JURISPRUDENCE COURSE HANDBOOK

Important Legal Principles Practitioners Need to Know

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Introduction and Overview

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

This book will first discuss the concepts of professionalism and self-regulation. The *Health Professions Act,* RS.B.C. 1996, c. 183 (the "*HPA*") is based on these concepts. The book will then look at how proper communication with patients and colleagues is fundamental to a professional practice. For example, informed consent is not possible without communication. The book will then review the various laws that practitioners are most likely to have to deal within their practice.

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

- Adult Guardianship Act
- CCALA - Community Care and Assisted Living Act
- CFCSA - Child, Family and Community Service Act
- FOIPPA - Freedom of Information and Protection of Privacy Act
- HCCCFAA - Health Care (Consent) and Care Facility (Admission) Act
- HPA - Health Professions Act
- Human Rights Code
- Labour Mobility Act
- Medical and Health Services Regulation
- Medicare Protection Act
- Ombudsperson Act
- PIPA – Personal Information Protection Act

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1. Professionalism and Self-Regulation

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

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

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

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

A. The concept of self-regulation

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

In British Columbia, 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. British Columbia has chosen the self-regulation model so that those who best understand the profession are involved in its regulation.

Self-regulation means that the British Columbia government has made a statute (often called an Act) giving the duty to regulate the profession to a separate body (called a College) the majority of whose Board is elected by the profession. The College is a regulatory body, not an educational institution. The Board establishes the bylaws and policies of the College and oversees the administration of the regulatory activities of the College (e.g., it establishes the budget for the quality assurance program of the College). The College operates through committees (e.g., the Registration Committee, the Inquiry Committee, and the Discipline Committee) the majority of whose members are from the profession, with other members coming from the public.

The mandate of the College is to serve the public interest. It does this by regulating the profession in the public interest. Under the Health Professions Act (the "HPA"), the College has a duty to "serve and protect the public" and to exercise all of its powers and carry out its responsibilities "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, nor can it advocate to the government on behalf of the interests of the profession); that is the role of a professional association, not a regulatory College. Self-regulation does not mean self-interest; in fact it means exactly the opposite. Self-regulation means serving the public interest. That is, the College ensures that the members of the profession act honestly and competently.

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

i. The Board and the committees of the College also have public members on them (i.e., non-practitioners appointed by the government). The Act requires that public members on the Board must not be less than one-third of the total board membership. There must also be government-appointed members or public representatives on certain committees.

ii. Board meetings and discipline hearings are open to the public. Observers can attend and watch what happens.

iii. The College must consult with members of the profession and the public before making or amending a bylaw affecting them. The College must provide notice of most proposed bylaws or amendments at least three months before the proposed bylaw or amendment is filed with the minister.

iv. Decisions of certain committees of the College can be reviewed by other bodies. For example, decisions of the Registration Committee and the Inquiry Committee can be appealed by the affected individuals by requesting a review to the Health Professions Review Board (HPRB). Decisions of the Discipline Committee can be appealed to the Supreme Court.

v. The Office of the Ombudsperson of British Columbia, under the Ombudsperson Act, makes sure that the College's decision-making practices are transparent, impartial and fair.

vi. The Board has to report to the Minister. It has to make an annual report containing information required by regulation. The Minister has the ability to appoint a person to inquire into any aspect of the College's operations and may issue directives to the Board following such an inquiry. Thus, while the College is separate from the government, it is still accountable to the Minister of Health Services.

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 Board need to be careful about their role. As mentioned above, Board members are like directors of a corporation who have a duty of loyalty and good faith to the mandate of their organization. Board members are not like politicians who represent and serve those who elected them. The only role of Board members is to represent the public and to exercise their authority at all times in the public interest.

Sample Exam Question

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

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

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

B. Ethics, professional standards, professional misconduct, incompetence, incapacity

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

This section of the book looks at each of them.

Code of Ethics

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

The College is authorized under the HPA to create bylaws that establish standards of professional ethics for its members, including standards for avoidance of conflicts of interest. Schedule "A" of the College bylaws contains the College's Code of Ethics. 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 core values which members of the profession must uphold in their relationships with their clients, other members of the profession, other health care providers, and the public. If a practitioner follows the principles of the Code of Ethics (e.g., being honest) they will avoid engaging in professional misconduct (e.g., they will not issue a false or misleading document).

Ethics Scenario

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

Practice Standards

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

Schedule "B" of the College bylaws contains the College's general Standards of Practice. There are also more detailed practice standards regarding specific activities.

Although the College has some written practice standards (Consent to Treatment, Sexual Misconduct, Draping for Patients), most practice standards are not written down anywhere by the College. For example, the College does not have a document describing exactly how a practitioner assesses a patient. Indeed, often how the standard is applied changes with the circumstances (e.g., the answers the patient gives to the practitioner's questions will change how the assessment is done). Professional standards are learned through one's education, professional reading and learning, experience in practice and in discussions with other practitioners. Practice standards are always changing and it is critical for members of the College to keep abreast of those changes.

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

Discontinuing Professional Services Scenario

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

Professional Misconduct

Professional misconduct is conduct that falls below the minimum expectations of a safe and ethical practitioner. The HPA defines professional misconduct broadly to include "sexual misconduct, unethical conduct, infamous conduct and conduct unbecoming a member of the health profession". Many College publications will assist practitioners to recognize how to avoid engaging in professional misconduct.

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

Permitting Illegal Conduct Scenario

Practitioner X is registered with the College. X's father is not registered with the College. Practitioner X's father sometimes drops into X's office to treat his long-term patients. The office assistant refers to X's father as "Doctor" when booking patients. A patient complains to the College when her extended health insurance refused to pay for X's father's services because he was not registered with the College. Is Practitioner X responsible for his father's conduct?
The answer is yes. It is professional misconduct to permit a person to hold themselves out as practising the profession when they are not registered. Practitioner X condoned the conduct that occurred at his office. Practitioner X, by being registered, gave credibility and status to the illegal conduct of his father. X could face a discipline hearing.

Incompetence

Incompetence is where a practitioner demonstrates a lack of knowledge, skill or judgment when assessing or treating a patient. A concern that a practitioner is incompetent can be investigated by the Inquiry Committee and can result in a discipline hearing. If the Discipline Committee finds that a practitioner is not competent to practise, it can impose conditions and restrictions on the practitioner's registration (e.g., the practitioner must undertake remedial work and cannot practice in a certain way, such as with children), or it can suspend or cancel 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 (the Inquiry Committee and the Discipline Committee) will have other practitioners on it who know the difference between good and bad practice.

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

Incapacity

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

When a concern regarding a practitioner's capacity to practice is brought to the College's attention, it will conduct an investigation and may require the practitioner to see a specialist for an examination to obtain more information about the state of the practitioner's health. If the concern is justified, the practitioner may be asked to agree to a consent order which places terms on his or her registration pending his or her return to health or the matter will be referred to a hearing. In an extreme case where there is risk to public safety (e.g. where the practitioner continues to see patients while impaired), the Inquiry Committee can take extraordinary action to suspend the practitioner's registration or place conditions on it pending the outcome of the investigation or hearing.

Incapacity Scenario

Practitioner Z has been drinking a lot more alcohol over the last few months. He has been coming to work with a hangover. More recently he has been drinking at lunch. One day Z comes back after lunch impaired. Paul, a patient, notices that Z smells of alcohol and that Z is stumbling around the office. Paul tells the College. At first Z denies he has a problem. However, on investigating, the College learns that some of Z's colleagues have noticed a significant change in Z's behaviour in recent months. The College also learned that Z has been charged with impaired driving. The College requests Z to see a medical specialist who diagnoses Z with a serious substance abuse disorder. The College encourages Z to go for treatment at the Homewood Health Centre. Z agrees. Z and the College agree to a consent order requiring Z to stop drinking, attend Alcoholics Anonymous group meetings, see his new substance abuse specialist regularly and have a colleague watch Z at work and send regular reports to the College to ensure that he has capacity to practise and does not pose a risk to his patients.

Conclusion

Each of the above provisions looks at different aspects of professional practice. The Code of Ethics deals with the ethical obligations of practitioners. Practice standards deal with ways in which to practise safely, effectively and professionally. Professional misconduct deals with the minimum conduct necessary to avoid discipline. Incompetence deals with having an adequate level of knowledge, skill and judgment in the assessment and treatment of a patient. Incapacity deals with health conditions that prevent a practitioner from thinking clearly.

Sample Exam Question

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

i. The definition of professional misconduct.

ii. Practice Standards published by the College.

iii. The Code of Ethics.

The best answer is iii). Being sensitive is a requirement of the Code of Ethics. Answer i) is not the best answer because professional misconduct deals with the minimum conduct that is necessary to avoid discipline. Answer ii) is not the best answer because practice standards deal with ways in which to practice safely, effectively and professionally. A practice standard would likely provide practical suggestions about how to practice sensitively (e.g., advice on how to listen to the patient first before doing anything else).

2. Communication

A. Introduction

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

B. Informed consent

Patients have the right to control their bodies and their health care. Practitioners do not have the right to assess or treat a patient unless the patient agrees to it (i.e., consents). The *Health Care (Consent) and Care Facility (Admission) Act* (the '*HCCCFAA*") prohibits any health care practitioner from providing health care without consent. The College Practice Standards also address consent to treatment. 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) and professional (e.g., a discipline hearing) consequences. This section of the book deals with consent for the assessment and treatment of patients. Other parts of the book deal with the need for consent when dealing with a patient's personal health information or for billing them.

General Principles

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

- *Relate to the Proposed Health Care and Treatment.* The practitioner cannot receive consent for one procedure (e.g., taking a history of the patient's health) and then use it to do a different procedure (e.g., physically examine the patient). The patient's consent must be for what is actually going to be done.

- *Be Specific.* The practitioner cannot ask for a vague consent. For example, one cannot ask for the patient to consent to any treatment the practitioner believes is appropriate. The actual assessment or treatment procedure must be explained. This means that the practitioner often has to obtain the patient's consent many times as new procedures become advisable. This also means that a practitioner cannot obtain a "blanket consent" when the patient first comes in to cover every procedure.

- *Be Informed.* It is necessary that the patient understands what they are agreeing to. The practitioner must explain to the patient everything the patient needs to know before asking the patient to give consent. For example, if someone asks for your consent to drive your car without telling you that they intend to use it to race over rocky fields, your consent was not informed. To be informed, consent must include the following:

    - *Nature of the Assessment or Treatment.* The patient must understand exactly what the practitioner is proposing to do. For example, does the practitioner intend to just ask questions or will the practitioner also be touching the patient? If the practitioner is going to be touching the patient, describe what the patient should expect.
    - *Who Will be Doing the Procedure?* Will the practitioner be doing the procedure personally or will an assistant or colleague be doing it? If it is an assistant or colleague, is he or she registered with the College, another College, or not registered at all?
    - *Reasons for the Procedure.* The practitioner must explain why he or she is proposing that procedure. What are the expected benefits? How does the procedure fit in with the overall plan of the practitioner? How likely is it that the hoped-for benefits will happen?
    - *Material Risks and Side Effects.* The practitioner must explain any "material" risks and side effects. "Material" risks or side effects are those that a reasonable person would want to know about. For example, if there is a high risk of a modest side effect (e.g., sleeplessness), the patient should be told. Similarly, if there is low risk of a serious side effect (e.g., death or suicide), the patient needs to be told.
    - *Alternatives to the Procedure.* If there are reasonable alternatives to the procedure (e.g., a more cautious approach), the patient must be told. Even if the practitioner does not recommend the option (e.g., it is too aggressive and has a higher risk), the practitioner should describe the option and tell the patient why the practitioner is not recommending it. Also, even if the practitioner does not provide the alternative procedure (e.g., it is provided by a member of a different profession, such as a physician), the practitioner must tell the patient if it is a reasonable option.
    - *Consequences of Not Having the Procedure.* One option for a patient is 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 practitioner knows or should know that if the individual patient has a special interest or concern in some aspect of the procedure (e.g., its nature, a side effect), the patient needs to be told (e.g., the procedure would violate the patient's religious beliefs).

- *Voluntary.* The practitioner cannot force a patient into consenting to a procedure. This is particularly important when dealing with younger or older patients who may be overly influenced by family members or friends. This is also important where the assessment or treatment will have financial consequences for the patient (e.g., the patient will lose his or her job or will lose financial benefits if the patient refuses to consent). The practitioner should discuss with the patient that it is up to the patient whether to give consent and that the patient should not let anyone pressure them into doing something the patient does not want to do.

- *No Misrepresentation or Fraud.* The practitioner must not make claims about the assessment or treatment that are not true (e.g., telling the patient that a treatment will cure them when in fact the results are uncertain). This situation would not result in a true consent. Patients must be given accurate factual information and honest opinions.

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

Consent Scenario No. 1

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

Sample Exam Question

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

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

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

Ways of Receiving Consent

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

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

- Verbal Consent. A patient can give consent by a verbal statement. A verbal consent is the best way for the practitioner and the patient to discuss the information and ensure that the patient really understands it. However, it is important to make a brief note in the patient record of the discussion as that will provide useful evidence later that consent was obtained in the event there is a complaint. The College's Practice Standard on Consent to Treatment also requires a practitioner to record that informed consent has occurred in the clinical record.

- Implied Consent. A patient can give consent by their actions. For example, in Consent Scenario No. 1, above, the patient Paula could just nod her head. That would be implied consent for Practitioner Y to begin asking her questions. The main disadvantage of implied consent is that the practitioner has no opportunity to check with the patient to make sure that the patient truly understands what is going to happen. It is also important to make a brief note of such consent in the patient record in accordance with the College's Practice Standard on Consent to Treatment.

Consent Scenario No. 2

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

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

Consent Where the Patient is Incapable

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

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

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

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

The issue is whether the patient is capable of giving consent for the proposed procedure. A patient can be capable to give consent for one procedure but not capable for another. For

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

example, a fifteen-year old patient might be capable of consenting to nutritional counselling but not be capable of consenting to treatment for a major eating disorder.

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

Unless it is an emergency, the practitioner must then obtain consent for the assessment or treatment from the personal guardian or representative or substitute decision maker. To provide substitute consent, the decision maker must meet the following requirements:

- The substitute must be at least 19 years of age.
- The substitute must, themselves, be capable. In other words, the substitute must understand the information and appreciate the consequences of the decision.
- The substitute must be able and willing to act.
- There must be no higher ranked substitute who is able and willing to act. The ranking of the substitute decision maker is as follows (from highest ranked to lowest ranked):
    - A court appointed guardian of the person.
    - A person who has been appointed by the patient 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.
    - The spouse or partner of the patient. A partner can include a same-sex partner or any- one living with the person in a marriage-like relationship.
    - A child of the patient.
    - A parent of the patient.
    - A brother or sister of the patient.
    - A grandparent of the patient.
    - A grandchild of the patient.
    - Anyone else related by birth or adoption to the adult.
    - A close friend of the patient.
    - A person immediately related to the patient by marriage.
    - The Public Guardian and Trustee if there is no one else.

Here is a scenario that shows how these rules work.

Consent Scenario No. 3

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

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

A substitute decision maker must comply with the following rules:

- The substitute must act in accordance with the last known capable wishes of the patient, if known. For example, if a patient clearly said, "never send me to the hospital" before he became so ill that he could not think clearly, the substitute needs to obey those wishes.

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

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

Consent Scenario No. 4

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

The above rules on obtaining informed consent when a patient is incapable come from the *HCCCFAA*. Practitioners must be familiar with that statute and the College's Practice Standard on Consent to Treatment.

Sample Exam Question

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

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

The best answer is i). Only a court appointed guardian is higher ranked than a power of attorney for personal care. Answer ii) is not the best answer because the patient's spouse or partner is a lower ranked substitute decision maker. 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.

Emergencies

One exception to the need for informed consent is in cases of emergencies. A health care provider may provide health care to a patient without the patient's consent if all of the following conditions are met:

- it is necessary to provide treatment without delay in order to preserve the patient's life, to prevent serious physical or mental harm or to alleviate severe pain;
- the patient is apparently impaired by drugs or alcohol or is unconscious or semi-conscious for any reason or is, in the health care provider's opinion, otherwise incapable of giving or refusing consent,
- the patient does not have a personal guardian or representative who is authorized to consent to the health care, is capable of doing so and is available, and
- where practicable, a second health care provider confirms the first health care provider's opinion about the need for the health care and the incapability of the patient.

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

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

Consent Scenario No. 5

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

C. Boundaries and Sexual Misconduct

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

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

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

Self-Disclosure

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

Self-Disclosure Scenario

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

Giving or Receiving of Gifts

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

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

Gift-Giving Scenario

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

Dual Relationships

A dual relationship is where the patient has an additional connection to the practitioner other than just as a patient (e.g., where the patient is a relative of the practitioner). Any dual relationship has the potential for the other relationship to interfere with the professional one (e.g., being both the individual's practitioner and employer). It is best to avoid dual relationships whenever possible.

Where the other relationship predates the professional one (e.g., a relative, a pre-existing friend), referring the patient to another practitioner is the preferred option. Where a referral is not possible (e.g., in a small town, where there is only one practitioner), special safeguards are essential (e.g., discussing the dual relationship with the patient and agreeing with the patient to be formal during visits and never talk about the issues outside of the office). It is never a good idea to treat a relative.

Dual Relationships Scenario

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

Ignoring Established Customs

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

Personal Opinions

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

Personal Opinions Scenario

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

Becoming Friends

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

Touching and Disrobing

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

Managing boundaries is important for both practitioners and patients.

Sexual Misconduct

The HPA and the College bylaws are designed to eliminate any form of sexual contact between practitioners and patients. Because of the status and influence of practitioners, there is a potential for any such sexual contact to cause serious harm to the patient. Even if the patient consents to the sexual contact, it is prohibited for the practitioner.

The term “professional misconduct” is defined broadly in the HPA to include sexual misconduct. The College bylaws define “professional misconduct of a sexual nature” as:

- 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 misconduct. Hanging a calendar on the wall with sexually suggestive pictures (e.g., women in bikinis, a “fire fighters” calendar) is sexual misconduct. Non-clinical comments about a patient’s physical appearance (e.g., “you look sexy today”) and dating a client are both forms of sexual misconduct.

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

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

> *Sexual Misconduct Scenario No. 1*
>
> *Practitioner Y tells a colleague about her romantic weekend with her husband at Niagara-on-the-Lake for their anniversary. Y makes a joke about how wine has the opposite effect on the libido of men and women. Paula, a patient, is sitting in the reception area and overhears. When being treated by Y, Paula mentions that she overheard the remark and is curious as to what Y meant by this, as in her experience, wine helps the libido of both partners. Has Y engaged in sexual misconduct? Y clearly has crossed boundaries by making the comment in a place where a patient could overhear it. However, the initial comment was not directed towards Paula and was not meant to be heard by her. It would certainly be sexual misconduct for Y to answer Paula's question. Y should apologize for making the comment in a place where Paula could hear it. Y needs to state her focus is on Paula's treatment.*

Because sexual misconduct is such an important issue, Colleges must take it very seriously. Each College must take steps to prevent sexual misconduct from occurring. For example, the Patient Relations Committee of the College must establish a patient relations program to prevent professional misconduct of a sexual nature that will educate practitioners, and develop educational programs for practitioners and the public.

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

Complaints of sexual misconduct are always taken seriously. If the complaint involves sexual touching and if there is evidence to support the complaint, the Inquiry Committee will direct the issuance of a citation for a discipline hearing. In all cases where a finding of sexual misconduct has been made, the practitioner will be reprimanded, ordered to pay costs, and lose the right to practise for a period of time or indefinitely.

Practitioners should therefore consider ways of preventing sexual misconduct (or even the perception of sexual misconduct) from arising. Experience indicates that most sexual misconduct 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 must put a stop to them and transfer the care of the patient to another practitioner.

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

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

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

Sexual Misconduct Scenario No. 2

Practitioner X is attracted to his patient Paula. X notices that he is looking forward to working on the days when Paula will be there. X extends the sessions a few minutes in order to chat informally with Paula. X thinks Paula might be interested as well by the way that she makes eye contact. X notices that he is touching Paula on the back and the arm more often. X decides to ask Paula to join him for a coffee after her next visit to discuss whether Paula is interested in him. If Paula is interested, he will transfer Paula's care to a colleague. If Paula is not interested then he will make the relationship purely professional. X decides to ask a colleague, Y, for advice.
Y, correctly, tells X that he has already engaged in sexual misconduct by letting the attraction develop while continuing to treat Paula. Y also says that it is important for X to transfer the care of Paula right away.

Sample Exam Question

Which of the following is sexual misconduct:

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

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

D. Interprofessional collaboration

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

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

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

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

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

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

- Will the setting have shared records or will each practitioner have separate records?
- If the records are shared, will the practitioner keep any private notes outside of the shared record? If so how will the practitioner make sure that the other health care providers have access to the information they need?
- How does the setting deal with the wording used in the records? For example, will everyone use the same abbreviations?
- What happens to the records if the practitioner leaves to practise elsewhere? Will the patient be told where the practitioner has gone? Will another practitioner from the setting take over the patient's care? Will the patient be given a choice? The patient really should be given a choice although some settings will do so only if the patient asks.
- Who is the health information custodian that owns the records?

- Will there be one person who has overall responsibility for the care of the patient? If so who? If not, how will the patient's care be coordinated?
- How will disagreements in the approach to the care of the patient be dealt with? If it is the practitioners who are in disagreement, when and how does the practitioner tell the patient?
- Is the patient aware of all of the above?

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

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

Interprofessional Collaboration Scenario

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

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

E. Billing

The College does not set fees for practitioners to charge. Establishing fees is not part of the mandate of the College. In fact, the College does not regulate the amount a practitioner can bill the patient unless the fee is excessive or fraudulent. 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, transparent and honest. Patients must be told the amount of the practitioner's fees before the service is provided. This includes the cost of any products before they are sold to the patient. The best way to tell patients the amount of the fees is to give patients a written list or description of the fees of the practitioner. However, the patient can also be told verbally or there can be a sign clearly displaying the fees in the reception area of the practice. The problem with those methods of notification is that the patient might forget. The list or description of the fees must include all charges including any penalties for late payment.

A practitioner must provide an itemized bill for any patient who asks for it. The bill must describe the services that were provided and the products that were given. Any document relating to fees (e.g., a bill or a receipt) must be accurate. In the case of a practitioner providing receipts for treatment that has not been provided, or for dates when treatment was not provided, such dishonesty may result in the practitioner being disciplined or even charged for criminal offences. 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 acupuncture was performed when in fact a herbal remedy was provided.
- bill for services at more than the practitioner's usual rate because the service is being paid for by an insurance company.
- indicate that a service was performed when, in fact, no service was performed. For example, it is unprofessional to indicate that a patient visit occurred when, in fact, the patient missed the appointment and a late cancellation fee is being billed.
- bill for a product for more than its actual cost. The actual cost can include a reasonable amount for the staff time for storage and handling.

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

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

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

Billing Scenario

Practitioner X, has a posted rate of $120 per visit in the reception area of his office. In fact, if the patient is paying for the service personally and does not have extended health insurance coverage, X will provide a credit reducing the rate to $99 per visit. If a patient has special financial needs, X will consider reducing his rate even further; in fact he has three regular patients who pay only $5 per visit. The above scenario is contrary to the advertising and marketing rules in the College bylaws. In effect X's posted fees are not honest and accurate. X is, in effect, billing patients with insurance more than his actual regular rate.
It is acceptable, however, for X to lower his actual fee in individual cases of financial hardship. X has to do this on a case by case basis and not through a general policy intended to hide his true fee.

F. Claiming for MSP benefits

While acupuncture treatments are covered by Medical Services Plan (MSP) for certain types of patients, under s. 29(1) of the Medical and Health Services Regulation, Medicare Protection Act, services provided by a practitioner to himself or his family members are not covered by MSP. Therefore, practitioners should not submit MSP claims for treatments provided to family members or themselves.

3. Law

A. Types of law

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

- *Statutes.* Most often when one thinks of law, one thinks of statutes (also called Acts). There are overriding statutes that take priority over other statutes such as the *Canadian Charter of Rights and Freedoms* which forms part of the Constitution. There are also statutes that are not constitutional in nature but still override other statutes such as the *Human Rights Code* and the *Freedom of Information and Protection of Privacy Act.* The statutes that practitioners will need to be most aware of are the *HPA and the HCCCFAA. These provincial* statutes are made by the Legislative Assembly in Victoria.

- *Regulations.* Regulations are made by the government when a statute permits them to be made. Under the *HPA,* regulations can be made by the Minister of Health Services. The *Traditional Chinese Medicine Practitioners and Acupuncturists Regulation* is a regulation made by the Minister under the authority of the *HPA.*

- *Bylaws.* Bylaws are proposed by the College Board and require approval by the Minister of Health Services. Under the *HPA,* amendments to most bylaws are subject to a public notice period of at least three months, unless the Minister specifies a shorter period. Bylaw amendments must be filed with the Minister of Health Services in order to be effective. College bylaws deal primarily with the internal operations of the College and the obligations on practitioners in relation to such matters as professional liability insurance, protection of patient personal information, information that practitioners must provide to the College, the election of practitioners to the Board 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 Inquiry Committee and hearings by the Discipline Committee).

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

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

B. *Health Professions Act (HPA)*

The *HPA* applies equally to all 25 regulated health professions which are governed by 22 colleges. Sometimes described as an "umbrella" statute, the *HPA* sets out the duties and responsibilities of the Minister of Health Services, the Colleges, f the Health Professions Review Board and the reporting obligations of practitioners. It also lists the bylaws that College Boards have authority to make (subject to Ministerial approval) and the processes for reviewing decisions of the Inquiry Committee and Registration Committee and appealing decisions of the Discipline Committee.

(i) Scope of Practice

Scope of practice statements are the concise descriptions, in broad, non-exclusive terms, of each regulated professions' activities and areas of professional practice outlined in the regulations that govern each profession which are authorized by the *HPA* (eg. Section 4 of the Traditional Chinese Medicine Practitioners and Acupuncturists Regulation provides that the scope of practice for an acupuncturist includes the use of traditional Chinese medicine diagnostic techniques and the recommendation of dietary guidelines or therapeutic exercise).

These statements describe in general what each profession does and how it does it. They are not intended to be exhaustive lists of every service that the profession may provide, nor do they exclude other regulated professions or unregulated persons from providing services that fall within a particular profession's scope of practice.

Scope of Practice Scenario

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

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

(ii) Restricted Activities

Restricted activities (formerly called reserved acts) are a narrowly defined list of invasive, higher risk activities that must not be performed by any person in the course of providing health services, except:

- Members of a regulated profession that has been granted specific authority to perform these activities in their regulations, based on their education and competence.

Individual professions will be granted a list of specific restricted activities from a "master list" commensurate with their education and competencies, which may be performed while providing the services described in their respective scope of practice statements. The master list is currently under development. The same restricted activities may be granted to more than one profession. Not all professions will be granted authorization to perform restricted activities. The "master list" and any exemptions to it will also be established by regulation.

This approach abandons the historical concept of professional exclusivity in which legislation prohibits any person other than a member of the profession from performing certain services or procedures, except where another profession is also specifically authorized by legislation. Under the new model which is in the process of being developed, many aspects of the scope of practice of each regulated profession may overlap, or be shared. This new shared scope of practice/restricted activities regulatory model that is being adopted under the *HPA* is similar to that adopted in Alberta, Ontario and Manitoba.

As of October 2013, 11 of the 22 colleges have completed the retrofitting of their regulations under the new model. The CTCMA is currently in the process of retrofitting the Traditional Chinese Medicine Practitioners and Acupuncturists Regulation to the new model.

(iii) Standards, Limits and Conditions

Standards, limits and conditions will be applied to certain restricted activities and will identify the terms under which restricted activities can be performed by individual registrants. By law, all registrants must perform restricted activities in accordance with any standards, limits and conditions that apply to those restricted activities.

"Standards" will define a required level of performance (e.g. a practitioner must have patient's consent to treatment). "Limits" will specify the limitations on what the practitioner may do (e.g. putting substances into the ear canal only up to the eardrum). "Conditions" will set out the circumstances required for a practitioner to perform a restricted activity (e.g. a practitioner may be required to be certified in order to treat patients with point injection therapy).

It is important for practitioners to be familiar with the current Traditional Chinese Medicine Practitioners and Acupuncturists Regulation and to refer to the College website and Newsletter for updates on the retrofitted regulations listing the restricted activities and any standards, limits and conditions applied to the restricted activities.

(iv) 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 British Columbia. If a person is not from one of the approved health professions, he or she cannot use the title in a clinical setting even if the person has an earned doctoral degree (i.e., the person holds a Ph.D). Allowing a staff person to call the health care practitioner "Doctor" would constitute an offence.

The second rule is that the regulations for each College established under the *HPA* regulate the use of titles relating to their profession. Each profession has specific titles that only persons registered with their College can use as a professional title. For example, only practitioners can use the titles "acupuncturist", "traditional Chinese medicine practitioner", "doctor of traditional Chinese medicine" and "traditional Chinese medicine herbalist" under the *Traditional Chinese Medicine Practitioners and Acupuncturists Regulation.* In addition, even if the person does not use the reserved title, he or she cannot hold himself or herself out as a practitioner. This prevents people from pretending that they are practitioners when they are not and engaging in unauthorized practice.

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

The third set of rules is created by each College for its members. For example, each class of registration is given a specific designation for them to use (e.g., R. TCMP, or R. Ac). Practitioners with other classes of registration cannot use those designations unless specifically permitted to do so. In addition, since the profession does not have recognized specialties, practitioners cannot use titles or designations inferring specialist status or certification (e.g., pediatrician, gerontologist).However, practitioners are free to describe their areas of practice so long as it does not imply specialist status or certification (e.g., practice limited to children).

Finally, there are College bylaws preventing the use of misleading titles or designations or engaging in false or misleading advertising. For example, it would be professional misconduct for a practitioner to refer to an educational degree that had not been received.

Use of Titles Scenario

X, a registered TCM practitioner, teaches at a school that trains practitioners. The school has a clinic where it sees patients. X supervises the students at the clinic. The students refer to him as "Doctor X" at the clinic. The Dean of the school pulls X aside and tells him to ask his students to stop calling him "Doctor" in the clinic where there are patients. X reviews the Health Professions Act and Traditional Chinese Medicine Practitioners and Acupuncturists Regulation and realizes that the Dean is correct. X is assisting in the treatment of patients there and thus is not permitted to call himself (or allow others to call him) "Doctor" there. X also recognizes that he was being a poor model for the students.2.6.3 Illness and Work Restrictions

(v) 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 *HPA* carefully balances the need to protect patients by requiring practitioners to make a report and to prevent the health care system from being disrupted with many unnecessary reports. The statute also recognizes that if practitioners unnecessarily report on their colleagues, it will harm the atmosphere necessary for interprofessional collaboration. This section of the book describes the mandatory reporting provisions under the *HPA.* There are some mandatory reporting provisions in other statutes (e.g., the *Child, Family and Community Service Act*) which are either dealt with below or are too uncommon for practitioners to warrant discussion in this book.

Both the *HPA* and case law provide immunity to practitioners who make a mandatory report in good faith.

The mandatory reporting requirements also create an exception to the practitioner's duty of confidentiality.

Sexual Misconduct

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

The report must be made in writing to the Registrar of the College to which the alleged offending practitioner 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 should be made as soon as reasonably practicable. 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 Misconduct Mandatory Report Scenario

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

Danger to public/termination of business relationship

A practitioner must report if he or she has reasonable grounds to believe that the continued practice of a health profession by another health care provider might constitute a danger to the public. A practitioner must also report to the College if he or she terminates the employment of another health care provider, revokes, suspends or imposes restrictions on the privileges of that person, or dissolves a partnership or association with that person. If the practitioner was going to make a report, the report must be made even if the person quits or resigns first.

The report must be made in writing to the Registrar of the College that regulates the other health care provider. The report should be made as soon as reasonably practicable.

Hospitalized registrants

In addition, the chief administrative officer of a hospital, and the attending medical practitioner who has care of a health care provider who has been hospitalized for psychiatric care or treatment, or treatment for alcohol or drug addiction, has a mandatory duty to report the hospital admission to the Registrar of the College that regulates the health care provider. Again, the report must be made in writing to the Registrar of the College to whom the alleged health care provider belongs. The report has to contain the reporting practitioner's name and the grounds of the report. The report must be made promptly.

Risk of Public Harm Mandatory Report Scenario

X, a practitioner, learns that his employer (a traditional Chinese medicine practitioner) is an alcoholic. X tries to help his employer get treatment, but the employer keeps relapsing. The day before, the employer came back after lunch totally impaired such that X had to call in his employer's wife to pick him up and take him home. X had to cover for the patients. What scared X the most was that his employer treated three patients after lunch before X found out about his condition. X is preparing his letter of resignation. He consults a lawyer about what to do. X's lawyer advises him that X must make a written report to the Registrar of the College of X's employer.

Duty to Warn

Under case law, a practitioner who has reasonable grounds to believe that another person is likely going to cause death or severe bodily harm has to warn the appropriate people of the risk. Where a practitioner learns of an incident of unsafe practice by another practitioner, the first practitioner must report this to the Registrar. This duty to report does not include all forms of incompetence, incapacity or professional misconduct. It only applies where the practitioner risked the safety of a person (normally, but not always, a patient).

Duty to Warn Mandatory Report Scenario

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

Sample Exam Question

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

i. No. Dirty jokes are not sexual misconduct.
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 misconduct.

The best answer is iv). Sexual misconduct includes comments of a sexual nature to a patient. Reporting sexual misconduct is mandatory. While it is unlikely that significant action will be taken by the College (perhaps a sensitivity course), it is still important that practitioners learn that such conduct can be harmful to some patients. One never knows what experiences patients have had in their past that might make even a dirty joke harmful. Answer i) is incorrect because dirty jokes are sexual misconduct. Answer ii) is not the best answer because there are no mandatory reporting requirements under the Human Rights Code. Also the College bylaws use the term sexual misconduct 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. 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.

(vi) Public Register

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

The register must contain the following information about each practitioner:

- Name;
- Business address and telephone number;
- Name, business address and telephone number of each professional corporation;
- Class of registration;
- Any limits or conditions on the registration;

- A notation of each cancellation or suspension of the person's registration; and

Any other information that the regulations or bylaws say should go on the register (the College bylaws provide that the College must disclose whether or not the Discipline Committee has ever issued an order and the details of that order, whether or not the person has ever signed a consent order and the details of the consent order).

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.

C. Traditional Chinese Medicine Practitioners and Acupuncturists Regulation and College Bylaws

The *HPA* authorizes the government to designate a health profession by regulation. The *Traditional Chinese Medicine Practitioners and Acupuncturists Regulation* designates traditional Chinese medicine and acupuncture as a health profession and establishes the College to govern the profession. The TCMPA Regulation defines what is encompassed by "acupuncture" and "traditional Chinese medicine" and sets out the four reserved titles for registrants of the College:

a) Acupuncturist;

b) Traditional Chinese Medicine Practitioner;

c) Traditional Chinese Medicine Herbalist;

d) Doctor of Traditional Chinese Medicine.

The TCMPA Regulation sets out the scope of practice for an acupuncturist and a traditional Chinese medicine practitioner and certain limits and conditions on the services that may be provided. British Columbia is implementing a new shared scope of practice/restricted activities regulatory model under the HPA. The new model is characterized by two essential elements: scope of practice statements and restricted activities. Scope of practice statements are the concise descriptions, in broad, nonexclusive terms of each regulated profession's activities and areas of professional practice. They are not exhaustive lists of every service the profession may provide. Restricted activities are a narrowly defined list of invasive, higher risk activities that must not be performed by any person in the course of providing health services, except members of a regulated profession that has been granted specific authority to do so in their regulations, based on education and competence. As of May 2014 the government has amended half of the regulated health professions according to the new model. CTCMA is currently in the process of drafting proposed regulation amendments. CTCMA has undertaken a comprehensive consultation process with

registrants and other stakeholders. It is anticipated that the proposed regulation with amendments incorporating the new model will be submitted to government later this year.

Until the Government approves an amended Regulation, the current Regulation remains in place. This Regulation remains basically unchanged from the year 2000 and includes limits and conditions. However these limits and conditions will be removed when the amended Regulation comes into force. For example, it provides that no acupuncturist or herbalist may treat an active serious medical condition unless the client has consulted with a medical practitioner, naturopath, dentist or doctor of traditional Chinese medicine as appropriate. A traditional Chinese medicine practitioner or an acupuncturist may administer acupuncture as a surgical anaesthetic only if a medical practitioner or a dentist is physically present and observing the procedure. An acupuncturist or herbalist must advise the client to consult a medical practitioner, naturopath, dentist or doctor of traditional Chinese medicine if there is no improvement in the condition for which the client is being treated within two months of receiving treatment. If the client does not consult with one of those health care professionals in those circumstances, the acupuncturist or herbalist must discontinue treatment if: (a) there is no improvement in the condition for which the client is being treated after four months; (b) the condition worsens; or (c) new symptoms develop.

The *HPA* authorizes the Board of the College to make bylaws with respect to the regulation of the profession. The TCMPA Regulation and College bylaws are both forms of law. The major difference between a bylaw and a regulation is that a bylaw is made directly by the Board of the College (subject to Ministerial approval), while a regulation is made by the Cabinet or a Minister of the provincial government of British Columbia. Bylaws typically relate to the administration and internal affairs of the College. Regulations generally deal with matters of broader public concern.

The College will be presenting the provincial government with a proposal to amend the Regulation in compliance with the government's new shared scope of practice/restricted activities regulatory model. Until the amendment is approved by the government, the current Regulation remains in force including the limits and conditions which will be replaced with new limits and conditions.

(i) Registration under College bylaws

Part IV of the College bylaws set out the requirements for obtaining and maintaining registration with the College. It is intended to make sure that members of the College are competent and have good character.

The registration regulation establishes eight classes of registrants:

1. Registered Acupuncturists, abbreviated as "R.Ac.";
2. Registered Traditional Chinese Medicine Herbalist, abbreviated as "R.TCM.H";
3. Registered Traditional Chinese Medicine Practitioner, abbreviated as "R.TCM.P";
4. Doctor of Traditional Chinese Medicine, abbreviated as "Dr. TCM";
5. Limited registration - an applicant may apply for registration for a period of up to one year where certain conditions are met but the applicant does not meet all of the requirements for full registration;

6. Student registration - for applicants who are enrolled in an approved student training program;
7. Non-practising registration - for existing registrants who are not currently practicing the profession but wish to remain registrants with the College; and
8. Temporary registration - for recognized and skilled traditional Chinese medicine practitioners and acupuncturists from other jurisdictions to practice in British Columbia for a short period of time.

General Requirements

There are certain requirements that must be met by all applicants for registration with the profession. All applicants must complete an application form fully and pay applicable fees. The applicant must also follow the instructions on the College's website to complete the criminal record check. The application form requires applicants to provide information regarding the applicant's training and experience and past professional experiences (including previous registration with another regulatory body). The College may also require police report in addition to the criminal record check. The applicant must be a Canadian citizen or permanent resident of Canada or be otherwise authorized to work in Canada. The applicant must not be incapacitated (i.e., have an illness that prevents them from practising safely, like a drug addiction that is not under control) unless adequate safeguards are in place.

Specific Requirements

There are specific requirements for each class of registration. For example, applicants for full registration must be graduates of a traditional Chinese medicine education program recognized by the Board for the purpose of registration and set out in Schedule H of the College bylaws, have successfully completed not less than two years of liberal arts or sciences study (comprised of at least 60 credits) in an accredited college or chartered/approved university, and pass the registration examination.

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

General Conditions

Once a person is registered with the College, he or she must continue to meet the requirements set out in the TCMPA Regulation and College bylaws. For example, if the member no longer has professional liability insurance coverage as required under the College bylaws, the member must tell the College. Members of each class of registration are assigned a specific title that the members must use so that the public can identify their registration status. Members must display their certificate of registration prominently where they practice.

Registration Scenario

X is a TCM acupuncturist who practices in Ontario and is registered with the College in Ontario. He has been invited by a colleague to come to British Columbia to demonstrate a particular technique at a conference, and provide demonstrations with patients in British Columbia. It has been suggested that he come over for two months and see patients under the supervision of a registered TCM acupuncturist in British Columbia so that others can learn and benefit from his expertise. Is X required to be registered in British Columbia? Yes. The College has a Temporary class of registration that allows X to register for up to 90 days in British Columbia so long as he is already registered and is holding a certificate in good standing from a regulatory body governing the practice of traditional Chinese medicine in a jurisdiction approved by the Board. In addition, if he wanted to, X could rely on the mobility provisions to register as a Full member to practice as an Acupuncturist.

(ii) Protection of Personal Information of Patients under College Bylaws

Part VI of the College bylaws sets out the requirements in relation to the collection, use and disclosure of the personal information of patients. Registrants are prohibited from collecting personal information (any identifiable information about an individual) regarding a patient unless the information relates directly to and is necessary for providing health care services to the patient or for related administrative purposes, or the collection of that information is expressly authorized by a statute. Registrants must collect personal information about a patient directly from the patient and not from other sources except in limited circumstances set out in s. 73(2) of the College bylaws. Registrants are required to maintain the confidentiality of personal information collected from patients and to ensure that such information is current, and is legibly, accurately and completely recorded. Generally, registrants may only use personal information for the purposes of providing health care services to the patient or related administrative purposes, or if the patient has consented to the use.

Section 80 of the College bylaws sets out the limited circumstances in which a registrant may disclose personal information; if the disclosure is not authorized under one of those subsections, it must remain confidential. Registrants must retain personal information for a period of at least ten years.

Section 83 of the College bylaws provides that registrants must ensure that all records pertaining to their practice which contain personal information are safely and securely stored. Section 84 sets out the only ways that records can be disposed of. Section 85 provides that a registrant who ceases to practise for any reason must dispose of personal information in accordance with Part VI of the College bylaws and provide written notification to the College of the steps that he or she has taken to dispose of the personal information.

Section 86 provides that registrants must protect personal information by making reasonable security arrangements against such risks as unauthorized access, collection, use, disclosure or disposal. Section 88 sets out the process for remedying a breach of security where there has been an unauthorized access, use, disclosure or disposal of personal information.

Patients have the right to access their personal information in the custody or control of registrants under s. 89 of the College bylaws. If a patient or the patient's representative requests access to personal information about the patient, a registrant must comply with the request within 45 days by providing access to all or a portion of the patient's records or providing written reasons for refusing access. Registrants are only authorized to refuse access: (a) where there is a significant likelihood of a substantial adverse effect on the physical, mental or emotional health of the patient; (b) where there is a significant likelihood of harm to a third party; or (c) if the disclosure could reasonably be expected to disclose personal information regarding another individual.

(iii) Requirement to Maintain Liability Insurance under College Bylaws

The College bylaws require all registrants and their employees to be insured against liability for negligence in an amount of at least $1,000,000 per occurrence. The failure to have professional liability insurance in place would constitute professional misconduct.

(iv) Restrictions on Advertising under College Bylaws

Advertising is an appropriate way to provide information to potential new patients but registrants must follow the restrictions contained in s. 92 of the College bylaws. Practitioners can use appropriate advertising to communicate the type and availability of services within their scope of practice to the public, or to other health professionals. The purpose of advertising should be to provide relevant information to the public in order for them to make informed choices in regards to their health care needs. However, advertising must not be dishonest, misleading or irresponsible.

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

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

Advertising should be factual, accurate, objectively verifiable, independent of personal opinion, comprehensible and professionally appropriate. It should not include any information that is misleading by either leaving out relevant information, or including non-relevant, false, or unverifiable information. For example, providing before and after pictures of how one's services can enhance a patient's appearance is inherently misleading and unverifiable.

Practitioners should also take reasonable steps to ensure that the advertisements placed by others (i.e., employees, marketing consultants) meet these standards. In particular, references to qualifications in the advertisement should be consistent with the College's rules. For instance, the title the member can use will depend on their class of registration. A R.TCM.H. cannot use the title of Doctor. Off-shore qualifications need to be clearly stated.

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

Further, advertisements are prohibited if they:

- promote a demand for any unnecessary services,
- make a claim or promise a result that cannot always be delivered (i.e., or be interpreted as a guarantee as to the success of a service provided),and
- use comparative (e.g., "better"), superlatives (e.g., "best"), suggestion of uniqueness, or appeal to a person's fears about any service quality, products or people (e.g., comparing one's services to another's, or claims that one's service is superior to others).

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

Advertising Scenario

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

Sample Exam Question

Which of the following requirements for advertisement is the best description:

i. Accurate.
ii. Verifiable.
iii. Not contain personal opinions.
iv. All of the above

Answer iv) is the best answer. All of the qualities are those that are required of advertising. There are also more qualities that advertisements should be such as factual, objective, comprehensible, and appropriate.

(v) Record-keeping

One important aspect of the standard of practice is record-keeping. Keeping records is essential for providing good client care; even practitioners with excellent memories cannot recall all of the details of their patients' health status and treatment. Records permit the monitoring of changes in patients. Records also ensure proper continuity of care by assisting 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 is a failure to maintain minimum professional standards and is professional misconduct.

The information that must be recorded

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

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

The record should include all relevant subjective and objective information gathered regarding the patient. This includes all relevant information provided by the patient (or his or her authorized representative, or other health care professionals involved in the patient's care) to the practitioner regardless of the medium or format (e.g., communicated in person, on paper, email, fax, telephone, etc.).

It should also include any records regarding findings from assessments or during observations (e.g., how the patient walked into the office, what were his or her complaints, symptoms, signs and family history. If an inquiry, diagnosis, or investigation relevant to the patient's problems has been done, the results should also be recorded.

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

The record should contain a summary of the patient's problems and his or her treatment plan. Then the actual treatment provided (including the specific acupuncture points used) should be noted. The record should also include any progress notes of how the patient progressed during treatment, any changes in the patient's condition, or any reassessments or modifications of the treatment plan. It should be clear to any practitioner reading the record what happened.

If the patient was a referral, the person who made the referral and the reason for the referral should be in the record. If the practitioner has referred the patient to another health care provider, that should also be recorded.

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

The form in which records can be kept

The College bylaws require that 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.

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 initial of the person correcting the error).

The record should be in English although information can be recorded in other languages; however, the registrant may have to provide a translation to the College in the event that a complaint is filed about his or her conduct.

How long the information must be maintained

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

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

Maintaining or transferring records upon leaving a practice or retiring

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

Even when a practitioner retires or leaves the practice (i.e., resigns as a member of the College) the original record should be kept for the ten year retention period, unless the record has been transferred to another practitioner who will maintain the record. The patient must be notified of the transfer. In those circumstances, the original record can be transferred to the new practitioner. The practitioner must transfer records in accordance with the procedures set out in the College bylaws and must provide notice to the College and a written summary of the steps taken to transfer the records.

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

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

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

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

Confidentiality and privacy issues

Practitioners should take reasonable steps to keep records safe and secure. The College bylaws set out specific requirements for confidentiality and protection of personal information. In general, no one outside of the authorized circle of care of health professionals should be able to access the records. Privacy protections must be in place to ensure the records cannot be seen or taken by others. Paper records should be kept under lock and key. Computer records need to be password protected on computers that have firewall and virus protections and must be backed up regularly.

Patient access to records

Generally, a patient has the right to review and receive a copy of all clinical records kept by a practitioner unless access would significantly jeopardize the health or safety of a person.

Although the practitioner may own the health care record and be responsible for it, patients are authorized by College bylaws to access their personal information and by the *Personal Information Protection Act* to access their record. Also, the patient has the right to correct any errors in the health record. If a patient requests any relevant parts of the record, the practitioner should provide them with a copy and not the original.

Record Keeping Scenario

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

Sample Exam Question

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

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

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

(vi) Conflicts of Interest

A practitioner cannot engage in a conflict of interest. The Code of Ethics for Registrants contained in Schedule "A" of the College bylaws provides that registrants must not exploit clients' vulnerabilities for their own interests or gain, whether sexual, emotional, social, political, financial, or in any other way.

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

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

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

Some common examples of conflicts of interest are as follows:

- splitting fees with a person who has referred a patient;
- receiving benefits from suppliers or persons receiving referrals from the practitioner;
- giving gifts or other inducements to clients who use the practitioner's services where the service is paid for by a third party (e.g., insurance);
- working for an unregistered person who can interfere with professional decisions (e.g., how much time is set aside for each appointment);
- using or referring a patient to a business in which the practitioner has a financial interest; and
- selling an unnecessary product to a patient for a profit.

Many of the examples depend on the reasonableness of the circumstance in determining if a conflict of interest exists. Practitioners should always ask themselves – would another objective and reasonable person think that there is a conflict of interest, given this circumstance? For example, it probably would be appropriate to give a patient a small calendar to record their future appointments even if an insurance company pays for the treatment.

However, giving the patient a new pair of expensive running shoes is unreasonable in the circumstances (even if the patient needs to exercise).

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

- disclosed the nature of the relationship with the health store (e.g., "my spouse owns the store");
- provided alternative options (e.g., "here are three other places you could get the product I am recommending for you"); and
- reassured the patient that choosing another store will not affect the patient's care (e.g., "You are free to choose any of the places to get the product; you will still be welcome here as my patient").

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

Conflict of Interest Scenario No. 1

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

Conflict of Interest Scenario No. 2

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

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

(vii) Conduct towards Colleagues

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

(viii) Conduct towards the College

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

- Publicly challenging the integrity of the College's role or actions.
- Breaching an undertaking given to the College.
- Failing to co-operate in, or obstructing, an investigation by the College.

- Failing to participate in the quality assurance program.
- Failing to respond appropriately and promptly to correspondence from the College.
- Failing to report a practitioner to the College who has jeopardized the safety of a patient.

(ix) Disregarding Restrictions on Certificate of Registration

A practitioner must confine his or her practice to what is legally permissible. If the Act or a committee of the College 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 TCM acupuncture cannot offer herbal remedies.

D. The College

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

(i) Registration process

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

To become a member of the College a person files an application form with the Registrar, and pays the applicable fees. The form is available on the College website. Through the application form the applicant provides the College with information about his or her training and experience, his or her past conduct, and other information that may affect his or her ability to practise effectively. The applicant should provide enough information to demonstrate that he or she meets the requirements for registration. The applicant must not make any false statements on the application as to do so would constitute professional misconduct.

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

However, if it appears that the applicant does not meet the registration requirements (or if the Registrar is not sure) the Registrar will refer the application to the Registration Committee. The Registration Committee will consider the application further and determine the applicant's suitability to become a member. If the Registration Committee has concerns that the applicant does not meet the conditions

for registration, the applicant will be told of the concerns and given an opportunity to provide a written response to the concerns. If, following receipt of a written response, the Registration Committee concludes that the applicant meets the requirements, a certificate of registration will be issued. If the Registration Committee concludes that the applicant does not meet the requirements it can make a number of decisions including:

1. directing the applicant that he or she will not meet the conditions for registration until he or she completes further training or examinations.
2. registering the applicant with terms, conditions and limitations (for example, if the missing requirement is exemptible and the public can be protected in the circumstances).
3. refuse the application.

If registration is not granted by the Registration Committee, or it is granted on terms and conditions, the applicant has further options. The applicant may seek review by the Health Professions Review Board ("HPRB"). The HPRB is appointed by the government and is independent of the College. HPRB will review the file and may hear from witnesses. HPRB can determine that an applicant meets the registration requirements or require the Registration Committee to obtain additional information and make a new decision. HPRB's decision can be challenged by way of a judicial review application to the courts.

Where an applicant is registered in another part of Canada, the College must, with rare exceptions, accept the applicant's education, experience and examination credentials without further inquiry because of the mobility requirements under the *Labour Mobility Act*. However, the College can still review the other registration requirements (e.g., good character and professional liability insurance).

Registration Process Scenario 1 – Making False Statements

X filled out his application form for registration, but when asked if he had any previous criminal findings he did not want to put down the shoplifting conviction he received twenty years ago. He was worried it would affect his application. So, on his application he reported that he did not have any previous criminal findings. On the basis of the application form, the College registers X. A few years later the College is told about X's previous conviction. The College realizes that X made a false statement. The College can refer this matter to the Inquiry Committee to investigate. The Inquiry Committee may direct the issuance of a citation for a discipline hearing. The Discipline Committee may cancel X's registration because he made the false statement on the application form.

Ironically, if X had disclosed the conviction, the Registration Committee would probably have accepted X for registration since he had had no difficulties in twenty years. However, making a false statement on the application form is so serious and reflects current dishonesty, such that now he may be removed from the profession.

(ii) Complaints and discipline process

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

The following outlines how the complaints and discipline process works.

The Inquiry Committee

The Inquiry Committee (the "IC") is the statutory committee of the College that handles member-specific concerns (e.g., professional misconduct, incompetence and incapacity).

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

There are two ways that issues of concern can arise:

1. The Inquiry Committee receives a written complaint; or
2. The Inquiry Committee may initiate an investigation on its own in certain circumstances.

Intake of Written Complaints

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

- the complaint must be in writing;
- the complainant must be identified;
- the member against whom the complaint is being made must be identifiable (the College may be able to assist in identifying the member based on the information provided by the complainant);
- the complaint must identify some conduct or actions that are of concern (i.e., not just the complaint that a member is "unprofessional", "incompetent" or "incapable" but instead including some level of detail to demonstrate those complaints); and
- the complainant must intend the matter to be a complaint.

The Registrar must refer the complaint to the IC for investigation unless it falls within the narrow category of matters that can be summarily dismissed. Once the complaint is referred to the IC, there is a mandatory duty to investigate the complaint and the IC must provide notice of the complaint to the member.

Inquiry Committee Initiated Investigations

The Inquiry Committee has authority to initiate its own investigation even in the absence of a formal complaint with respect to any of the following matters:

- a contravention of the *HPA,* the *Traditional Chinese Medicine Practitioners and Acupuncturists Regulation* or College bylaws; a conviction of an indictable offence; a failure to comply with a standard, limit or condition imposed under the *HPA;*
- professional misconduct or unprofessional conduct;
- competence to practice the health profession; and a physical or mental impairment; an emotional disturbance or an addiction to alcohol or drugs that impairs his or her ability to practise the health profession.

Once the IC initiates an investigation on its own motion, the matter proceeds very similarly to the way it does with a complaint.

Investigations

The investigations by the IC must be adequate, neutral, objective and fair.

- Frivolous or Vexatious Complaints: The Registrar has authority to dismiss such complaints although that decision is subject to review by the IC. This happens rarely. Generally, it must be fairly obvious that there is little merit to the complaint and the processing of the complaint is unfair in the circumstances. For example, a complainant repeating a complaint without any new evidence would be frivolous and vexatious.
- Investigative Steps: The complaint is forwarded to the member for a response. The member's response is provided to the complainant who may then file a reply (which is also shared with the member). Both complainant and member are usually first asked to provide all documentation available to them. The IC will then determine, on the basis of the written submissions from the parties and the documentation that they have provided, whether it is necessary to appoint an inspector to gather additional evidence or whether it has sufficient information to make a disposition decision under s. 33(6) of the *HPA*. If an inspector is appointed, the inspector may interview the parties and gather additional information from a variety of sources such as employer files, public databases (i.e., court files), other regulators, witnesses and other practitioners.
- IC Disposition Decision: At the completion of the investigation the IC makes its decision about the disposition of the complaint under s. 33(6) of the *HPA*.

Time Limits: A complaint is filed when it is delivered in written form to the Registrar of the College. An investigation process is supposed to be completed within 120 days after a complaint is filed with the College. After that the parties must be provided with notices of extension in accordance with timelines set out in regulation. If the College takes too long, the complainant or the member can ask the Health Professions Review Board to take action.

IC Disposition (Decision)

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

- The IC can decide to take no further action if the complaint is frivolous or vexatious or made in bad faith or the conduct to which the complaint relates was satisfactory.
- The IC can take any action it considers appropriate to resolve the matter between the complainant and member (usually mediation or some form of alternative dispute resolution).
- The IC can seek a consent order from the member. This means that a member promises to do certain things (or refrain from doing certain things). A consent order results in the IC taking no further action because the undertakings contained in the consent order addresses the concern.
- Referral to Discipline: Discipline is intended for serious concerns (e.g., dishonesty, breach of trust, willful disregard of professional values, inability to practice competently). Even then the IC must ensure that there is reasonable evidence to support the concern.

Review before HPRB

In a complaint matter, either party (i.e., the complainant or the practitioner) may seek a review of an IC decision before the Health Professions Review Board (HPRB) (unless the decision was referred to discipline proceedings). HPRB may confirm a decision of the IC or return the matter to the IC to make a new decision.

Discipline Proceedings

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

In very serious cases the IC may make an interim order (for example, the suspension of the member's certificate of registration or the imposition of restrictions on registration) to protect the public during or at the end of an investigation and while awaiting a discipline hearing. The power to make an interim order is only used when absolutely necessary to protect patients from harm.

Procedure before the Discipline Hearing Starts

- The issuance of a citation officially initiates proceedings before the Discipline Committee. The citation contains information necessary to ensure that the member can participate effectively in the hearing. It usually is accompanied by a statement of allegations outlining the facts, and legal conclusions to be drawn from the facts (i.e., incompetence, or category of professional misconduct).
- Disclosure of information that the College will be relying on to prove the allegations.
- The Chair of the Discipline Committee selects a panel from among the members of the Discipline Committee to hold the hearing for any allegations referred to it. The panel members must be disinterested and unbiased.

Procedure at the Discipline Hearing

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

Evidence at the Discipline hearing

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

Findings of Professional Misconduct

- Once a Discipline Committee determines what a practitioner has done, it must then decide whether or not that behaviour constitutes professional misconduct as described above.

Findings of Incompetence

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

Bifurcated Hearings

- If a Discipline Committee determines that the practitioner has engaged in professional misconduct, unprofessional conduct or is incompetent, it must then convene the second part of the hearing (either orally or in writing) to hear submissions on the appropriate penalty or regulatory action.

Decisions and Orders in Discipline Cases

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

- Cancellation of registration - the removal of the member from the profession.
- Suspension of registration– the temporary removal of a member from the profession. It can be fixed or flexible, or dependent on an event occurring (e.g., successful completion of a course).
- Limits or Condition on practice – can either be for a specified period (e.g., until the practitioner successfully completes certain remedial training) or for an indefinite period (e.g., the practitioner cannot consume any alcohol). The limits and conditions must be related to the finding made by the Discipline Committee. For example, if the practitioner was dishonest because of a substance abuse problem, the condition cannot be to take remedial education courses because there was no finding that the practitioner lacked any basic knowledge.
- Reprimand – conversation between the Discipline Committee and the practitioner where the Discipline Committee tells the practitioner its views of his or her conduct and how to avoid similar problems in the future.
- Fine – the Discipline Committee can impose a fine of up to $35,000.

- Costs can be ordered by the Discipline Committee to cover a portion of the expenses associated with the hearing.

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

Appeals

There is an option for appeal to Supreme Court by any party at the discipline hearing. The Supreme Court has the power to confirm, vary or reverse a decision of the Discipline Committee, or refer the matter back to the Discipline Committee with or without directions, or make any order it considers appropriate if it determines that the Discipline Committee acted unreasonably or made an error of law.

Complaints and Discipline Scenario – The Typical Complaint

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

E. Other laws

(i) Personal Information Protection Act

Practitioners have a legal and professional duty to protect the privacy of patients' personal health information both under College bylaws and under the *Personal Information Protection Act* ("*PIPA*"). Both govern the practitioners' use of personal health information, including its collection, use, disclosure and access. *PIPA* helps guide the general duty of confidentiality described above.

Personal information refers to almost anything that would be in a practitioner's files on a patient. It is defined broadly in *PIPA* as information about an identifiable individual but excludes business contact information. *PIPA* applies to all "organizations" in the private sector. Organizations include health care practitioners and other professionals.

A sole health care practitioner is responsible for the personal information that he or she collects. If the health care practitioner works for a health services organization such as a private hospital, the organization is responsible for compliance with the Act (although the practitioner must still meet the individual requirements imposed by the College bylaws). If the health care practitioner works for a public hospital, the public hospital is covered by a different act (the *Freedom of Information and Protection of Privacy Act*, *FOIPPA).* Two or more practitioners who work together may decide to act as a single organization for the purposes of *PIPA*. 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 *PIPA*.

PIPA requires every practitioner and organization to appoint a contact person (often called an Information Officer). An Information Officer is the person who ensures compliance with the privacy policy and requirements of *PIPA*. The Information Officer's duties include reviewing the organization's privacy practices, providing training, and monitoring compliance. The Information Officer is also the contact person for public information requests.

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

PIPA Scenario

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

a. Protecting personal health information

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

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

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

Practitioners or organizations also need to securely retain, transfer and dispose of records in accordance with the College's requirements. For example, the College requires that patient records be kept for ten years from the last contact with the patient (or if the patient was not an adult at the last contact, ten years from when the patient turned 19).

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

b. Collection, use and disclosure of personal information

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

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

Under PIPA, collection, use and disclosure of personal information is permitted without consent in limited circumstances. An individual is deemed to have consented to the collection, use or disclose of personal information under PIPA if at the time the consent is deemed to be given, the purpose would be considered to be obvious to a reasonable person, and the individual voluntarily provides the personal information to the practitioner or organization for the purpose. A practitioner or organization may collect personal information about an individual without consent if the collection is necessary for the medical treatment of the individual and the individual is unable to give consent.

Family and friends

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

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

Disclosure related to risk

A practitioner may disclose a person's personal 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 deal with the threat.

Other laws

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

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

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

c. Access to personal information

Every patient has a right to access his or her own personal 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 information, the practitioner or organization must:

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

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

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

Sample Exam Question

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

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

The best answer is answer ii). A patient's right to access his or her personal 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 information may be restricted in some circumstances (e.g., where there is a serious risk of significant bodily harm). Answer iii) is not the best answer because a practitioner's opinion about whether it is good for the patient to see the record is irrelevant. Only if the practitioner believes on reasonable grounds that viewing the information would seriously harm the patient's treatment, may access be refused. Answer iv) is not the best answer because a practitioner does not have a general right to refuse a person access to personal information.

Correction of personal health information

Individuals generally have a right to request corrections to their own personal information. A practitioner or organization receiving a written request must respond to it by either granting or refusing the request within thirty days. It is wise to respond to verbal requests as soon as possible as well.

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

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

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

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

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

Complaints

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

(ii) Health Care (Consent) and Care Facility (Admission) Act

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

If the patient has no representative or substitute decision maker, the practitioner should notify the Office of the Public Guardian and Trustee which may make a court application under the *Adult Guardianship Act* for the appointment of a substitute decision maker or guardian for the patient or a change to an existing order appointing a substitute decision maker or guardian.

(iii) Child, Family and Community Service Act

A practitioner who suspects that any child is in need of protection must report this to a director with the Ministry of Children and Families under s. 14 of the *Child, Family and Community Service Act* (the "*CFCSA*"). This duty overrides all privacy and confidentiality duties and laws, including the *PIPA*. No legal action can be taken against a practitioner for making a report, unless the person making the report knowingly reports false information. The College cannot discipline a practitioner for making such a report in good faith.

As a result of a report, a Ministry child protection worker will investigate the report further, and where action is needed, in many cases the Ministry will offer a family such services as counseling and parenting. A report to the Ministry will not usually result in a child being taken away from a family except if it is imperative to protect the child from harm.

A practitioner has a duty to report with respect to any child under the age of 19. This includes all children, including a child of a patient, or a child who is a patient, or any other child. However, a practitioner has a special responsibility to report information about a child who is a patient or client if the information was obtained while providing treatment or services to the child. A practitioner who fails to promptly make a report that a child needs protection commits an offence under the *CFCSA*. A person who commits such an offence is liable to a fine of up to $10,000 and/or to imprisonment for up to six months.

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

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

The child has been or is at risk of harm

A report is required if a child has been or is at risk of likely being physically harmed by the child's parent or if the child has been or is likely to be physically harmed because of neglect by the child's parent.

A report is also required if a child has been or is at risk of being sexually abused or exploited by the child's parent or another person and if the child's parent is unwilling or unable to protect the child.

A report is also required if the child is emotionally harmed by the parent's conduct.

Failure to provide or consent to services or treatment

There are 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:

- the child is deprived of necessary health care; and
- the child's development is likely to be seriously impaired by a treatable condition and the child's parent refuses to provide or consent to treatment.

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.

> *Mandatory Reporting Scenario 1*
>
> *Y, a practitioner, has a patient who discloses that she has physically harmed her son. Y has a duty to make a report, even if the patient reported this in confidence or in the course of assessment or treatment. If two months later the patient says something that makes Y suspect that the patient has physically harmed her son again, Y has a duty to make another report.*

(iv) Community Care and Assisted Living Act

The *Community Care and Assisted Living Act* ("*CCALA*") regulates community care facilities and assisted living residences in British Columbia.

Resident care and rights

The *CCALA* sets out the rights of an adult person in care which include the right to a care plan developed specifically for the adult on the basis of his or her unique abilities and preferences, the right to protection and promotion of his or her health, safety and dignity, the right to be protected from abuse and neglect, the right to privacy, the right to participate in his or her own care and the right to transparency and accountability in the delivery of services.

A community care facility and assisted living residence must have a zero-tolerance policy with respect to abuse and neglect of residents. Abuse includes physical, sexual, emotional, verbal or financial abuse.

Complaints

Practitioners have a duty to report abuse and neglect of residents and certain other conduct to the Director of Licensing at the Ministry of Health Services. A practitioner should submit a report if the practitioner suspects on reasonable grounds that any of the following have occurred:

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

- Neglect of a resident by staff, including management, that resulted in harm or a risk of harm to the resident;
- Unlawful conduct that resulted in harm or a risk of harm to a resident;
- Misuse or misappropriation of a resident's money; or
- Misuse or misappropriation of funding provided to a community care facility or assisted living residence.

A person who reports abuse in good faith is immune from legal action.

Complaints and reports about the care of a resident or the operation of a facility or residence must be investigated by the Ministry of Health Services if they involve certain matters including abuse of a resident by anyone, and neglect of a resident by staff.

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

(v) Human Rights Code

Every person is entitled to access and receive health care services in a manner that respects his or her human rights. The British Columbia *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, religion, ethnic origin, citizenship, sex, sexual orientation, age, marital status, family status or physical or mental disability (the "prohibited ground" or "prohibited reason".

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

Duty not to discriminate

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

- refusing to accept a new patient for a prohibited reason;
- refusing to continue treating a patient for a prohibited reason;
- making a treatment decision for a prohibited reason;
- insulting a patient in relation to a prohibited reason;
- refusing to permit a patient with a disability to meet with the practitioner with a support person; and

- making assumptions, not based on clinical observation or professional knowledge and experience, about a person's health or abilities, but because of his or her age or another prohibited reason.

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

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

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

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

Duty to accommodate

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

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

Examples of accommodation may include the following:

- permitting a patient who uses a wheelchair to reschedule an appointment with less than 24 hours' notice if the elevator in the practitioner's office is temporarily out of service;
- offering an extended appointment time (without additional cost) to a patient with an intellectual, learning, or mental health disability who may need a longer time to explain his or her symptoms;
- permitting a person with a disability to enter your premises with a support person, service animal, or assistive device; and

- communicating in writing if a person with a hearing impairment or other disability requests this.

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

Human Rights Code Scenario No. 1

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

Human Rights Code Scenario 2

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

Human Rights Code Scenario No. 3

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

(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 granted and regulated by the municipality, and not by the provincial government. A municipal licence does not give a practitioner the right to be registered with the College. However, a practitioner may be registered with the College and also hold a municipal licence.

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

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

Municipal licensing scenario

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

Conclusion

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