wants you to assess Olivia. On questioning, you learn that Robert is not the custodial parent; he just has access rights. He says there is no provision in their separation agreement about his right to authorize medical care for Olivia. What do you do?

In this scenario, *Non-Custodial Parent*, consider the following points:

- Assessments require informed consent. While the *Health Care Consent Act* does not expressly require it, professional standards and case law do.
- While a health care professional is not supposed to rely on age to determine the capacity to consent, the reality is that few, if any, 8-year-olds would be able to appreciate the potential consequences of agreeing to this assessment.
- It is possible that at some point you could have a reasonable suspicion that Olivia was a child in need of protection. For example, if you saw Olivia in the waiting room, her appearance, along with Robert's information, could provide grounds for such a report. Indeed, you might even be in that position simply by obtaining sufficient information from Robert, although you would be cautious about his objectivity.
- To determine whether Robert can provide substitute consent, you need to know if he is a custodial or access-only parent, and inquire about the terms of any separation agreement or court order. Table 7-1, *Substitute Decision-Makers Ranked Highest to Lowest*, on the next page, lists the substitute decision-makers in priority from highest to the lowest. If a higher ranked substitute decision-maker would object, a lower ranked substitute usually cannot give consent.

As a practical matter, when dietitians are dealing with a family member of an incapable client, they merely have to establish:

1. Whether the family member knows of any formally appointed substitute; and, if not,
2. Whether the family member knows of another higher ranked substitute who would object to the family member making the decision.

If a formally appointed substitute (such as a power of attorney or another higher ranked family member) would object to a decision, then the dietitian cannot rely on the lower level substitute to make it. The dietitian must try to obtain consent from a higher level substitute if they are available and willing. In this example, you would have to obtain consent from Olivia's mother, the custodial parent, for her nutritional assessment.

COLLEGE GUIDELINES FOR DEALING WITH INCAPABLE CLIENTS

Dietitians will want to keep the incapable client as involved as possible in their treatment and personal service decisions. The following guidelines have been developed by the College of Dietitians of Ontario:

1. The dietitian will inform the incapable client that they will need a substitute decision-maker to assist them in understanding the proposed intervention, and that the substitute decision-maker will be responsible for the decision regarding treatment.
2. The dietitian will inform the client of the substitute decision-maker's name.
3. The dietitian will involve the incapable client, to the extent feasible, in discussions with the substitute decisionmaker.
4. If the client disagrees with the substitute decision-maker, the dietitian will offer to assist the client to identify another substitute decision-maker of the same or more senior rank. If the client indicates that they are still uncomfortable with the substitute decision-maker, the dietitian will also inform the client that he/she may apply to the Consent and Capacity Board for the appointment of a representative of the client's choice.
5. If the client disagrees with the finding of incapacity, the dietitian will inform the client of the right to appeal the finding of incapacity to the Consent and Capacity Board for review. If the client requests clarification on this finding, the dietitian will give the client the name of the health professional who made the finding.

Emergencies

In an emergency, consent is not needed when the delay in obtaining it would prolong suffering or put the client at risk of sustaining serious bodily harm. The definition of what

constitutes an emergency is set out in the *Health Care Consent Act*. In particular, an emergency includes circumstances where a client "is apparently experiencing severe suffering" or is at risk of "sustaining serious bodily harm". In addition, an emergency can exist when a client is capable, but communication or language difficulties create a barrier causing a serious delay in treatment, and there is severe suffering or a risk of serious bodily harm.

One of the rare situations where a dietitian will face an emergency is when force-feeding anorexic clients. As noted above in Scenario 7-2, *Refusal to Eat*, if a client is capable, he or she can refuse to eat. Force-feeding can only occur if the client is incapable and there is an emergency (i.e. consent or refusal cannot be obtained on a timely basis) or a substitute decision-maker consents to it. [5]

FIGURE 7-1
Substitute Decision-Makers Ranked Highest to Lowest

1. Guardian of the person appointed by the courts;
2. Attorney for personal care conferred by a written form when the client was capable;
3. Consent and Capacity Board appointed representative;
4. Spouse or partner;
5. Child or custodial parent;
6. Access parent;
7. Brother or sister;
8. Any other relative;
9. Public Guardian and Trustee.

Where a substitute from the first three on this list is able and willing to make the decision, then he or she must be used. At the family member level, any available substitute on the list can be relied upon, so long as no higher ranked substitute is available who is known to want to make the decision (see discussion below). The Public Guardian and Trustee, a government official, is relied upon as a last resort.

For more information about the *Office of the Public Guardian and Trustee for Ontario*, see: http://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/

Conclusion

Dietitians must understand the complexities of the legal requirements for consent to treatment. It is important to remember that consent is always required for treatment, except for an emergency. Written, verbal and implied consents are all valid, but in the latter case, dietitians should be sensitive to their clients' treatment needs and wishes. They should also remember that capacity to consent is not age related, but depends on a client's ability to understand the scope of the treatment and its consequences. In cases where clients are not capable of consent, a substitute decision-maker has to be found.[5]

1 Dietitians of Canada and College of Dietitians of Ontario. *Professional Standards for Dietitians in Canada*. Toronto: 1997, Standard 1, page 6.

2 Hoop c. Lepp, [1980] 2 R.C.S. 192.

3 Effective December 15, 2009, for the purposes of the *Health Care Consent Act,* Registered Dietitians have been permitted to act as an evaluator to find a person capable or incapable of providing consent with respect to admission to a care facility where consent is required by law. This change enabled dietitians to work as Case Managers within *Community Care Access Centres* (CCACs).

4 Adaptation of the example from College of Dietitians of Ontario, *Health Care Consent Act* (HCCA) Guidelines for Members (HCCA).

5 Lisa Braverman, "The Application of the *Health Care Consent Act* to the Force Feeding of Anorexic Patients", *Health Law Review* 1997: Vol. 5, No. 2, p.25-32.

FIGURE 7-2

Consent Form

I hearby consent to the following treatment:

Describe treatment as specifically as possible but in words that are understandable to lay people.

I have been told about the following:

- ☐ What the treatment is
- ☐ Who will be providing the treatment
- ☐ The reasons why I should have the treatment
- ☐ The alternatives to having the treatment
- ☐ The important effects, risks and side-effects of the treatment and the alternatives to the treatment [consider adding "including the following: {list major risks}"];
- ☐ What might happen if I do not have the treatment?

I understand the explanation and have no further questions.
My consent is voluntary.

Date

WITNESS SIGNATURE

SIGNATURE OF CLIENT

PRINT NAME OF WITNESS

PRINT NAME OF CLIENT

Quiz

Provide the best answer to each of the following questions. Some questions may have more than one appropriate answer. Explain the reason for your choice. See *Appendix 1* for answers.

1. **In Scenario 7-1, "Energy Supplementation", what should the dietitian do?**
   a. Nothing, the residents are not the dietitian's client.
   b. Nothing, the residents signed blanket consent forms at the time of admission to the facility.
   c. Nothing, energy supplementation is not a treatment.
   d. Ensure that informed consent is obtained.

2. **In Scenario 7-4, "Developmentally Challenged Client", is the client capable?**
   a. Probably not, since the client does not appear to understand the material considerations.
   b. Probably not, since the client does not appear to appreciate the reasonably foreseeable consequences of her decision.
   c. Probably not, as she is developmentally challenged.
   d. Probably yes, since she is capable for other treatment decisions having life altering consequences, such as the need to take insulin injections.

3. **In Scenario 7-4 "Developmentally Challenged Client", what should the dietitian do?**
   a. Do not accept the physician's and home care nurse's view of capacity at face value.
   b. Speak to the client about involving her mother in this treatment.
   c. Seek the involvement of the mother so long as there are no known higher ranked substitutes.
   d. All of the above.

4. **A signed written consent from a client:**
   a. Is the best protection you can have for a risky treatment decision.
   b. Is better than a verbal consent.
   c. Provides some evidence of informed consent.
   d. Needs to be witnessed to be effective.

5. **A client can withdraw consent:**
   a. At any time.
   b. Only in the same form in which the consent was originally given (e.g. in writing, verbally).
   c. If it is informed.
   d. Through a power of attorney for care.

Resources

COLLEGE OF DIETITIANS OF ONTARIO

Code of Ethics Interpretative Guide (I999).

Dietitians of Canada and College of Dietitians of Ontario. *Professional Standards for Dietitians in Canada.* Toronto: 1997.

Guidelines: Health Care Consent Act (HCCA).

Articles at www.collegeofdietitians.org . Enter topic in the search box:

- "The Circle of Care and Consent to Treatment", Winter 2005, 9-11.
- "Changes in the Plan of Treatment & Consent", Winter 2007, 4-5.
- "Documenting Consent", Summer 2009, 12-13.
- "Managing Conflicts Between RDs & Substitute Decision-Makers", Fall 2009, 6-8.

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Braverman,Lisa . "The Application of the Health Care Consent Act to the Force Feeding of Anorexic Patients", Health Law Review 1997: Vol. 5, No. 2, 25-32.

Hoffman, B.F. The Law of Consent to Treatment in Ontario, 2nd ed. Toronto: Butterworths Canada Ltd., 1997.

Rozovsky, L.E. *The Canadian The Canadian Law of Consent to Treatment*, 2nd ed. toronto: Butterworths Canada Ltd., 1997.

LEGISLATION

Office of the Public Guardian and Trustee for Ontario, *Substitute Decisions Act*, S.O. 1992, C30.

Health Care Consent Act, S.O. 1996, chapter 2, Schedule A.

Back to Table of Contents

EIGHT

College of Dietitians of Ontario

Record Keeping

AT A GLANCE

SCENARIOS

TABLES

NEED TO KNOW

1. Keeping appropriate records is important for client care and enabling dietitians to respond to accountability issues.

2. There are various acceptable ways of keeping records, so long as dietitians have access to the necessary information when needed.

3. Records must be kept secure, confidential, available for professional use, and available for clients to review and correct if necessary.

4. Employers/payers may establish reasonable procedures for access to information by clients, as long as these do not create unnecessary barriers for clients.

The Client Health Record

Record keeping is important for all businesses and professional practices. Dietitians working in industry would certainly document their analysis and recommendations to their employers. While some of the principles discussed in this chapter would apply to all dietitians, the focus is about keeping client health records. Keeping an accurate health record will assist in four areas:

1. Day-to-day practice;
2. Communicating with team members;
3. Preparing reports; and
4. Accountability.

1. DAY-TO-DAY PRACTICE

The primary use for a client health record is to assist dietitians in their day-to-day practice. Obviously, this use is more important for ongoing treatment plans than for one or two-visit encounters. In follow-up visits, dietitians need to review:

- the reasons for treatment;
- the details of the treatment plan;
- progress to date;
- baseline data with subsequent data; and
- the discharge plan.

2. COMMUNICATING WITH TEAM MEMBERS

Good record keeping will also be useful to the other members of a health or residential care team such as physicians, nurses, therapists and food service workers. These individuals will refer to dietetic entries in a client's chart when preparing their own treatment or when implementing nutrition care plans. Often, dietitians never know that others have reviewed their records. Omitting information, or recording it incorrectly or late, may result in inappropriate treatment decisions.

3. PREPARING REPORTS

Records are commonly needed to prepare assessment, treatment and prognosis reports. Clients are entitled at any time to a dietitian's reports, and may request them for use by insurers, employers and lawyers. Failure to provide an adequate report because of poor records may lead, at best, to professional embarrassment for the dietitian. At worst, failing to provide a report when requested to do so is also professional misconduct, according to the College's *Professional Misconduct Regulation:*

> 24. Failing, without reasonable cause, to provide a report or certificate relating to an assessment or treatment performed by the member, within a reasonable time after a client or his or her authorized representative has requested such a report or certificate.

4. ACCOUNTABILITY

The axiom, "if it wasn't recorded, it wasn't done," is not that far from the truth. Records are critical in a dietitian's accountability for services. Clients, employers, payers and the College will rely heavily on a dietitian's record in assessing the adequacy of a dietitian's conduct or competency. Adjudicators will rely on records in dealing with client claims, even more so than on evidence provided by either the clients or dietitian.

Accountability is not restricted to disputes with clients. A dietitian's record is often the focus of risk management and quality supervision by employers. In its Quality Assurance Program, the College may also rely upon those charts. The quality of a dietitian's records is generally seen as a good barometer of the quality of his or her practice.

Common Objections to Keeping Health Records

Some health professionals minimize the importance of record keeping by suggesting that it detracts from the real practice of dietetics, and that it signifies the usurping of the profession by lawyers. However, as noted above, record keeping is an integral part of a high quality practice.

Is keeping accurate health records time consuming and tedious, taking time away from other "pressing" work such as client contact or meetings? During a busy day, it can certainly seem so. The fact that the health records may not be urgently needed, and that years can pass before an entry becomes critical, further conceals the importance of keeping records. However, once dietitians become familiar with a record keeping system, charting can be done quite efficiently. A system might include references to other documents, a set of usual abbreviations and possibly use of a preprinted form. With experience, you will learn what is significant to record (see *What Should be Recorded* below).

Some health professionals worry that thorough record keeping means that mistakes will be recorded as well, resulting in easier legal liability. While theoretically possible, the reality is that for every case where a dietitian might regret recording a detailed note, there will be a thousand cases where they will be thankful, and wish that even more had been recorded.

What Should be Recorded?

There is an element of professional judgment as to what should be recorded in a client's record, which depends partly on the nature of the dietitian's practice, who has access to records, and what forms of accountability the dietitian is most likely to face.

1. EQUIPMENT SERVICE RECORDS

These are important where the equipment can have health consequences, or where the accuracy of measurements taken from the equipment is vital. Include a record of the date of inspection or service, and who did it, (which can be crucial if a problem develops), and a reliable reminder system for such inspections or maintenance.

2. FINANCIAL RECORDS

When billing occurs, financial records are needed. Audits of financial payments are a fact of life in both the private and the public sector. Typically, they include:

- a client identifier;
- the date, time, nature, and length of service;
- the method of determining the fee, if it is not uniform in the practice (units of time, block fee, fee schedule, based on a prior estimate, etc.); and
- the actual fee and the method and date of payment.

3. A RECORD OF CONSENT

A record of consent obtained from a client for any risky, invasive or otherwise significant service is valuable. As noted in Chapter 7, a signed consent form is desirable, though not necessary. What really counts is evidence that the client was given the necessary information and provided consent. It is often sufficient to record in the client health record that informed consent was obtained after a discussion with the client. Both a signed consent form and a dietitian's note of obtaining consent in the chart are legally recognized ways of demonstrating that actual consent was obtained.

4. A CLIENT HEALTH RECORD

Client health records have the most extensive content requirements. It should give a clear idea of what happened during a visit and why, and describe:

- the client's condition;
- the dietitian's assessment and treatment plan;
- progress of any ongoing interventions, including modifications of treatment; and
- pertinent discharge information if there was ongoing care.

Furthermore, a health record contains documents obtained from others, such as referral slips, consultation reports and laboratory results.

Perhaps the most commonly omitted entries are those that relate to:

- the goal of the treatment plan, e.g. increasing a client's weight to an ideal

body weight or increasing intake of certain nutrients;
- monitoring and evaluation, such as noting that the client is tolerating the diet well; and
- discharge planning, e.g., recording the follow-up required.

Here is a detailed list of what should be recorded in a client record:

(a) the client's full name and address;
(b) the date of each of visit to or by the member;
(c) the name and address of primary care physician and any referring health professional if applicable;
(d) the reason for referral, if applicable;
(e) the client's relevant medical history, including medical and social data related to the nutrition intervention, and a reference to the appropriate document;
(f) the assessment conducted, the findings obtained, the problems identified, the goals for nutrition intervention, and the nutrition care plan;
(g) the recommendations made by the member for diet orders, nutrition supplements, and test and consultations to be performed by another person;
(h) progress notes containing a record of services rendered and any significant findings, including those resulting in changes to the nutrition care plan;
(i) relevant reports received by the member in respect of the client's health;
(j) particulars about discharge planning, including the referral of the client by the member to another health professional when applicable;
(k) any relevant reason a client may give for cancelling an appointment or refusing the service of a member, when applicable;
(l) particulars of nutrition care that was commenced but not completed, including reasons for non-completion;
(m) copies of reports issued to other sources;
(n) copies of any written consent provided by the client;
(o) a notation of any controlled act performed for the client and the authority for performing it; and
(p) a copy of any written communication sent to the client.

There are also other clinical record keeping issues to consider, such as the making and signing of entries by dietetic interns and the co-signing of those records. Different approaches can be taken so long as they are clear and reasonable. For example, if a dietitian co-signs an entry made by a dietetic intern, she or he should indicate the meaning of the co-signature. Does the co-signature mean:

- that the matter was used as a teaching experience?
- That the dietitian is verifying the accuracy of the entry? or
- That the dietitian agrees with the care provided? [1]

It is not necessary to keep all records in the same place. For example, equipment records can be kept with the equipment or in a separate file organized by piece of equipment rather than by client. Financial records can be kept in a dedicated financial record. So long as the information can be readily obtained and, where necessary, cross-referenced to the client, the system is adequate.

Record Keeping Methods

HANDWRITTEN NOTES ON BLANK PAPER
This method is fine and provides maximum flexibility (if not maximum legibility).

PRE-PRINTED FORM WITH HEADINGS AND CHECKLISTS
Forms save time and help ensure that information is not forgotten. However, diligence is needed so that points are not checked off thoughtlessly, resulting in inaccurate records. Inaccuracies might include ticking off a series of boxes without reading them, or omitting information because the form does not have a specific space for it.

COMPUTERIZED OR ELECTRONIC RECORDS
Electronic records are becoming the norm. They can work well and are legible. However, for their own protection, dietitians should use a program that leaves an audit trail to demonstrate when each change was made and by whom. Again, pre-established computerized forms can be helpful, but take care not to cut and paste information from other files that does not apply, and take special security measures.

CHARTING BY EXCEPTION
This is feasible as long as clearly written protocols specify what is meant by a lack of entry or an exception. Dietitians must ensure that they are familiar with and consistently follow the protocol. If it can be established by other records that a dietitian did not consistently follow the protocol, the record will not be considered reliable and the benefit of having it will be lost.

CHARTING BY REFERENCE
This method is acceptable. Referring to a medical directive, a written assessment protocol, a recurring consent to treatment information sheet or a known treatment regime can be a handy and quick way of incorporating a lot of information in a very brief entry. To be credible, it is important that the reference be accurate and complete.

ABBREVIATIONS
Abbreviations are acceptable as long as they are recognizable by others on your team who share access to the client health records (or by outside readers). Have a master list of usual abbreviations for reference.

DICTATION
Dictation is acceptable but resource intensive because someone needs to transcribe the tape, unless voice recognition computer software is used. In addition, the many steps in this system of record keeping can lead to errors, misfiling, or even record loss. A dietitian should review and sign off on the transcribed records to ensure accuracy. If this is not possible, at a minimum, transcribed records should be spot-checked to ensure that they are generally accurate and catch systemic errors.

Joint Records

SCENARIO 8-1
Joint Records

You work in a public health unit and participate in a Canada Pre-natal Nutrition Program for high-risk expectant mothers. The program is operated by an independent community agency and the clients are those of the agency, not the public health unit. Your notations are kept only in a record on the premises of the agency. You know that the agency does not follow the College's expectations for chart security and retention. Are you at risk for this record keeping approach?

Dietitians often work in settings where they are expected to use a joint record, because this makes practical and clinical sense for a team practice. However, this places some obligation on the dietitian to ensure that the record keeping practices of the facility, employer or team are consistent with the expectations of the College and the dietetic profession. Professionals in public facilities such as hospitals, government departments or settings where only health practitioners work are more likely to share values and approaches. Even in these situations, dietitians should check record keeping practices to ensure their quality.

Where the employer, facility or program is privately operated, the dietitian may need to exercise a higher degree of scrutiny of the record keeping practices. In Scenario 8-1, *Joint Records*, the records are partially those of the dietitian, so he or she has to ensure that the facility meets minimal professional expectations (Checklist 8-1, *Joint Record Keeping,* next page). Usually this can be achieved by communication between the parties.

Where the facility, employer or program does not meet the record keeping expectations of the dietetic profession, the dietitian must advocate for a change to the practices or, failing to reach compliance with the College's regulation, may need to keep separate records. This should not be done secretly (see *Private Records* below).

CHECKLIST 8-1
Joint Record Keeping

- ☐ Chart kept securely;
- ☐ Confidentiality maintained - only those with express or implied consent of the client may access the chart (see Chapter 6);
- ☐ Reasonable client access to record;
- ☐ Appropriate policy for correction of errors;
- ☐ Records maintained for a minimum of 10 years;
- ☐ Dietitian will have reasonable access to the chart both before and after leaving the job or facility;
- ☐ Reasonable plan for transfer of records if facility or program closes.

It is important to resolve record keeping issues when starting a position. If you are already in a job where you have these issues, resolve them now. Once a relationship ends or a dispute arises, it is very difficult to resolve them. In some private practices, the records are a crucial component of "goodwill" and their ownership can be contentious. The employment or partnership agreement should discuss who owns the records, and how a departing dietitian will obtain necessary access. If the owner of the records is not a dietitian, there should be explicit agreement by the owner to comply with the College's expectations and the *Personal Health Information Protection Act*, 2004. For non-profit operations, the record keeping obligations for security and retention can be onerous.

Private Records

The temptation by practitioners to keep their own records separate from the central record keeping system is illustrated in Scenario 8-2 *Keeping Private Records*. This practice is not recommended. The difficulty is that keeping private records prevents the facility or organization from meeting its own record keeping obligations, e.g. maintaining security, providing access to clients, and destroying the record in accordance with an established retention policy.

Private records consist of entries that are not included in the official chart of the facility or employer for whom a dietitian works. Unlike rough notes, which can be destroyed after they have been completely transcribed onto the official chart, these records are typically maintained by a dietitian for some time for private use. There are a number of reasons why a dietitian might wish to keep a private record:

- The official chart requires a form that does not lend itself to recording all of the information the dietitian wishes to record;
- The employer or facility discourages the extensive recording of information that the dietitian wishes to do or that is required by the College;
- The official record is inconvenient to access, because of the procedures, the length of time it takes to retrieve the record, or because others are often using it;
- The dietitian believes that the information handling policies of the facility or employers do not permit compliance with College regulations or other legal requirements (e.g. providing adequate access to clients);
- A dietitian's private record tends to be messy and not in a form that is useful or appropriate for others on the health care team to see;
- On rare occasions, the dietitian may be concerned about the lack of privacy afforded to the official record, e.g., where very private information is revealed that a client does not want the entire team to know, or where the employer or facility is privately owned and does not respect confidentiality; or
- The dietitian is concerned that a copy of or access to the official record will not be given when leaving the facility or the job.

SCENARIO 8-2
Keeping Private Records

You work at a facility with other health professions. The facility has an approved form that it expects all members of the health care team to follow. You place the traditional information (medical history, major findings on assessment, treatment plan) on the approved form. However, there is not an appropriate space to put your detailed meal plan calculations and energy intake notes; these entries are rough and messy, and you would be embarrassed to put them in the central chart. They would be of no use to anyone but you. Can you keep those notations in a separate file that you keep as long as you are seeing the client and then discard?

However, serious problems can arise when a dietitian maintains private records without the knowledge and authority of the facility or employer:

- It is difficult for the information policies of the facility or employer to apply to a dietitian's private record, e.g., it might not be kept with the same degree of security as the official record;
- Valuable information may be inaccessible to the rest of the health care team; and
- The legal obligations of the facility or employer cannot be fulfilled. If a client wishes to exercise his or her right to see the entire file, the facility or employer cannot provide this access where it has no knowledge of the dietitian's private record. Or if the entire chart is required to be produced in a legal proceeding, the private record will not be included, placing the facility or employer in contravention of the law.

Some solutions to these competing considerations include:

- Do not keep private records. Record everything that needs to be recorded in the official chart.
- Advise the facility or employer that you are keeping private records and negotiate appropriate policies and procedures respecting them, such as access by others, security and ability to remove private records when leaving, etc.
- Discuss with the facility or employer the reasons for keeping private records in the first place, so that any underlying issues are appropriately addressed.

Safeguards for Securing Personal Information

While health records must be securely maintained, no uniform approach or simple set of rules guide dietitians. So much depends on the nature of the practice and the record keeping system chosen (e.g., paper or electronic). In some sense, that ambiguity is positive; dietitians have a lot of flexibility in developing a system of safeguards. On the other hand, the lack of guidance in developing security measures leaves little doubt that some organizations, particularly smaller private ones, have minimal safeguards.

Dietitians must ask themselves whether the system in place in their facility provides adequate safeguards to allow only authorized persons to have access to records. A system of safeguards should cover the matters identified in Checklist 8-2, *Safeguards for Securing Personal Information*, on the previous page.

Access to records must be on a need-to-know basis within the organization. Sharing of information should have at least the implied consent of the client, and any external disclosure should be with consent or with other legal authority (see the discussion of the implied consent and the "circle of care" in Chapter 6).

CHECKLIST 8-2
Safeguards for Securing Personal Information

- ☐ Have a written *Privacy and Access Code* for the organization.
- ☐ Provide a copy of the *Privacy and Access Code* to staff of the organization upon the hiring or retaining of new staff.
- ☐ Train staff about the confidentiality of personal information. Access is on a need-to-know basis.
- ☐ Train staff in the methods of maintaining security of personal information.
- ☐ Require staff to sign a confidentiality statement.
- ☐ Require that personal information that is not in a secure area be locked or otherwise protected from unauthorized access.
- ☐ Require personal information in paper form to be shredded or otherwise destroyed before its disposition.
- ☐ Require the use of password protection and other recognized security measures for electronic information.
- ☐ Mobile devices need to be encrypted.
- ☐ Require that electronic data be destroyed before the hardware holding the data is discarded.

Where a dietitian is not responsible for the information practices of an organization, changes to those practices should be advocated to redress security issues. In the long run, a dietitian should not give client information to an organization that has ongoing, serious security weaknesses.

WHAT ABOUT EMAIL?
As a general rule, it is not acceptable to send personal health information through regular email. Acceptable options include obtaining the person's consent to use email, encrypt the email, or make the information anonymous. Sometimes consent can be inferred by the fact that the person has initiated the communication by email, or has asked the dietitian to respond by email.

SCENARIO 8-3
Email Communications

You work in public health and communicate with a lot of clients by email. Some of those emails deal with individual health concerns (in some cases, concerns about third parties) and with sensitive matters (e.g. sexually transmitted diseases). What considerations arise here?

However, the dietitian should ensure that the consent was "informed", in that the recipient knows the sensitivity of the type of information that will be contained in the email. Also, keep in mind that the consent of the recipient does not apply to any third person discussed.

Retention of the email is another important issue. If the information in the email must be noted in the client file, for instance, a recommendation for a diet order, then a copy of the email must be kept on file. Even if the information is not required for College purposes, it should be kept for other reasons. For example, if the client has follow-up questions or challenges your advice, having a copy of the email is important.

Client Access and Correction Rights

A client has the right to access his or her complete chart, under case law [2] and the *Personal Health Information Protection Act*, 2004. Exceptions are rare and relate primarily to any serious safety concerns for third persons or the client. This right of access applies to the entire chart, including consultation reports and any documents provided by other practitioners.

A client's right of access extends to persons authorized by the client to access the chart, including family members, other practitioners and lawyers. Where a client is incapable, a substitute decision-maker would authorize the access (see Chapters 5 and 6).

Reasonable fees or administrative obligations can be imposed on a client's access rights. Before allowing clients to view the records, for instance, dietitians may require that the entries be reviewed with them to explain any abbreviations or technical terms. However, fees and administrative obligations should not be barriers to prompt and easy access to records by clients. Unless the entries are particularly sensitive, dietitians should consider providing a copy of the chart at cost.

A client will occasionally challenge some of the entries. Where a request relates to a factual entry and the dietitian agrees that the record is inaccurate, then a change should be made. However, for audit trail purposes, the original entry should not be obliterated. Rather, indicate that the original entry was in error, striking it out with one line so that it is still legible (or some reasonable equivalent for electronic records, such as a link containing the corrected information). Insert a corrected entry indicating the date and the name of the person making the correction. It would be appropriate for the dietitian to send the corrected entry to those who have had access to the erroneous information within the past year.

If the dietitian does not believe that the entry is wrong, then make no correction. This is particularly true where the entry contains an

evaluative component or an expression of professional opinion. However, if the client continues to dispute the entry after the dietitian's explanation, the dietitian should permit the client to file a statement of disagreement in the chart. Depending on the nature of the issue, the dietitian might also send the statement of disagreement to those who had access to the entry in the past year.

Where there is a joint record, the custodian of the record should consult with the person making the entry before taking any corrective measures. For example, it would be unfortunate if an office manager decided to change the results of an assessment recorded by a dietitian at the request of a client, without first discussing the matter with the dietitian.

Retention of Records

Records need to be retained for a reasonable period, not only for ongoing care but also for accountability. Indeed, it is in a dietitian's own interest to have the record available should there be any question about the intervention. A client health record should be kept for at least 10 years following:

- The client's last visit; or
- The date at which the client turned 18, if the client was less than 18 at the time of the last visit. (This is in recognition of the fact that the limitation period for a child suing a dietitian does not begin until the child turns 18.)

Even where the client dies, the record should be retained for the remainder of the period described above. The estate of the client may have questions about the care received. The dietitian might need the chart if sued. In addition, the dietitian would still be accountable to the College even though the client is deceased.

Once the time period set out in the retention policy has elapsed, the record should be destroyed promptly. The continuing existence of the record is a security risk. Also, any non-compliance with one's privacy policies creates legal risk to the dietitian. A record should be made indicating when client charts were destroyed. At a minimum, the record may note the name of the client, any file number, the date of last treatment and the date the file was destroyed.

Where a particular statute (e.g. *Long-Term Care Homes Act*, *Retirement Homes Act*, or the *Mental Health Act*) specifies a different retention period for client records, the dietitian may follow that provision rather than the College guideline. For example, under the *Public Hospitals Act*, a diagnostic imaging record (other than of the breast) need only be kept for 5 years, and most videotape records do not need to be retained at all.

Terminating or Transferring a Practice

If a dietitian retires or sells a practice, client records must be dealt with responsibly. While a piece of paper or computer disk may belong to the dietitian, the information on them belongs to the client. The College has developed a requirement in its *Professional Misconduct Regulation* specifying the obligations to clients when a practice is terminated or transferred:

> "26. Failing to take reasonable steps before terminating services to a client or resigning as a member, to ensure that, for each client health record for which the member has primary responsibility,
>
> i. The record is transferred to another member, or
>
> ii. The client is notified that the member intends to resign and that the client can obtain copies of the client health record."

When records physically leave an office, make reasonable efforts to ensure that clients know where their charts are and that they have control over who holds them. "Reasonable" depends on the circumstances. A one-time encounter with a client eight years earlier might not require a letter of notification if the chart is transferred to another dietitian. However, it would be appropriate to send a letter to a client who has received an intensive amount of assistance in recent months, or to one who is still requiring ongoing intervention. Such a

client may direct that their record be transferred to a place of their own choosing.

Under the *Personal Health Information Protection Act*, 2004, a Health Information Custodian also has an obligation to notify clients when the practice has been sold. This enables the client to make decisions about the health record, such as transferring a copy elsewhere.

In any transfer of records, a written agreement should specify what will be done with the records and ensure that the dietitian will have ongoing access where needed to fulfill his or her professional obligations (e.g., responding to a complaint).

IN THE EVENT OF SUDDEN INCAPACITY OR DEATH

Dietitians in private practice should have a business plan and/or indicate in their will the designated individual who will be responsible for their client health records in the event of their sudden incapacity or death.

The designated person does not have to be a dietitian. They could be a spouse, another family member, friend, or colleague. Since the designated HIC may not be familiar with the Ontario laws and College guidelines for client health records, it is important to leave instructions about how the client health records should be managed. The instructions should include information about keeping the records private, confidential and secure; appropriate retention periods; and, keeping the records accessible if clients wish to access them, or if the College or police need access to them during an investigation.

The instructions should direct the designated HIC to:

1. Notify the College in writing of the dietitian's incapacity or death. In the letter to the College, indicate the location of the records and how clients may access their chart. This ensures the College has the information to assist clients to access their records should the need arise.
2. Contact each client to inform them of the dietitian's sudden incapacity or death. Specify the retention period and where the records will be kept if clients should ever need to access this information (See sample letter next page).
3. Provide resources to help clients find follow-up dietetic services (e.g., direct clients to the "Find a Dietitian" section of the Dietitians of Canada website or to EatRight Ontario).[3]

Conclusion

Good client records are needed to support quality dietetic services and health care. As an essential part of a dietitian's accountability to clients, employers, payers and the College, records must capture significant information such as the information described in the College's proposed records regulation. There are many charting styles, including electronic records, and dietitians should be mindful of the opportunities and risks associated with all of these. Dietitians are accountable no matter what charting system or style may be in use.

Dietitians must take necessary steps to ensure accuracy, security and appropriate access to client records in their entirety. Joint records and private records pose special problems related to access, security and retention. Give careful consideration to managing your client health records to ensure that legal and professional requirements are met in all cases.

1 College of Dietitians of Ontario *Record Keeping Guidelines for Registered Dietitians,(2014)* p. 13.

2 McInerney v. MacDonald (1992), 93 D.L.R. (4th) 415 (S.C.C.).

3 *"Private Practice RDs: Do You Have Plans in Place To Manage Client Health Records?", Summer 2011, p. 7.*

FIGURE 8-3 PRIVATE PRACTICE DIETITIANS - SAMPLE LETTER TO CLIENTS
In the Event of Sudden Incapacity or Death

<Date>

<Client Name>
<Address>
<City, Postal Code>

Dear <Client's Name>,

I regret to inform you that your RD <Name> has <been in an unforeseen accident or passed away suddenly>. The purpose of this letter is to inform you that your client health record will be kept at <insert location address>. If you would like a copy of your records you may do so by contacting <insert contact details>. Copies of client health records will incur a fee of <insert amount>.

Records will be kept private and confidential according to the record retention requirements for health professionals in Ontario:

1. For Adults: 10 years after the date of the client's last visit.
2. For Children: 10 years after the date that the client turns 18 years of age.

If you would like to seek further private practice dietetic services, you can do so by going to the "Find a Dietitian" section of the Dietitians of Canada website, where you can search for Dietitians in your local area according to postal code: http://www.dietitians.ca/Find-A-Dietitian/Search-FAD.aspx

For general questions regarding healthy eating and nutrition issues, please feel free to contact EatRightOntario, a free dietitian telephone and email/website service. You can contact EatRightOntario by calling 1-877-510-5102 or visit their website at: www.Ontario.ca/Eatright

The College of Dietitians of Ontario has a record of where RD <Name> records will be kept. If you need assistance accessing your chart you may contact the College at www.collegeofdietitians.org.

If you have any further questions or concerns, please don't hesitate to contact me.

Kind regards,

<insert name of the designated person responsible for the client health records>
<insert contact information for further questions>

Quiz

Provide the best answer to each of the following questions. Some questions may have more than one appropriate answer. Explain the reason for your choice. See *Appendix 1* for answers.

1. **In Scenario 8-1 "Joint Records", is the record keeping system adequate?**
   a. No, because the records are not kept in accordance with College and professional expectations.
   b. No, because the people who control the record are not regulated health practitioners.
   c. Yes, because the person served is a client of the organization, not the dietitian.
   d. Yes, because the record is maintained according to the criteria of the dietitian's employing agency.

2. **In Scenario 8-1 "Joint Records", what should you do?**
   a. Keep your own records separate and apart from the agency's chart.
   b. Make your entries on the agency's chart but keep a copy for yourself.
   c. Discuss with the agency if it will change its record keeping practices to meet the College's and professional expectations.
   d. Explain the situation to the client and obtain his or her consent to follow the agency's record keeping practices.

3. **In Scenario 8-2 "Keeping Private Records", should you keep separate records and then discard this additional information?**
   a. Yes, as no one else needs this additional information.
   b. Yes, so long as you get the permission of your facility and do not discard the information for 10 years.
   c. Yes, as the official chart contains the minimal information expected by the College.
   d. No, private records are too dangerous to keep.

4. **Which of the following is not a reasonable security measure for client health records?**
   a. Written policies and procedures.
   b. Records will never leave the facility.
   c. All staff sign a confidentiality agreement.
   d. Access to records is on a need-to-know basis.

5. **Client records should be retained for how long?**
   a. 10 years from each visit.
   b. 10 years from the last visit.
   c. 10 years from the last visit or since the client turned 18, whichever is longer.
   d. 5 years for most diagnostic imaging records.

Resources

COLLEGE OF DIETITIANS OF ONTARIO

***Record Keeping Guidelines for Registered Dietitians* (2014)**

résumé articles at www.collegeofdietitians.org. Enter topic in search box to access articles:

- "Records Relating to Members Practices: Answers to your questions", Fall 2005, 5-6.
- "Where have all the records gone?", Winter 2006, 5 & 11.
- "Destroyed Health Records", Fall 2007, 9 & 11.
- Dr. Ann Cavoukian, *Information and Privacy Commissioner of Ontario*, "Three Strikes and We're In: Abandoned Health Records", Fall 2007, 9-10.
- "Business Practice: Meeting your financial record keeping obligations with Online Payment Options", Winter 2009, 10-11.
- "Documenting Consent", Summer 2009, 12-13.
- "RD Documentation in an IPC Environment", Spring 2011, p. 9.
- "Private Practice RDs: Do You Have Plans in Place To Manage Client Health Records?", Summer 2011, p. 7.

PUBLICATIONS

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Haydon, John H. Q.C. " Legal Aspects of Health Information ", *Health Law in Canada*, 1999, vol. 20, no 12, 1-12.

Grant, A.E. and A.A. Ashman. *A Nurse's Practical Guide to the Law,* Aurora, Canada Law Book Inc., 1997.

Morris, J.J., M.J. Ferguson and M.J. Dykeman. *Canadian Nurses and the Law*, 2nd ed., Toronto, Butterworths Canada Ltd., 1999.

LEGISLATION

Public Hospitals Act, (Provincial Statute)

Personal Health Information Protection Act, 2004 at www.elaws.gov.on.ca

Back to Table of Contents

NINE

College of Dietitians of Ontario

Conflict of Interest

AT A GLANCE

SCENARIOS

FIGURE

NEED TO KNOW

1. A conflict of interest occurs where, in the mind of a reasonable person, a dietitian has a personal interest that could improperly influence their professional judgment.

2. Some conflicts are best managed by complete avoidance.

3. Most conflicts can be successfully managed by the DORM principle:
   - Disclosure
   - Options
   - Reassurance
   - Modifying the circumstances.

What is a Conflict of Interest?

The fiduciary duty of dietitians to their clients, reviewed in Chapter 1, includes being loyal and diligent, and acting in good faith in the best interests of clients. Where dietitians do not have a traditional practitioner/client relationship, they may still have a duty to others such as the consumers affected by their decisions, their employers or to the general public. Clients need to be able to trust dietitians. Having a conflict of interest can undermine that trust.

A conflict of interest occurs when, *in the mind of a reasonable person*, a dietitian has *a personal interest* that could *improperly influence* their *professional judgment*. In this context, "improperly" means that a dietitian considers their own, the interest of a relative or someone else's interests rather than the interests of their clients. Four concepts are fundamental to this definition of conflict of interest:

1. personal interest;
2. professional judgement;
3. improper influence;
4. the “reasonable person” test.

1. PERSONAL INTEREST

The dietitian has a personal interest, which can include any benefit, gift, advantage or preferential treatment. Examples might be monetary payment, hospitality, a rebate or discount, a loan, or other business opportunities. The interest might be direct (a cash payment to the dietitian), or indirect (a benefit to a family member, or an advantage for the employer for which the dietitian would obtain recognition). The personal interest could also be of a moral nature, (a religious or moral objection to a client choosing to hasten his or her own death).

2. PROFESSIONAL JUDGMENT

The interest relates to a professional judgment that has to be made, whether explicit (a specific treatment recommendation) or implicit (by not objecting, the dietitian may be deemed to be supportive of an action, program or product). A common factor in all conflicts of interest is that a dietitian's professional status and capacity are in question. Decisions solely related to a dietitian's private or personal life are not the issue. A conflict between family members about who should be invited to a wedding, for instance, would not be relevant to a dietitian's professional life.

3. IMPROPER INFLUENCE

The personal interest could improperly influence a dietitian. It must be something that could hold sway over the dietitian because she or he wants the benefit or wants to avoid a loss that accompanies the interest. Thus, a customary or trivial benefit, such as a pen offered to attendees at a conference by a supplier, would not constitute a conflict of interest. On the other hand, paying for a dietitian's attendance at the conference might be viewed as an improper influence.

4. THE "REASONABLE PERSON" TEST

The interest must be weighed from the perspective of a "reasonable person" (a neutral observer, not the dietitian). Consequently, the fact that a conflicting interest did not actually influence the dietitian is irrelevant; the test of what constitutes a conflict of interest is what most people would think reasonable. As a result, a perceived or potential conflict of interest is as significant as a real conflict of interest. In this area of professionalism, appearances count.

The main goal of this chapter is to help readers recognize possible conflicts of interest and to manage them appropriately. While it would be wrong for a dietitian to avoid every benefit offered on the basis that it might be viewed as a conflict of interest, it would also be a mistake to simply assume that there is nothing wrong with accepting a benefit so long as it does not go into one's own pocket.

Categories of Conflicts of Interest

One of the greatest difficulties in dealing with conflicts of interest is that they are often hard to recognize because they come in many shapes and forms. Reviewing some of the recurring forms and examples may be the best way to study them.

RECEIVING A BENEFIT FROM A SUPPLIER

Scenario 9-1, *Gifts to Purchasing Manager*, p. 103, is one illustration. A related conflict is conferring a benefit for a referral of business. This can promote unnecessary services or, at the very least, result in a third party steering clients to a dietitian based on criteria other than a client's best interest.

INAPPROPRIATELY USING INFLUENCE OR STATUS

As regulated health professionals, Registered Dietitians have a special status in our society. In a professional relationship, clients are always vulnerable. Using professional influence to pressure people to make a particular decision, or to encourage them to make thoughtless decisions, could constitute a conflict of interest. For example, encouraging a client to change his or her will to include one's favourite charity would be inappropriate. So would advising a client to undertake an unnecessary and expensive course of treatment.

PERSONAL, MORAL OR PHILOSOPHICAL BELIEFS INTERFERE WITH PROFESSIONAL JUDGMENT

Having strong views about the morality of eating meat, for example, should not interfere with giving professional advice about its nutritional value.

SELLING A PRODUCT FOR PROFIT

Clients come to dietitians primarily for professional advice, and expect to pay for that expertise. However, selling nutrition or exercise supplies to clients requires caution, so that clients are not misled as to whether the price of the product is at cost or includes a hidden mark-up. The conflict resides partly in any perceived personal profit motive for recommending products. Clients should be informed that the product is sold for profit and they should feel free to shop around. Dietitians should be mindful that some clients might feel pressured to buy products from them, fearing that the quality of professional service might otherwise suffer.

REFERRING DIETITIAN HAS A PERSONAL INTEREST

A similar concern exists when a client is preferred to an apparently arm's length organization in which the referring dietitian has a personal interest. Referring a client to a nutritional supplement outlet, partly owned by the dietitian's family, results in conferring an indirect benefit to that dietitian. Again, a dietitian should be mindful of personal motives in recommending products from a family business and about how this activity might be perceived by others. At a minimum, clients should be informed of the dietitian's relationship to the family outlet and they should feel free to shop around without feeling pressured.

A DIETITIAN SEEKING A CLIENT'S PARTICIPATION IN A RESEARCH PROJECT

This situation has an inherent conflict of interest. While the dietitian (and perhaps society as a whole) benefits from the client's participation, it may not benefit the client, and in some circumstances, may be potentially harmful. As explained below, this potential conflict of interest can be managed through proper safeguards.

PERSONAL USE OF THINGS BELONGING TO CLIENTS OR EMPLOYERS.

Depending on company policy, using an employer's computer to surf the Internet may be

viewed as a misuse of resources intended for professional purposes. This is a potential conflict of interest. More troublesome would be using a client's computer on a home visit. Even if the client purported to consent, the client might have felt pressured because of the dietitian's influence, and even question the basis of the dietitian's professional concern. In this case, boundary crossing is of greater concern than any subtle influence gifts might have on one's professional judgment (see Chapter 10, *Boundary Issues*).

GIFTS FROM CLIENTS.

Unless very small (and even when not solicited), gifts from clients raise the same concerns as described above. Again, that is not to say that all gifts offered by clients should be refused. The point is to consider all of the circumstances to ensure that no harm will result from accepting the gift.

Addressing Conflicts of Interest

Some conflicts of interest need to be avoided, while others can be managed through safeguards and policies. There are many examples where appropriate safeguards can remedy a conflict of interest, but three conflicts are significant and recurring situations for the profession:

1. self-referral;
2. referral to a supplier; and,
3. participation in a research project.

1. SELF-REFERRAL

A conflict of interest may occur where a member, or a related person or related corporation, directly or indirectly benefits through a self-referral, unless:

- access to comparable service, necessary products or devices is not reasonably possible for the client;
- the member has explored and exhausted all other sources as reasonably as possible; and
- the member has disclosed his/her interests to clients when making the referral.

2. REFERRAL TO A SUPPLIER

A recommendation or referral to a supplier of nutritional products, a health care facility, or a nutritional program, in which the member or related person or related corporation has a financial interest can also lead to a conflict of interest, unless the member at the same time:

- fully discloses the financial interest;
- provides the client with the name of at least one other supplier, facility or service in the same geographical area;
- informs the client that he or she has the option of using an alternative supplier, facility or service; and
- assures the client that the choosing of an alternative supplier, facility or service will not affect the quality of health services provided by the member.

3. PARTICIPATING IN A RESEARCH PROJECT

A member who participates in a research project involving professional services provided to a client may be in conflict of interest unless:

- the member fully discloses the nature of the research project and gives the client the option of refusing to be involved in it and withdrawing from it at any time; and
- the member assures the client that refusing to be involved in the research project or withdrawing from it will not affect the quality of services provided by the member.

It is important to recognize that not all conflicts of interest are prohibited. They all require an action of some sort, but complete avoidance is not necessarily the answer. Sometimes other alternatives are acceptable. Below are five scenarios illustrating conflicts of interests that might occur in dietetic practice with suggestions for dealing with them.

ACCEPTING GIFTS

SCENARIO 9-1
Gifts to Purchasing Manager

You are the food services manager and make a number of purchasing decisions for your organization. A few of your suppliers have made small gifts to you such as a box of chocolates at Christmas. Occasionally, you are taken out to lunch where you mostly discuss business. The odd tickets have also been sent your way. Now a supplier is offering to provide a significant financial contribution towards your department's education budget after hearing that it had been cut in half. Is there a conflict?

This scenario, *Gifts to Purchasing Manager,* illustrates a classic conflict of interest. Dietitians must consider whether, in the mind of a reasonable observer, the gifts offered by the suppliers would be considered to have an improper influence over their professional judgment in purchasing supplies. In assessing whether a gift should be accepted from a vendor, consider:

- the value of the benefits;
- the frequency of the gifts;
- who actually consumes the benefits;
- any policies that exist in the organization;
- the employer's knowledge of these activities;
- any generally accepted practices in the industry and profession.

Assuming that no company policy exists to the contrary, a reasonable approach would be to accept the chocolates as a trivial goodwill gesture, but make them available to all staff.

Accepting a rare lunch without alcohol at a modest establishment, where business is the primary topic of discussion, could be justified on the basis of developing a good relationship with the supplier. This would enhance the information needed to make good purchasing decisions and to avoid distractions at the office. It would be prudent, however, to advise the employer that this is happening. If not frequently offered, the tickets may be accepted, making it clear to the supplier that they will be contributed to the organization's fundraising drive, and that they will not influence any purchasing decisions.

In many circumstances, these items could be reasonably viewed as being too inconsequential to influence professional judgment. Even if any one of the gifts were insignificant, cumulatively they might become significant so a dietitian would want to ensure that their frequency did not create an appearance of conflict. A significant financial contribution to the education budget, however, could reasonably be viewed as influencing a dietitian's professional judgment and could potentially constitute a conflict of interest. In this case, the concern is that purchasing decisions would not be based on quality and value alone, but on circumventing the limitations of the organization's budgetary process. The financial arm of the organization and the board of directors might well have chosen to reduce the purchasing budget instead of adding to the education budget.

This does not mean that it is impossible to ever receive benefits when a potential conflict of interest exists. There may be more than one way to resolve a conflict. In this case, the dietitian would definitely have to discuss the matter with her or his supervisor or employer. A contribution such as this one might be rejected outright, or alternatively, it might be accepted under strict conditions.

SCENARIO 9-2
Corporate Partnerships

You work in public health. Your organization partners with other agencies for student nutrition programs. One partner provides lunch boxes for participants at a formal fundraising event, which contain a fruit drink box, a coupon for a donut, and Vitamin C supplements for adults (1000 mg/tablet). What do you do?

MIXED MESSAGES

The primary dietetic exercise in Scenario 9-2, *Corporate Partnerships*, is communicating an educational message to students about nutrition. This message could be compromised by

the subtext that would accompany the distribution of lunch boxes containing a coupon for donuts. The target audience, the students involved in the fundraising activity, would receive a mixed message about what was nutritious.

The competing interest is indirect. You are relying on a partner, and possibly sponsors, to assist financially or otherwise in communicating a very worthwhile message about nutrition to students. Alienating the partner and sponsors could jeopardize your program. The influence is subtle pressure to acquiesce to the mixed message for the sake of a larger program. Some sort of intervention is indicated in this scenario and perhaps the challenge lies in finding the best one (see below: *Conflicts that Can be Managed Through DORM*).

SCENARIO 9-3
Promoting a Product

You work in industry. Your company produces low fat frozen meals and part of your job is to promote the sale of this product to purchasing agents for various retail outlets. The purchasing agents know that you are a dietitian. Are you in a conflict of interest?

PROMOTING A PRODUCT

The company hiring you wishes to make a profit from selling the products that you are asked to promote, and knows that consumers respect your professional opinion about nutrition. They are buying that trust. The perceived conflict lies between the interests of the company paying you to represent their product, and that of consumers and other dietetic professionals.

A reasonable person could question whether your interest lies with the company or the consumer. In most circumstances, transparent, honest and evidenced-based promoting of a product would be perceived as managing the conflict appropriately.

The situation would be quite different if you were not employed by the company, but were retained as an independent expert to endorse the product only to purchasing agents. Purchasing agents are not clients except in the most commercial sense of the term. They can still reasonably expect, however, that you would be transparent and clearly identify your role as a sales agent for your employer. They can also reasonably expect that any nutritional claims you make would be fair and accurate, based on evidence and not misleading by omission. In that context, you would have a competing duty in your role as an "independent" dietitian and your minimal professional duty to the purchasing agent. You must ensure that representation of the product is always based on evidence.

The situation would also be quite different if, as a dietitian, you were to participate in advertisements to the general public endorsing a product with words like, "I am a dietitian and I recommend X to all of my lactose intolerant clients because it is the best product on the market". Dietitians may wish to avoid a personal endorsement of this type entirely because they are so open to misunderstanding. In that context, their duty to the general public would be a competing interest. When working for a commercial entity that deals directly with the public, dietitians should always identify themselves as representatives of their company, and should avoid any perception that they are making a clinical recommendation to anyone.

USING WORK TIME FOR SPEAKING

SCENARIO 9-4
Speaking Engagement

Normally, you work on salary from 8:30 to 4:30. Your job provides you with a lot of independence and you are often out of the office. A community partner asks you to speak to a community group during a weekday afternoon. This presentation is not in your job description. You will be paid a modest honorarium. No one will miss you at work, and you believe that this speaking engagement will enhance your relationship with the community partner. Is there a problem?

ENGAGEMENTS

In Scenario 9-4, *Speaking Engagement*, the fact that you are keeping your attendance a secret from your workplace is a good indication that something is wrong. Your primary client in this context is your employer. You are supposed to be working from 8:30 to 4:30 for your employer, and are being paid for that time. Your competing personal interest would certainly include the honorarium and using work time for other activities.

Even if you were not paid the honorarium, you would have to be confident that your employer would approve of your spending work time to "enhance" this relationship. In many jobs, it would be natural for you to discuss the invitation with your supervisor before accepting it.

SCENARIO 9-5
Sponsored Conference

You have developed an expertise in hyperlipidemia. You have been asked to speak at a conference and present a paper on a nutrition treatment of hyperlipidemia for second and third generation Asian immigrants. After agreeing to speak, you receive the conference materials and learn that each session has a corporate sponsor. A low fat yoghurt company sponsors your session. Is there a problem?

SPONSORED CONFERENCES AND ENDORSEMENTS

As in Scenario 9-3 about promoting a product, one dilemma in Scenario 9-5, *Sponsored Conference*, is whether you are using your professional status to implicitly endorse the yoghurt company. You want to avoid a situation where you felt pressured to slant a presentation in a particular way in order to avoid upsetting the sponsor. There might be an inference of influence over the content of the paper if, for example, the yoghurt company's logo was on your paper or handouts. To a large extent, the perception of conflict would depend on:

- how the sponsorship was portrayed before, during and after the conference;
- how much influence the sponsor had or appeared to have over the content of the presentation; and
- what other safeguards were in place.

Additional information would clarify the situation. A possible safeguard might be a disclaimer in the written materials indicating that you had no connection with the sponsor. The organizers of the conference could also be approached to ensure that there was no actual or perceived influence of the sponsor over the content of the presentation.

Conflicts That Should be Avoided Entirely

Some conflicts of interest need to be avoided entirely. In some cases, no amount of safeguards can present a reasonable level of confidence in the appropriate exercise of professional judgment. Accepting a benefit beyond the trivial from a supplier of products that a dietitian recommends to clients should probably be avoided at all times. No amount of disclosure to clients will provide an objective and reasonable level of confidence in a dietitian who accepts a Caribbean holiday from a company whose products they recommend to their clients. If in doubt as to whether a conflict of interest should be avoided, discuss the issue with experienced and respected colleagues.

Three conflicts of interest are not salvageable by safeguards. These occur where a member or a related person or related corporation, directly or indirectly:

1. accepts a gift, rebate, credit or other benefit due to the member referring a client to any other person or company;
2. offers, makes or confers a rebate, gift, credit or other benefit by reason of the referral of a client to the member; and
3. enters into any arrangements respecting a lease or use of premises or equipment, under which any amount payable by or to a

member or related person or related corporation is related to the amount of fees charged by the member, or to the volume of clients seen by the member.

The following circumstances should also be avoided entirely to prevent a serious conflict of interest from arising:

- **Conflicts involving clients who are more vulnerable or less able to protect themselves.** For example, a dietitian asking a client to run a personal errand is difficult to justify. Individual health clients are more likely to be vulnerable than an employer or a business colleague.
- **Conflicts that relate directly to client assessments or that involve treatment recommendations.** An example would be an employer who offers a dietitian a bonus for referring at least twenty clients a month to his brother's gym.
- **Accepting larger benefits.** It is difficult to deny the potential influence on a dietitian of increasingly large gifts. It is more likely that a reasonable observer would believe that a vacation would have a greater influence on a dietitian's judgement than a pair of theatre tickets. It is better to avoid these entirely.
- **Asking for a donation for a research project or for a loan for your business.** Always avoid any situation that puts pressure on clients, and where clients are vulnerable and may not be able to protect themselves from such a request. For example, asking a client for a loan for business start-up costs is clearly a conflict of interest. Saying that you will not treat them differently if they say no is unlikely, in the real world, to protect the client from the inherently damaging nature of the request.

SCENARIO 9-6

Promoting a Family Business

You are a dietitian with a private practice and refer clients to the dietetic nutritional supplements store owned by your family. Are you in conflict of interest?

Conflicts That Can be Managed Through DORM

Promoting a Family Business, Scenario 9-6, may be perceived as a conflict of interest. However, many conflicts of interest like this can be managed through safeguards that involve openness and transparency. Safeguards also foster an environment where clients are not pressured to make choices. These safeguards are developed using the DORM principle:

- **Disclosure**
- **Options**
- **Reassurance**
- **Modification**

Disclosure

The primary safeguard in managing any conflict of interest is disclosing to clients and any other interested party, such as an employer, the nature of the conflict and the potential benefit. While simply disclosing a conflict may not always be sufficient, failing to disclose it will almost always be a breach of professional duty. In the scenario above, *Promoting a Family Business*, you would advise the client that your family owns the store. Upon request, disclosure should also be made to the College.

Options

Providing clients with additional options will permit them to make an informed choice. In the nutritional supplements store example, you would provide your client with a list of two or three other stores for similar products or services.

Reassurance

In Scenario 9-6, a common client concern is that you will be insulted or put out if they do not accept your recommendation to buy from your family's business. It is important to reassure them that choosing another product or service from the list will not affect the quality of your professional services to them. The only exception would be where choosing the other

supplier could result in inconsistent treatment, a rare occurrence and one that is difficult to envision in this particular example. An example of possible inconsistent treatment is where a dietitian recommends a nutrition treatment with a specific combination of vitamin and mineral supplements, and the client chooses to go to an unregistered nutritionist for advice on the vitamin and mineral component of the program.

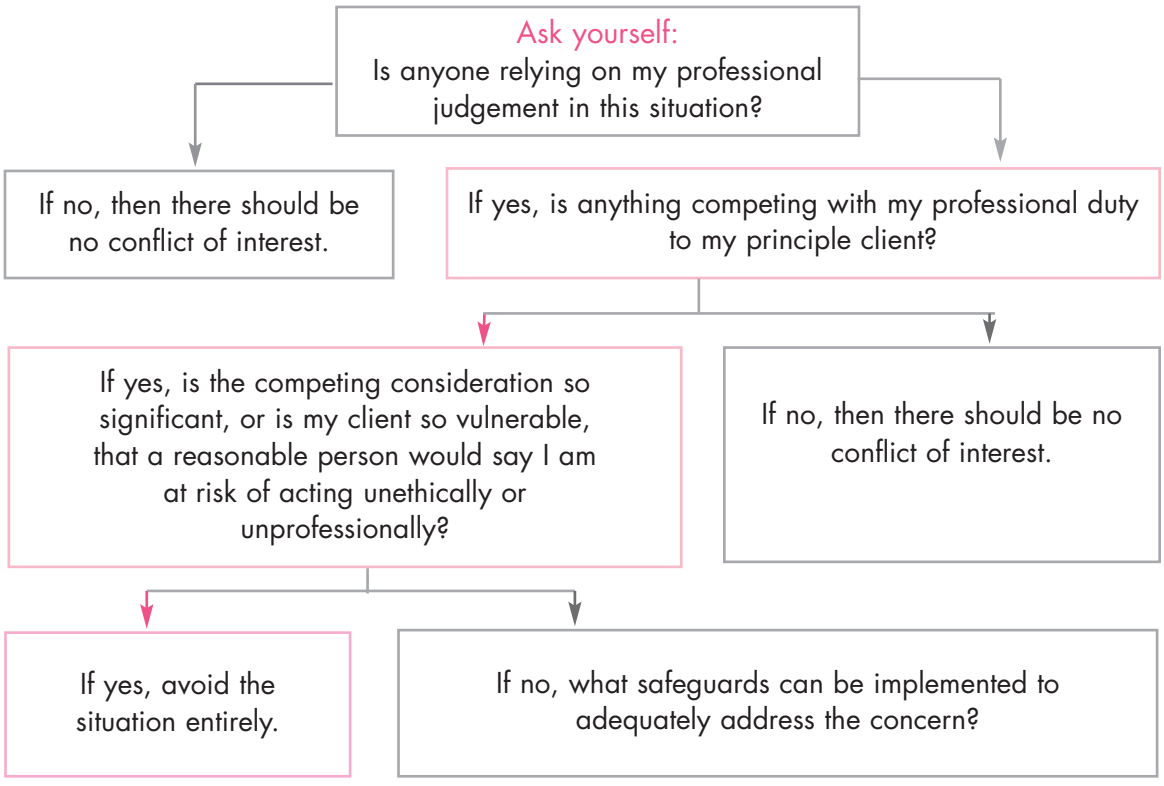
Modification

Occasionally, making a small modification in a situation can remove or greatly reduce the potential for conflict. For example, much concern would be alleviated if you were to arrange for your family's nutritional supplements store to provide recommended products to your clients at no profit.

Conclusion

A conflict of interest occurs when a personal interest exists that could improperly influence a dietitian's professional judgment in the mind of a reasonable person. Although some conflicts are best managed by complete avoidance, most conflicts can be successfully managed by the DORM principle. If in doubt, discuss the matter with a trusted colleague or phone the College for guidance. Consider applying the decision

FIGURE 9-1
AM I IN A CONFLICT OF INTEREST?



Quiz

For the scenarios discussed earlier in this chapter, express your view as to whether the concern can be addressed through the DORM principle. If so, set out the safeguards that might successfully manage the potential conflict. See *Appendix 1* for answers.

Scenario 9-1	Gifts to Purchasing Manager
Scenario 9-2	Corporate Partnerships
Scenario 9-3	Promoting a Product
Scenario 9-4	Speaking Engagement
Scenario 9-5	Sponsored Conference

Resources

COLLEGE OF DIETITIANS OF ONTARIO

Code of Ethics Interpretative Guide, Part B: Responsibilities to the Client. See examples of financial conflicts of interest, 3-6.

résumé at www. cdo.on.ca > Resources > Publications

- "Conflicts of Interest and RD Practice", Winter 2009, 4-8.
- "Advertising and Solicitation", Winter 2010, 4-7.
- "Testimonials and Direct Solicitation of Clients", Spring 2010, 5-7.
- "Solicitation of a Client for Business When Your Client is a Group", Summer 2010, 7-8.

PUBLICATIONS

Richard Steinecke. "A Complete Guide to the *Regulated Health Professions Act"*. Aurora: *Canada Law Book*, section on conflicts of interest.

Back to Table of Contents

TEN

College of Dietitians of Ontario

Boundary Issues

AT A GLANCE

SCENARIOS

TABLE

NEED TO KNOW

1. A boundary crossing occurs where a dietitian permits another type of relationship or feelings towards a client to interfere with the professional relationship.

2. Boundary crossings are insidious and can creep up through goodhearted actions.

3. It is always the responsibility of the dietitian to maintain professional boundaries.

The Concept of Boundaries

It has been said that a boundary crossing is like a conflict of interest, except that the competing interest is personal feelings rather than financial considerations or gifts. A boundary crossing has a two-fold risk:

1) It can interfere with professional judgment because of an emotional or other benefit gained, or because of fears that an inappropriate conduct will be exposed;
2) Conversely, it can compromise a client's ability to accept or question your treatment suggestions, or provide an informed and voluntary consent.

Intrusion and Distancing

Boundary concerns operate in opposing ways: intrusion (being to close) and distancing (being too distant). Both situations compromise the professional relationship. To remain objective with clients, it is important to maintain a professional distance at all times: not too close and not too distant.

Most of the boundary crossings discussed in this chapter illustrate intrusion into a client's or a professional's personal space. However, excessively distancing yourself from clients can also affect client care. Professionals may remove themselves or back away from clients for all sorts of reasons, including uneasiness with strong body odour, discomfort with certain cultural differences or a fear of clients with HIV. Whatever the case, excessive distancing conveys the impression that you do not care about the client and that, when seeing them, you are simply performing a distasteful obligation. You should always critically examine your attitudes and behaviour, and be sensitive to external feedback from colleagues and clients for signs that you are inappropriately distancing yourself.

Why Boundary Crossings Occur

SCENARIO 10-1
Formula Recommendation

You work at a hospital. After careful consideration, a client who has just given birth tells you that she has made an informed decision and she will not be breastfeeding. She asks for your recommendation for the best formula on the market for her baby. What do you do?

Dietitians, like most health practitioners, often choose their career to "help" people. They try to establish a therapeutic relationship of trust and openness on the part of the client. It is only human for a dietitian to try to reciprocate by being open as well, without realizing that this may not always be appropriate.

It is also important to keep in mind that a client can initiate a boundary crossing in good faith, without understanding the boundary or the reason why it exists. It's up to the dietitian, as the professional in the relationship, to maintain professional boundaries. In the professional relationship, the dietitian has the power that comes from knowledge and expertise. Unfortunately, because dietitians are often "helpful", they may find it hard to say no.

The request for a formula recommendation in Scenario 10-1 is relatively benign. It appeals to your sense of expertise and includes you in the family relationship. However, the client is trying to include you in a personal decision that really is hers to make. Limiting comments to the relative nutritional qualities of the formulas on the market, if essentially the same, would leave you with no legitimate role in this decision. However, a greater concern would be if you were asked to become increasingly involved in the childcare decisions respecting the baby, moving from dietetic issues to where the baby should sleep.

Be mindful of self-deception. Typically, boundary problems present themselves in a dietitian's area of weakness or vulnerability.

A dietitian with a tendency towards rescue fantasies will be able to handle a sexually precocious young client by identifying the need to keep the boundary clear, but may get into trouble with an isolated and depressed teenager, becoming a "friend" in order to help "save" this client. It is always the responsibility of the dietitian to see and maintain the boundary.

Categories of Boundary Crossings

Boundary crossings are subtle and are often motivated by what appear to be noble intentions. They are not, for the most part, products of predatory behaviour. Boundary crossings are insidious, usually beginning with small innocuous actions that, over time, become cumulatively significant. A boundary can be crossed in a number of ways. Here are some of the more common examples.

SELF-DISCLOSURE

While careful and limited disclosure of personal details can help develop a rapport, it has to be managed with extreme care. Sharing personal details about your private life can confuse clients. They might assume that the dietitian wants to have more than a professional relationship. Self-disclosure suggests that the professional relationship is serving a personal need, and can also result in the dietitian developing dependency upon the client, which is damaging to the therapeutic relationship.

GIVING OR RECEIVING OF GIFTS

Gift-giving is potentially dangerous to the professional relationship. A small token of appreciation by the client purchased while on a holiday, around New Year's, or given at the end of treatment can be acceptable. However, anything beyond that can indicate that the client is developing a personal relationship with the dietitian, holds the practitioner in excessive regard, or may even expect something in return.

Gift-giving by a dietitian is also open to misinterpretation. Even small gifts that have an emotional component such as a "friendship" card can raise similar questions even though the financial value is small.

DUAL RELATIONSHIPS

SCENARIO 10-2
Hiring a Client

You work for a community agency that serves new immigrant women. You have spent some time assisting Felicia, and she has shared with you some of the terrible things that have happened in her life. You know she has virtually no money. Felicia asks if she could clean your house. In fact, you are looking for a house cleaning service and would be very pleased to pay her generously. Is there a problem?

There are a number of complications arising from dual relationships and some are illustrated in Scenario 10-2, *Hiring a Client*. You are being asked to enter into a dual relationship with the client, to be both her dietitian and her part-time employer. Consider how the following difficulties can occur:

- The employer-employee relationship tends to be more directive than the more collaborative dietitian-client relationship. The client might feel compelled to follow your treatment recommendations without question in appreciation of her other relationship with you or for fear of losing her job with you.
- If the client failed to meet your house cleaning expectations, you might have to confront her and perhaps even terminate her services. Such actions could easily damage your ability as a dietitian to engage the client in a continuing dietetic program.
- The client would learn much about your private life, and whether they respect or disdain you for it, this could interfere with the clinical relationship. Either way, the

healthy dialogue and give-and-take of the professional relationship could be damaged.

- You could become dependent on Felicia's excellent service and be prone to let it interfere with your professional judgment concerning her clinical care. For example, you may keep her on as a client beyond what is indicated in order to maintain the house cleaning relationship. Or, you may give undue weight to her requests for special or even inappropriate assistance.
- Other clients who find out about the house cleaning arrangement might feel that you are treating Felicia as "special". They might ask for similar consideration and be upset if you say no.

Social Networking

SCENARIO 10-3
Social Networking

You have been helping Jennifer through her difficult prenatal period. She was a pleasure to work with. After the birth of her baby, Jennifer updates her Facebook page and sends you an invitation to become her friend. You will be involved for some time still on her postnatal dietetic needs. How should you respond?

Scenario 10.3, *Social Networking*, further illustrates the concerns about a dual relationship. Accepting the invitation to be her friend on Facebook , even with strict privacy settings will involve you in Jennifer's private life and will expose some information about your own non-professional circumstances. Also, accepting the invitation characterizes your relationship as social as well as professional. The best approach would be to send a polite response or to discuss personally with Jennifer at her next visit, if it is soon, why you cannot accept.

Any dual relationship has the potential to have the other relationship interfere with the professional one. Even selling non-health products such as cosmetics or insurance to clients can lead to problems (e.g. if the product does not perform as expected or if the client thinks that the price was too high). It is best to avoid dual relationships whenever possible. Where the other relationship pre-dates the professional one (e.g. a relative or friend), it's best to refer to another practitioner. Where a referral is not possible (e.g. in a small town, where there is only one dietitian in a facility), take special precautions.

IGNORING ESTABLISHED CONVENTIONS

Established conventions usually exist for a reason. Ignoring them, such as having treatment sessions over a meal at a restaurant or drinks in a bar, is a professionally high-risk activity, as it confuses the nature of the professional relationship with that of friendship.

RESCUE FANTASIES

Most health care workers like to help people. It is an important part of their self-image. However, there is a point where rescue fantasies of fragile or vulnerable clients can fulfill the needs of the dietitian and be harmful to the client. Dietitians should attempt to cultivate the autonomy of clients, and not foster their dependence upon the dietitian.

BECOMING FRIENDS

Being a personal friend is a form of dual relationship. Clients should not be placed in the position where they feel they must become a friend of the dietitian in order to receive ongoing dietetic care. It is difficult for all but the most assertive of clients to communicate to the dietitian that they do not want to be friends.

ROMANTIC RELATIONSHIPS

The most obvious boundary crossing is developing a romantic or sexual relationship with a client. This is discussed in more detail below.

TOUCHING

Touching can be easily misinterpreted. A client can view an act of encouragement by a dietitian as an invasion of space or even a sexual gesture. Extreme care must be taken in any touching between dietitians and their clients.

Sexual Abuse Boundaries

In the prohibition against "sexual abuse" found in the *Regulated Health Professions Act* (RHPA), sexual abuse means any sexual words, gestures or touching between a registered health professional and a client. Under this definition,

1. Sexual abuse does not have to involve actual sex. Sexualized banter or other nontouching activities are included.

2. Consent is irrelevant. Even if the client initiates or willingly participates in the sexual activity, it is still prohibited.

3. Evidence of exploitation is not required. Even though both parties are genuinely in love at the time, sexual relations with a client are never permitted.

This strict approach is taken to prevent the abuse of the power and status that health practitioners often have over their clients in a clinical context. Sometimes, the parties are even fooling themselves and only realize afterwards how inappropriate the relationship was.

WHY VIGILANCE IS NEEDED

Most dietitians think that the sexual abuse provisions in the RHPA would never apply to them. However, complacency in this area is dangerous for a number of reasons:

- **Sexual abuse can be "consensual".**
  The popular notion of a practitioner physically assaulting a client is not what most sexual abuse is about in the health professions. Dietitians who "fall in love" with their clients, and who believe that their clients return the feeling and "consent" to the personal relationship, are engaging in sexual abuse. Indeed, it is no defence if the client vigorously initiates the relationship. Such "consent" is not valid where there is an imbalance in the relationship.

  By definition clients come to a dietitian because they have a "problem" and want to access the expertise of the dietitian. This and other circumstances, such as the social status accorded to health professionals, create an imbalance of power between the dietitian and the client that requires the maintenance of professional boundaries. Registered Dietitians cannot have sex with a client.

- **The development of the sexual relationship can be insidious.**
  A common pattern of sexual abuse is that the crossing of professional boundaries begins with small steps, such as personal disclosures, and progresses incrementally over time. Typically, the relationship meets an unmet personal need of the dietitian, such as being idealized or loved by another. Afterwards, the dietitian is often as surprised as anyone about what has occurred.

- **The definition of sexual abuse is very broad.**
  It includes not only sexual intercourse or other forms of physical sexual relations with a client, but any touching, behaviour or remarks of a sexual nature. An exception is where the touching, behaviour or remark is clinically appropriate, for example, when taking a sexual history. This definition of sexual abuse prohibits the telling of a joke with sexual undertones or innuendos to a client or posting a sexually provocative calendar. It would also include the dietitian laughing at a sexual joke told by a client in the presence of another client.

- **A dietitian may become involved through the conduct of others.**
  As discussed in the mandatory reporting portion of Chapter 3, when learning about

CHECKLIST 10-1
Assessing Whether a Boundary Crossing May be Occurring

- ☐ Is this in my client's best interest?
- ☐ Whose needs are being served?
- ☐ Could this action affect my services to the client?
- ☐ Could I tell a colleague about this?
- ☐ Could I tell my spouse about this?
- ☐ Am I treating the client differently?
- ☐ Is this client becoming special to me?

the sexual abuse of a client by another practitioner, the dietitian may need to make a mandatory report.

NO SPOUSAL EXCEPTION

There have been major court challenges to the RHPA regarding sexual abuse asserting that the provisions were "over-sweeping" in nature. In each case, the Ontario Court of Appeal affirmed the validity (including constitutional validity) and societal importance of the provisions.

In Leering v. the College of Chiropractors of Ontario (2010), for example, the complaint was initiated by the chiropractor's sexual partner after the relationship ended badly. There was no dispute that the client consented to the sexual activity. In fact, the person first became a sexual partner and developed an established personal relationship with the chiropractor before receiving any treatment. The determining factor in the ruling was whether there was an *ongoing clinical relationship* or not. In the Leering case, the chiropractor had clearly provided clinical care and billed for it as treatment. The court held that the definition of "sexual abuse" in the RHPA was clear; *there is no spousal exemption.*

The Court suggested that incidental care (e.g., the usual domestic support of a spouse undergoing a headache, fever or cold) would likely not make the family member a client. Dietitians who give the usual sorts of guidance about food and lifestyle choices would not be making their spouse a client simply because the dietitian was more knowledgeable about those issues. However, where more than a casual assessment is involved, or where the support becomes ongoing or systematic, then a spouse could well become a client. This would be the case where the dietitian is replacing what would generally be done by another dietitian in a clinical setting. For example, if the spouse had diabetes and would ordinarily be seeing a dietitian for counselling and dietary planning, the family member would become a client if the dietitian took over that role. However, there likely would not be a dietitian-client relationship where a dietitian supported a spouse in implementing the treatment plan of the treating dietitian. RDs should not conclude from the Leering case that as long as one does not create a chart or submit a bill, that the person is not a client. *The issue is whether a clinical relationship has developed*.

REGISTRATION WILL BE REVOKED FOR AT LEAST 5 YEARS FOR SEXUAL ABUSE

The zero tolerance provisions for sexual abuse in the RHPA are clear:

1. Registered Dietitians cannot have sex with a client.
2. Registered Dietitians cannot treat a sexual partner.

A member found guilty of sexual activity which involves frank sexual acts with a client, like sexual intercourse, will have their registration revoked for at least five years.

MAINTAIN FIRM BOUNDARIES

Maintaining clear and firm boundaries with clients is essential to avoid conduct that could be perceived as sexual. Here are some protective measures:

- Avoid any sexual behaviour;
- Politely but firmly stop clients when they initiate such behaviour, whether by telling a joke or flirting;
- Avoid misinterpretation — do not make any suggestive or seductive comments or gestures;
- Do not take a sexual history unless it is needed for a nutrition assessment and monitoring;
- Do not comment on a client's body or sex life;
- Never date a client;
- Avoid self-disclosure;
- Detect and deflect clients who attach themselves emotionally; and
- Document any intimate talk, touch or exposure even where it is entirely clinical and quite appropriate.

Touching a Client

Health procedures are often in conflict with a client's concept of privacy. For this reason, it is important that dietitians convey professionalism, and that the client understands that this is a professional encounter. Follow these principles in all physical encounters with clients:

(a) Obtain the client's consent before touching;

(b) Acknowledge that the client has the right to change his or her mind about consenting to procedures;

(c) Avoid causing unnecessary hurt to the client by inappropriate touching;

(d) Show respect by maintaining the client's dignity;

(e) Respect the client's personal sense of space;

(f) Use firm and gentle pressure when touching the client to give reassurance and produce a relaxed response;

(g) Avoid hesitant movements by being deliberate and efficient;

(h) Understand when to use gloves for reasons relating to infection control and to decrease intimacy;

(i) Use proper draping techniques;

(j) Provide reassurance and explanations throughout the procedure;

(k) Constantly check for level of understanding and consent;

(l) Touch only when necessary.

Boundaries that Protect the Dietitian

Respecting professional boundaries not only protects the client, but also the dietitian. This is particularly true when considering:

1. abuse of dietitians;
2. client confidentiality;
3. working with a team; and
4. working for third parties.

1. ABUSE OF THE DIETITIANS

While rare, some clients can become verbally, emotionally or physically abusive towards a dietitian. Typically, this occurs where a client has other psychological, personality or emotional issues. The first thing to realize is that the abuse is not about the dietitian's behaviour, but has been triggered by something that has occurred in the dietitian/client encounter. Often a dietitian may be able to review what is known about the client and how the client has responded to previous interactions to form a good idea as to the true reason for the abusive conduct.

If the abusive behaviour is in its milder and earlier stages (swearing and making sarcastic comments), a dietitian can sometimes respond successfully by fixing firm boundaries. This could involve advising the client that such conduct is not appropriate and asking the client to be more careful in the future. Sometimes changing the context or circumstances of the interactions can help. One way to do this would be to meet in a more open place where others can see physical movements or loud outbursts. Sometimes an assistant or colleague can join the sessions.

Where the abusive behaviour is significant or repetitive (threats or actual violence, overt and ongoing sexual propositioning), consider terminating the relationship. In most contexts, the dietitian would transfer the care of the client to another professional depending on the requests of the client. In some contexts, the dietitian may still choose to continue with treatment with a high degree of safeguard in place (e.g. a public hospital, a long term care facility, or a mental health institution where nutrition care is desperately needed and alternatives are not readily available). A dietitian's own need for protection and safety, which is valid and important, must be balanced with the client's need for care.

A dietitian will want to be sure that the transfer of the client is made in accordance with paragraph 9 of the *Professional*

Misconduct Regulation, which prohibits the following:

> "Discontinuing professional services that are needed unless,
>
> i. the client requests the discontinuation;
>
> ii. alternative services are arranged; or
>
> iii. the client is given reasonable notice to arrange alternative services."

This prohibition only applies where the services are needed. If the rule does apply, what constitutes "reasonable" notice will include a fair consideration of the safety concerns for the dietitian as well as the availability of alternative services, and whether any harm would reasonably result to the client pending the finding of new services.

2. CLIENT CONFIDENTIALITY

Another boundary that is difficult to maintain at times is client confidentiality. As discussed in Chapter 6, client consent or other legal authority is required to disclose any client information. The boundary is usually challenged in the area of implied consent where a person assumes they have the authority to access the information and are surprised if the dietitian raises the issue. Common danger areas include:

- Spouse of client seeking information about the client;
- Parents of a teenage client seeking information about the client;
- Third parties who pay for the treatment seeking information about the treatment; and
- Investigators, including police, seeking information and mentioning that a refusal might constitute "obstruction".

In all of these cases, the dietitian must ensure that there is clear authority to disclose the information before complying with the request, such as having consent from the clients, their representative or a legal obligation, expressed in statute.

3. WORKING WITH A TEAM

Another boundary relates to a dietitian who works with a team of other health practitioners. The dietitian has a primary duty to her or his client. However, the dietitian also has an obligation to be collegial and to work collaboratively with others on the team.

It is becoming increasingly common for clients to choose others to be part of their health care team without prior discussion with the their existing practitioners. For example, a client might well choose to consult a naturopath at the same time as seeing a dietitian. If you are faced with such a situation, consider the following points:

- Avoid uncoordinated care. Obtain consent to consult with the others on the client's health care team if consent has not already been given. Where the dietitian is part of a pre-existing health care team and the client understands this, there may be implied consent. Under *Personal Health Information Protection Act,* 2004, the circle of care concept permits dietitians to approach other practitioners providing services to the client without explicit consent, where obtaining timely consent would otherwise not be feasible unless the client indicates otherwise (see Chapter 5).
- If you have consent to consult with the other practitioners on the team, first attempt to resolve any differences in approach with them. Avoid placing a client in the middle of any disagreement if at all possible.
- If you must involve a client in a disagreement, take the high road. Do not criticize the other practitioner or the client for choosing him or her. Simply explain that inconsistent approaches are being followed and that it does not appear that they can be reconciled. Explain the rationale for your own approach and encourage the client to discuss the rationale of the other practitioner's approach with him or her.
- Respect the client's choice.

4. WORKING FOR A THIRD PARTY

A dietitian working for a third party, particularly in a for-profit practice, must ensure that professional boundaries are maintained with the third party. Overbilling is abusive and unprofessional and ultimately can interfere with client care. Billing made on behalf of dietitians should always be fair and accurate. Rationing of services where a dietitian is not given enough time to engage clients in their treatment is distancing. Taking on more clients than you can manage can also result in distancing. Methods for maintaining proper professional boundaries with third parties (e.g. employers and payers) and prospective clients are discussed in Chapter 1, *Introduction to Professionalism*.

Conclusion

Intrusive or distancing boundary violations interfere with professional relationships and responsibilities of dietitians towards their clients. Dietitians have the responsibility of identifying when they or their clients are crossing boundaries and taking appropriate corrective actions.

Boundary violations can be insidious, and dietitians need vigilance to understand the vulnerability of their clients as well as their own. Sexual abuse is a serious boundary violation and includes both comments as well as inappropriate touching of a sexual nature. Non-sexual boundary crossings may be difficult to recognize and just as harmful as sexual abuse.

Quiz

Provide the best answer to each of the following questions. Some questions may have more than one appropriate answer. Explain the reason for your choice. See *Appendix 1* for answers.

1. In Scenario 10-1, "Hiring a Client", what is the primary concern?

a. You are seeing a client in your own home.
b. You should not be paying money to a client.
c. House cleaning is a demeaning service to perform.
d. Your dual relationship will create conflicting duties.

2. If a client expresses a romantic interest in you, which of the following applies?

a. There is no boundary crossing unless you respond.
b. You should transfer the client.
c. You should politely explain that you can only have a professional relationship with the client.
d. Tell the client to "hold that thought" until after treatment is completed.

3. What is the concern about a boundary crossing?

a. It interferes with your professional judgment.
b. It undermines your client's ability to maintain a therapeutic relationship with you.
c. It can confuse your client.
d. It can confuse other clients who observe it.

4. If a client tells a sexual joke, what should you do?

a. Laugh so that the client does not feel bad, but tell the client not to do that again.
b. Laugh only if no other clients are present, but tell the client not to do that again.
c. Report the client on a mandatory basis for sexual abuse.
d. Politely advise the client that such comments are not appropriate in the treatment setting.

5. Which of the following statements are true?

a. Boundary considerations are designed to protect the client.
b. Boundary considerations are designed to protect the dietitian.
c. Boundary considerations are designed to protect other clients.
d. Boundary considerations are designed to protect the client, the dietitian and others exposed to the behaviour.

Resources

COLLEGE OF DIETITIANS OF ONTARIO

résumé articles at www.collegeofdietitians.org. Enter topic or title in the search box.

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- Lenglet, Marcia. "Managing Professional Relationships, Part 2", Winter 2005, 1-4.
- "Conflicts of Interest and RD Practice", Winter 2009, 4-8.
- Richard Steinecke, LL,B. "Zero Tolerance for Sexual Abuse", Fall 2010, 5-6.
- Deborah Cohen, MHSc, RD, "Zero Tolerance for Sexual Abuse - Practice Scenarios", Fall 2010, 7-8.

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Health Professions Regulatory Advisory Council. *The Common Elements of a Patient Relations Program: Sexual Abuse Prevention, Complaints about Sexual Abuse and Funding for Therapy*.
http://www.hprac.org/en/projects/PR_Program_Elements.asp

McPhedran, Marilou; Armstrong, Harvey; Long, Briar; Marshall, Pat; and Roach, Roz. *What About Accountability to the Patient? Task Force on Sexual Abuse of Patients*. November 25, 1991. This report was the basis for many of the sexual abuse provisions of the *Regulated Health Professions Act*. It can be found in many libraries.

Steinecke, Richard. A *Complete Guide to the Regulated Health Professions Act*. Aurora: Canada Law Book, updated annually. See sections on sexual abuse.

Back to Table of Contents

College of Dietitians of Ontario

Answers to Quiz Questions

Chapter 1

INTRODUCTION TO PROFESSIONALISM

1. **The best answer is (b).** Overusing employer resources and showing independence is almost certainly not intended to apply to this situation. In fact, your employer will probably want you to consult the in-house mentor on this issue. If you explained your role properly to the client at the beginning, you likely have actual or at least implied consent to discuss difficult issues with your mentor.

   Answer (a) is not wrong, but fails to recognize that your agency would want to know about this matter. If your mentor is not familiar with anorexia nervosa, you might approach another colleague, inside or outside of the agency, for assistance. If you consult with someone outside, be careful not to disclose personal client information without proper consent.

   Answer (c) while appropriate in many circumstances, is risky given your background and the seriousness of the issue posed here. Your employer's direction is no justification for taking unnecessary risks.

2. **The best answer is (a).** This scenario is a classic case of competing obligations. However, the ultimate "client" of your services is the residents. It is for their benefit that your expertise is sought.

   Answer (b) is a close second because the Administrator is seeking information to ensure that the home is operated safely and similar incidents do not occur in the future. The Administrator has a reasonable expectation of an answer from those managers who have relevant information.

   Answers (c) and (d) recognize that you owe a duty of collegiality to the supervisor and coworkers. However, your colleagues are not the primary focus of your professional obligations.

3. **The best answer is (d).** All of these answers fairly describe the differences as discussed at the beginning of the chapter. Answer (c) uses new language to describe the same concept as (b).

4. **The best answer is (b).** The nurse should only be reading the chart for a professional reason.

   Answer (a) is too rigid. While you have to be honest, you do not have to record everything told to you by the client no matter how irrelevant. This answer may also insult the client and discourage further openness.

   Answer (c) creates a dual charting system, which leads to many problems (see Chapter 7).

   Answer (d) is misleading the client by omission and is, consequently, dishonest.

5. **The best answer is (a).** This question raises issues related to both competence and honesty. In this setting, you are not likely to be in a decision-making role. Your job is more likely to provide the information that others need to make sound decisions.

   Answer (b) is probably more appropriate for lawyers than for you. However, you can certainly provide what information you know, so long as you are not providing definitive legal advice.

   Answer (c), using your professional status in this way, is probably not your role, even though the concern is significantly reduced by the fact that you are not endorsing a specific product (see Chapter 8: *Conflicts of Interest*).

   Answer (d) does not provide the breadth and balance of information that would most benefit your employer.

Chapter 2
COMMUNICATION SKILLS

1. **The best answer is (b).** Dietitians generally do not have the required expertise and this client probably needs professional assistance.

   Answer (a) assumes that you have expertise in this specialized and high risk area. Unless you have that expertise, you may cause harm or do little good.

   Answer (c) could also be correct if you had confidence that the physician will address the entire picture, but may be insufficient if the physician does not address the more important non-physical issues. Answer (c) might be a good adjunct to answer (b).

   Answer (d) involves you trying to decide something that the client has to decide for herself.

2. **The best answer is (c).** Your client is at risk, according to your assessment. The physician has not yet heard your concern, and there may still be ways of finding a solution that benefits your client.

   Answer (a) might be correct as a last resort. However, you first want to exhaust all communication options with the doctor and with others in the organization.

   Answer (b) does not give the client the information needed to decide on their own and begins to draw the client into the dispute. Basically, the client is left to choose whose advice to follow without adequate information.

   Answer (d) clearly draws the client into the dispute in an unhelpful way.

3. **All of (a) to (d) can occur with poor communication.** Answer (a), however, focuses more on the client than the dietitian.

4. **The best answer is (a).** The question asks about the best first step, which is to clearly and effectively communicate your concern through proper channels.

   Answers (c) and (d) may well be appropriate later in the process, depending on the seriousness of the situation and once it is clear that the first channels of communication cannot solve the problem.

   Answer (b) appears to involve the dilution of services, which is never the appropriate response.

5. **The best answer is (b).** Inherent in the dietitian-client relationship is that the dietitian possesses knowledge, and the client comes in needing that expertise. Perhaps the greatest challenge for a dietitian is to understand the client's perspective. The remaining answers all have an element of truth and are not wrong.

   Answer (a) perhaps misconceives the point slightly, which really is that because dietitians are highly educated professionals possessing intellectual capabilities, it sometimes takes extra care to see the client's perspective.

   Answers (c) and (d) are realities that need to

be considered when communicating with clients. However, it is probably incorrect to call these the most significant barriers to good communication.

Chapter 3

REQUIREMENTS FOR DIETITIANS UNDER THE *REGULATED HEALTH PROFESSIONS ACT* AND OTHER RELATED STATUTES

1. **The best answer is (b).** If there is a problem in responding, you should always advise the College right away, but late is better than never. Apologize for the delay and provide a doctor's slip as soon as you can (do not delay your request to the College for an extension in order to obtain a doctor's slip). There is no guarantee that the College will grant your request for an extension, but it will at least try to accommodate you.

   Answer (a) does nothing to address your responsibility. It is professional misconduct to fail to respond to the College.

   Answer (c) does not help the College much because it is not a full response. In addition, it does not recognize your personal circumstances.

   Answer (d) could be viewed as an attempt to interfere with the investigation.

2. **The best answer is (c).** The scenario suggests that there are reasonable grounds for suspecting sexual abuse of the client by a registered health practitioner.

   You cannot include the client's identity in the report unless the client consents in writing. Answer (a) suggests that the identity of the client is included without mentioning the need for written client consent.

   Answer (b) incorrectly suggests that if a client refuses to consent, that a report will not be made.

   Answer (d) is not correct because the report has to be made to the Registrar of the College of the person who is said to have abused the client.

3. **The best answer is (c).** Technically speaking, since the child is over 16, the mandatory reporting requirements under the *Child and Family Services Act* do not apply, eliminating answer (a). However, if you went to the local *Children's Aid Society* and they were willing to deal with the matter, you could justify this action under your "duty to warn".

   Answer (b) fails to recognize that implied consent is lost when you have an express direction to the contrary (see Chapters 5 and 6).

   Answer (d) suggests you can shop around for substitutes rather than go to the highest ranked available substitute (see Chapters 5 and 6).

   Bonus points for those who thought that this is really a consent issue and that the dietitian should act under the *Health Care Consent Act,* either by approaching the *Public Guardian and Trustee* or the *Consent and Capacity Board.*

4. **The best answer is probably (a).** The resident is capable and should know what is going on. It would help prepare the resident for what will be happening next and maintain as high a level of trust as the circumstances permit.

   Answer (d) is also justifiable, because you do not want to inadvertently jeopardize the investigation. But it would be rare that telling the resident would have that effect.

   The *Long-Term Care Homes Act* is silent on the issue, so answers (b) and (c) do not apply.

5. **The best answer is (d).** It addresses the primary reason why you would want the administration of the long-term care or nursing home to know of your information.

   Answer (a) is also possible. However, it suggests that you are delaying in making a mandatory report pending the opinion of others, which is risky. If you have reasonable

grounds, you must make the report. On the other hand, it is possible that new information provided by the administration's investigation, if very prompt, would clarify matters.

Answer (b) focuses on considerations that are less probable and less relevant to the making of this decision. Answer (c) also focuses on a less relevant consideration.

Chapter 4

SCOPE OF PRACTICE, CONTROLLED ACTS, DELEGATION AND ORDERS

1. **The best answer is (d).** There would appear to be a serious risk of harm to the client by the nutritionist's false assurance and omission to deal fairly with the orthodox options. In fact, the conduct would probably be criminal negligence. Multiple vitamins are considered drugs under the *Drug and Pharmacies Regulation Act*. As a practical matter, the dietitian might approach the College to see about pursuing the Harm Clause issue and, failing that, go to the police.

2. **The best answer is (d).** The nutritionist avoided getting specific about the problem and focused on the treatment.

   Answer (a) refers to only part of the definition of the first controlled act, communicating a diagnosis.

   Answer (b) is not an accurate summary of the scenario.

   Answer (c) is arguable and so is not the best answer. However, the enforcement options described in question 1 still apply.

3. **The best answer is (a).** All of the other statements are accurate. While at the time of writing, acupuncture is still in the public domain, it will become a controlled act in the future. Either way, however, one could not characterize skin pricking for the purpose of blood analysis as constituting acupuncture. The purpose of the procedure is relevant here as to whether it is a controlled act.

4. **The best answer is (a).** It is a routine treatment performed by dietitians every day.

   Answer (b) is incorrect unless it is accompanied by something else that is a controlled act, such as a drug.

   Answer (c) is only correct in some settings, such as a public hospital, where there is a setting-specific provision or rule in place.

   Answer (d), overlooks the fact that dietitians can teach a therapeutic diet on their own.

5. **The best answer is (c).** The *Routine Activities of Living* exemption applies to this situation.

   Answer (a) does not appear to relate to a genuine religion. The exception relating to a tenet of a religion refers to an established religion, and not a scheme designed to circumvent the legislation.

   Answer (b) is not correct because insulin injections are not a part of traditional healing.

   Answer (d) is not correct because registered practical nurses are not authorized to order or delegate injections.

Chapter 5

PRIVACY OBLIGATIONS

1. **The best answer is (a).** This question raises the issue of only gathering the personal information that is necessary from the client. Using discretion is probably the best approach. When in doubt, it is probably acceptable to ask the questions, but in some cases some of the questions will clearly not be relevant and therefore should not be asked.

   Answer (b) may remove the reminder role that keeping the questions on the form provides. You may then forget to ask the questions when they are relevant.

   Answer (c), while useful, does not address

the issue of whether it is necessary to ask the questions.

Answer (d) can result in unnecessary intrusiveness in private areas of a client's life. You can always ask the questions later if they become potentially relevant.

2. **This best answer is (d) because a verbal request is most likely to result in actual consent.** This option is still not ideal because it does not necessarily include full disclosure (i.e. that you are being paid for this information) and is unworkable. Also, it does not guarantee a written record of the consent, which would be prudent in this case. A better alternative, not on the list, is to obtain express written consent after making full disclosure.

   Answer (a) is only half right. It is true that a weight loss centre is not covered by the *Personal Health Information Protection Act, 2004*. However, it would then be covered by the federal statute, the *Personal Information Protection and Electronic Documents Act,* which operates on similar principles.

   Answer (b) relies on an opt out clause buried in other documents and would likely not constitute fair and informed consent.

   Answer (c) just provides some disclosure (again missing key facts, e.g., your employer is getting paid for this information) and does not involve obtaining actual consent.

3. **The best answer is (b).** Even if the information did not contain the client's name, it might contain other identifying information. Also, you do not want to be "willfully blind" to a likely problem. In any event, this is a good teachable moment. Leaving a case in the cloakroom is unsafe. At home the information should be locked away.

   Answer (a) while important, is not complete. There may still have been identifiable information. In any event, you don't know whether Shelley's casual storage practices might apply to other identifiable information as well.

   Answer (c) may be appropriate in some circumstances (e.g., where the office has a policy of never taking work home or where there is no reason for Shelley to do so). However, this approach is often impractical in many work contexts, and Shelley probably has an obligation to her school program to make some notes of her activities.

   Answer (d) may be an overreaction since one does not know all the facts. Also, this is exactly the kind of situation where clinical placements are the most useful. Even if the school must be advised under the expectations of the placement program, that is secondary to the immediate concern for your organization.

4. **All of the answers are appropriate responses to the situation.** However, the best answer is probably (d) because it recognizes that the information belongs to the clients and they have a right to know. Such a response is, in fact, required under the *Personal Health Information Protection Act, 2004*. Reporting the matter to the police is useful in case the purse turns up, but that is not sufficient on its own. It may be that the purse with the files will just turn up but, again, this is an insufficient response on its own. Changing the Privacy Policy to address this specific threat is useful for the future but does not address the current problem**.**

5. **The best answer is (a).** The case of McInerney v. MacDonald (1992), 93 D.L.R. (4th) 415, (mentioned in Chapter 3) is a decision of the Supreme Court of Canada, which indicates that clients generally have a right to look at and obtain a copy of their chart from their health practitioner, including consultation reports. This principle is reaffirmed in the *Personal Health Information Protection Act, 2004* (where this ground is only a basis for declining to make a change in the record, not to providing the client with access to it in the first place).

   Answers (b) and (c) fail to recognize that the information belongs to the client. Unless

there are reasonable grounds to fear that significant harm will occur, you likely have an obligation to provide access.

Answer (d) sets up artificial barriers, which is contrary to both McInerney v. MacDonald and the principles underlying the *Personal Health Information Protection Act, 2004.* While you can establish reasonable procedures to follow in making access requests, for example, to ensure that the complete chart is made available and to explain any abbreviations and technical language, etc., you cannot set up artificial hurdles that effectively discourage or deny client access.

Chapter 6

CONFIDENTIALITY OBLIGATIONS

1. **The best answer is (b).** Obtaining the information from the public source means you have not used confidential information. Even here, it can be argued that the client's name is confidential client information.

   Answers (a) and (d) do not recognize the principle that all client information is confidential. Answer (d) is better than answer (a) in that business contact information is not usually associated with personal information, but it still came from the client.

   Answer (c) recognizes the principle of consent, but still uses other confidential information (the client's address) without prior consent and may still upset some clients.

2. **The best answer is (c).** If there is imminent risk of serious harm, there is probably a duty to warn. In these circumstances, you would probably also have to doubt Beatrice's capacity to appreciate the consequences of her instructions to you.

   Answer (a) assumes that there is always consent to speak with members of the health care team, but such consent can be withdrawn.

   Answer (b) fails to recognize that implied consent can often be withdrawn, as was the case here.

   Answer (d), while possible, may lead to severe harm or even death of the client and does not adequately address the concerns about Beatrice's capacity and possible duty to warn.

3. **The best answer is (a).** This information was given in a non-clinical context, is unrelated to treatment and is likely a generally known fact. There is nothing in the context to suggest that it is being communicated to you because of your professional relationship. Even here, there is a chance that the client is sharing the information with you because of your professional relationship, but it has all the appearances of simple social discourse.

   Answer (b) was given in the context of a professional visit and is personal information.

   Answer (c) was also given in the context of a professional visit and relates to treatment.

   Answer (d) was also given in the context of a professional visit and, while not personal information, would be considered by many to be confidential information.

4. **The best answer is (a).** The remainder of the chart would be useful to the facility and you have consent to disclose it. However, it would be misleading to not say anything about the deleted portions because the facility would assume it was complete. The client should be advised that you are obliged to provide this minimal information if you provide any portion of the chart. This question relates to the client's ability to control their personal health information. This approach is also consistent with the "lock-box" concept from the *Personal Health Information Protection Act*, 2004.

   Answer (b) is another possible solution. However, it is probably not the best one because the client consents to the release of most of the chart, and it would be of some

use for the facility to have part of it rather than none of it.

Answer (c) is not helpful at all and the confidentiality concern about the explanation can usually be managed through the approach discussed above for answer (a).

Answer (d) is not our suggested approach because one cannot assume that a client is incapable simply because she or he disregards your advice and, if the client were incapable, you would still need substituted consent.

5. **The best answer is (d).** Answer (a), advising the client is prudent so that you and the client do not have any surprises at the hearing. Your client can probably tell you more about what to expect and may give you permission to speak with the client's own lawyer, if he or she has one.

   Answer (b) is appropriate because you must obey the summons. The court may want either the original or a copy of the chart, so making a copy in advance will ensure you have at least a copy afterwards.

   Answer (c) balances courtesy and self-interest with client confidentiality.

Chapter 7

CONSENT TO TREATMENT

1. **The best answer is (d).** Obtaining informed consent for this intervention would be relatively easy and the dietitian would probably not need to do it personally. In fact, a simple investigation may reveal that other staff at the facility had already obtained the consent for a plan of treatment, including the dietetic plan of care. Indeed, in some circumstances, there may even be implied consent if the facility makes clear to residents that their diets may be supplemented, if recommended by the health staff.

   Answer (a) may be true in some circumstances, but amounts to buck-passing. The dietitian should clarify that someone is taking responsibility for the consent.

   Answer (b) is risky. The dietitian would want to know what that consent states to make sure it applies and that the process of obtaining the consent was meaningful. However, because the intervention here has so little risk, in some circumstances, the blanket consent can perhaps be relied upon.

   Answer (c) is also likely incorrect because a supplemented diet for calorie needy residents is probably a treatment in the technical sense of that term.

2. **The best answer is (b).** The client does not appreciate that failing to come to grips with her diet and other lifestyle decisions can have significant implications for diabetic management. That, in turn, can significantly affect her health and even her life.

   Answer (a) focuses on understanding factual information, which is not really this client's problem. Her problem appears to be appreciating the significance of the facts.

   Answer (c) focuses on assumptions rather than observations, which the *Health Care Consent Act* expressly prohibits. Not all developmentally challenged clients are incapable regarding their treatment decisions.

   Answer (d) focuses too much on the importance of the decision, and fails to give sufficient weight to the complexity of the decision.

3. **The best answer is (d).**

   Answer (a) recognizes that you have your own professional responsibility for assessing capacity of the client. In addition, aspects of the dietetic treatment plan have not been covered by the other practitioners on the team.

   Answer (b) is consistent with the College's guidelines for dealing with incapable clients, and in particular to involve the client as much as possible in the circumstances.

Answer (c) addresses the most likely substitute decision-maker in the circumstances and reminds the dietitian to check whether other higher ranked substitutes are available.

4. **The best answer is (c).** A signed written consent provides some evidence that could later be used to defend you from an allegation that no consent was sought or obtained. The client could still say that the form was not explained and no opportunity was given to read it, but at least some burden rests upon the client to explain the signature.

   Answers (a) and (b) both overemphasize the piece of paper. What really counts is that there was a meeting of minds and that the client truly gave informed consent. A true verbal consent is better than a paper that was signed without thought. A witness' signature is not legally required; it just helps you locate and refresh the memory of a witness who can help you prove that the consent was obtained. Even without a witness, you can often prove the signature either through the client's own admission or, failing that, a handwriting expert.

5. **The best answer is (a).** With very rare exceptions, consent can be withdrawn at any time.

   Answer (b) is not correct in that consent can be given in one form and withdrawn in another. However, the client should be asked to confirm the withdrawal of consent in writing.

   Answer (c) fails to recognize that once consent is clearly withdrawn, the dietitian should stop treatment first and then check to see if the withdrawal is informed afterwards. Continuing with treatment (unless it cannot be stopped at the moment) while determining if it is informed, is risky for the dietitian.

   Answer (d) is not responsive to the question. A power of attorney for care authorizes a substitute to make decisions on behalf of the client (usually when the client later becomes incapable), and does not normally deal with the withdrawal of a consent that has already been given.

Chapter 8
RECORD KEEPING

1. **The best answer is (a).** These are health care records and they should be created and maintained according to professional expectations.

   Answer (b) assumes that no appropriate record keeping safeguards can be established where non-regulated persons control them. While clearly it is more difficult to ensure that adequate safeguards are in place for unregulated custodians, it is not impossible.

   Answer (c) fails to recognize that even if the person is primarily the client of the organization, the person is also a client of the dietitian.

   Answer (d) inadequately reflects the independent professional obligation on the dietitian to ensure that appropriate records are kept. While there is some consideration of the organization's criteria, the dietitian has some responsibility to ensure that the records are kept appropriately.

2. **The best answer is (c).** It addresses the issue in a consultative and collegial fashion and could provide the best solution.

   Answer (a) may work as a last resort, but requires that you advise the agency of your intent and deprives the others using the chart at the agency from access to your records.

   Answer (b) only addresses the retention and client access issues. It does not address concerns such as the security and confidentiality of the agency's copy of the record.

   Answer (d) is not preferred because it likely involves your discrediting the agency you work with. In addition, obtaining client consent to compromise professional standards is never the best solution.solution.

3. **The best answer is (b).** If the facility agrees to your keeping these separate records and makes appropriate references to them in its record keeping practices, then most of the problems are solved. However, this answer places a burden on you to secure and organize the records appropriately.

   Answer (a) misses the point. Even if the others on the team could never want access to the record, other issues need to be dealt with, such as security, confidentiality and access should clients approach the facility for their "complete" record, etc.

   Answer (c) similarly misses the point. A record, once made, must be treated accordingly. The fact that the official facility chart meets your minimal obligations does not detract from the fact that an additional private record was made. As such, your private record must be linked to the official chart and retained for 10 years.

   Answer (d) however, implies that the record is filed with the official record and is a possible solution. The reason answer (b) is preferred is because it is more transparent and collegial.

4. **This question tests your mental agility because you are searching for the worst rather than the best answer.**

   The worst answer is (b) because it may be necessary to remove a record from a facility for some purposes (e.g. a home visit or to testify at a hearing). Thus, it is better to have appropriate measures for such eventualities than to try to prohibit them entirely. All of the other answers should be part of a security program for client records.

5. **The best answer is (c) as it most closely reflects the College's expectations.**

   Answer (a) misses that the triggering event is the last client visit.

   Answer (b) misses the special provision dealing with clients who are minors.

   Answer (d) focuses on a minor point. Where the *Public Hospitals Act* or other statute applies, those provisions take precedence. However, it would be rare for the dietitian to have such a record in their chart.

Chapter 9

CONFLICT OF INTEREST

1. **Depending on the circumstances, the concerns can probably be successfully managed by the DORM principle with the possible exception of the contribution for training programs.** Safeguards would include:
   a. Not consuming the chocolates or tickets personally;
   b. Advising the supplier that the gifts will not affect purchasing decisions;
   c. Advising your manager of the gifts;
   d. Advising the budget and finance department and the board of directors of the contribution to the education budget;
   e. If the other departments of the organization accept the contribution to the training program, mentioning that consideration in future requests for proposals.

2. **Depending on the circumstances, the concerns can probably be successfully managed by the DORM principle.** Safeguards would include:
   a. Not letting the situation develop by clarifying the role of the partners and sponsors;
   b. Expressing your concerns with the partner and seeking a mutually satisfactory resolution in collaboration. Perhaps the partner can use the questionable components of the lunch boxes in another activity;
   c. As a last resort, withdrawing your agency's participation in this event.

3. **Depending on the circumstances, the concerns can probably be successfully**

managed by the DORM principle. Safeguards would include:

a. Ensuring that you clearly identify yourself as a representative of your company;

b. Ensuring that your communications are fair and accurate and that you can base your claims for the product on evidence;

c. Avoiding any misunderstanding that you are making a clinical recommendation. Given the information available, you might also conclude that there was no conflicting duty to a client identified by this scenario.

4. Depending on the circumstances, the concerns can probably be successfully managed by appropriate action, although perhaps not the DORM principle itself. Safeguards would include:

   a. Notifying your employer of the speaking engagement offer and obtaining approval for your participation. Be prepared to justify clearly the benefits to the employer by your enhanced relationship with this community partner;

   b. Declining payment or signing over the payment to your employer or, at a minimum, booking off from work for the time spent on the speaking engagement.

5. **Depending on the circumstances, the concerns can probably be successfully managed by the DORM principle**. Safeguards would include:

   a. Obtaining all necessary information to ensure that participating in the conference is not compromising your professional status;

   b. Exploring the possibility of the organizers switching the sponsor with that of another session, where the connection to your topic would be less direct;

   c. Confirming in writing with the conference organizers that there are no restrictions on your ability to present your views on the topics, and that there will be no "slant" in the session as a whole;

   d. In your written materials, putting in a disclaimer indicating that you are not affiliated with any sponsor for the conference, have not received any benefit from any sponsor, and that your presentation is not to be taken as endorsing any product or service offered by a sponsor.

Chapter 10

BOUNDARY ISSUES

1. **The best answer is (d).** Boundary crossings often interfere with the professional relationship in unexpected ways. Some of the various types of interference are discussed in the text.

   Answer (a), while a real concern, is not the primary concern in this circumstance especially as the attendance at the home is for a limited, non-therapeutic purpose and there are no romantic or other connotations to it.

   Answer (b), while a real concern, does not address the core of the boundary issue.

   Answer (c) only has significance because of the boundary issue. House cleaning is honest work. By becoming Felicia's boss, you create an imbalance in the therapeutic relationship.

2. **The best answer is (c).** It is your responsibility to maintain the boundaries. You may have to take additional action, depending on the response to your attempt to reestablish the boundaries (e.g. transfer the client's care), but that is the first step.

   Answer (a), while perhaps technically true, looks to your responsibility for the client's actions rather than a solution to the problem that has been created. You need to take some action.

   Answer (b) may ultimately be necessary in some cases but is not necessary in every case.

   Answer (d) leaves hope that there may be a

romantic relationship in the future. Such a response does not deal with the harm that is occurring now to your professional relationship and is inappropriate.

3. **All of the answers are true.** Answer (c) is really a subset of answer (b). Which concern is paramount depends on the circumstances of the case, although (b) would often be at the top of the list.

4. **The best answer is (d).** You can convey this message to the client in a way that does not embarrass the client or attack their self-esteem. For example, you can suggest that jokes that make fun of dietitians are the only humour permitted in your practice setting.

   Answers (a) and (b) involve your legitimizing the conduct. It is true that answer (a) may not involve sexual abuse on your part, and answer (b) does technically involve sexual abuse on your part. However, both answers involve at least a technical crossing of a boundary.

   Answer (c) is incorrect as the mandatory reporting obligations only apply to health practitioners, not clients.

5. **The best answer is (d) as it is the most inclusive.** The other answers are all true, but are incomplete. The chapter includes examples of boundary rules that protect the client, the dietitian and others who observe or otherwise learn of the conduct.

APPENDIX 2

College of Dietitians of Ontario

Selected Statutes Relevant to Dietitians

All statutes are from Ontario unless indicated "(Canada)".

Business Corporations Act

Child and Family Services Act

Consumer Protection Act, 2002

Controlled Drugs and Substances Act (Canada)

Criminal Code (Canada)

Dietetics Act, 1991

Discriminatory Business Practices Act

Drug and Pharmacies Regulation Act

Employment Standards Act, 2000

Evidence Act

The Good Samaritan Act, 2001

Freedom of Information and Protection of Privacy Act

Health Care Consent Act, 1996

Health Protection and Promotion Act

Human Rights Code

Long-Term Care Homes Act, 2007

Partnerships Act, 1990

Personal Information Protection and Electronic Documents Act (Canada), 2004

Personal Health Information Protection Act, 2004

Patient Restraints Minimization Act, 2001

Public Guardian and Trustee Act

Public Hospitals Act

Regulated Health Professions Act, 1991

Retirement Homes Act, 2010

Substitute Decisions Act, 1992

Workplace Safety and Insurance Act, 1997

Back to Table of Contents

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All provincial statutes and regulations can be found at www.e-laws.gov.on.ca or Federal statutes at http://laws.justice.gc.ca/en/:

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Drug and Pharmacies Regulation Act, R.S.O. 1990

Chapter H.4, Part IV, Pharmacy, Interpretation, Part VI: Section 117.

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Ministry of Small Business and Consumer Services http://www.sbe.gov.on.ca/ontcan/sbe/en/home_en.jsp.

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Regulated Health Professions Act, 1991, S.O. 1991, Chapter 18, Schedule 2: Health Professions Procedural Code. Partnerships Act, R.S.O. 1990, c. P.5.

Back to Table of Contents