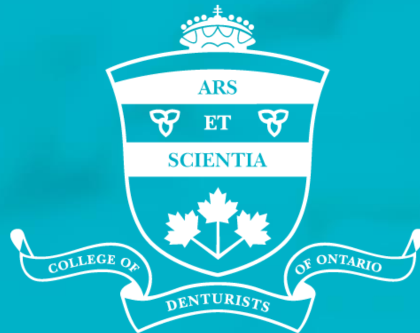
Jurisprudence Handbook

Important Legal Principles Practitioners Need to Know

College of Denturists of Ontario

(Current to February 2019)



COLLEGE OF
DENTURISTS
OF ONTARIO

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IMPORTANT LEGAL PRINCIPLES PRACTITIONERS NEED TO KNOW

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INTRODUCTION AND OVERVIEW

The purpose of this Handbook is to provide information on the ethical and legal issues affecting the practice of denturism in Ontario.

This Handbook will first discuss the ideas of professionalism and self-regulation. The *Denturism Act, 1991* is based on these concepts. The Handbook will then look at how proper communication with patients and colleagues is basic to a professional practice. For example, informed consent is not possible without communication. The Handbook will then review the various laws that practitioners are most likely to have to deal with in their practice.

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

- *AODA* – Accessibility for Ontarians with Disability Act
- *Code* – Health Professions Procedural Code which is Schedule 2 to the RHPA
- CYFSA – Child*,* Youth and Family Services Act
- *HCCA* – Health Care Consent Act
- *PHIPA* – Personal Health Information Protection Act
- *PIPEDA* – Personal Information Protection and Electronic Documents Act
- *RHPA* – Regulated Health Professions Act

Other abbreviations and short forms include the following:

- CAS – Children's Aid Society
- CCB – Consent and Capacity Board
- HPARB – Health Professions Appeal and Review Board
- the College – the College of Denturists of Ontario
- ICRC – Inquiries, Complaints and Reports Committee
- MOHLTC – The Ministry of Health and Long-Term Care
- OFC – Office of the Fairness Commissioner
- QA – Quality Assurance
- SDM – substitute decision maker

1. PROFESSIONALISM AND SELF-REGULATION

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

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

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

Professionals must also obey the law. There are many different laws that apply to a practitioner. The purpose of this Handbook is to describe some of these laws in a general way so that practitioners understand the basic principles. It does not cover all of the things that happen in real life. If a practitioner has a specific legal question about their own circumstance, they should ask their own lawyer for help.

a. The idea of self-regulation

The "regulation" of an activity means that the law imposes restrictions on the activity to ensure that the public is not harmed, and actually benefits, from the activity. There are many ways in which an activity can be regulated. For example, the government could choose one of the following approaches:

1. No regulation at all. This allows the consumer to choose. For example, in Ontario, shoe sales people are not regulated.
2. Consumer protection legislation. For example, buying a membership with a fitness centre is governed by Ontario's *Consumer Protection Act*.
3. Direct government regulation. The government could have the Ministry of Health and Long-Term Care regulate the profession just like it regulates laboratories.
4. Self-regulation. The government can delegate authority to a profession to regulate itself under an Act.

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

Self-regulation means that the Ontario government has made a statute (often called an Act) giving the duty to regulate the profession to a separate body (called a College). Most Council members are elected by the profession. The Council is the Board of Directors of the College. The Council establishes the policies of the College (e.g., it makes the professional misconduct regulations) and oversees the administration of the regulatory activities of the College (e.g., it approves the budget for the College). The College operates through committees (e.g., the Registration Committee, the Discipline Committee). Most of the members of each committee are practitioners, with other committee members coming from the public.

The College is a regulatory body, not an educational institution. The role of the College is to serve the public. It does this by regulating the profession in the public interest. The College cannot serve the self-interest of the profession (e.g., the College cannot set fees to be charged to patients). That is the role of a professional association, not a regulatory College. The College ensures that the profession acts honestly and competently.

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

1. The Council and the committees of the College also have public members on them (i.e., non-practitioners appointed by the government). Almost half of Council and committee members are public members.
2. Council meetings and discipline hearings are open to the public. The date, time, agenda and supporting materials for all upcoming Council meetings must be posted on the College's website in advance. The date, time and statement of allegations for upcoming discipline hearings must

also be posted on the College's website in advance. Observers can attend and watch what happens to see for themselves whether decisions are being made in the public interest and they can see that justice is being served in the disciplinary process;

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3. The College must consult with members of the profession and the public before making a regulation and many by-laws. The College must circulate the proposed wording of the regulations and certain by-laws for comment for a period of at least 60 days so that people can comment on them.
4. Decisions of the committees of the College can be reviewed by other bodies. For example, decisions of the Registration Committee or the Inquiries, Complaints and Reports Committee can be reviewed by the Health Professions Appeal and Review Board (HPARB). Decisions of the Discipline Committee or the Fitness to Practise Committee can be reviewed by the Divisional Court.
5. The government has appointed two bodies who ensure that the College acts in the public interest. The Office of the Fairness Commissioner (OFC) makes sure that the College's registration practices are transparent, objective, impartial and fair. In addition, the Minister of Health and Long-Term Care (MOHLTC) can refer concerns about the College's regulations or activities to the Health Professions Regulatory Advisory Council (HPRAC) for review.
6. The College has to report to the Minister each year. The College also has to make more reports to the Minister if the Minister asks. The Minister can make recommendations or give orders to the Council of the College. If there are serious concerns, the Minster can audit the operations of the College. The Minister can also appoint a supervisor to take over its operations. As of 2017, the Minister can require the College to provide information about how it handled individual registration, complaints, investigation, discipline and other matters.
7. The College has to publish its discipline decisions. The College also publishes other information about practitioners on the public register. The public register is on the College's website.
8. The College must also put on its website a description of its activities.

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

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

Sample Quiz Question

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

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

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

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

An important part of the College's role is to make rules. The College makes different types of rules and, sometimes, enforces a Code of Ethics and professional standards. The College takes action where there is professional misconduct, incompetence and incapacity. Each of these concepts is slightly different in its role and purpose.

This section of the Handbook looks at five different kinds of rules:

- Code of Ethics;
- Professional standards;
- Professional misconduct;
- Incompetence; and
- Incapacity.

Code of Ethics

Professions have ethical principles to guide their members. These ethical principles include being honest at all times, respecting the confidentiality of a patient, treating patients with sensitivity and respect, maintaining competence and allowing patients to make informed choices as to their health care.

The College is authorized under its Act to develop a Code of Ethics for practitioners. The College's Code of Ethics takes priority over the Codes of Ethics of professional associations.

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

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

Ethics Scenario

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

Professional Standards

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

Often, the details of the professional standard are not written down anywhere by the College. For example, the College may not have a document describing exactly how a practitioner assesses a patient. Often, how practitioners apply the standard changes with the circumstances (e.g., the answers the patient gives to the practitioner's questions will change how the assessment is done). Professional standards are learned through one's education, professional reading and learning, experience in practice and in discussions with other practitioners. Professional standards are always changing.

However, to assist members, the College develops written documents that explain professional standards. These publications can have different names (e.g., Standards of Practice, Policies, Guidelines). The purpose of these documents is to remind practitioners how to practise safely, ethically and effectively. These publications are on the College's website and cover a wide variety of topics.

The College's Standards of Practice and Guidelines describes professional expectations on topics ranging from advertising and clinic names, informed consent and consent to treatment and record keeping.

While professional standards are not "law" in the same way that a statute or regulation is, failing to comply with a published standard will often lead to a violation of the law or will result in professional misconduct.

Clinic Name Scenario

Donna Chan, a denturist, wants to call her clinic "Chan Denture Clinic". She reads the College's professional misconduct regulation on clinic names which says that, while practitioners can use their surname in the clinic name, the name should not be similar to that of another practitioner and should be approved by the Executive Committee. Donna cannot see why she needs to get approval for her name and the only other Chan Denture Clinic is on the other side of town. A patient complains to the College after getting confused as to which clinic was owned by whom. After investigating the complaint the College requires Donna to appear before it to receive a verbal caution because Donna did not follow the policy and adopted a confusing clinic name. Donna had to change the name of her clinic. Failure to follow the professional misconduct regulation cost her more than $10,000 to change her signs and letterhead.

Professional Misconduct

Professional misconduct is behaviour that falls below the minimum expectations of a safe and ethical practitioner. Professional misconduct is written in either the Act or the regulations. The rules in the Act and regulations are described in more detail below in the section on the Professional Misconduct Regulation. Many College publications will help practitioners to know how to avoid engaging in professional misconduct.

A practitioner who behaves unprofessionally can be disciplined. The Discipline Committee can fine, suspend or even revoke a practitioner's certificate of registration. It is very serious for a practitioner to do something that is professional misconduct.

Permitting Illegal Practise/Conduct Scenario

David, a denturist, is registered with the College. David's father is not registered with the College. David's father sometimes comes to David's office to treat his long term patients. The office assistant refers to David's father as "Doctor" when booking patients. A patient complains to the College when her extended health insurance refuses to pay for David's father's services because he was not registered with the College. Is David responsible for his father's conduct?

The answer is yes. It is professional misconduct to permit a person to hold themselves out as practising the profession when they are not registered. David, a denturist, allowed the conduct that happened at his office. The title "Doctor" is restricted in the health care context and the use of the title in reference to David's father was not permitted. David allowed the illegal conduct of his father. David could face a discipline hearing.

Incompetence

Incompetence happens where a practitioner shows a serious lack of knowledge, skills or judgment when assessing or treating a patient. It is defined in the Act. The College can investigate a concern that a practitioner is incompetent. Incompetence can result in a discipline hearing. If the Discipline Committee finds that a practitioner is incompetent, it can order restrictions on the practitioner's registration. For example, it could order that the practitioner use a supervisor, or the Committee can suspend or revoke the practitioner's registration.

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

Incompetence Scenario

Donna, a denturist, does not really assess her patients. She is always in a hurry to treat as many patients as possible in a day. She just makes an impression and runs off. She does not bother to take medical dental history or perform an intra-oral exam. A patient, Paula, came in with a serious intra-oral condition. Donna did not recognize it. Paula's family doctor found it when Paula's mouth sores would not go away. Paula's doctor could not believe that her denturist did not notice the sores when fitting Paula's denture. Paula complained about Donna's incompetence. The Inquiries, Complaints and Reports Committee looked at Donna's patient records and heard Donna's explanation for what she had done. Donna said that since she could not communicate a diagnosis to Paula, she had no duty to do anything about the sores (which Donna claimed to notice, but made no note of). The ICRC sent the case to discipline. The Discipline Committee agreed that Donna showed a lack of knowledge, skills and judgment. It ordered Donna to take numerous courses and be supervised by a colleague for a year.

Incapacity

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

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

Incapacity Scenario

Sargon, a denturist, has been drinking a lot more alcohol over the last few months. He has been coming to work with a hangover. More recently he has been drinking at lunch. One day, Sargon returns from lunch and is drunk. Paul, a patient, notices that Sargon smells of alcohol and that Sargon is falling. Paul tells the College. At first Sargon denies he has a problem. However, during the investigation, the College learns that some of Sargon's colleagues have noticed a significant change in Sargon's behaviour in recent months. The College also learned that Sargon has been charged with impaired driving. The College sends Sargon to a medical specialist who diagnoses Sargon with a serious substance abuse disorder. The College encourages Sargon to go for treatment at the Homewood Health Centre. Sargon agrees. The matter is referred to the Fitness to Practise Committee. Sargon and the College agree to an order which includes strict terms, conditions and limitations placed on Sargon's Certificate of Registration requiring Sargon to stop drinking, attend Alcoholics Anonymous group meetings, see his new substance abuse specialist regularly and have a colleague watch Sargon at work and send regular reports to the College. Such intensive monitoring of Sargon's health and behaviour ensures that the public is protected.

Conclusion

Each of the above sections looks at a different part of professional practice. Each of these rules also serves a different purpose. The Code of Ethics deals with the ideals which practitioners try to achieve. Professional standards deal with how to practise safely, effectively and professionally. Professional misconduct deals with the minimum behaviour necessary to avoid discipline. Incompetence deals with having an adequate level of knowledge, skills and judgment in the assessment and treatment of a patient. Incapacity deals with health conditions that prevent a practitioner from thinking clearly.

Sample Quiz Question

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

i. The definition of incapacity in the Act.
ii. The definition of incompetence in the Act.
iii. The definition of professional misconduct in the Act and regulations.
iv. Professional standards made by the College.
v. The Code of Ethics made by the College.

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

2. COMMUNICATION

a. Introduction

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

b. Informed consent

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

General Principles

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

- *Relate to the Treatment.* The practitioner cannot receive consent for one step (e.g., taking a history of the patient's health) and then do a different activity (e.g., physically examine the patient). The patient's consent must be for what is actually going to be done.
- *Be Specific.* The practitioner cannot ask for a vague consent. For example, one cannot ask for the patient to consent to any treatment the practitioner wants to do. The actual assessment or treatment plan must be explained. This means that the practitioner often has to obtain the patient's consent many times during a visit. This also means that a practitioner cannot obtain a "blanket consent" to cover every activity when the patient first comes in.

- *Be Informed.* It is necessary that the patient understands what they are agreeing to. The practitioner must explain to the patient everything the patient needs to know before asking the patient to give consent. To take an example from daily life, if someone asks for consent to drive your car without telling you that they intend to use it to race over rocky fields, your consent would not be informed. To be informed, consent must include the following:
  - *Nature of the Assessment or Treatment.* The patient must understand exactly what the practitioner is proposing to do. For example, does the practitioner intend to just ask questions or will the practitioner also be touching the patient? If the practitioner is going to be touching the patient, describe what the patient should expect.
  - *Who will be doing the Treatment Plan?* Will the practitioner be doing the work personally or will a colleague or student be doing it? If it is a colleague or student, are they registered with the College, another College, or not registered at all?
  - *Reasons for the Treatment Plan.* The practitioner must explain why they are proposing that step. What are the expected benefits? How does the step fit in with the overall plan of the practitioner? How likely is it that the hoped for benefits will happen?
  - *Material Risks and Side Effects.* The practitioner must explain any “material” risks and side effects. “Material” risks or side effects are ones that a reasonable person would want to know about. For example, if there is a high risk of a modest side effect (e.g., irritated gums), the patient should be told. Similarly, if there is low risk of a serious side effect (e.g., choking), the patient needs to be told.
  - *Alternatives to the Treatment Plan.* If there are reasonable alternatives to the treatment plan (e.g., a more cautious approach), the patient must be told. Even if the practitioner does not recommend the option (e.g., it is unlikely to help soon), the practitioner should tell the patient about it and explain why the practitioner is not recommending it. Also, even if the practitioner does not provide the alternative treatment plan (e.g., it is provided by a member of a different profession, such as a physician), the practitioner must tell the patient if it is a reasonable option.
  - *Consequences of Not Having the Treatment Plan.* One option for a patient is to do nothing. The practitioner should explain to the patient what is likely to happen if the patient does nothing. If it is not clear what will happen, the practitioner should say so and provide some likely consequences.
  - *Particular Patient Concerns.* If the individual patient has a special interest in some aspect of the treatment plan (e.g., its nature, a side effect), the patient needs to be told

(e.g., the treatment plan would involve an injection by a partnering dentist and the patient is afraid of needles).

- *Voluntary.* The practitioner cannot force a patient into consenting to a treatment plan. This is particularly important when dealing with younger or older patients who may be overly influenced by family members or friends. This is also important where the assessment or treatment will have financial consequences for the patient (e.g., the patient will lose their job or will lose financial benefits if the patient refuses to consent). The practitioner should discuss with the patient that it is up to the patient whether to give consent and that the patient should not let anyone pressure them into doing something the patient does not want to do.
- *No Misrepresentation or Fraud.* The practitioner must not make claims about the assessment or treatment that are not true (e.g., telling the patient that a treatment will end their jaw pain when in fact the results are uncertain). This situation would not result in a true consent. Patients must be given accurate factual information and honest opinions.

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

The College's Standard of Practice: Informed Consent provides more information that can help practitioners. For example, it discusses some of the ways in which denturists can obtain evidence that a patient has consented to treatment.

Consent Scenario No. 1

Donna, a denturist, meets a new patient named Paula. Paula complains about how her old dentures are unstable and food gets under them. Donna says, "I would like to fully understand your eating habits and how you use your dentures. This information will help me know your case and make the best recommendations for your situation. If you are uncomfortable with any of my questions, please let me know. OK?" The patient nods in agreement. Donna has just obtained informed consent for taking the patient's history.

Sample Quiz Question

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

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

The best answer is iii). Informed consent requires the patient to understand all of the relevant information including the nature, risks and side effects of the available choices. It is impossible for the patient to know these things upon her first visit. Answer i) is not the best answer because it focuses on a side issue and does not address the main issue. Answer ii) is not the best answer because having confidence in the practitioner is not enough for there to be informed consent. A patient may trust the practitioner and that may motivate the giving of consent, but the patient still needs to understand to what they are being asked to agree. Answer iv) is not the best answer because it focuses on a side issue and does not address the main issue.

Ways of Receiving Consent

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

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

- *Verbal Consent.* A patient can give consent by a verbal statement. A verbal consent is the best way to get consent. That way, the practitioner and the patient discuss the information and the practitioner can ensure that the patient really understands it. Making a brief note in the patient record of the discussion can provide useful evidence later on if there is a complaint. Relying just on a generic consent form signed by the patient to document the consent process is not prudent.

- *Implied Consent.* A patient can give consent by their actions. For example, in Consent Scenario No. 1, above, the patient Paula could just nod her head. That would be implied consent for Donna, a denturist, to begin asking her questions. The main disadvantage of implied consent is that the practitioner has no opportunity to check with the patient to make sure that the patient truly understands what is going to happen.

Consent Scenario No. 2

David, a denturist, proposes that his patient, Paul, get partial dentures. David does not mention anything about dentures over implants because David would then have to refer the patient elsewhere. Paul spends a lot of money on the partial dentures. On his next dentist's visit, Paul learns of the denture over implants option that would have been much better for Paul in his particular case. Paul complains to the College about not being given his full options. Nothing in the file supports that David told Paul of the dentures over implants option. The Inquiries, Complaints and Reports Committee issues a decision cautioning David for not obtaining informed consent because he did not give Paul all of the relevant options.

Consent Where the Patient is Incapable

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

- does not understand the information; or
- does not appreciate the reasonably foreseeable consequences of the decision.

For example, if the practitioner recommends dentures to a patient with dementia that is so advanced the patient does not understand what is going on, it is pretty clear that the patient does not appreciate the consequences of the decision.

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

A patient can be capable to give consent for one activity, but not capable for another. For example, a patient with moderate dementia may not be able to make financial decisions but may be able to consent to repairing an existing denture.

If a practitioner concludes that the patient is not capable of giving consent for a treatment plan, the practitioner should tell the patient. The practitioner should also tell the person who will make decisions on their behalf – for example, a close relative. This person is called a "substitute decision maker". The practitioner should still include the patient in the discussions as much as possible. Sometimes, however, it is not possible to include the incapable patient in the discussions (e.g., if it will be quite upsetting to the patient).

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

- The substitute must be at least 16 years of age.[1] There is an exception where the substitute is the parent of the patient (for example, a 15-year-old mother can be the substitute decision maker for the care of her child).

- The substitute must, themselves, be capable. In other words, the substitute must understand the information and appreciate the consequences of the decision.

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[1] While there is no minimum age of consent for a capable patient, a substitute decision maker must normally be at least 16 years old.

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

Here is a scenario that shows how these rules work.

Consent Scenario No. 3

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

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

A substitute decision maker must comply with the following rules:

- The substitute must act in accordance with the last known capable wishes of the patient, if known. For example, if a patient clearly said, "Never pull my teeth unless I am in pain" before he became so ill that he could not think clearly, the substitute needs to obey those wishes.

- The substitute must act in the best interests of the patient if the substitute does not know of the last known capable wishes of the patient. For example, if a proposed treatment is simple and painless, would cause little risk of harm but would make the patient more comfortable, the substitute decision maker should consent to it.

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

Consent Scenario No. 4

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

The above rules on obtaining informed consent when a patient is incapable come from the *Health Care Consent Act*. Practitioners should be familiar with that Act.

Sample Quiz Question

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

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

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

Emergencies

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

- Where the patient is incapable and a delay in treatment would cause suffering or serious bodily harm to the patient.
- Where there is a communication barrier (e.g., language, disability) that cannot be reasonably accommodated without delaying care and a delay in treatment would cause suffering or serious bodily harm to the patient.

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

Emergencies are rare for denturists, but can occur.

Consent Scenario No. 5

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

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

c. Boundaries and sexual abuse

In order to understand the nature of professional boundaries and the harm that can result from crossing boundaries, including sexual abuse, it is useful to consider the following concepts.

Trust

The professional relationship between a denturist and a patient is based on trust. The patient must feel safe with the practitioner in order for the practitioner to provide the best possible care. Safety is not limited to physical safety. A fear, no matter how misguided, that a practitioner may disclose the patient's personal health information means that the patient will not provide the information needed by the practitioner. Similarly, a concern that the practitioner is judging the patient may result in the patient answering questions incompletely or inaccurately.

Power

The practitioner-patient relationship involves a power imbalance in favour of the denturist. The patient comes to the practitioner in a position of need. In large part, the patient chooses a practitioner to ensure that the patient is kept safe. As such the patient depends on the expertise and judgment of the practitioner. The patient has to disclose personal information to the practitioner. (In contrast, the practitioner is not expected to – and indeed usually should not – disclose personal information to the patient). The practitioner will usually have to touch the patient's body, which involves intimacy and vulnerability. The patient may feel under scrutiny as the practitioner examines their face. The patient may have a sense that their body, values or beliefs are unusual.

Choice

As discussed above, a fundamental concept of both our legal and health care systems is that patients should have control over their bodies and their healthcare. In part, this balances the power of the practitioner. It also reflects the values of our society. The power of the patient to control their body and their healthcare requires that the patient provide informed consent for all care decisions. This includes the practitioner's asking of questions and touching of a patient.

Principles

As a result of these foundational concepts, the following principles apply:

1. The practitioner must always act in the patient's best interests.
2. It is the practitioner's responsibility to keep professional boundaries. The patient is not responsible to do this.
3. Failing to keep boundaries can affect the quality of the outcome for the patient.
4. Crossing boundaries can harm patients and can compromise the public's trust in the profession.
5. Patients must be protected from sexual abuse.

Boundaries

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

It is a delicate balance between maintaining a suitable professional distance and being engaged with the patient. Being too distant or being too close can both compromise the patient's care.

Maintaining professional boundaries is about being reasonable in the circumstances. For example, one should be careful about accepting gifts from patients, but there are some circumstances in which it is appropriate to do so (e.g., a small New Year's gift from a patient). In other areas, however, crossing professional boundaries is never appropriate. For example, it is always professional misconduct to engage in any form of sexual behaviour with a patient.

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

Self-Disclosure

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

Self-Disclosure Scenario

Donna, a denturist, is providing a denture for Paula. Paula is having difficulty deciding whether to marry her boyfriend and talks to Donna about this issue a lot during their visits. To help Paula make up her mind, Donna decides to tell Paula details of her own doubts in accepting the proposal from her first husband. Donna tells of how those doubts had long-term consequences, gradually ruining her first marriage as both her and her husband had affairs. Paula is offended by Donna's behaviour and stops coming for adjustments even though she still needs them. Eventually Paula stops wearing the denture. Donna's self-disclosure was inappropriate and unprofessional.

Giving or Receiving of Gifts

Giving and receiving gifts is potentially dangerous to the professional relationship. One must be sensitive to the patient's culture where refusing a gift could be considered to be a serious insult. However, anything beyond small gifts can indicate that the patient is developing a personal relationship with the practitioner. The patient may even expect something in return.

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

Gift-Giving Scenario

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

Dual Relationships

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

Dual Relationship Scenario

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

Becoming Friends

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

Ignoring Established Customs

Established customs usually exist for a reason. Ignoring a custom confuses the nature of the professional relationship. For example, professional visits are usually held during regular business hours at the office (or if the patient has reduced mobility) at the patient's home. By ignoring this custom (e.g., by scheduling the visit in the denturist's home kitchen and offering the patient a glass of wine), the patient

might begin thinking that the meeting is a social visit. Treating patients as special or different from other patients can be easily misinterpreted.

Personal Opinions

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

Personal Opinions Scenario

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

Touching

Touching can be easily misinterpreted. A patient can view an act of encouragement by a practitioner (e.g., a hug) as an invasion of space or even a sexual gesture. Extreme care must be taken in any touching between practitioners and their patients. The nature and purpose of any clinical touching must always be explained first and the patient should always give consent before the touching begins. Instruments or materials should never be placed on the patient’s chest. Cultural sensitivities should be respected. The presence of a third party should be permitted and even offered where appropriate. The touching must always have a clinical relevance that is obvious to the patient.

Managing boundaries is important for both practitioners and patients.

Sexual Abuse

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

The term “sexual abuse” is intended to convey how seriously the behaviour is taken. However, it should not be thought that only deliberately exploitative behaviour is sexual abuse. In fact, sexual abuse includes behaviour that might, on the surface, appear to be genuine and sincere.

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

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

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

This definition of sexual abuse includes treating one’s spouse. The College is seeking a regulatory amendment to permit members of the College to treat their spouses. **However, at this time, members are not permitted to treat their spouses. Unless and until the law is changed, any member who treats their spouse may be found guilty of sexual abuse by the Discipline Committee.** Practitioners need to transfer the care of their spouse or any sexual partner to other practitioners. It does not matter that the other relationship came first.

The regulations under the *RHPA* contain a broad definition of who constitutes a patient. It includes circumstances where any one of the following has occurred:

i. the practitioner has, in respect of a health care service provided to the individual, charged or received payment from the individual or a third party on behalf of the individual.
ii. the practitioner has contributed to a health record or file for the individual.
iii. the individual has consented to the health care service recommended by the practitioner.
iv. the practitioner has prescribed a drug for which a prescription is needed to the individual.

These criteria are not exhaustive. There is a very narrow exception where there is a pre-existing sexual relationship and there is an emergency or service of a minor service is provided in circumstances where referring the person to another practitioner was not possible. It would be rare for those circumstances to arise in a denturist’s practice.

While sexual abuse only relates to patients, sexual misconduct towards other persons can constitute disgraceful, dishonourable and unprofessional conduct. For example, flirting with the relative of a patient would generally be unprofessional. So would sexual harassment of a colleague or employee.

Touching, behaviour or remarks of a clinical nature is not sexual abuse. For example, touching the mouth and face of a patient will often be clinically necessary (and, as discussed above, must be done only after receiving informed consent).

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

Sexual Abuse Scenario No. 1

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

Because sexual abuse is such an important issue, Colleges must take it very seriously. Each College has a Zero Tolerance policy towards sexual abuse. This means that all complaints or reports are taken seriously, investigated thoroughly and acted upon responsibly. The alternate dispute resolution process is not used.

The College must take steps to prevent sexual abuse from occurring. For example, the Patient Relations Committee of the College has developed a sexual abuse prevention plan that will implement training programs, and educate practitioners, employers of practitioners and the public about avoiding sexual abuse.

In addition, practitioners are required to make a report where the practitioner has reasonable grounds to believe that another health care practitioner has engaged in sexual abuse. The report is made to the Registrar of any health College where the other practitioner is registered. For example, if a patient tells a practitioner that her physiotherapist touched her sexually, the practitioner must make a written report

to the Registrar of the College of Physiotherapists of Ontario. This reporting obligation is discussed in more detail below, under the heading "Mandatory Reports".

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

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

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

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

- put a stop to them immediately; or
- transfer the care of the patient to another practitioner immediately; however, this does not necessarily mean that the denturist can initiate a romantic relationship with that patient immediately.

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

- Do not engage in any form of sexual behaviour or comments around a patient.
- Intervene when others, such as colleagues and other patients, initiate sexual behaviour or comments.
- Do not display sexually suggestive or offensive pictures or materials. Monitor the advertising posters, calendars and magazines used in the clinic.
- If a patient initiates sexual behaviour, respectfully but firmly discourage it.

- Monitor warning signs. For example, avoid the temptation to afford special treatment to certain patients, such as engaging in excessive telephone conversations or scheduling visits outside of office hours. Be cautious about connecting with patients on social media.
- Unless there is a very good reason for doing so, avoid meetings outside of the office.
- Do not date patients.
- Avoid self-disclosure.
- Avoid comments that might be misinterpreted (e.g., “You are looking good today”).
- Do not take a sexual history unless there is a good clinical reason for doing so. If one must take a sexual history (which would be rare but perhaps not inconceivable for denturists), explain why first and be very clinical in one’s approach.
- Do not touch a patient except when necessary for assessing or treating them. Before touching a patient, explain the nature of the touching first, the reason for the touching and be very clinical in one’s approach (e.g., wear gloves).
- Do not place instruments or materials on a patient’s chest.
- Be sensitive when offering physical assistance to patients who may not be mobile. Ask both whether and how best to help them before doing so.
- Avoid hugging and kissing patients.
- Be aware and mindful of cultural, religious, age, gender and other areas of differences. If in doubt ask if one’s proposed action is acceptable to the patient.
- Do not comment on a patient’s appearance or romantic life.
- Sufficiently document any clinical actions of a sexual nature and ensure that any incidents or misunderstandings are fully and immediately recorded.

Dating former patients is a sensitive issue. Amendments to the legislation in 2018 require a one-year cooling off period between the termination of the professional relationship and when a sexual relationship can begin. Otherwise it will still be sexual abuse. However, it can still be unprofessional where the practitioner still has power over the patient even after the one-a year period has elapsed. The length of the cooling off period, beyond the one year, will depend on the circumstances (e.g., how long the person was a patient, how intimate the professional relationship was).

Sexual Abuse Scenario No. 2

David, a denturist, is attracted to his patient of many years, Paula. David notices that he is looking forward to working on the days when Paula will be there. David extends the sessions a few minutes in order to chat informally with Paula. David thinks Paula might be interested as well by the way that she makes eye contact. David notices that he is touching Paula on the back and the arm more often. David decides to ask Paula to join him for a coffee after her next visit to discuss whether Paula is interested in him. If Paula is interested, he will transfer Paula's care to a colleague. If Paula is not interested then he will make the relationship purely professional. David decides to ask a colleague, Donna, for advice.

Donna, correctly, tells David that he has already engaged in sexual abuse by letting the attraction develop while continuing to treat Paula. Donna also says that it is important for David to transfer the care of Paula right away and not to get together for coffee.

Sample Quiz Question

Which of the following is sexual abuse:

i. Touching a patient's cheek to see how the denture is fitting.
ii. Using glamour shots of scantily dressed Hollywood stars as your interior design theme in order to attract younger patients.
iii. Telling an employee a sexual joke when there are no patients around.
iv. Dating a former patient after one year has passed.

The best answer is ii). These pictures sexualize the atmosphere at the clinic, which is inappropriate in a health care setting. Answer i) is not the best answer because suitable clinical touching (assuming this touching was indicated) is appropriate when it is needed to assess the patient and it is done professionally. Answer iii) is not the best answer because the sexual abuse rules only apply to patients. Sexual behaviour with employees may, however, constitute sexual harassment of an employee and may be both unprofessional under another definition of professional misconduct and a breach of the Human Rights Code, but it is not sexual abuse (unless the receptionist was also a patient). Answer iv) is not the best answer because the person is not a patient at the time of dating and for one year afterwards. However, it might still be unprofessional to date a former patient soon after they stop being a patient.

Professional boundaries are established to protect both practitioners and patients from inappropriate behaviour. A professional boundary is the point where the professional relationship has crossed over to another sort of relationship. Sexual abuse is a particularly serious example of boundary crossing.

Practitioners need to understand what kinds of conduct amount to sexual abuse, the harm that can result from such behaviour, the need to participate in the province-wide effort to eliminate sexual abuse and take reasonable measures to avoid even the perception of sexual abuse. A practitioner found to have engaged in sexual abuse will face serious consequences including, in some cases, revocation of their registration for at least five years.

d. ***Interprofessional collaboration***

It is in the best interest of patients if all of their health care practitioners work with each other. Members of different professions working together to serve the same patient is called interprofessional collaboration. Such collaboration would help ensure that treatments are coordinated and as effective as possible. Collaboration would also reduce the chances of there being conflicting or inconsistent treatment (e.g., a post being inserted by a dentist when the patient is already having partial dentures made). Collaboration could also reduce the chances of patients receiving inconsistent information and advice.

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

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

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

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

Where interprofessional collaboration involves working in a multi-disciplinary setting (i.e., in an oral health centre), other issues arise, including the following:

- Will the setting have shared records or will each practitioner have separate records?

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

This is one of the many areas covered in this Handbook in which a practitioner should consider consulting with their own lawyer before entering into practice at a multi-disciplinary setting.

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

Interprofessional Collaboration Scenario

David, a denturist, practises alone. His patient, Paula, also has a family dentist. Paula's family dentist calls unexpectedly to say that Paula is not accepting the dentist's recommendation for implants. The dentist has just learned that David is also treating Paula. The dentist wonders if anything that David is doing might interfere with Paula's decision. David remembers that he has hinted to Paula that, given her sensitivity to pain, Paula might not be a good candidate for implant surgery. What should David say?

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

e. Billing

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

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

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

- Indicate that the practitioner has provided the service when someone else did.
- Indicate the wrong date for the service. For example, it is unprofessional to put in a date when the patient had insurance coverage rather than the actual date of service because the patient would not have insurance coverage.
- Indicate that one service was performed when, in fact, another service was provided. For example, it is unprofessional to indicate that an adjustment was performed when in fact denture supplies were provided.
- Bill for services at more than the practitioner's usual rate because the service is being paid for by an insurance company.
- Indicate that a service was performed when, in fact, no service was performed. For example, it is unprofessional to indicate that a patient visit occurred when, in fact, the patient missed the appointment and a late cancellation fee is being billed.

No fee can be billed when no service was provided. The only exception is that a fee can be billed when a patient misses an appointment or cancels the appointment on very short notice. However, the patient, not the insurance company, must pay that fee.

Practitioners sometimes offer a reduction in the fees for service(s) if the account is paid at the outset of a treatment plan. With this approach, it is imperative that such a practice in no way results in disproportionate levels of treatment (i.e. better levels of service provided to those who pay their account in full at the beginning of treatment). Although this billing practice is not currently considered an act of professional misconduct, this may change in the future as opinions regarding this practice within the health regulatory community are shifting. A practitioner can charge interest in overdue accounts because there is an actual cost to practitioners in collecting them.

Billing Scenario

David, a denturist, has a posted rate of $1500 per denture in the reception area of his office. In fact, if the patient is paying for the service personally and does not have extended health insurance coverage, David will provide a credit reducing the rate to $1000 per denture. If a patient has special financial needs, David will consider reducing his rate even further; in fact he has three regular patients who pay only $500 per denture.

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

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

3. LAW

a. Types of law

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

- *Statutes.* Most often when one thinks of law, one thinks of statutes (also called Acts). There are overriding Acts, such as the *Canadian Charter of Rights and Freedoms*, that take priority over other statutes. The Acts that practitioners will need to be most aware of are the *Regulated Health Professions Act* and the *Denturism Act*. Statutes are made by the Legislative Assembly (in Ontario, the Legislative Assembly is often called Queen's Park).

- *Regulations.* Regulations are made by the government when a statute allows them to be made. Under the *Regulated Health Professions Act* regulations can be proposed by the College (e.g., registration, professional misconduct, quality assurance) or by the Minister of Health and Long-Term Care (e.g., controlled acts, professional corporations).

- *By-laws.* By-laws are made by the College. They mostly deal with the internal operations of the College. Some by-laws affect members (e.g., fees, professional liability insurance, information that must be provided by practitioners to the College, information that could be put on the public register, election of practitioners to the Council of the College).

- *Case Law.* Court decisions are used as a guide by lawyers and judges when similar issues arise in the future. Courts try to be consistent, so long as the result is not unfair. Court decisions are particularly important in guiding the procedure of College committees (e.g., investigations by the Inquiries, Complaints and Reports Committee, hearings by the Discipline Committee).

- *Guiding documents.* The College publishes official documents called Standards of Practice, Policies and Guidelines. These documents are not actually "law". However, they help practitioners and College committees understand and interpret the law. As such these documents can be very useful for practitioners to read and understand. These documents are sometimes called "soft law".

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

b. RHPA

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

i. Controlled acts and delegation

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

The fourteen controlled acts are as follows:

1. Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.
2. Performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.
3. Setting or casting a fracture of a bone or a dislocation of a joint.
4. Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust.
5. Administering a substance by injection or inhalation.
6. Putting an instrument, hand or finger,
    - i. beyond the external ear canal,
    - ii. beyond the point in the nasal passages where they normally narrow,
    - iii. beyond the larynx,
    - iv. beyond the opening of the urethra,
    - v. beyond the labia majora,
    - vi. beyond the anal verge, or
    - vii. into an artificial opening into the body.
7. Applying or ordering the application of a form of energy prescribed by the regulations under this Act.

8. Prescribing, dispensing, selling or compounding a drug as defined in the *Drug and Pharmacies Regulation Act*, or supervising the part of a pharmacy where such drugs are kept.

9. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.

10. Prescribing a hearing aid for a hearing impaired person.

11. Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or a device used inside the mouth to protect teeth from abnormal functioning.

12. Managing labour or conducting the delivery of a baby.

13. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response.

14. Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning.

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

1. Electricity for,

   i. aversive conditioning,
   ii. cardiac pacemaker therapy,
   iii. cardioversion,
   iv. defibrillation,
   v. electrocoagulation,
   vi. electroconvulsive shock therapy,
   vii. electromyography,
   viii. fulguration,
   ix. nerve conduction studies, or
   x. transcutaneous cardiac pacing.

2. Electromagnetism for magnetic resonance imaging.

3. Soundwaves for,

   i. diagnostic ultrasound, or
   ii. lithotripsy.

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

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

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

Unfortunately, this definition refers to a number of other provisions. Practitioners may need to do some research or ask for advice when dealing with a specific substance. A general rule is that if a substance has a DIN (drug identification number) it is usually considered to be a drug.[2]

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

[2] Some non-drug substances have different kinds of drug numberings, for example, a Natural Product Number (NPN) or Homeopathic Medicine Number (DIN-HM).

Controlled Acts Scenario No. 1

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

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

- ***Authorization.*** Being authorized to perform the controlled act by the health care practitioner's enabling statute. The *Denturism Act* authorizes practitioners to perform the controlled act of fitting and dispensing removal dentures. In addition, while not strictly being a controlled act, the *RHPA* prohibits anyone from designing, constructing, repairing or altering a dental prosthetic, restorative or orthodontic device unless the work is supervised by a dentist or dental technologist. There is an exception for denturists doing (or supervising) lab work for their own patients.

  The College has developed policies that help denturists understand procedures that are controlled acts. For example, College policies indicate that fitting and dispensing anti-bruxism devices to protect teeth from abnormal wear is a controlled act. In addition, performing oral cancer cytology tests could involve the controlled acts of performing a procedure below the mucous membrane and communication of a diagnosis.

- ***Exceptions.*** The *Regulated Health Professions Act* creates a number of exceptions permitting people to perform controlled acts in certain circumstances. These exceptions include the following:
  - Helping someone in an emergency.
  - While in formal training to become a member of a College authorized to perform the controlled act, as long as the act is performed under supervision or direction of a member of the profession.
  - Performing the controlled act under supervision.

  - Treatment by prayer or spiritual means pursuant to one's religion.
  - When done for a member of one's household. This applies only to communicating a diagnosis (e.g., telling one's child that they have a cold), administering a substance by injection or inhalation or entering a body opening when done for a member of one's household.
  - Helping a person with their routine activities of daily living where it includes administering a substance by injection or inhalation or entering a body opening (e.g., on a home visit helping a patient with their insulin injection).
  - Counselling a person (so long as the counselling does not amount to communicating a diagnosis).
  - Providing aboriginal healing within the aboriginal community.
- ***Exemptions.*** In addition to the exceptions listed in the *Regulated Health Professions Act*, the Minister of Health and Long-Term Care has provided a number of exemptions in a Minister's regulation. Most of those exemptions are limited in scope (e.g., dentists are permitted to apply electricity for electrocoagulation). A few of the exemptions apply to more people, including the following:
  - Anyone can perform cosmetic body piercings and tattooing.
  - Anyone can perform electrolysis.
  - Members of seven health Colleges can perform acupuncture under exemption.[3]
  - Anyone can perform male circumcision.
- ***Delegation.*** A health care practitioner who is allowed under their legislation to perform a controlled act can sometimes delegate the controlled act to others. For example, physicians often delegate procedures to nurses that are not allowed to do on their own. Delegation can be made to another health care provider or to an unregistered person. Delegation is subject to a number of rules, including the following:
  - The person giving the delegation is limited by any regulations or professional standards of their College. For example, the professional misconduct regulation of the College

[3] They are: chiropody, chiropractic, massage therapy, naturopathy, nursing, occupational therapy, physiotherapy and dentistry. There are members of other Colleges, such as physicians and traditional Chinese medicine and physicians, who can perform acupuncture under the authorization of their profession-specific Acts.

prohibits the delegation of the controlled act by practitioners except to a student of a denturism program or a graduate awaiting the registration examination.

- The person accepting a delegation is limited by any regulations or professional standards of their College (if the person is a member of a regulated College). For example, under the professional misconduct regulations, denturists are not currently permitted to receive the delegation of a controlled act by others.
- The person delegating the procedure is responsible for the actions of the person receiving the delegation. For example, if a practitioner delegated fitting and dispensing a denture to a student and the denture was unsuitable, the practitioner could be held accountable by both the College and the courts.

Controlled Acts Scenario No. 2

Donna, a denturist, performs acupuncture on her patient Paula. Acupuncture is a controlled act that is not authorized to denturists under the Denturism Act or the Minister's exemption regulation. Donna is not permitted to perform that controlled act.

Controlled Acts Scenario No. 3

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

Controlled Acts Scenario No. 4

Donna, a denturist, only works part time. Her other job is to perform artistic body piercings. Her professional training has improved her fine motor skills and comes in handy when performing this procedure. Even though such piercings go beyond the dermis, this procedure is exempted under the Minister's regulation on controlled acts when done for cosmetic purposes.

Controlled Acts Scenario No. 5

David, a denturist, works with a physician. David was a physician in his country of birth. Because of David's experience with medicine and his ability to speak Mandarin, the physician trusts David to perform Vitamin B injections of the physician's Mandarin-speaking patients in two long-term care facilities. The physician delegates intra-muscular injections of Vitamin B to these patients. David is not authorized by the delegation to perform these injections because the professional misconduct regulation does not currently permit denturists to receive delegation.

Sample Quiz Question

A denturist performing a home visit finds a patient recovering from a fall. The patient has a number of wounds. Which of the following is a controlled act:

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

iv. Wrapping the patient's wounds.

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

ii. Scope of practice

Each regulated health profession has a scope of practice statement in its statute. However, because the *Regulated Health Professions Act* uses controlled acts to protect the public from potentially dangerous health procedures, no profession has an exclusive scope of practice. Members of other professions can do the same things that practitioners can do. There are two exceptions:

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

Risk of Harm Provision

The risk of harm provision in the *RHPA* prohibits a person from treating or advising a person "with respect to their 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"[4]. This provision is designed to prevent individuals from taking advantage of vulnerable patients, even if they do not do a controlled act. For example, encouraging a cancer patient to try diet as the only means of treatment might fall within this risk of harm provision.

However, the risk of harm provision does not apply to practitioners practising within their scope of practice. Thus it is not an offence for a practitioner to provide treatment within the scope of practice of denturism even if there is a risk to the treatment. If the treatment is not performed competently, the

[4] Section 30 of the *Regulated Health Professions Act.*

practitioner is not committing an offence, but rather is accountable to the College for their conduct. However, if a practitioner provides treatment outside of the scope of practice of the profession, the risk of harm provision does apply. For example, if a denturist treats a patient's cancer by using procedures associated with physicians and which are not part of the scope of practice of denturist, then the denturist could face prosecution under the risk of harm provision.

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

Scope of Practice Statement

A profession's "scope of practice" is a description of what that profession does.

Under the *Denturism Act*, the scope of practice statement reads as follows:

> 4. The practice of denturism is the assessment of arches missing some or all teeth and the design, construction, repair, alteration, ordering and fitting of removable dentures.

While fairly broadly worded, this scope of practice statement does not suggest that a practitioner can provide treatments that are outside of the usual practices of denturists. For example, any form of surgery is not included in this scope of practice.

Practitioners are allowed to perform procedures outside of their scope of practice so long as they are not dangerous. For example, providing mouth guards to patients who play sports would often be permissible. However, patients need to know whether or not a practitioner is acting as a denturist. A practitioner providing mouth guards to patients should tell the patient that this is not part of the practise of denturism. In fact, to ensure that a patient is not misled, separate appointments, records and billings should be made.

Scope of Practice Scenario

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

In this case, Donna appears to have provided treatment that is outside of the scope of practice for denturists. The treatment also appears to have no evidence to support Donna's claims. There was an inherent risk of harm in advising the patient to reject the proposed medical treatment that had evidence of a reasonable chance of recovery.

iii. Use of titles

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

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

The second rule is that each profession-specific Act regulates the use of titles relating to their profession. Each profession has specific titles that only persons registered with their College can use as a professional title. For example, only members of the College can use the title "denturist" or any variation of that title. In addition, no one, not even members of the College, can use the title "denture therapist". Finally, even if the person does not use the protected title, they cannot hold themselves out as a practitioner. This prevents people from pretending that they are denturists when they are not.

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

The third set of rules is created by each College for its members in the professional misconduct regulation. For example, it is professional misconduct to use a term, title or designation other than one authorized by the Act or the regulations. The term "denturist" is the protected title for members of the College. It would also be professional misconduct to use a false or misleading title or designation. For example, since the profession does not have recognized specialties, practitioners cannot use titles or designations inferring specialist status or certification (e.g., paediatrician, gerontologist). However, practitioners are free to describe their areas of practice so long as it does not imply specialist status or certification (e.g., practice limited to partial dentures).

Finally there is a specific regulation on the use of clinic names to prevent misleading the public. The relevant portion of the regulation reads as follows:

2. (1) A member shall not use a name or title other than their name as set out in the register in the course of providing or offering to provide denturist services, unless the name or title,

(a) reasonably refers to and describes the location of the practice;
(b) has been approved by the Executive Committee; and
(c) is accompanied by the name of the member, as set out in the register.

(2) When a member practises denturism in association or in partnership with one or more other members and uses a name or title approved under subsection (1), the member shall notify the College within thirty days of a change in the association or partnership.

Use of Titles Scenario

David, a denturist, teaches at a school that trains denturists. The school has a clinic where it sees patients. David supervises the students at the clinic. The students refer to him as "Doctor David" at the clinic. The Dean of the school pulls David aside and tells him to ask his students to stop calling him "Doctor" in the clinic where there are patients. It is OK in the classroom, but not the clinic. David reviews the Regulated Health Professions Act and realizes that the Dean is correct. David is assisting in the treatment of patients there and thus is not permitted to call himself (or allow others to call him) "Doctor" there. David also recognizes that he was being a poor model for the students.

iv. Mandatory reports

Part of being a member of a regulated health profession is that one cannot remain silent when another health care provider is harming a patient. A practitioner must speak up in those circumstances. In other words, making a report is mandatory. The *Regulated Health Professions Act* carefully balances the need to protect patients by requiring practitioners to make a report against the need to avoid disrupting the health care system with many unnecessary reports. The statute also recognizes that if practitioners unnecessarily report on their colleagues, it will harm the supportive atmosphere necessary for interprofessional collaboration. This section of the Handbook describes the mandatory reporting duties of the *Regulated Health Professions Act*. There are some mandatory reporting provisions in other Acts (e.g., the *Child and Family Services Act,* the *Personal Health Information Protection Act*). The most common mandatory reporting duties in other Acts are discussed below.

Both the *Regulated Health Professions Act* and case law provide immunity (i.e., legal protection) to practitioners who make a mandatory report in good faith. For example, they cannot be successfully sued for damages (i.e., money). Retaliation against people making mandatory reports is prohibited and any such retaliation would likely constitute professional misconduct.

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

Sexual Abuse Reports

A practitioner must report sexual abuse of a patient by another health care provider. The duty arises where:

- the practitioner has reasonable grounds to believe the sexual abuse occurred and
- the practitioner learned this information in the course of practising the profession or while operating a health facility (which probably includes an office or clinic).

Reasonable grounds could arise even if the practitioner did not personally observe the sexual abuse. For example, if a patient tells the practitioner details of the abuse, that would likely constitute reasonable grounds. A practitioner does not have to investigate the events first to see if it is true. Nor does the practitioner have to actually believe that the information is true (e.g., the practitioner might know the alleged abuser and cannot believe that they would do such a thing). If the information constitutes reasonable grounds, the report must be made. Reasonable grounds means information that would cause a reasonable person who does not know the individual involved to conclude that it is more likely than not that the information is correct.

The report must be made in writing to the Registrar of the College to whom the alleged sexual abuser belongs. The report has to contain the reporting practitioner's name and the grounds of the report. ***However, the report cannot contain the patient's name unless the patient agrees in writing that the name can be included.*** This limitation is intended to protect the privacy of patients who may be in a vulnerable position. The report must be made within 30 days of receiving the information. If it appears that patients are continuing to be harmed and there is an urgent need for intervention, the report must be made right away.

Sexual Abuse Mandatory Report Scenario

Donna, a denturist, is told by Paula, a patient, that she had an affair with her family doctor. Donna asks Paula if her family doctor was treating her while the affair was ongoing. Paula says yes. Donna tells Paula that she is required by law to report this information to the Registrar of the College of Physicians and Surgeons of Ontario (CPSO). Donna explains that the CPSO will want to investigate the report. It will be very difficult for the CPSO to investigate the report if Paula's name and contact information is not included in the report. The CPSO will likely want to interview Paula about the affair. The investigation could lead to a discipline hearing. However, the law is clear that Donna cannot include Paula's name and contact information unless Paula is prepared to sign a written consent permitting Donna to do so. Donna says that they can call the CPSO now, on an anonymous basis, to see what the process would be like. Paula agrees to the telephone call. After the call is completed Paula says that she will not give her consent to include her name and contact information. Donna then provides the report in writing without identifying Paula.

Incompetence, Incapacity and Professional Misconduct Reports

A practitioner must report if they end a business relationship with another health care provider on the basis that the other health care provider is incompetent or incapacitated or engaged in professional misconduct. Examples of business relationships include employer- employee, partners, shareholders in a professional corporation or space sharing arrangements. The report must be made even if the person quits or resigns first if there are reasonable grounds to believe that the departure or resignation reasonably relates to the person's professional misconduct, incompetence or incapacity. A report must also be made where the person resigns or quites or during an investigation into such concerns.

The report must be made in writing to the Registrar of the College that regulates the other health care provider. The report must be made within 30 days of ending (or proposing to end) the business relationship. Under this mandatory reporting obligation the name of the patient can be included without the patient's consent.

In addition, if a practitioner operates a health facility (which probably includes an office or clinic), the practitioner must report any reasonable grounds to believe that another health care provider is incompetent or incapacitated.[5] This report must be made even if the business relationship with the other health care provider is not ended. For example, if a health care provider at the facility is found to have a drug addiction and goes into a treatment program while the job is kept for him or her, the report would still have to be made.

Again, the report must be made in writing to the Registrar of the College to whom the alleged incompetent or incapacitated health care provider belongs. The report has to contain the reporting practitioner's name and the grounds of the report. Under this mandatory reporting obligation, the name of the patient can be included without the patient's consent, so long as it is not involving sexual abuse. The report must be made within 30 days of receiving the information. If it appears that patients are continuing to be harmed, the report must be made right away.

Incompetence, Incapacity and Professional Misconduct Mandatory Report Scenario

David, a denturist, learns that his employer (another denturist) abuses alcohol. David tries to help his employer get treatment, but the employer keeps relapsing. Just yesterday the employer returned from lunch totally impaired and David had to call his employer's spouse to pick him up and take him home. David had to cover his employer's patients. What scared David the most was that his employer treated three patients after lunch before David found out about his condition. David is preparing his letter of resignation. He consults a lawyer about what to do. David's lawyer advises him that David must make a written report to the Registrar of the College of David's employer.

Offences – Self Report

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

[5] This duty to report, unlike the termination reports discussed above, does not apply if the person just committed professional misconduct but is not incompetent or incapable (e.g., the health care practitioner published a misleading advertisement).

Practitioners are also required to report any bail conditions or other restrictions imposed on or agreed to by them. For example, if the terms of release for the charge require the member to only see patients under supervision, that must be reported.

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

- the name of the practitioner filing the report;
- the nature of and a description of the offence;
- the date the practitioner was found guilty of the offence;
- any bail conditions or other restrictions imposed on or agreed to
- the name and location of the court where the charges were laid or that found the practitioner guilty of the offence; and
- the status of any appeal initiated respecting the finding of guilt.

The report will be reviewed by the College and may result in an investigation. Also, the Registrar is required to put relevant offence charges and findings on the public register (see the discussion of the register below).

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

Offence Mandatory Report Scenario

Donna, a denturist, is found guilty of failing to wear a seatbelt under the Highway Traffic Act. Six months later, on the College's annual renewal form she sees a question asking if she has been found guilty of any offence. She cannot believe that this question is meant to include her seatbelt charge. She calls the College for clarification. She is told that the *Regulated Health Professions Act* requires all offences to be reported. The intent of requiring such reports is to prevent practitioners from deciding whether the findings are relevant or not. The Act wants that decision to be made by the College. In fact, Donna should have reported the charges at the time they were laid and the finding when it occurred and not waited six months for the annual renewal form. Donna makes the report. A few weeks later she receives a letter from the College thanking her for her report, stating that the College does not believe that this finding is worth investigating further and reminding her that in the future such findings need to be reported right away.

Professional Negligence – Self-Report

Practitioners have to report themselves when they have been sued and found to have engaged in professional negligence or malpractice. Findings of professional negligence or malpractice are only made by the courts. Thus any findings by a tribunal do not have to be reported under this provision. If a lawsuit is settled, it does not have to be reported unless the settlement involved a court finding.

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

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

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

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

Professional Negligence Mandatory Report Scenario

David, a denturist, is sued in Small Claims Court by a patient, Paul. Paul claims that he told David about pain in his jaw but that David attributed those symptoms to stress. Two years later, with increasing pain, Paul went to the emergency department. Paul was referred to surgery for TMJ arthritis. Paul claims David should have referred him to another health care provider to rule out TMJ impairment before assuming the symptoms were purely stress related. The Small Claims Court judge agreed and ordered David to pay Paul $10,000 for the pain and suffering caused by this malpractice. David reported the finding to the College. The College placed a note about the finding on the public register.

Duty to Warn

Under case law, a practitioner who has reasonable grounds to believe that another person is likely going to cause severe bodily harm to themselves or someone else has to warn the appropriate people of the risk. This duty applies even if the person who will likely cause the harm is the patient of the practitioner. For example, if a patient threatens to kill someone and has the means to do so (e.g., is believed to have a gun), the practitioner should advise the police and, where feasible, the subject of the threat.

Duty to Warn Mandatory Report Scenario

Donna, a denturist, learns from Paula, a patient, that another practitioner, David, strongly recommended that Paula undergo a month-long cleanse. The cleanse involved no food and drinking only lemon juice and water. Paula is in her fifties and is underweight. Paula says that at least two other patients of David had been given similar advice. Donna is concerned that such a cleanse is not safe for many people and certainly not for someone like Paula. Donna is also concerned that David is acting outside of his scope of practice in a dangerous way. Donna makes a report to the Registrar of the College.

Sample Quiz Question

Is a mandatory report required where a practitioner overheard another practitioner telling two male patients a sexually explicit joke that causes the patients to laugh loudly?

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

The best answer is iv). Sexual abuse includes comments of a sexual nature to a patient. Reporting sexual abuse is mandatory. While it is unlikely that punitive action will be taken by the College (perhaps the joke-telling practitioner will receive a caution or be asked to complete a sensitivity course), it is still important that practitioners learn that such conduct can be harmful to some patients. One never knows what experiences patients have had in their past that might make such a dirty joke harmful. Answer i) is incorrect because dirty jokes are sexual abuse as that term is defined in the Regulated Health Professions Act. Answer ii) is not the best answer because there are no mandatory reporting requirements under the Human Rights Code. Also, the Regulated Health Professions Act uses the term sexual abuse rather than sexual harassment and gives that term a much different meaning. Answer iii) is not the best answer because whether the patient was a willing participant or not is irrelevant. The comment still should not have been made. Also, one never knows what experiences patients have had in their past that might make such a dirty joke harmful. In addition, sexualizing the practice of the profession is inherently confusing to patients who assume that there is no sexual aspect to their relationship with practitioners.

v. Public register

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

The register must contain the following information about each practitioner:

- Name
- Business address and telephone number
- Name and business address and telephone number of each professional corporation
- Class of registration
- Any terms, conditions and limitations on the registration
- Referrals to the Discipline Committee for a discipline hearing
- Discipline hearings, inspections and their outcomes
- Oral Cautions and SCERPs (specified continuing education or remediation)
- A summary of every finding of professional misconduct, incompetence or incapacity
- Findings by a court of professional negligence
- Findings of guilt, undertakings and bail conditions
- Every suspension of registration for any regulated profession
- Every revocation of registration for any regulated profession
- Applications for and decisions surrounding reinstatement and
- Any agreement to resign and never reapply for registration.

The College's by-laws provide that additional information must also be placed on the public register such as the name of a practitioner's educational institution and full details of pending discipline hearings. Additional information placed on the public register includes:

- Details of a practitioner's registration with other regulators; and
- Information agreed to be placed on the public register by the practitioner.

These by-laws are constantly changing as society's expectations about what information should be available to the public evolve. So practitioners need to carefully read notices from the College about new information being added to the public register.

There are only a few circumstances where the College can choose not to put this information on the register or to remove information from the register. However, the College can choose not to make the following information public:

- The information (e.g., contact information) would jeopardize the safety of a practitioner (e.g., if a practitioner is being stalked).

- The information is obsolete or no longer relevant (e.g., the finding of professional misconduct related to conduct that is now acceptable, for example if a practitioner was prosecuted for fee advertising but the advertising rules have since changed).

- Unnecessary information about the personal health of a practitioner (e.g., in incapacity matters).

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

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

Public Register Scenario

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

vi. Professional corporations

Practitioners can choose to practise personally (i.e., in their own names), through a partnership or through a professional corporation (i.e., a special type of corporation for regulated professionals). Practitioners cannot practise through regular business corporations; they can only practise through a professional corporation.

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

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

Practitioners cannot avoid professional liability through a professional corporation. Patients who are injured can sue the practitioner personally. However, practitioners working through a professional corporation do have protection against trade creditors. For example, if suppliers or other creditors are not paid by the professional corporation, they cannot sue the practitioner personally.

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

- the *RHPA* applies to practitioners despite their practising through a professional corporation;
- a practitioner's fiduciary (i.e., loyalty and good faith) and ethical obligations to patients remain in place and now apply equally to the professional corporation as well;
- during investigations and other proceedings involving practitioners, the College has the same powers over the professional corporation (e.g., access to premises and documents) as it does over the practitioner;
- any monetary orders against practitioners are also payable by the professional corporation;

- any duty to a patient, the public or the College takes precedence over the duties of the practitioner as an officer or director of the professional corporation;
- any terms, conditions and limitations against a practitioner apply to the professional corporation as well; and
- any knowingly false representation made to obtain a certificate of authorization is an offence.

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

- Select a name for the professional corporation. Ministry regulations require that the name must contain the surname of at least one shareholder (as set out in the College register). The name can also include the person’s given name and initials. The name of the corporation must also indicate the name of the practitioner’s health profession (i.e., “denturist”). The name must also include the words “professional corporation”. The name cannot include anything else.
- The professional corporation must then be incorporated with the government. This involves preparing articles of incorporation, corporate by-laws, paying a fee and submitting an application form with the government. If the paperwork is acceptable, the government will issue a corporation profile report and a certificate of incorporation.
- Within 30 days of obtaining one’s corporation profile report, the professional corporation must apply to the College for a certificate of authorization. Such an application will require the following:
    - Completing the application form that can be obtained from the College. The application form will require the name, registration numbers and addresses of each shareholder. The application form will require the applicants to specify which shareholders hold which positions with the corporation. The business premises or practice locations of the corporation will have to be identified.
    - Paying the fee required by the College in its by-laws.
    - Enclosing a copy of the corporation profile report issued by the Ministry that is no more than 30 days old.
    - Enclosing a copy of the certificate of incorporation issued by the government.

- Providing a written declaration from a director of the corporation that was completed not more than 15 days before the application date that certifies the accuracy of the documents submitted with the application and that the corporation will only practise the profession or related or ancillary activities.

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

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

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

Professional Corporation Scenario

Donna, a denturist, wants to set up a professional corporation. She practises in an office that includes registered massage therapists. She asks the massage therapists if they want to become shareholders of her professional corporation. They say yes. Donna also wants family members to be non-voting shareholders so she can split her income for tax purposes. She goes to her lawyer who says that only registered denturists can be shareholders, officers or directors of the professional corporation. Even non-voting shareholders must be registered with the College.

c. *Denturism Act, regulations, by-laws and standards*

The *Denturism Act* is the profession-specific statute of the College of Denturists of Ontario. As mentioned before, the *Denturism Act* works together with the *Regulated Health Professions Act* so that they can be treated as if they were one Act. Together, these Acts authorize the College to develop regulations and by-laws to regulate the profession.

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

i. Registration regulation

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

There are certain registration requirements that are non-exemptible; applicants have to meet them. They include successful completion of a three-year acceptable denturist educational program, successful completion of the qualifying examination and having immigration status in Canada. In addition, there are a number of other requirements that can be exempted in appropriate cases including completing the application form, paying appropriate fees, demonstrating good character, having reasonable fluency in English or French.

Once registered, there are a number of ongoing requirements including disclosing offence findings or findings of professional misconduct, incompetence or incapacity, demonstrating current knowledge, skill and judgment, paying annual fees and providing the College with all required information.

Denturists practising under regulation in other Canadian jurisdictions do not have to demonstrate their qualifications. Those are assumed to exist. Non-competency requirements such as good character still have to be demonstrated.

At the time of writing, amendments to the registration regulation are pending. For example, the new regulations would create additional classes of registration for inactive, and temporary (e.g., someone coming in from another province to teach a course).

The College has published a number of policies to assist applicants for registration and their employers know how to meet the registration requirements.

It is the responsibility of all applicants for registration to have read and comply with the expectations set out in the College’s registration policies located on the College’s website.

Registration Regulation Scenario

Upeksha graduated as a dentist in Asia. She applies to be registered with the College as a denturist. The Registration Committee assesses her education and finds that it is not substantially equivalent to what a denturist learns in a denturist program in Canada. The Registration Committee identifies a number of competencies that Upeksha is missing. Upeksha approaches a denturist program in Ontario which gives her advanced standing so that she can obtain her diploma in a significantly reduced time. Upeksha then obtains registration with the College.

ii. Misconduct regulation

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

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

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

Standards of Practice

The professional misconduct regulation makes failing to meet the standard of practice of the profession professional misconduct. Usually, this relates to the assessment and treatment of patients by the practitioner. The standards of practice may be written, or unwritten. Standards of practice reflect a shared understanding of the profession and how it should be practised effectively and safely. This is based on what would be reasonably expected of the ordinary competent practitioner in their type of practice. Expert witnesses are often used to describe a standard of practice and how it applies.

One specific standard of practice in the professional misconduct regulation is that a practitioner must refer a patient to another health care provider where the patient has a condition that is beyond the knowledge, skills and judgment of the practitioner. For example, if a patient had symptoms that suggested the patient has a cavity or an oral lesion, the practitioner should not try to handle this alone. A referral to a dentist would be required.

Inappropriate Behaviour towards Patients or the Public

Many provisions in professional misconduct regulation relate to inappropriate behaviour towards patients or the public. For example, in addition to sexual abuse, physical or verbal abuse of patients is professional misconduct. This includes rude behaviour towards patients, members of the public or other health professionals. Similarly a denturist must not abandon a patient. If the relationship has to be ended for a valid reason (e.g., a breakdown of communication), then the denturist must give notice to the patient and provide an opportunity for the patient to find a new denturist. Similarly, denturists have to fulfil their agreement with patients.

Record Keeping

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

Informed Consent

Informed consent has been discussed in more detail above in the section on communication, and is also mentioned in regards to record keeping.

Controlled Acts, Delegation and Supervision

Delegation of controlled acts is discussed in detail above. To delegate a controlled act means to allow another person to perform a controlled act on one's behalf. The professional misconduct regulation says that members should not delegate a controlled act except to a student or a graduate registered to take the qualifying examination. The College has published a policy on the Supervision of Students or Examination Candidates which sets out the expectations on denturists supervising such as obtaining the informed consent of the patient.

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

Confidentiality

Practitioners must keep all patient information confidential. Failing to maintain confidentiality can be considered professional misconduct. There may be exceptions depending on the circumstances to this duty of confidentiality. For example, patients can consent to the practitioner disclosing information. Also, where a practitioner is required (e.g., by a court summons) or permitted (e.g., when selling one's practice) by law to disclose patient information, it can then be disclosed. The concept of confidentiality is discussed further in the section below on the *Personal Health Information Protection Act.*

Conflict of Interest

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

Improper Billing and Fees

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

Misrepresentation

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

Improper Use of Names, Titles or Descriptions

A particular form of misrepresentation is to use an improper name, title or description. This is intended to ensure consistent, appropriate and clear use of titles that help the public know with whom they are dealing and to prevent confusion. Also, members of the College cannot use a term, title or designation indicating or implying that they have a specialization in an area or areas of practice (e.g., saying they are a gerontologist). Also, practising the profession under a name that is not registered with the College may be considered professional misconduct (e.g., if a practitioner uses a nickname when practising, the College must be told of that nickname first).

Improper Advertising

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

Conduct towards Colleagues

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

another health care provider, the practitioner must not make insulting comments about the other health care provider to the patient.

Conduct towards the College

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

- Publicly challenging the integrity of the College's role or actions;
- Breaching an undertaking given to the College;
- Failing to cooperate in, or obstructing, an investigation by the College;
- Failing to participate in the quality assurance program;
- Failing to comply with an order or direction of a Committee of the College (e.g., ICRC, Discipline Committee, QA Committee or Registration Committee); and
- Failing to respond appropriately and promptly to correspondence from the College.

Disregarding Restrictions on Certificate of Registration

A practitioner must confine their practice to what is legally permissible. If the Act or a committee of the College restricts a practitioner in certain areas, it would be professional misconduct to exceed those restrictions. For example, a practitioner who is limited by the Registration Committee to only provide complete dentures cannot offer partial dentures. It is also professional misconduct to practise while suspended.

General 'Catch-all' Provisions

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

Professional Misconduct Regulation Scenario

Donna, a denturist, has recently been criticized by her colleague, Wendy, who works in the same practice as her, that sometimes Donna is too loud with her patients. Wendy mentions that in speaking loudly she is disrupting other practitioners in the office. Donna tells Wendy that she is sorry for disrupting her and any of her patients, and that she will try to keep her voice down or lower it out of respect for the rest of the practice. But Wendy feels this is a serious problem, and that she should report Donna to the College for professional misconduct. Wendy wants the very best atmosphere created for her patients, and thinks loud talking is completely unprofessional.

Is Wendy correct in saying this would be professional misconduct according to the regulations? Probably not. Wendy holds a particular view about Donna's level of voice that may not be consistent with the rest of the profession. Unless the conduct persists and unless it is so loud that most neutral observers would agree that Donna is disrupting the rest of the office, it is not professional misconduct. While it is courteous for Wendy to raise the issue with Donna so that they can come to a reasonable resolution, professional misconduct is not meant to apply to uniquely personal views of unacceptable behaviour. Instead, it is intended to be based on conduct that is considered unacceptable by a general consensus of the profession.

Sample Quiz Question

Which of the following situations is/are possible professional misconduct according to the professional misconduct regulation?

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

The best answer is iv). The regulation describes many types of professional misconduct. All of the situations described involve conduct that is specifically prohibited in the Professional Misconduct Regulation. Answer i), ii) and iii) are not the best answers because all of the situations listed in the question are clear examples of professional misconduct.

iii. Record-keeping

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

The record keeping expectations apply to multi-media data (pictures of the patient, images of patient's teeth or oral cavity, patient's dentures, email messages, or other digital images or recordings) in the same way as they do to as paper notes.

The College has a Standard of Practice: Record Keeping that deals with matters such as:

- The information that must be recorded;
- The form in which records can be kept (e.g., written, computerized);
- How long the information must be kept;
- Maintaining or transferring records upon leaving a practice or retiring;
- Confidentiality and privacy issues; and
- Patient access to records.

The College's Standard of Practice: Record Keeping deals with the following kinds of records that need to be kept:

- Daily appointment record;
- Health record; and
- Financial records.

<u>The information that must be recorded</u>

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

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

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

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

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

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

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

<u>The form in which records can be kept</u>

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

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

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

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

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

<u>How long the information must be maintained</u>

The practitioner (or health information custodian for whom the practitioner works) needs to keep the record for seven years from the last interaction with the patient.

The rule regarding keeping records for seven years includes financial records, appointment and attendance records.

<u>Maintaining or transferring records upon leaving a practice or retiring</u>

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

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

However, if the patient has just been referred to another health care professional and the patient record has not been transferred, then the retention period of the entire original record (i.e., seven years from the last interaction with the patient) is still mandatory.

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

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

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

Confidentiality and privacy issues

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

Patient access to records

Generally, a patient has the right to review and receive a copy of all clinical records kept by a practitioner unless access would significantly jeopardize the health or safety of a person[6]. Although the practitioner may own the health care record and be responsible for it, patients are authorized by *PHIPA* to access the record. The information in the record really belongs to the patient. Also, the patient has the right to correct any errors in the health record. If a patient requests any relevant parts of the record, the practitioner should provide them with a copy and not the original. This topic is discussed later in the section on the *Personal Health Information Protection Act (PHIPA)* below.

[6] Health and safety concerns in disclosing a denturist record are rare. An example might be if the spouse of a patient were to disclose to a denturist that they were afraid of the patient's anger when the patient drank. Disclosure of that information could put the spouse at risk.

Record Keeping Scenario

David, a denturist, has been practising for 45 years in the same practice, and has built up a busy and successful practice. He decides he is ready for retirement but wonders what he is supposed to do with his patient records. Does he have to retain them himself? Ordinarily he would have to retain patient records for seven years from the last interaction with the patient. But in this case David may be selling his practice to another practitioner to take over the business and patients. If this is the case, he does not have to retain the records himself, but needs to notify the patients of the transfer of their patient records. This can be done through a combination of telling patients on their next visit, sending out letters and placing a notice in the local newspaper. All three of these strategies should be followed unless every patient has been reached in person and by letter.

Sample Quiz Question

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

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

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

iv. Conflicts of interest

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

There is no need for proof of an actual conflict of interest because this would require knowing what the practitioner was thinking (to know if the practitioner was influenced by the conflicting interest). Instead, one looks to what a reasonable person would conclude from the circumstances. A conflict of interest can be actual, potential or perceived. In that way, the conflict of interest rules are intended to prevent concerns from arising.

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

Some common examples of conflicts of interest are as follows:

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

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

Some conflicts of interest are prohibited outright. But, there are certain circumstances where safeguards could remove the concern. For example, referring a patient to a tooth-whitening business owned by the denturist's spouse would not raise concerns if the practitioner did the following:

- Disclose the nature of the relationship with the business (e.g., "my spouse owns the business");
- Provide alternative options (e.g., "here are three other places you could get this service"); and
- Reassure the patient that choosing another business will not affect the patient's care (e.g., "You are free to choose any of the places to get the service; you will still be welcome here as my patient").

Practitioners must provide the College with any documents, explanations or information regarding a suspected conflict of interest if requested. This helps the College to know whether a conflict of interest is a concern. Take the example of where the College receives information that a practitioner is making unusual payments to a nursing home that refers patients to the practitioner. The College could ask for an explanation of those payments, and any financial records related. This information would help the College decide whether there is a conflict of interest.

Conflict of Interest Scenario No. 1

Donna, a denturist, owns a practice down the street from a retirement home. She has been practising there for less than a year. She is trying to build her practice and wants people to know she is new to the neighbourhood. Donna offers to give the Administrator of the retirement home a free cruise to the Mediterranean in return for having him and his staff refer patients to her practice. The Administrator of the retirement home thinks this is a great idea and offers Donna a free large screen television if Donna also refers patients to his retirement home. While this may seem like a good business decision, Donna is in a conflict of interest for two reasons. Donna cannot give a free trip to the Administrator of the retirement home in order to get referrals as this would constitute a collateral (or side) benefit. Patients should be referred to Donna because they need her services and not because the referring person is getting a free cruise. Further, Donna cannot accept a free television as this would conflict with her duty to refer patients to a retirement home only if she honestly believed that this would be in their best interest. The referrals should be based on professional judgment and not on any 'kickbacks' she may receive.

Conflict of Interest Scenario No. 2

David is a denturist who has a busy and successful practice. Recently, he began using a new acrylic tooth that he has noticed appears quite natural for his patients. They are quite realistic. He calls the company to tell them his feedback from his patients and that he likes using the product and to order more of them. The company asks him if he would like to be in a new advertising campaign they are going to put into some magazines aimed at retired people. David would repeat what he has just said so that the company could promote the teeth. The company plans to put a picture of David in the advertisement and identify him by name and title. The company cannot pay David because they are still a new company, and don't have the budget for it. David thinks, why not? He likes the product and, since he is not getting paid, he is not inappropriately benefiting from the relationship.

Unfortunately for David, this would still likely be a conflict of interest and would be professional misconduct. Denturists cannot use their professional status to promote products commercially, even if they are not being paid. David can still benefit from the advertisement in some indirect manner (for example, he may have more patients from those who see the advertisement). Also, without making any observations or assessments of an individual, the denturists should not be making any sort of clinical recommendations. David can give advice on products and remedies, including choosing what type of tooth to use, provided that it is based on professional judgment regarding a patient's individual needs through proper assessment.

v. Advertising

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

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

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

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

In particular, references to qualifications in the advertisement should follow the College's rules. For example, the title the member can use will be the one approved by the College. No practitioner can use the title of Doctor.

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

Further, advertisements are not permitted if they:

- promote a demand for any unnecessary services;
- make a claim or promise a result that cannot always be delivered (or be interpreted as a guarantee as to the success of a service provided);

- use comparative (e.g., “better”) words, superlatives (e.g., “best”), have a suggestion of uniqueness, or appeals to a person’s fears (e.g., comparing one’s services to another’s, or claiming that one’s service is superior to others, is not verifiable); and
- contain testimonials from a patient, former patient, or other person about the practitioner.

Advertising should also not involve pressuring vulnerable patients. Calling people by telephone or sending them an email to ask them to become your patients is called “solicitation” and is unprofessional. However, it is acceptable to remind existing patients of appointments, new developments or changes in the office.

Advertising Scenario

Donna is a denturist. She wants to let other people know how cosmetically appealing her dentures are, so that patients can choose to come to her for them. Donna also wants other health care providers to refer patients to her. Donna, with the consent of a few of her patients, takes some before and after pictures and publishes them in the local paper. Donna feels that people can then decide for themselves based on the pictures if they want to try her services. Unfortunately, in doing so Donna has violated the advertising rules. Before and after pictures are inherently misleading as they cannot be verified. Also, before and after pictures may be seen as raising expectations that will not always happen.

Sample Quiz Question

Advertising needs to be:

i. Accurate.
ii. Verifiable.
iii. Without any personal opinions.
iv. All of the above.

The best answer is iv). All of those things are required in advertising. Advertisements should also be factual, objective, comprehensible and appropriate. Answer i) is not the best answer because all of the things listed in the question are fine. Answer ii) is not the best answer because all of the things listed in the question are fine. Answer iii) is not the best answer because all of the things listed in the question are fine.

d. The College

The College does a number of things in order to protect the public. Under its Act, the College has to have various committees and operate various programs. The following are some of the most important things the College does when regulating the profession.

i. Registration process

As mentioned above, registration is the way for a person to enter into the profession and become a member of the College. Applicants must meet the requirements set out in the registration regulation. The process of registration itself is described in the Act.

To become registered as a member of the College, a person files an application form with the Registrar and pays the applicable fees. The form is available on the College's website. On the application form, the applicant provides the College with information about their training and experience, their past conduct, and other information (e.g., language skills, professional liability insurance, current experience, etc.). The applicant should provide enough information to demonstrate that they meet the requirements for registration. The applicant must not make any false statements on the application.

Where the applicant meets the requirements, the Registrar's office will simply approve the application. Then a certificate of registration is sent to the new member of the College.

However, if it looks like the applicant does not meet the registration requirements (or even if the Registrar is not sure) the Registrar will send the application to the Registration Committee. The applicant will be told of the concern and will be given an opportunity to provide a written statement. The Registration Committee will consider the information and decide. If the Registration Committee decides that the applicant meets the requirements, a certificate of registration will be issued. If the Registration Committee decides that the applicant does not meet the requirements, it can do one of the following:

1. Tell the applicant to complete further training or examinations;
2. Register the applicant with terms, conditions and limitations (where the requirement is not necessary and the public can be protected in another way); or
3. Refuse the application.

If registration is not given by the Registration Committee, the applicant has some choices. The applicant may appeal the decision to the Health Professions Appeal and Review Board ("HPARB"). HPARB is appointed by the government and is independent of the College. HPARB will review the information. HPARB can decide that the applicant meets the registration requirements, require the Registration Committee to get more information and make a new decision, or approve the decision of the Registration Committee. HPARB's decision can be appealed to the courts.

To ensure that a College's registration process is fair, it is reviewed by the Office of the Fairness Commissioner of Ontario. The Act requires the registration process of Colleges to be transparent, objective, impartial and fair.

If an applicant is registered in another part of Canada, the College must usually accept the applicant's qualifications without further investigation (i.e., the applicant's education, experience and examination credentials). The College can still review some other registration requirements (e.g., good character, professional liability insurance, jurisprudence, and sometimes language fluency).

Registration Process Scenario 1 – Making False Statements

David, a graduate denturist, filled out his application form for registration, but when asked if he had any previous criminal findings, he did not want to put down the shoplifting conviction he received twenty years ago. He was worried it would affect his application. So, on his application form he reported that he did not have any previous criminal findings. The College registered David. A few years later the College is told about David's previous conviction. The College realizes that David made a false statement. The College can revoke David's registration because he made the false statement on the application form. Ironically, if David had disclosed the conviction when he applied for registration, the Registration Committee would probably have registered him (since he had had no difficulties in twenty years). However, making a false statement on the application form is very serious. It shows that David is dishonest now. David may now be removed from the profession.

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

ii. Complaints and discipline process

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

The following is a description of the complaints and discipline process.

The ICRC

The Inquiries, Complaints and Reports Committee (ICRC) is the committee of the College that looks at concerns about individual practitioners (e.g., professional misconduct, incompetence and incapacity).

The ICRC can only look at concerns about practitioners and some former practitioners of the College. In addition, the ICRC only looks at allegations of professional misconduct, incompetence or incapacity. It does not look at claims about professional negligence (i.e., civil lawsuits), criminal or quasi-criminal offences of a practitioner unless the behaviour is also unprofessional.

For professional misconduct and incompetence, concerns can reach the ICRC in one of two ways:

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

Incapacity concerns are also looked at by the ICRC, but will be discussed in a later section because they are handled differently.

Intake of Complaints

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

- the complaint must be in writing or recorded (e.g., on tape, film, disk or other medium);
- the complainant (person making the complaint) must be identified;
- the practitioner must be identified (the ICRC may be able to help identify the practitioner based on the information provided by the complainant);
- the complaint must describe some behaviour that is concerning (i.e., not just a general statement; some details must be given); and
- the complainant must want the matter to be a complaint.

The Registrar gives the practitioner notice of the complaint. This must be done within 14 days of the complaint being made.

<u>Intake of Registrar's Reports Investigations</u>

The ICRC also looks at Registrar's Reports. The process is as follows:

- the Registrar learns of a concern that the Registrar believes needs investigation;
- the Registrar brings the concern to ICRC to approve the appointment of an investigator;
- an investigator is appointed;
- the investigation is done and the investigator makes a report to the Registrar; and
- the Registrar then makes a Registrar's Report to the ICRC.

Once a Registrar's Report is made to the ICRC, the process is much the same as for a complaint.

<u>Interim Orders</u>

At any point after a complaint is received or an investigator is appointed by the Registrar, the ICRC may make an interim order to protect the public while awaiting the outcome of the investigation and any discipline hearing. For example, the ICRC may order that the practitioner's registration be suspended until the investigation and any discipline hearing is finished. Interim orders are fairly rare and are only used when necessary to protect patients from harm.

<u>Investigations</u>

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

1. <u>Complaints Investigations:</u>

- Frivolous or Vexatious Complaints: The ICRC does not need to investigate every complaint. When a complaint is 'frivolous or vexatious', made in bad faith, moot or is otherwise an abuse of process, the ICRC can choose not to investigate it. It is rare for the ICRC to consider a complaint to not be worthy of any investigation. Usually it must be obvious that there is nothing to the complaint for the ICRC to take no action at all. For example, repeated complaints without any new information would be "frivolous and vexatious". The ICRC tells both the practitioner and the complainant before it decides to take no action at all.
- Investigative Steps: Both complainant and practitioner are usually first asked to provide all relevant documents to the ICRC. The ICRC staff gathers additional information until all relevant information has been obtained. Information can come from many sources including College files, public databases (i.e., court files), other regulators, witnesses and other practitioners.

- ICRC Decision: At the end of the investigation the ICRC makes its decision about the complaint.
- Time Limits: A complaint is supposed to be decided within 150 days of it being given to the College. After that, the parties must be given a written update about the progress of the complaint. If the College takes too long, the complainant or the practitioner can ask the Health Professions Appeal and Review Board to take action.

2. <u>Registrar's Reports on Investigations:</u>

- There are three types of appointment of investigators: 1) Concerns that come to the attention of the Registrar; 2) Request made by the ICRC to help investigate a complaint; and 3) Information from the Quality Assurance Committee.
- Any concern about the behaviour of a practitioner that is not a formal complaint is generally brought to the attention of the Registrar. If a Registrar believes that there are "reasonable and probable grounds" (i.e., a reasonable basis to believe) that the practitioner engaged in serious professional misconduct or is incompetent, the Registrar asks the ICRC to approve the appointment of an investigator.
- Complaints Investigations: If the ICRC cannot get important information about a complaint on its own (e.g., a person refuses to provide it), the ICRC can ask the Registrar to use their special powers to help.
- Appointments based on Quality Assurance Committee Information: Where a practitioner does not cooperate with the quality assurance program, the Quality Assurance Committee can tell the ICRC. Also, if the Quality Assurance Committee has serious concerns about the professional misconduct, incompetence or incapacity of a practitioner, it can tell the ICRC. The ICRC can then ask the Registrar to appoint an investigator.
- The Investigation: Any investigator appointed by the Registrar has special powers. For example, the investigator can enter the office of the practitioner and examine files, can summons documents and can compel witnesses to answer questions.
- Time limits: There is no set deadline to finish a Registrar's Report on Investigation and make a decision. However, they should be completed within a reasonable time.

<u>ICRC Decision</u>

Once the investigation is finished, the ICRC makes a decision. There are many choices for the ICRC. The concerns can be referred to discipline for a hearing, although discipline is not the only option. The ICRC is a 'screening' body. The ICRC cannot make findings of credibility on disputed facts, cannot find wrongdoing (i.e., professional misconduct, incompetence), and cannot impose a disciplinary order (i.e.,

fine or suspension). Only the Discipline Committee can do these things. The following are some of the choices that the ICRC can make.

- Withdrawal of Complaint: In complaints matters, if a complainant wishes to withdraw (stop) a complaint, the ICRC can still decide to investigate the concerns if they are serious. However, the Registrar or the ICRC could also choose to stop the investigation and take no further action if it believes that the public interest would not be served in proceeding with the complaint.

- Undertaking: An undertaking is where a practitioner promises to do certain things (or not do certain bad things). The ICRC can then decide to take no further action because the undertaking addresses the concern.

- Referral to Discipline for a Hearing: Discipline is intended for serious concerns (e.g., dishonesty, breach of trust, deliberate unprofessional behaviour, inability to practise competently). Even then the ICRC must make sure that there is reasonable evidence to support the concern. This disposition is placed on the public register.

- Referral for Incapacity Proceedings: This is where the behaviour may be caused by an illness or health condition. The procedure is described separately below. This disposition is placed on the public register.

- Appearance for a Caution: The practitioner can be required to appear before the ICRC for a verbal caution. A caution is a conversation between the practitioner and the ICRC to encourage the practitioner to be more careful. This disposition is placed on the public register.

- Other Actions: The ICRC can be creative in their decisions. For example, the ICRC can require the practitioner to undergo a specified continuing education and remediation program (SCERP) such as a record keeping course. This disposition is placed on the public register).

- Taking No Action: If there is no basis for concern, the ICRC can take no action on the concern.

Unless the ICRC refers the concerns to discipline for a hearing or begins the incapacity process, the ICRC must give written reasons explaining why it made its decision.

Review before HPARB

In a complaint matter, either party (i.e., the complainant or the practitioner) may seek a review of an ICRC decision before the Health Professions Appeal and Review Board (HPARB). Again, there is an exception (e.g., if the decision was to refer the concerns to discipline for a hearing or to begin the incapacity process). HPARB may approve the decision of the ICRC or return the matter to the ICRC to make a new decision. HPARB can also make recommendations to the ICRC.

Discipline Proceedings

All discipline matters are referred to the Discipline Committee by the ICRC. Formal complaints and other concerns first go through the ICRC and are investigated by the ICRC. The ICRC refers "specified allegations" to discipline. The Discipline Committee holds a hearing to decide if the concerns are true. If the concerns are proved, the Discipline Committee makes an order (sometimes called a "penalty").

Procedure before the Hearing Starts

- The College gives the practitioner a document called a Notice of Hearing. The notice describes the concerns about the practitioner and explains the hearing process. It also explains how the practitioner can participate in the hearing.

- The College discloses all relevant information in the College's files to the practitioner. Disclosure will help the practitioner to present the best possible defence.

- The Chair of the Discipline Committee chooses a panel to hold the hearing. The panel is usually five people (two must be public members and three are usually professional practitioners). These decision makers must be neutral and unbiased.

- A prehearing conference may be held before the discipline hearing. This is a meeting with the practitioner, the practitioner's lawyer (if there is one) and the College's lawyer. At the prehearing conference the parties try to reach an agreement on as many issues as possible. The parties also plan the hearing. Discussions at pre-hearing conferences are confidential. If an agreement is reached, it is presented later to the panel of the Discipline Committee for approval.

Procedure at the Discipline Hearing

- The procedure at a discipline hearing is formal. It is similar to a court case in that there are two sides that each present their arguments and evidence to the panel. Usually both the College and the practitioner are represented by lawyers. The Discipline Committee panel ensures that the cases are presented fairly. The panel listens carefully to the evidence and arguments. After both parties have completed their presentations the panel decides the issues.

- The hearing is open to the public unless there is a good reason for privacy in order. A public hearing makes the discipline process open and fair. There are only a few limited exceptions where the hearing may be closed (e.g., confidential patient information would become public and there is no other way to protect the patient's privacy).
- The College presents its witnesses first. Then the practitioner is permitted to call their witnesses. The practitioner may choose to testify. The College can then call witnesses to reply to what the practitioner's witnesses said.

Evidence at the Discipline hearing

- Generally, the rules of evidence that apply to civil court trials apply to discipline hearings. For example, hearsay evidence is not admissible.
- Decisions are to be based only on the evidence heard or seen by the panel. The hearing panel cannot rely on any information that was not presented as evidence.
- A record is kept of all the exhibits of evidence.

Findings of Professional Misconduct

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

Findings of Incompetence

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

Orders in Discipline Cases

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

- Revocation – the removal of the practitioner from the profession (lasts at least one year, then the practitioner must satisfy the Discipline Committee that they ought to be permitted back into the profession).

- Suspension – the temporary removal of a practitioner from the profession. A suspension can be fixed (e.g., three months) or flexible, (e.g., ending on the successful completion of a course).
- Terms, conditions or limitations – can either be for a specified period (e.g., the denturist cannot fit and dispense partial dentures until the practitioner successfully completes a course) or for an indefinite period (e.g., the practitioner cannot consume any alcohol until a new order is made).
- Reprimand – a conversation between the Discipline Committee and the practitioner where the Committee tells the practitioner its views of their conduct and how to avoid similar problems in the future.
- Fine – the Discipline Committee can impose a fine of up to $35,000.
- Reimbursement for funding in sexual abuse cases – in a finding of sexual abuse the Discipline Committee can require a practitioner to reimburse the College for any funding provided by the College to the patient.
- Minimum order in sexual abuse cases – cases involving frank sexual acts must have an order of both a reprimand and revocation. No reinstatement can be made for five years after revocation on these grounds. The minimum order can also be imposed where the practitioner has been found guilty by another regulator of professional misconduct of a frank sexual nature.
- Costs - the Discipline Committee can order either the practitioner or the College to pay the other party money. The money is to cover some of the expenses of the hearing.

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

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

Appeals

Either party can appeal a decision by the Discipline Committee to the Divisional Court. The Divisional Court has the power to approve, change or reverse a decision of the Discipline Committee.

Complaints and Discipline Scenario – The Typical Complaint

A patient sends a letter of complaint to the Registrar of the College saying that David, a denturist, was rude to her. The patient says that David became angry when she said that the denture was not comfortable. The patient says that David "threw her out of the office". The Registrar sends a letter telling David about the complaint and asking David for a response. David writes a letter saying that the patient was extremely difficult to deal with. After doing all that he could for the patient, the patient became verbally abusive and David had to ask the patient to leave his office. David's letter is sent to the patient who writes back saying that she was never verbally abusive to David and that David is making this up to avoid trouble with the College. The Inquiries, Reports and Complaints Committee (ICRC) sends someone to interview the patient's husband, David's receptionist and a couple of patients who were in the office at the time. The information is confusing, but it looks like there was an argument where both the patient and David may have used intemperate language. The ICRC decides that this is not a case for discipline, especially since there have been no previous complaints about David. However, the ICRC sends David a letter of caution reminding him of the need to be professional in his dealing with patients even in challenging circumstances.

iii. Incapacity process

As noted above, "incapacity" has a particular meaning under the *Regulated Health Professions Act*. "Incapacity" is where a practitioner has a physical or mental condition which requires some restrictions on their practice. This section looks at what happens when incapacity becomes a concern.

The goal of the incapacity process is not to punish a practitioner who is ill. The goal of the incapacity process is to ensure that the practitioner receives appropriate treatment and is supervised and monitored so that they can continue to practise without being a risk to the public. It is rare for a practitioner to have their certificate of registration suspended or revoked by the Fitness to Practise Committee.

The Beginning of the Process

When a practitioner is so ill that it will affect their practice, the concern is brought to the Inquiries, Complaints and Reports Committee (ICRC) by either the Registrar or by another panel of the ICRC. The information of possible incapacity can come from a law enforcement agency, a mandatory report by an employer, or an expression of concern by a practitioner of the profession or the public. Typically the illnesses dealt with by the College affect judgment (e.g., substance abuse disorders, some mental illnesses) and demonstrate themselves through the conduct and behaviour of the practitioner.

ICRC Inquiry

Once an ICRC panel is selected, the practitioner is told that the ICRC panel will inquire into whether the practitioner is incapacitated. The ICRC panel investigates. The ICRC gathers information and then decides if a hearing is needed. The ICRC investigation may involve the following:

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

If the ICRC orders a specialist examination, the practitioner must go to the specialist to be examined. The specialist is usually someone who works in the area of substance abuse or psychiatry/psychology. The practitioner must cooperate with the specialist (e.g., answer questions, participate in an examination).

The ICRC prepares a report of its investigation and gives a copy to the practitioner. The ICRC decides if the matter should be referred to the Fitness to Practise Committee for a hearing. As in discipline cases, at any point the ICRC can impose an interim order (i.e., suspension, or terms, conditions and limitations) where the practitioner is likely to expose their patients to harm or injury.

ICRC Decision to refer to Fitness to Practise Committee for hearing (or not)

The concerns are referred to a hearing only when the practitioner's condition is serious. The decision to refer to the Fitness to Practise Committee for a hearing is not taken lightly. There must be sufficient evidence of, and a reasonable prospect of finding, incapacity. This is usually when there is some concern that the practitioner's illness will, now or in the future, interfere with their professional practice. Usually the illness involves a lack of insight by the practitioner into their condition.

Hearing before the Fitness to Practise Committee

Hearings before the Fitness to Practise Committee are similar to the hearings before the Discipline Committee. Usually the procedure at a Fitness to Practise hearing is as follows:

- The chair of the Fitness to Practise Committee chooses a panel – a panel has at least three people, at least one of whom is a public member of College Council.
- Disclosure of evidence – the College has the same disclosure obligations as in discipline hearings.
- Closed hearing – usually fitness to practise hearings are closed to the public because the concern is the practitioner's health. Such a hearing is not meant to be punishment to the practitioner. The hearing only protects the public because the practitioner is too ill to realize they are not acting safely. Only the practitioner can request that the hearing be opened to the public.
- Order of hearing – similar to discipline hearings. The burden of proving the practitioner is incapacitated is on the College. The College presents its case first.

Decisions of Fitness to Practise Hearing

The Fitness to Practise Committee must decide if the practitioner is indeed incapacitated. In other words, does the practitioner have a physical or mental condition that requires restrictions on the practitioner's practice (e.g., supervision or treatment) to protect the public. The decision is based on evidence presented at the hearing (usually expert opinions on the practitioner's health condition). The hearing panel looks at the present health condition of the practitioner.

If the Fitness to Practise Committee finds the practitioner to be incapacitated, it must also decide what restriction to place on the practitioner's certificate of registration. It can revoke a practitioner's certificate, suspend a practitioner's certificate, or impose terms, conditions or limitations on the

practitioner's certificate of registration. Usually terms, conditions or limitations on the certificate are made. For example, an order for treatment followed by monitoring and supervision.

The Committee can change their orders over time. A party can bring a motion for the Committee to make a change where the practitioner's condition changes. For example, if a practitioner's condition improves (i.e., stops drinking) the Committee can reduce the restrictions on the practitioner's registration.

Appeals

Either party can appeal a decision of the Fitness to Practise Committee to the Divisional Court. Even if an appeal is made, any order from the Fitness to Practise Committee takes effect right away while the appeal is pending.

Fitness to Practise Scenario – The Typical Case

David is a denturist working with Ivan, another practitioner. Ivan reports to the College that he is ending his partnership with David because David's drinking is affecting his work. Ivan is tired of helping David when he comes to the office two hours late after a drinking binge. The Registrar makes some inquiries that confirm Ivan's report. David, however, denies he has any problems. The Registrar reports the matter to the ICRC. The ICRC asks David for consent to obtain a copy of his medical records, which David provides. Those records indicate that David has separated from his wife, who accuses him of drinking. The records also show that David has recently been charged with impaired driving. The ICRC directs that David attend an assessment with a specialist in substance abuse disorders. The report from the specialist says that David clearly has a substance abuse disorder. The ICRC refers David to the Fitness to Practise Committee for a hearing and suspends David's certificate of registration until the hearing can be finished. David's lawyer persuades David to enter and successfully complete a thirty-day in-patient treatment program for substance abuse. David is now an active participant in an after-care program. At the Fitness to Practise Hearing David's lawyer and the College's lawyer present an agreement asking the Committee to find that David is incapacitated, as defined in the Act. The agreement also asks the Committee to order that David's certificate of registration be restored on the condition that he continues in regular treatment, that he works with another practitioner who will monitor his performance at work, and that he make regular reports to the College on his progress. The Committee approves the agreement.

iv. Quality Assurance Program

1. *Purpose of the program*

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

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

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

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

2. *Self-assessment and professional development*

Practitioners must participate in self-evaluation and professional development activities. Each year the practitioner must make a declaration telling the College that the practitioner has completed the required quality assurance activities. A practitioner must produce evidence of their quality assurance activities upon the request of the College.

Professional development activities allow practitioners to remain informed about practice standards and techniques and to develop skills, knowledge and judgment.

3. *Peer and practice assessment and remediation*

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

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

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

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

Role of the Committee

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

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

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

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

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

Quality Assurance Scenario No. 1

Donna, a denturist, is asked to provide her Self-Evaluation and Professional Development forms to the College. Donna has not kept any record of professional development activities. The Quality Assurance Committee asks Donna to complete the forms now and then reviews Donna's professional development and self-assessment activities. The Committee sees that Donna has in fact done a lot of professional development but has not documented it. The Committee decides that there is no reason to take any formal action because Donna has learned from this experience about the importance of keeping records of professional development activities. However, Donna is flagged for a review of her Self-Evaluation and Professional Development forms in two years' time.

Quality Assurance Scenario No. 2

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

Sample Examination Question

If a practitioner is selected for a peer and practice assessment, the practitioner should:

i. Cooperate with the practice assessor's review, including providing any requested records.
ii. Permit the practice assessor to inspect their home.
iii. Give the assessor all records except those that are confidential.
iv. Complete all required professional development records and fill in gaps in patient records before sending them to the practice assessor.

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

e. *Other laws*

i. Personal Health Information Protection Act (PHIPA)

(a) Personal health information

Practitioners have a duty to protect the privacy of patients' personal health information. The *Personal Health Information Protection Act* (*PHIPA*) directs practitioners' use of personal health information. The Act looks at the collection, use and disclosure by practitioners. It also looks at the access practitioners give to patients on the patient's personal health information. This Act helps guide the general duty of confidentiality described above.

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

i. Relates to the person's physical or mental health, including the person's family health history;
ii. Relates to the providing of health services to the person, including the identification of a person as someone who provided health services to the person;
iii. Is a plan of service within the meaning of the *Home Care and Community Services Act, 1994* for the person;
iv. Relates to the person's payments or eligibility for health care, or eligibility for coverage for health care;
v. Relates to the donation by the individual of any body part or bodily substance of the person or is derived from the testing or examination of any such body part or bodily substance;
vi. Is the person's health number; or
vii. Identifies a person's substitute decision-maker.

(b) Health Information Custodians

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

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

If a practitioner works for a health services organization such as a dentist's office, the dentist office is usually the Custodian of health records.

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

(c) Information Officers

PHIPA requires every individual practitioner and organization to appoint a contact person (often called an Information Officer). An Information Officer is the person who makes sure everyone follows the privacy policy and requirements of *PHIPA*. The Information Officer reviews the organization's privacy practices, provides training, and monitors compliance. The Information Officer is also the contact person for requests for information from the public.

A sole practitioner usually acts as Information Officer themselves. A health services organization may appoint a person within the organization, or may hire a person outside of the organization to be its Information Officer.

PHIPA Scenario

A denturist works in two dental offices, each of which has dentists and dental hygienists working there. In the first office the denturist is an employee paid by the hour. The dentist in charge chooses to act as the Information Officer for the entire office (i.e., the Health Information Custodian). In the second office the denturist basically rents space and the dentist wants no control over the denturist's records. In the second office the denturist becomes the Information Officer and the denturist becomes the Health Information Custodian for the denturist records.

(d) Protecting personal health information

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

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

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

Practitioners or organizations need to systematically review all of the places where they may temporarily or permanently hold personal health information (including laptops, smartphones and other

handheld devices) and assess the adequacy of the safeguards. Almost every organization that has not done this before will find that it needs to make changes.

Practitioners or organizations also need to securely keep, transfer and dispose of records in accordance with the College's requirements. For example, the College requires that patient records be kept for seven years from the last interaction with the patient.

Where there has been a privacy breach, practitioners or organizations need to inform the patients affected. In some circumstances, the Information and Privacy Commissioner and the College must also be notified.

Where a practitioner has been involved in a privacy breach that results in the custodian taking action against the practitioner (or the practitioners leaving voluntarily), the custodian must report the conduct to the College. In addition, custodians must report serious privacy breaches to the Information and Privacy Commissioner.

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

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

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

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

Under *PHIPA*, collection, use and disclosure of personal health information is permitted without consent in limited circumstances such as within the patient's "circle of care"..

Circle of Care

A practitioner can share personal health information with other individuals within a patient's "circle of care" for the purposes of providing health care, without the patient's express consent. A circle of care may include other health professionals who provide care to the same patient (e.g., a dentist). A practitioner may assume that they have a patient's implied consent to disclose personal health information to other health providers in the patient's circle of care.

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

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

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

An exception to the circle of care rule is if a patient or patient's substitute decision maker says that they do not want the information to be shared. The information must then not be shared unless another provision in *PHIPA* permits it (this is often referred to as placing the information in a "lock box").

Circle of Care Scenario

Donna, a denturist, receives a telephone call from a registered nurse at a local hospital. The nurse advises Donna that her patient has just been admitted to the hospital in a diabetic coma and appears to have something lodged in her airway. The nurse reports that she has been unable to contact the patient's substitute decision-maker. The nurse wants to know about whether the patient has a denture and its size and shape (an appointment card for a visit with Donna was found in the patient's pocket). Donna recalls that the patient told her never to tell anyone that she wears a partial denture. In this case, the "circle of care" principle does not allow Donna to disclose her patient's personal health information. However, an exception, noted below, applies if Donna believes on reasonable grounds that the disclosure would reduce a risk of serious harm to the patient (or any other person). Thus, Donna tells the registered nurse about the patient's treatment so that the patient can receive emergency care.

Family and friends

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

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

Disclosure related to risk

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

For example, if a patient has threatened to kill someone, the practitioner can warn the person being threatened and the police. The practitioner could share information about the patient that will help the police to deal with the threat. In some circumstances this principle can apply to the patient as well (e.g., where the patient is suicidal).

Other laws

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

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

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

(f) Access to personal health information

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

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

- permit the person to see the record and provide a copy at the person's request;
- determine after a reasonable search that the record is unavailable, and notify the person of this in writing as well as their right to complain to the Information and Privacy Commissioner of Ontario; or

- determine that the person does not have a right of access, and notify the person of this as well as their right to complain to the Information and Privacy Commissioner of Ontario.

The Information and Privacy Commissioner, a government appointed official administering *PHIPA*, may review the practitioner's or organization's refusal to provide a record, and may overrule the decision.

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

Sample Quiz Question

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

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

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

Correction of personal health information

Individuals generally have a right to ask for corrections to their own personal health information. A practitioner or organization receiving a written request must respond to it by either granting or refusing

the request within 30 days. It is wise to respond to verbal requests as soon as possible as well. If the request cannot be fulfilled within 30 days the person should be advised of this in writing.

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

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

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

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

- prepare a concise statement of disagreement that sets out the correction that the practitioner refused to make;
- require the practitioner to attach the statement of disagreement to their clinical records and disclose the statement of disagreement whenever the practitioner discloses related information;
- require the practitioner to make all reasonable efforts to disclose the statement of disagreement to anyone to whom the practitioner has previously disclosed the record; or
- make a complaint about the refusal to the Information and Privacy Commissioner.

<u>Complaints</u>

Every organization must have a system in place to deal with complaints regarding personal health information. Patients should also be made aware of their right to complain to the College and/or to the Information and Privacy Commissioner, particularly where there has been a privacy breach.

ii. Personal Information Protection and Electronic Documents Act (PIPEDA)

Another privacy law that practitioners should know about is the *Personal Information Protection and Electronic Documents Act* (*PIPEDA*). *PIPEDA* is a federal law that looks at the collection, use and disclosure of personal information in relation to commercial activity **outside of** health care.

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

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

1. Accountability: Someone in an organization (the "privacy officer", sometimes called an "information officer") must be accountable for the collection, use and disclosure of personal information. The privacy officer must develop privacy policies and procedures and ensure that staff receives privacy training.
2. Identifying Purposes: An organization must identify the purposes for which personal information will be used at the time that the information is collected.
3. Consent: Consent is required to collect, use and disclose personal information, except in limited circumstances (e.g., in emergencies or where the law otherwise permits this).
4. Limiting Collection: An organization must only collect the information that is necessary to collect for the identified purposes.
5. Limiting Use, Disclosure and Retention: An organization must only use, disclose and retain personal information that is necessary for the identified purposes and is obtained with consent. It should be retained no longer than necessary.
6. Accuracy: An organization must make reasonable efforts to ensure that any personal information collected is accurate, complete and up-to-date.
7. Safeguards: An organization must protect personal information with appropriate safeguards in order to protect against loss, theft, unauthorized access, disclosure, copying, use, or modification.
8. Openness: An organization must make its privacy policies readily available.
9. Individual Access: Upon request, an individual must be informed of the existence, use and disclosure of their personal information, and be given access to it. An individual can request corrections to the information. Access may be prohibited in limited circumstances such as the privacy of other persons, if there is a prohibitive cost to provide it, or for other legal reasons.
10. Challenging Compliance: An organization must have a complaints procedure relating to personal information and must investigate all complaints.

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

iii. Health Care Consent Act

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

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

- The CCB can consider a patient's challenge to a decision by a practitioner that they are incapable with respect to a treatment. The CCB may agree with the health practitioner or may overrule the practitioner and find that the patient is capable with respect to the treatment. If the CCB overrules the practitioner, the practitioner cannot treat the patient unless the patient consents.
- The CCB can provide direction to a substitute decision-maker about an incapable person's wishes (e.g., whether the patient's previously stated wishes applies to the circumstances or whether or not the wish was expressed when the person was capable).
- The CCB can also consider a request from a substitute decision-maker to depart from a person's wish that was expressed while the person was capable.
- The CCB can review decisions regarding a person's capacity to consent to treatment, admission to care facilities, or the use of a personal assistive service.
- The CCB can appoint a substitute decision-maker to make decisions for an incapable person with respect to treatment, admission to a care facility, or use of a personal assistance service.
- The CCB can amend or terminate the appointment of a representative (called a substitute decision maker).
- The CCB can review a decision to admit an incapable person to a hospital, psychiatric facility, nursing home, or home for the aged for the purpose of treatment.
- The CCB can review a substitute decision maker's compliance with the rules for substitute decision-making.

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

Health Care Consent Act Scenario

David, a denturist, is hired by a patient's daughter to repair a denture. The patient feels comfortable with the denture just like it is. The patient has dementia. The denturist is prepared to proceed with the repairs because they are needed and the patient is incapable. However, the patient's son, who is estranged from his sister, helps the patient to challenge the decision to make repairs to the CCB. The CCB holds a hearing. It hears testimony from the son, the daughter and the patient, and decides that the patient is capable of consenting to the decision to refuse to repair the denture. In this case, David must respect the patient's choice, even if David believes stopping the repair is not in the patient's best interests.

iv. Child, Youth and Family Services Act (CYFSA)

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

As a result of a report, a CAS worker may investigate the report further and, where action is needed, in many cases a CAS worker will offer a family services such as counselling and foster parenting.

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

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

A practitioner must make a report if they have reasonable grounds to suspect any of the following:

<u>The child has been or is at risk of harm</u>

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

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

<u>Failure to provide or consent to services or treatment</u>

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

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

- the child requires medical treatment to cure, prevent or alleviate physical harm or suffering;

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

It is rare for denturists to be involved in these sorts of treatment issues.

Abandonment

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

Failure to supervise a child

A report is required if a child has injured another person or damaged another person's property more than once as a result of the person having charge of a child encouraging the child to do so.

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

CAS Reporting Scenario 1

Donna, a denturist, has a patient who discloses that she has physically harmed her son. Donna has a duty to make a report, even if the patient reported this in confidence. If two months later the patient says something that makes Donna suspect that the patient has physically harmed her son again, Donna has a duty to make another report.

CAS Reporting Scenario 2

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

v. Human Rights Code

(a) Human Rights Code

Every person is entitled to receive health care services in a way that respects their human rights. The Ontario Human Rights Code requires every practitioner to treat patients, potential patients, employees and others equally, regardless of the person's race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability (known as the "prohibited grounds").

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

Duty not to discriminate

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

- Refusing to accept a new patient for a prohibited reason;
- Refusing to continue treating a patient for a prohibited reason;
- Making a treatment decision for a prohibited reason;
- Insulting a patient for a prohibited reason[7];
- Refusing to permit a patient with a disability to meet with the practitioner with a support person; and
- Making assumptions about a person's health or abilities because of their age or another prohibited reason and not based on clinical observation or professional knowledge and experience.

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

In order to meet the obligations of the College and to avoid a misunderstanding that could lead to a human rights complaint, practitioners should always clearly communicate their reasons for making clinical treatments, referrals and other decisions. Practitioners should always make decisions to refuse or end treatment in good faith and should not use their own lack of competence as an excuse to refuse to provide services to a person if there is no real competence issue.

Practitioners are similarly entitled to rely on professional knowledge, judgment and experience to make comments upon clinically relevant matters that relate to a person's age or sex. For example, recommending that a patient's jaw can no longer support a traditional full denture because of bone erosion is not discrimination on the basis of age.

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

[7] While insulting a patient is always professional misconduct, insults are only subject to enforcement by the Human Rights Tribunal if the insult is related to a characteristic of the person protected by the Human Rights Code (e.g., gender, race).

Duty to accommodate

If a practitioner's conduct or policy discriminates against a person based on a prohibited ground, the practitioner has a duty to accommodate that person unless the accommodation would result in undue hardship (e.g., because of a real risk to health or safety or because of undue cost).

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

Examples of accommodation may include the following:

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

The duty to accommodate applies to all of the prohibited grounds of discrimination.

Human Rights Code Scenario No. 1

Donna, a denturist, determines she is not competent to continue to treat her patient because the patient's bone atrophy has made treatment too complex. The patient is unhappy about Donna's decision and believes that Donna has always had a problem with him because of his race and religion. Donna should carefully communicate her reasons so that the patient is not left with the misunderstanding that the decision was for a prohibited reason such as the patient's age. Donna should also make an appropriate referral (e.g., to a dentist for consultation on implant options) that is acceptable to the patient, if possible.

Human Rights Code Scenario 2

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

Human Rights Code Scenario No. 3

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

The *Accessibility for Ontarians with Disabilities Act* (*AODA*) helps support the *Human Rights* Code, particularly in the area of disabilities. The *AODA* provides for accessible customer service, information and communications, transportation, employment, and built environment (i.e., physical facilities). The *AODA* applies to every person and organization in Ontario with at least one employee. Different standards apply depending on the number of employees an organization has. A sole proprietor or a group of persons in a partnership are not considered "employees" and therefore the *AODA* standards currently do not apply to some practitioners.

The goal of the standards is to achieve accessibility for Ontarians with disabilities by 2025. A practitioner or organization may be fined for not complying with the *AODA*. Practitioners should make sure that they are complying with the *AODA.*

vi. Municipal licensing

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

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

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

Municipal licensing scenario

Donna, a denturist, operates a dirty laboratory. The municipality receives a complaint and inspects the premises. The municipality issues an order for Donna to clean up the premises, which Donna disregards. The municipality charges Donna with an offence under its by-laws. The College learns of the concerns, conducts its own investigation and refers Donna to discipline for professional misconduct for failing to comply with sterility standards of practice. Both the municipality and the College have jurisdiction over Donna's inaction.

4. CONCLUSION

If a legal issue arises, practitioners are encouraged to discuss them with colleagues and to check with the College as to its expectations. The College cannot provide legal advice. Thus, on many issues, a practitioner may need to consult with their own lawyer.