College of Dietitians of Ontario

résumé

HIGHLIGHTS

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Cultural Sensitivity in Dietetic Practice

Elizabeth Wilfert,
President

Cultural competence involves refocusing one's behaviour, attitude, awareness, knowledge, skills and even policies to better serve the interest of the public.

In Ontario, you don't have to look very far to see the impact of cultural diversity. Canadians are proud of their 'cultural mosaic'. One simply has to 'Google' Ontario or Canada and Cultural Mosaic and pages and pages come up with not only information and statistics, but cities and towns who celebrate the diversity by way of festivals throughout the year.

According to the latest Canadian census in 2011, Canada has the highest foreign-born population, at 20.6%, among the G8 countries. While the majority of the foreign-born population was able to converse in English or French, 6.5% reported that they did not know either official language. Ethnic origin is another facet of our diversity, referring to the ethnic or cultural backgrounds of our ancestors. The census found more than 200 ethnic origins reported and, of these, there are thirteen different ethnic origins that have surpassed the one-million mark. Another factor the census looked at was religious affiliations. The census states that there has been an increase of 4.9% in the population of the Muslim, Hindu, Sikh and Buddhist faiths since the 2001, which represents 7.2% of the Canadian population.[1]

Given this diversity, it is becoming ever more important to understand how cultural competence affects the delivery of safe dietetic service. Cultural sensitivity doesn't just impact languages but also all the nuances that come with one's beliefs and values. Often, these subtle differences impede the client or patient's understanding or ability to carry out the directives of a health care provider best needed to see the patient to restored health. Health care providers in Ontario are challenged to not only provide the best possible care but also be cognizant of these cultural differences. As RDs, you are encouraged to be mindful of our cultural diversity and how it adds another dimension to the well-being of clients and patients. There are no 'cookie-cutter' approaches as the combinations of factors are too numerous. Cultural competence involves refocusing one's behaviour, attitude, awareness, knowledge, skills and even policies to better serve the interest of the public.

By the time this article is published many of you will likely have participated in the workshop "Enhancing the Cultural Competence of Registered Dietitians in Ontario" presented by the College's Practice Advisors and Policy Analysts, Carole Chatalalsingh, PhD, RD and Deborah Cohen, MHSc, RD. You have taken that step to understanding the relationship between cultural competence and safe dietetic practice. Our primary goal is public protection, and as you continue to ensure safe, ethical and competent nutrition services in your ever changing practice environment, it is important to include cultural sensitivity.

1. Statistics Canada, *Daily Report,* May 8, 2013

What information would you value as a health consumer?

Mary Lou Gignac, MPA
Registrar & Executive Director

As a parent, consumer and someone who guides others to health care providers, what information would you expect to have to make informed choices?

The College would like to hear your views as we continue to evolve its policies to regulate the profession in the interest of the public.

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The regulation of the profession of dietetics takes place within broad systems and societal environments. One example is the system of health professions regulation made up of the Ministry of Health and Long-Term Care; three government agencies including the *Health Professions Regulatory Advisory Council*, the *Health Professions Appeal and Review Board* and the *Office of the Fairness Commissioner*; and the 26 health regulatory colleges. All are governed by the requirements, authorities and procedures set out in the *Regulated Health Professions Act* (RHPA). Health professions regulation also takes place within the context of changing societal values and social behaviours. Information technology has definitely changed society's expectations about access to information, including access to information about the people and organizations who provide health care.

Are you aware of the information that is currently accessible about dietitians, physicians and other health professionals? As a Registered Dietitian or a consumer of health professional services, what information would you value?

All health profession colleges are required to maintain a register of members on their websites with, at minimum, the information specified by the RHPA. The College of Dietitians of Ontario By-Laws specify additional information to be included on the Register of Dietitians (for a complete list, refer to By-Law General 1, section 42). The register information covers:

- name and history of name changes while a member is practising;
- registration number;
- language(s) of practice;
- contact information for practice locations;
- history of registration (dates and reasons) including type of certificate, suspensions, revocations, and reinstatements;
- notation of a resignation and agreement not to practice when a member resigns during a proceeding such as an investigation, assessment, or a discipline or incapacity proceeding;
- discipline and incapacity proceedings including referrals to a panel, findings and reasons and a synopsis;
- terms, conditions or limitations on a certificate of registration including dates, reasons for them and any variations made to them;
- health professions corporation information parallel to the above.

If you search the college registers for some professions in Ontario, such as physicians, you will find that more information is available. Even so, some sectors of society are asking for

health profession regulatory colleges to provide more information to help people make informed decisions about the health professionals who provide their health care.

In January 2013, a series of Toronto Star articles[1] raised the question of whether the public is owed information about what was referred to as "serious cautions" issued to health professionals as a result of an investigation of a complaint or report about their conduct or competence.

1. The Toronto Star, 2013, January 11, *Doctors, dentists, pharmacists: The mistakes you can't know about*; January 14, *Health colleges given go-ahead to make cautions public*; January 16, *Health minister urged to tell colleges to publicize cautions.*

As a parent, consumer and someone who guides others to health care providers, what information would you expect to have to make informed choices?

The College would like to hear your views as it continues to evolve its policies to regulate the dietetic profession in the interest of the public.

1. **Call Mary Lou Gignac, 416-598-1725, ext 228.**
2. **Email: gignacm@cdo.on.ca**
   or
3. **Share your views using this link:**

http://www.collegeofdietitiansofontariosurveys.com/s/RegisterInformation/

4. **You can also access the survey on the CDO website under News.**

Are you a Health Information Custodian?

Carole Chatalalsingh RD, Ph.D.
Practice Advisor & Policy Analyst

A Health Information Custodian (HIC) is responsible for collecting, using and disclosing personal health information on behalf of clients. A HIC is generally the institution, facility or private practice health practitioner that provides health care to an individual.[1]

The *Personal Health Information Protection Act, 2004* (PHIPA), sets out the responsibilities of the HIC and the rules for handling health information. Within the various practice situations, RDs need to determine if they are a HIC, as outlined in section 3 of PHIPA. This means that RDs who are in private practice programs and services that provide health care directly to clients are HICs and need to be aware of the rules under PHIPA.

PHIPA defines health care as "any observation, examination, assessment, care, service or procedure that is done for a health-related purpose and is carried out or provided to diagnose, treat or maintain an individual's physical or mental condition; to prevent disease or injury or to promote health; or as part of palliative care." This includes making, dispensing or selling drugs, devices and equipment or other items by prescription, or community services provided under the *Long-Term Care Homes Act,* 2007.

AGENTS OF A HEALTH INFORMATION CUSTODIAN

Persons who are not HICs are often termed "agents" and would be required to meet the obligations of agents under the Act. PHIPA defines an agent as any person who is authorized by a HIC to perform services or activities on the HIC's behalf and for the purposes of that HIC. An agent may include an individual or company that contracts with, is

employed by, or volunteers for a HIC and, may have access to personal health information. This includes:

- Employees and consultants
- Health-care practitioners (if they are acting on behalf of the HIC)
- Volunteers
- Researchers
- Students
- Independent contractors (including physicians and third-party vendors who provide supplies or services).

PHIPA permits HICs to provide personal health information to their agents only if the HIC is permitted to collect, use, disclose, retain or dispose of the information.

RDS ACTING AS AGENTS

When RDs are contracted to provide services as agents of a facility under PHIPA, the HIC's (or their designated privacy officer) is required to ensure that all agents of the HIC are appropriately informed of their duties under the law, which may also include the signing of confidentiality forms. Depending on the circumstances, agents are to comply with PHIPA as well as policies in place by the HIC for whom they work.

PERSONAL HEALTH INFORMATION & CONSENT

Both HICs and their authorized agents are permitted to rely on an individual's implied consent when collecting, using, disclosing or handling personal health information for the purpose of providing direct health care.

For example, a staff member of a diabetes education program is an agent of the program under PHIPA. So is the shredding company hired to dispose of files that contain client personal health information. Given that agents collect, use, disclose and dispose of personal health information on behalf of the HIC, and not for their own purposes, agents must:

- collect, use and disclose personal health information with the same care and diligence as the HIC;
- comply with the HIC's obligation to collect as little personal health information as needed in the circumstances;
- not collect, use or disclose personal health information when other information is available or would serve the purpose;
- protect personal health information from being lost, stolen or inappropriately accessed,
- keep personal health information from unauthorized copying, modification and disposal; and
- inform the HIC as soon as possible if any personal health information they handle on behalf of the HIC is lost or stolen, or if someone has accessed it without authority.

SHARING PERSONAL HEALTH INFORMATION – CIRCLE OF CARE

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

RESPONSIBILITIES OF HICS & THEIR AGENTS

The obligations of RDs will differ in their workplace depending on whether they are the HIC or if they are the agent of a HIC.

HICs are responsible for setting the privacy standards for handling personal health information in their organization and for making sure that their agents understand what is expected of them to protect the privacy of personal client health information. This can be done in a variety of ways:

- providing education on PHIPA, in person, and through notice boards, publications and other written materials;
- reinforcing a privacy culture throughout their agency, and being clear about expectations;
- building a privacy component into annual performance reviews;
- informing all agents of their duties under PHIPA; and
- reviewing existing contracts with third party vendors to ensure that they have adequate safeguards for personal health information.

Above all, both HICs and agents of HICs are obligated to consider CASP (Consent, Access, Security, and Privacy) to protect personal health information.

Visit the website if the Office of the Information and Privacy Commissioner of Ontario to learn more about the roles and responsibilities of HICs and agents at: www.ipc.on.ca

QUESTIONS AND ANSWERS

What about grocery and drug stores where some RDs work?

Grocery and drug stores would have to say "Yes" to all of the following criteria in order to be HICs:

- They collect, use and disclose personal health information;
- They are a program or service for community health or mental health; and
- Their primary purpose is providing health care.

While pharmacies certainly do provide healthcare, typically, the primary purpose of grocery and drug stores is not health care under the definition of PHIPA. While some groceries and drug stores provide job opportunities for RDs and other regulated health care professionals, they typically do not provide primary health care. However, they still have a legal obligation to protect the personal information of their customers. As commercial organizations, grocery stores are governed by the *Personal Information Protection and Electronic Documents Act* (PIPEDA). PIPEDA is a federal law that applies to commercial organizations in Ontario that collect, use or disclose personal information while conducting their business.

What is the responsibility of a HIC who works for a non-HIC?

A health care practitioner, who has custody or control over personal health information but who contracts with, is employed by or volunteers for an organization that is not defined as a HIC under PHIPA, is not an agent. In such a circumstance, the individual would fall within the definition of a HIC and must ensure compliance with PHIPA. Examples of HIC who work for non-HICs include:

- an RD directly employed by a school board to provide nutrition education to students;
- an RD employed by a professional sports team to develop individualized meal plans for the players;
- an RD providing nutrition care services to clients of a spa or fitness center; and
- an RD providing nutrition counselling to employees of a large corporation through their employee assistance program.

Who are recipients and are they agents of HICs?

Recipients are institutions that may contract out health care services, such as those of an RD. Recipients are not agents of the HIC because they do not collect, use or disclose personal health information on the HIC's behalf. Typically, a recipient's activities are very separate from the HIC's. Examples of recipients include:

- schools;
- insurance companies;
- employers;
- family members (unless they have legal authority to act on behalf of the client, such as acting as the client's substitute decision-maker); and
- courts or tribunals such as the Consent and Capacity Board.

Are HICs able to give information to a recipient without client consent?

In some cases, a HIC will be able to give information to a recipient (see above) without client consent, such as where the PHIPA or another law allows or requires this disclosure.

HICs are not "recipients," even when they receive personal health information from other HICs.

When are RDs required to invoke the "lock-box" provision?

If RDs are HICs, they must invoke the lock-box provision, when a client asks that part or all of their information not be

shared with other health professionals, agents or HICs. Agents of HICs may also be required to invoke the lock-box provision if the HICs privacy policy dictates as such. The request from a client may be:

- not to collect or use or disclose a particular item of information contained in the record;
- not to collect or use or disclose the contents of the entire record;
- not to disclose their personal health information to a particular HIC, an agent of a HIC, or a class of health information custodians or agents, e.g. physicians, nurses, social workers;
- not to enable a HIC or their agent or a class of HICs or agents to use their personal health information.[2]

The College wrote an article regarding the lock-box provision in *résumé* Spring 2006. Please refer to the following link to access the article: http://www.cdo.on.ca/en/pdf/What%20is%20the%20Lock-Box%20Provision.pdf

Does PHIPA apply to agents of HICs?

PHIPA applies to a wide variety of individuals and organizations defined as HICs. PHIPA also applies to "agents" if they collect, use or disclose personal health information on behalf of a HIC.

What are the responsibilities of private practice RDs who are HICs?

In almost every instance, private practice RDs are the HICs responsible for the privacy, confidentiality, retention and destruction of client health records. In addition, RDs acting as HICs must have plans in place in the event of their sudden incapacity or death. They are encouraged to have a business plan and designate in their will who will be responsible for their client health records and how the records should be managed. (See *résumé*, summer 2011, http://www.cdo.on.ca/en/pdf/Do%20you%20have%20plans%20to%20manage%20records.pdf)

What is the role of the HIC and agent of a HIC in a situation where there is a security breach of personal health information?

In the event of a breach, the HIC, or their designate, must notify the individual as soon as possible that the privacy of their personal health information has been compromised. To act effectively when there is a breach, it is important for RDs who act as HICs to understand and/or develop privacy breach protocols. They must also ensure that their agents know that they must notify the HIC or the HIC's designated contact person within the organization as soon as possible (e.g., an organization's Information Officer).

I am engaged in telepractice dietetic services involving the collection, use or disclosure of personal information outside of Ontario; do I need to follow PHIPA?

RDs engaged in telepractice dietetic services involving the collection, use or disclosure of personal information outside of Ontario will need to follow PHIPA as well as comply with the federal *Personal Information Protection and Electronic Documents Act* available at: http://laws-lois.justice.gc.ca/eng/acts/P-8.6/index.html.

1. *Personal Health Information Protection Act.* (2004). Available from:: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_04p03_e.htm

2. Ann Cavoukian, PH.D. Information and Privacy Commissioner of Ontario. *Lock-Box Fact Sheet*, Number 8, July 2005.

Crossing Boundaries
Ten Cases and Ten Misconceptions

Richard Steinecke, LL.B.
Legal Counsel

Recently, the College had its first boundary crossing case go through the discipline process. Although exceptional for this College, sexual abuse and other forms of boundary crossings are not exceptional among some other health professions. In fact, crossing boundaries is a pervasive problem that can easily ensnare diligent and otherwise ethical practitioners. Even "minor" boundary crossings are risky and can escalate into unprofessional behaviour.

The following ten actual cases identify common misconceptions about the risk of crossing boundaries. These cases caution dietitians to be vigilant in maintaining professional boundaries.

MISCONCEPTION NO. 1: IT IS ALWAYS ABOUT SEX

Boundary crossings can be completely non-sexual. For example, in one anonymous social worker case, the allegations were that the social worker encouraged an elderly vulnerable client, who was in ill health, to sell her home and move into an apartment. The social worker (who was also a real estate agent) offered to sell the client's home and recommended a number of unsuitable apartments for the client. It was further alleged that the social worker arranged for their own spouse to do work in the client's new apartment. The social worker then terminated the client's treatment abruptly, without making adequate efforts to ensure continuity of care.

After learning of the complaint to the College, the social worker sued the client for facilitating the social worker's wrongful dismissal. The social worker's side of the story was never heard and the allegations were not determined because the social worker resigned from the profession. However, this case illustrates that entering into a dual relationship with a client is a form of boundary crossing that is fraught with risk to both the client and the practitioner.

MISCONCEPTION NO. 2: BOUNDARY CROSSINGS JUST HAPPEN

It is extremely rare for sexual abuse to begin suddenly. In almost every case the boundary crossings develop incrementally. For example, in Venema vs. College of Social Workers and Social Service Workers of Ontario, the social worker saw the client over decades. During the first course of treatment, Mr. Venema would hug the client and stroke her hair at the end of treatment sessions. There was a gap of thirteen years when they did not see each other. The client returned for treatment, and during that subsequent four-year period, the conduct escalated as follows:

a) complimenting the client on the client's body and appearance;
b) stroking the client's hair and massaging the client's back;
c) engaging in touching and behaviour of a sexual nature during sessions in the social worker's office;
d) inappropriately disclosing personal details about his private life to the client and making comments of a sexual (and non-clinical) nature;
e) meeting with the client outside of the member's office; and
f) sexual touching.

This conduct case was particularly concerning because the client had come to the social worker for issues of depression, anxiety, low self-esteem, gambling, alcohol addiction and marital difficulties. This case illustrates the point made by Chuck Palahnuik, the author of the book Fight Club, when he said: "Because after you've crossed some lines, you just keep crossing them."

MISCONCEPTION NO. 3: IT WAS DESTINY

Movies portray love as destiny. As Julia Roberts said, "I believe that two people are connected at the heart, and it doesn't matter what you do, or who you are or where you live; there are no boundaries or barriers if two people are destined to be together." While Hollywood can make good entertainment, it can idealize bad judgment. Destiny does not include crossing boundaries with a client.

For example, in Melunsky vs. College of Physiotherapists of Ontario, a female physiotherapist treated a male client. Their personal and sexual relationship did start during the course of treatment. However, treatment was terminated and the couple married. In fact, at the discipline hearing the client/spouse testified that the relationship was a positive one for him and he did not feel that he had been abused. The argument was that the law was interfering with a couple that was meant to be. Despite this testimony, the Discipline Committee found that there had been sexual abuse. The panel accepted that the sexual abuse provisions were designed to protect clients and that it would be impossible for a Discipline Committee to assess, on a case by case basis, whether the relationship had truly been exploitative or abusive. In fact there was expert evidence that over time the client could change his or her understanding of the genesis of the relationship. The finding of the Discipline Committee was upheld by the courts.

An interesting aspect of this case was that the mandatory order of five years revocation was not imposed. However, subsequent court decisions (see the Leering v. College of Chiropractors case below) have determined that the mandatory order is defensible because of the need to deter all sexual abuse even if in some cases it is arguably not predatory in nature.

MISCONCEPTION NO. 4: IT IS OK SO LONG AS THERE IS NO POWER IMBALANCE

Some argue that in some professional relationships there is no power imbalance and that a sexual relationship is not abusive when it is consensual. These arguments were certainly made in the Melunsky case described above. In that case, expert evidence showed that a practitioner always has inherent power over a client because the client comes to the practitioner with a health condition or a need and is relying on the judgment and expertise of the practitioner to help.

Discipline Committees routinely reject the argument that there is no power imbalance in some professional/client relationships. For example, in Khan vs. College of Physicians and Surgeons of Ontario an emergency room physician practising in Texas (but also registered in Ontario) had a brief (two month) personal and sexual relationship with a patient. The Texas board accepted his argument that he had made a mistake and was remorseful and, in effect, only ordered "probation".

When the matter came up for discipline in Ontario, Dr. Khan argued that there was no power imbalance as the relationship was consensual and the client had two other physicians who were addressing her mental health issues. The Discipline Committee rejected these arguments. It found that a sexual relationship with a client is "intolerable under any circumstances" and that the consent of the patient did not mean that there was no power imbalance. The Discipline Committee found the fact that the client was receiving treatment for mental health issues reinforced the power imbalance and did not militate against it. Despite the approach taken in Texas, where the conduct occurred, the Discipline Committee revoked Dr. Khan's registration.

The Ontario legislation starts with the proposition that a sexual relationship with a client is always a violation of the power imbalance.

MISCONCEPTION NO. 5: IT IS OK IF THE PERSONAL RELATIONSHIP COMES FIRST AND TREATMENT SECOND

There is a common misperception that if the personal relationship began first and the treatment relationship followed, there is no sexual abuse. This perception is most common where the practitioner and the client have an established spousal relationship. This "spousal defence" exception has been soundly rejected by Ontario's highest court, most recently in the case of Leering v. College of Chiropractors of Ontario. Dr. Leering met a woman through an online dating website.

Their personal and sexual relationship progressed quickly and within four months they were living together.

About five months after they met, and about a month after they were living together, Dr. Leering began to provide his partner chiropractic services. He did not bill his partner directly; rather he submitted claims to the insurance company for the services. This was after Dr. Leering told his partner that the treatments would be "off-book". When the money came in, the partner gave the money to Dr. Leering.

A few months later their personal relationship ended badly and Dr. Leering tried to claim the balance of the amount for his services from his former partner. She complained to the College about Dr. Leering trying to collect the money. However, the College was more interested in the fact that Dr. Leering treated her during the time that they were in a personal and sexual relationship. Dr. Leering argued the "spousal exception" defence which was, as noted above, rejected by Ontario's Court of Appeal.

There is no spousal exception defence. One cannot treat one's spouse. There is a proposed Bill to modify this rule. However, until the Bill is passed, one cannot treat one's spouse. In addition, the proposed Bill does not actually permit practitioners to treat their spouses. It simply allows each individual College to make a partial (or full) exception if that College believes it will serve the public interest. Thus, even if the Bill passes, the College would still have to make rules defining in what circumstances, if any, a practitioner can treat his or her spouse (and defining spouses for that purpose – a five month relationship may not qualify).

There is no spousal exception defence. One cannot treat one's spouse.

The Dr. Leering case illustrates just a few of the complications that arise when one treats immediate family members (or indeed, engage in any form of dual relationships). How can an insurance company be confident in the objectivity and necessity of the treatment? Also, Dr. Leering appeared to demonstrate that his personal feelings towards the client (i.e., former partner) affected his professional decisions towards her (i.e., determining how much the client owed him for services).

MISCONCEPTION NO. 6: SEXUAL ABUSERS ARE PREDATORS

Quite often sexual abuse flows from practitioners who want to help too much, rather than practitioners who want to take advantage of their clients. For example, in Bennett-Rilling vs. College of Social Workers and Social Service Workers of Ontario, social worker Bennett-Rilling provided counselling and psychotherapy services to an adolescent client for anger management issues, substance dependence and abuse, and difficulties with the client's parents.

However, Bennett-Rilling had sessions with the client outside of her office and outside of regular office hours. For a while Bennett-Rilling allowed the client to stay at her home when the client was released into her care after a court appearance. One night Bennett-Rilling and the client consumed alcohol in Bennett-Rilling's car while discussing counselling issues (i.e., what had happened earlier in the day between the client and her father). At some point they kissed in a sexual manner. Later that evening Bennett-Rilling failed a breathalyzer test while the client was present. There was no indication that Bennett-Rilling had preyed on her client. Rather, she allowed her desire to help the client to become woefully misguided.

MISCONCEPTION NO. 7: NO ONE IS GOING TO TELL

Where a sexual relationship is consensual and is conducted privately, a practitioner may believe that no one will find out. In Mizzau v. College of Dental Hygienists of Ontario, the sexual relationship began while the male client was still being treated by the dental hygienist. They married. Years passed. No one knew that their sexual relationship began during the course of their earlier professional relationship. The marriage failed and the client/spouse then made a complaint to the College. While one can question the motivation for making the complaint then, the fact remained that the practitioner was found to have engaged in sexual abuse and had her registration revoked for a minimum period of five years.

There is no "statute of limitations" on sexual abuse. Complaints and concerns can arise years afterwards and the College will investigate them.

MISCONCEPTION NO. 8: THEY CAN'T PROVE A THING

In DiNardo vs. College of Chiropractors of Ontario, a client made a bizarre-sounding allegation that Dr. DiNardo had put his penis on her forehead as she lay on the treatment table. No one else was present in the office. Dr. DiNardo denied the allegation and suggested that the client had misinterpreted his shirt tail as his penis. The Discipline Committee found the client credible and found Dr. DiNardo not to be credible.

A significant reason for finding Dr. DiNardo not to be credible was forensic evidence that demonstrated that Dr. DiNardo had rewritten part of his chart in an attempt to create grounds for doubting the client's story and to establish that the client was a chronic liar. The forensic evidence was established by indentations of a clinical note found on an x-ray made well after the events that matched the clinical note that was supposedly written years earlier at the time of the events.

MISCONCEPTION NO. 9: BEING COMPASSIONATE JUSTIFIES CROSSING BOUNDARIES

Many practitioners defend inappropriate conduct on the basis that they we simply showing compassion to the person. The unstated inference from this explanation is that boundaries are unreasonable rules created by uncaring rule-makers.

For example, in College of Nurses of Ontario vs. Duval, nurse Duval worked at a psychiatric facility. He met the client at the facility where the client was being treated for an aspirin overdose. After discharge, the nurse called the client and they became friendly. The extent of the relationship was disputed but it was established that Mr. Duval socialized with the client including attending the client's birthday party and the birthday party of the client's father. While Mr. Duval denied it, the Discipline Committee found that Mr. Duval gave the client a birthday card, attended family functions with the client; slept with the client and engaged in a sexual romantic relationship with the client involving: kissing, hugging, and holding hands. The Discipline Committee was not prepared to conclude that sexual intercourse had occurred.

Mr. Duval testified that he was a new nurse and that his compassion did not end with his nursing activities. The Discipline Committee rejected that explanation concluding that he clearly breached known professional standards with a vulnerable client. The Discipline Committee imposed a reprimand, an eighteen month suspension and terms, conditions and limitations.

MISCONCEPTION NO. 10: CONCEALING YOUR PROFESSIONAL STATUS REMOVES THE POWER IMBALANCE

A key component of sexual abuse is the misuse of professional status. Professional status gives a health practitioner the power that makes the crossing of the professional boundaries so harmful. However, downplaying or even concealing that professional status will not avoid accountability.

College of Nurses of Ontario v. Lapierre is one of the more bizarre boundary crossing cases on record. Nurse Lapierre treated a psychiatric client for only one shift. The client had been admitted as a result of a suicide attempt by drug overdose. Nine days later, after the client had been discharged, Mr. Lapierre called the client stating that he had met her at a music festival and the client had given him her number. The client agreed to meet with Mr. Lapierre and thought he looked familiar but did not realize, at the time, that he had been her nurse for one shift during her recent admission. Mr. Lapierre told the client that they had been high at the concert, had been attracted to each other and had been kissing. He said that if they had been alone they would have made love. Mr. Lapierre put his hand on hers and asked to kiss her. The client expressed discomfort and asked Mr. Lapierre to leave.

While Mr. Lapierre never identified himself as a nurse, the client later realized who he was. The Discipline Committee found that the conduct was unprofessional even though Mr. Lapierre was not using his professional status (and, indeed, actively concealed it) at the time he approached the client.

Assessing Whether a Boundary Crossing May be Occurring

- ☐ Is this in my client's best interest?
- ☐ Whose needs are being served?
- ☐ Could this action affect my services to the client?
- ☐ Could I tell a colleague about this?
- ☐ Could I tell my spouse about this?
- ☐ Am I treating the client differently?
- ☐ Is this client becoming special to me?

R. Steinecke and CDO, *The Jurisprudence Handbook for Dietitians in Ontario*, (Online Edition 2012) Checklist 10-1, p. 114.

The fact that the professional relationship was transitory and may not even be remembered by the client does not mean that no boundary crossing can occur.

AVOIDING MISCONCEPTIONS ABOUT BOUNDARY CROSSINGS IS A VALUABLE TOOL

These cases illustrate that crossing boundaries, particularly the boundary defined as sexual abuse, often catches diligent, caring and otherwise professional practitioners by surprise.

Anyone can slip into a pattern of behaviour that can cause harm to clients, others and themselves. Often the circumstances appear in an area of personal vulnerability such as during the breakdown of another relationship, reversals of fortune or arise from a character trait that is otherwise a strength (e.g., a caring nature; a willingness to overlook bureaucratic restrictions for the benefit of clients).

When in doubt, the checklist above, will help dietitians assess whether they are inadvertently crossing a boundary. This checklist is taken from the *Jurisprudence Handbook for Dietitians in Ontario,* Chapter 10, "Boundary Issues" It would be useful to review this entire chapter in light of the above ten cases.

You may also want to think about these quotes:

> *Boundaries are to protect life, not to limit pleasures.* Edwin Louis Cole

> *Earth has its boundaries, but human [foolishness] is limitless.* Gustave Flaubert

Avoiding misconceptions about boundary crossings is a valuable tool to help dietitians maintain excellence in their focus on client-centred care and to avoid harm.

Communicating a Diagnosis

Richard Steinecke, LL.B., Legal Counsel

The first court decision interpreting the controlled act of communicating a diagnosis has been released. While rendered in the context of massage therapy, it provides some valuable guidance to dietitians.

REVIEWING THE HISTORY

For two decades now, one of the most challenging controlled acts to understand, by both regulators and practitioners, is the first one prohibiting the communication of diagnosis. The precise wording of the provision is:

> "Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis." (*Regulated Health Professions Act,* 2 (1)).

There are three components to this prohibition. All three of these components must be present for the conduct to be prohibited:

1. Communication. It only covers communications with a client. It does not prohibit a dietitian from forming an impression leading to a diagnosis. It only prevents the dietitian from telling the client of a new or existing diagnosis for which the client is unaware.

2. **Content.** It is not every communication about a patient's health that constitutes a diagnosis. The diagnosis has to identify (i.e., label) a disease or disorder (which does not include symptoms, for example) as the cause of symptoms (rather than the mere existence of symptoms or what might assist in addressing the symptoms).
3. **Circumstances.** The communication only becomes a problem when the client is likely going to rely on it to make significant treatment decisions.

COMMUNICATING THE RESULTS OF AN ASSESSMENT

There is a fourth "C" to consider as well: Context. Even though dietitians are not authorized to communicate a diagnosis, they are legally obliged to obtain informed consent before providing care/service to a client. Informed consent requires a client to be told the reason, nature and prospects of any proposed treatment. The informed consent rule requires a dietitian to communicate the results of his or her assessment before commencing treatment. This context means that the prohibited communication of a diagnosis must be distinguishable from the required communication of the results of an assessment. How can dietitians thread this fine needle?

The Divisional Court of Ontario (Ontario's second highest court) has recently given some guidance on this question in *Spurrell v. College of Massage Therapists of Ontario*. Mr. Spurrell caused a pneumothorax on a client when administering acupuncture. When the client returned the next day complaining of breathing difficulties Mr. Spurrell stated that she was likely suffering from a muscle spasm and that it was unlikely that she had a pneumothorax. He also minimized the option of her going to the hospital. It turned out she did have a pneumothorax requiring medical treatment.

The Court concluded that while a muscle spasm may not be a "disease or disorder", a pneumothorax is one. By advising a client that she probably does not have a "disease or disorder" (i.e., a pneumothorax), the massage therapist communicated a diagnosis. In addition, the third component (i.e., client reliance on the communication) was clearly met by discouraging the client from going to the hospital.

Communicating symptoms is acceptable while communicating a formal medical label often is not.

This case confirms that communicating symptoms (e.g., a muscle spasm) is acceptable while communicating a formal medical label (e.g., pneumothorax) often is not. The case also confirms that the client's reliance on the communication involves, at the very least, discouraging a client from going to others for a second opinion or for other treatment. The requirement of client reliance may include more things, but it clearly includes that.

The Spurrell case raises more questions than it answers. However, it is a start in determining how to apply this, admittedly, confusing controlled act in one's practice.

HOW A DIETITIAN COMMUNICATES THE INFORMATION IS AS IMPORTANT AS THE INFORMATION ITSELF

Dietitians should feel comfortable in advising clients as to the findings of their assessment, including symptoms or areas for which treatment would be useful. Dietitians should also ensure that they obtain informed consent when initiating an intervention including describing the reason, nature and prospects of any proposed treatment. However, dietitians need to be cautious about communicating a formal medical label (that the client does not already know) or from discouraging a client from seeking a second opinion or other treatment. Advising a client that one has serious concerns in a particular area (e.g., concerning eating behaviours, gastrointestinal symptoms, abnormal biochemical tests) and encouraging them to see a practitioner who can diagnose them would, of course, remain appropriate.

As always, how a dietitian communicates the information is as important as the information itself. A dietitian will not get into trouble for saying "you have a number of symptoms consistent with diabetes, include x, y and z, and I think it is very important that you see your family doctor as soon as you possibly can". A dietitian will get into trouble for saying "I think you have diabetes."

As the Chinese proverb says: "To be uncertain is to be uncomfortable, but to be certain is to be ridiculous".

Certificates of Registration

GENERAL CERTIFICATES OF REGISTRATION

Congratulations to all of our new dietitians registered from July 18, 2013 to October 29, 2013.

Name	Reg. No.	Date
Danielle Lee Barkhouse RD	13038	06/08/2013
Rosanne Blanchet RD	13012	06/08/2013
Alle Choi RD	12887	22/07/2013
Tehreem Irfan RD	12427	22/07/2013
Sonia Jean-Philippe RD	13640	11/10/2013
Kristin Knight RD	12927	22/07/2013
Marc-André Lavigne RD	12898	23/07/2013
Amanda Macdonald RD	12893	22/07/2013
Jordan Mak RD	12871	19/07/2013
Rachel Nadeau RD	12805	03/09/2013
Alexes Papadopoli RD	13093	21/08/2013
Huda Rashid RD	13641	11/10/2013
Sarah Robert RD	13119	21/08/2013
Sylvia Santosa RD	11262	02/10/2013
Sarah Wafa RD	13638	11/10/2013
Cindy Wong RD	13597	13/09/2013

TEMPORARY CERTIFICATES OF REGISTRATION

Christina Agostino RD	13106	13/08/2013
Lara Al Dandachi RD	10892	22/07/2013
Julie Allison RD	13009	13/08/2013
Katie Amadeo RD	12996	30/07/2013
Amanda Andreevski RD	13056	08/08/2013
Megan Bailey RD	13121	22/08/2013
Jenna Baysarowich RD	12974	30/07/2013
Angela Beare RD	13635	09/10/2013
Maylinda Bernard-Hovington	13057	06/08/2013
Laura Bernstein RD	13007	13/08/2013
Marissa Bertens RD	12978	30/07/2013
Jessica Bigelow RD	13043	25/07/2013
Nicole Bloschinsky RD	12954	25/07/2013
Chantal Brazeau RD	13071	06/08/2013
Alexandra Brittain RD	13099	13/08/2013
Sonia Carretta RD	12984	30/07/2013
Fiona Cheung RD	13120	16/08/2013
Grace Cheung RD	13080	30/08/2013
Sarah Cugelman RD	13002	25/07/2013
Elin Czayka RD	13637	09/10/2013
Tori Da Silva Sa RD	13018	26/07/2013
Kavanagh Danaher RD	13535	24/10/2013
Isabel De Araujo RD	13037	25/07/2013
Chantal de Laplante RD	13072	13/08/2013
Michelle Dupuis-L'Heureux RD	13047	25/07/2013
Jenny Egilsson RD	13612	13/09/2013
Melissa Elia RD	12994	06/08/2013
Atara Fenig RD	13032	25/07/2013
Arielle Fortier-Lazure RD	13117	16/08/2013
Emily Foster RD	13059	26/08/2013
Isabelle Gagnon RD	12988	06/08/2013
Anna Gofeld RD	13010	30/07/2013
Sabrina Gonzalez RD	13051	30/07/2013
Lauren Harvey RD	12989	30/07/2013
Natalie Huang RD	13079	13/08/2013
Jemma Hunter RD	13060	13/08/2013
Sara Jafari RD	13074	08/08/2013
Jungsun Jo RD	13611	13/09/2013
Rebekah Keith RD	13029	30/07/2013
Heather Kelly RD	13030	06/08/2013
Sarah Kennedy RD	13618	26/09/2013
Lindsay Kerkvliet RD	13039	08/08/2013
Anna Kouptsova RD	13595	13/09/2013
Jessika Lamarre RD	13023	25/07/2013
Allison Langfried RD	13083	13/08/2013
Katherine Latko RD	13244	24/10/2013
Danielle Lawrence RD	13090	13/08/2013
Leahanne LeGrow RD	13086	08/08/2013
Jessica Love RD	12972	25/07/2013
Carmen Lovsin RD	13092	08/08/2013
Jennifer Magdics RD	13025	16/08/2013
Amanda Magnifico RD	13041	25/07/2013
Nadia Malik RD	10908	22/07/2013
Linnaea Mancini RD	13087	08/08/2013
Nicholas Martineau RD	13192	26/08/2013
Sarvin Maysami RD	12253	24/07/2013
Lesley McBain RD	13122	16/08/2013
Laura McCann RD	13021	06/08/2013
Lauren McDonald RD	13116	16/08/2013
Suzan McKenzie RD	13468	20/09/2013
Emily Mills RD	12968	30/07/2013
Isabelle Mongeon RD	13017	26/07/2013
Mireille Moreau RD	13609	26/09/2013
Kathryn Morgan RD	13069	30/07/2013
Teri-Lyn Morrow RD	13091	08/08/2013
Gillian Nearing RD	12958	25/07/2013
Katie Neil RD	13094	26/08/2013
Hillary Norris RD	13095	13/08/2013
Joy Okafo RD	13186	26/08/2013
Nicole Osinga RD	13016	30/07/2013
Jillian Owens RD	13042	22/08/2013
Jessica Paladino RD	13089	16/08/2013
Vanessa Panayotou RD	13139	22/08/2013
Stephanie Parent RD	13058	30/07/2013
Shannon Pelletier RD	13045	30/07/2013
Lisa Peters RD	13070	08/08/2013
Sylvie Piché RD	13044	25/07/2013
Meghan Poultney RD	13028	19/07/2013
Corinne Price RD	13617	26/09/2013
Valerie Pyra RD	13082	06/08/2013
Catherine Richard RD	13634	11/10/2013
Paula Ross RD	13073	30/07/2013
Asmaa Rouabhi RD	13123	22/08/2013
Shareen Ruddock RD	13097	30/08/2013
Sarah Sandham RD	12979	19/07/2013
Megan Scully RD	13040	22/08/2013
Andrea Senchuk RD	13008	13/08/2013
Debora Sloan RD	13614	13/09/2013
Charlotte Smith RD	13098	13/08/2013
Elyse Therrien RD	13084	06/08/2013
Fabienne Tougas RD	13096	16/08/2013
Emilie Trottier RD	13108	13/08/2013
Breanne Urquhart RD	12956	25/07/2013
Stephanie Varriano RD	13003	13/08/2013
Marcie Vides RD	13615	26/09/2013
Maria Vlahek RD	12953	25/07/2013
Kylie Whyte RD	12993	25/07/2013
Katy Wilson RD	13109	16/08/2013
Laura Wilson RD	13031	19/07/2013
Fiona Wong RD	13013	13/08/2013
Elaine Yao RD	13534	05/09/2013
Bahar Yeganeh RD	13616	04/10/2013
Jennifer Yu RD	13081	13/08/2013
Racha Zarzour RD	13034	13/09/2013
Sherry Zhang RD	13107	20/09/2013
Deanna Zidar RD	13005	19/07/2013
Andreea Zurbau RD	13118	26/08/2013

RESIGNATIONS

Diana Al-Qutub	11710	15/10/2013	Liz Hill	1770	22/08/2013	Rachel Nadeau	12805	09/10/2013
Heather Anderson	12442	13/08/2013	Joanne Kurtz	11847	09/08/2013	Joanne Nijhuis	1341	18/10/2013
Ashley Armstrong	12103	21/08/2013	Tanya L'Heureux	12821	30/09/2013	Nisha Pai	12425	17/08/2013
Kamaljit Bal	12315	15/10/2013	Jacynthe Lafreniére	12906	03/10/2013	Lana Palmer	1176	14/10/2013
Meghan Burek	12542	07/10/2013	Lisa Lagasse	3436	09/10/2013	Andrea Passmore	12230	03/10/2013
Carley Canuel	12817	08/10/2013	Sylvie Leblanc	12759	26/07/2013	Cindy Qu	11565	15/10/2013
Erika Charette	12631	26/10/2013	Ariadne Legendre	12248	15/10/2013	Alicia Ramos	3943	30/09/2013
Krista-Lee Christensen	12611	28/10/2013	Nancy Lemieux	11374	14/10/2013	Maha Saadé	12314	17/10/2013
Lydia Chudleigh	2401	23/10/2013	Milica Litt	2754	21/10/2013	Ghezal Sabir	10911	15/10/2013
Janice De Boer	11510	29/07/2013	Alison Lubin-Jacobson	3600	09/10/2013	Violaine Sauvé	1557	15/10/2013
Bernadette de Gonzague	1587	15/10/2013	Margarida Malcolm	12099	11/10/2013	Lara Steinhouse	12813	15/10/2013
Lorna Dobi	1453	07/10/2013	Roselle Martino	3053	15/10/2013	Audrey Tait	2459	15/10/2013
Sarah Finch	11732	14/10/2013	Natacha Mbuluku Mawisa	12819	15/10/2013	Susan Tran	12095	15/08/2013
Lilliane Francoeur	12498	10/10/2013	Andrea Melo	11525	11/10/2013	Emma Tucker	4446	30/09/2013
Kim Grant	11692	15/10/2013	Sheila Middleton	1442	11/10/2013	Quyen Vuong	12529	16/10/2013
Craig Hamilton	12241	30/09/2013	Megan Moroz	12800	01/09/2013	Caroline Wang	12658	10/09/2013
Jean Harvey	1390	16/10/2013	Joanna Mosko	11184	31/07/2013			

RETIRED

Joan Aird	1036	15/10/2013	Frances Jamison	1469	15/10/2013	Dorothy Nemeth	1174	15/10/2013
Denise Beatty	2406	15/10/2013	Barbara Jaques	2221	15/10/2013	Ritva Restall	2140	14/10/2013
Sylvie Bédard	1987	15/10/2013	Laurie Keefe	1590	15/10/2013	Erika Schieman	2317	22/07/2013
Lorraine Bellisle	1675	05/10/2013	Carole Kenny-Peters	2521	31/08/2013	Luce Scott	2447	07/10/2013
Mary Ann Bocock	2064	14/10/2013	Shirley Kosky	1609	14/10/2013	Colette Sewell	2329	15/10/2013
Lucy Brundage	2382	01/10/2013	Debra Lord	2001	14/10/2013	Betty Tapuska	1384	03/10/2013
Patricia Busch	2609	04/10/2013	Christine Macaulay	2163	15/10/2013	Carmen M.T. Ubbink	2747	12/10/2013
Jane Hatton-Bauer	1992	11/10/2013	Deborah McKinley	1673	01/10/2013	Carla Winchester	2043	11/10/2013
Susan Hubay	1111	04/10/2013	Susan Montgomery	1192	14/10/2013			

IN MEMORIUM

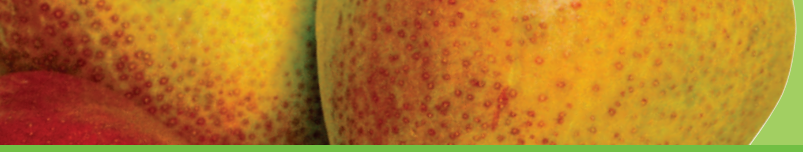
Gail Lehrbass	2473	30/08/2013

Important Reminder

Not receiving correspondence from the College is never an acceptable excuse for missing a deadline or for not complying with a College requirement. The College sends all important notices well ahead of deadlines and in multiple formats to accommodate member preferences. Important information is communicated in the *résumé* newsletter, on the website, by regular mail, and in broadcast emails. In spite of these multiple communication efforts, we hear from some members that they did not receive essential information. Usually, this happens because their contact information was not updated at the College when they moved or changed their work place.

UPDATING YOUR CONTACT INFORMATION IS A PROFESSIONAL DUTY

As regulated professionals, dietitians have a duty to update their contact information at the College so that we can communicate with them as necessary. Under the *Professional Misconduct Regulation* (s. 35.2), "Failing to inform the Registrar of a change of any information required to be contained in the College's register within 30 days after the change occurring", is considered professional misconduct.



WORKSHOP BLOG

ENHANCING THE CULTURAL COMPETENCE OF RDs IN ONTARIO

The CDO 2013 fall workshops are now over and RDs recognize that cultural competence is a lifelong learning process. Join the conversation and share your views and experiences about how cultural competence has positively impacted the quality of your dietetic services.

The workshop explored the concept of culture; identified ways that culture influences health; and discussed the importance of identifying our own values, biases and assumptions that can have an impact on effective outcomes. Workshop participants were able to build on existing knowledge and skills to help them become more competent in responding to people from diverse cultures. Some shared their experiences and stories about the importance of finessing effective cross-cultural communication skills when interacting with others in all areas of dietetic practice.

If you missed the workshop you may still share your views and participate in the discussion with colleagues from all corners of the province. We invite you to read our blog postings and share how your own experiences and learning surrounding cultural competence has impacted your dietetic practice.

To access the blog, log into your member home page from the College website and click on the link.

WORKSHOP BLOG

If you would prefer to contact us directly to discuss how cultural competence affects your dietetic practice, we welcome hearing from you.

Carole Chatalalsingh RD, Practice Advisor & Policy Analyst

Deborah Cohen RD, Practice Advisor & Policy Analyst

415-598-1725/800-668-4990, ext. 397

practiceadvisor@cdo.on.ca

Have you seen these elearning modules?

To view these resources, go to the News section on the bottom left of the CDO website home page at www.cdo.on.ca

- Interprofessional Collaboration eLearning Module 2013
- Pause Before You Post — Social Media Awareness for Regulated Healthcare Professionals
- Evidence-Based Practice