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**RESPONSIBILITIES OF EMPLOYERS,  
MANAGERS AND PARTNERS  
UNDER THE *REGULATED HEALTH  
PROFESSIONS ACT***

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by Richard Steinecke

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# RESPONSIBILITIES OF EMPLOYERS, MANAGERS AND PARTNERS UNDER THE *REGULATED HEALTH PROFESSIONS ACT*

by Richard Steinecke<sup>1</sup>

## INTRODUCTION

It is a mistake to believe that the *Regulated Health Professions Act* only imposes obligations on registered members of a health profession. Employers, managers, human resource directors and partners of health practitioners have a number of obligations under that Act even if they themselves are not registered.

Colleges are finding many employers, managers and partners, and their human resource departments, breaching the requirements of the *Regulated Health Professions Act*, mostly through ignorance. However, as the *Regulated Health Professions Act* becomes more established legislation, the expectation is that employers, managers and partners will bring themselves into compliance with the law. Ignorance of the law is no excuse and it will only be a matter of time before an employer, manager or partner of a health practitioner is sued or prosecuted for breaching their legal obligations.

This booklet sets out the responsibilities of employers, managers and partners of health practitioners and some practical suggestions for fulfilling these legal obligations. The subjects covered include the following:

- Mandatory reporting obligations.
- Unauthorized practice and improper use of titles.
- Record keeping requirements.
- Professional misconduct considerations.
- Duty to cooperate in College investigations.

It is also important to keep in mind that the *Regulated Health Professions Act* is part of a package of legislation. Attached to the *Regulated Health Professions Act* is a schedule, or appendix, that in effect contains another statute, called the *Health Professions Procedural Code*. In addition, each of the 21 health colleges have their own “profession specific” acts. For example, the College of Nurses of Ontario looks to the *Nursing Act* for part of its authority.

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## MANDATORY REPORTING OBLIGATIONS

Employers, managers and partners have a legal obligation to report certain concerns they may have about the behaviour of registered practitioners who work for or with them. These mandatory reports are made to the College which regulates the practitioner being reported. The different types of mandatory reports are set out in Table 1.

### (a) Sexual Abuse Reports

One type of mandatory report applies to “facility operators”. Facility operators must make a report if the operator has reasonable grounds to believe that a registered practitioner at the facility has “sexually abused” a patient. Where a corporation operates the facility, the reporting requirement applies to the individual who is responsible for the operation of the facility.<sup>2</sup>

The term “facility operators” is not defined but probably applies to all institutional settings where health care is provided, such as hospitals, nursing homes and homes for the aged. It may also apply to multi-disciplinary health centres and even to single disciplinary clinics.

To determine whether a mandatory report of sexual abuse must be made, an employer, manager and partner must understand the definition of sexual abuse. The definition is broader than the term itself might suggest. Sexual abuse is defined as follows:

- In this Code, "sexual abuse" of a patient by a member means,
- (a) sexual intercourse or other forms of physical sexual relations between the member and the patient;
  - (b) touching of a sexual nature, of the patient by the member, or
  - (c) behaviour or remarks of a sexual nature by the member towards the patient.<sup>3</sup>

This definition is further clarified as follows:

Touching, behaviour and remarks that are of a clinical nature appropriate to the service provided do not constitute sexual abuse of a patient by a member.

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<sup>2</sup> Section 85.2 of the *Health Professions Procedural Code*, which is Schedule 2 to the *Regulated Health Professions Act*.

<sup>3</sup> Section 1 of the *Health Professions Procedural Code*.

**TABLE 1**

<b>Different Types of Mandatory Reports</b>			
<b>Type of Report</b>	<b>Who Must Report</b>	<b>What Must Be Reported</b>	<b>Timing of Report</b>
Sexual abuse – general	1) all regulated health practitioners 2) facility operators	Sexual abuse	30 days unless reasonable grounds of additional abuse, then immediately
Sexual abuse – reported by psychotherapists	all regulated health practitioners providing psychotherapy to an abusing practitioner	1) opinion, if has one, of whether person will abuse in the future 2) that psychotherapy has ceased	1) 30 days unless reasonable grounds of additional abuse, then immediately 2) immediately
Termination reports	persons who terminate employment, revoke, suspend or impose restrictions on privileges or dissolve a partnership or association of or with a regulated health practitioner or who resolve a serious case before taking such action (e.g., a resignation made to avoid being fired)	Professional misconduct, incompetence or incapacity	30 days

The definition of abuse makes it clear that all gratuitous remarks of a sexual nature towards a patient constitute sexual abuse. Jokes with sexual content, even if directed primarily to staff or colleagues, may constitute sexual abuse if made within the earshot of a patient. Similarly, gratuitous comments about the patient's body or sexual activities are unacceptable.

The definition also covers behaviour of a sexual nature. "Behaviour" is a category of sexual conduct that is in addition to touching and comments. Behaviour of a sexual nature likely includes such conduct as obscene gestures, posting of sexist pictures or calendars, leering, remaining in the room while a patient dresses or undresses, and failing to appropriately drape patients.

The criteria for when a facility operator must make a mandatory report are set out in checklist form in Table 2.

Where an employer, manager or partner is also a regulated health practitioner, the criteria for making a mandatory report are broader. Even if the employer, manager or partner is not operating a facility, he or she must make a report if he or she obtains the reasonable grounds in the course of practising the profession. Table 3 sets out, in checklist form, the criteria for making a mandatory report by a regulated health practitioner.

Where a practitioner provides psychotherapy to a sexual abuser, special rules apply. Not only must the usual sexual abuse report be made to the College, but the practitioner must also express an opinion, if he or she has one, on whether the person will abuse in the future. Also, when psychotherapy ends, the treating practitioner must immediately report that fact to the College. These requirements apply to any practitioner providing psychotherapy, not just psychiatrists or psychologists. "Psychotherapy" is not defined. Any practitioner providing counselling might be considered to be a psychotherapist for the purposes of this provision.

TABLE 2

### CHECKLIST FOR REPORTING SEXUAL ABUSE BY FACILITY OPERATORS

Under the *Regulated Health Professions Act*, sexual abuse must be reported by a facility operator when the answers to all five of the following questions are "yes".

- (1) **Do you know the name of the alleged abuser?**
- (2) **Is the alleged abuser registered with one of the Colleges of a health profession?**  
 If you are uncertain whether the person is registered with a College, you may call the Registrar of the College that regulates the person's health profession.
- (3) **Was the other person involved a patient of the alleged sexual abuser?**  
 The purpose of the sexual abuse amendments was to deal with sexual abuse of patients and not to pry into the private activities of practitioners.
- (4) **Did the conduct involve one or more of the following:**
  - (a) **sexual intercourse or other form of physical sexual relations;**
  - (b) **touching of a sexual nature; or**
  - (c) **behaviour or remarks of a sexual nature?**

The term "sexual nature" does not include touching, behaviour or remarks of a clinical nature appropriate to the service provided. Appropriate sexual histories or physical examinations do not constitute sexual abuse.
- (5) **Does your information constitute "reasonable grounds"?**  
 This question sometimes involves a judgment call. Mere rumour or innuendo (e.g. when someone who barely knows X says "everyone knows that X sleeps with his patients" but can provide no particulars) does not constitute reasonable grounds. However, concrete information from a normally reliable source (e.g. a colleague reports to you that patient Y reported that practitioner X needlessly fondled Y's breasts) would normally constitute reasonable grounds even though you have not spoken to a direct participant to the incident. Most reports to you from a patient of a specific incident constituting sexual abuse of that patient would constitute reasonable and probable grounds.

TABLE 3

**CHECKLIST FOR REPORTING SEXUAL ABUSE  
BY A REGULATED HEALTH PRACTITIONER**

Under the *Regulated Health Professions Act*, sexual abuse must be reported when the answers to all six of the following questions are "yes".

- (1) **Do you know the name of the alleged abuser?**
- (2) **Is the alleged abuser registered with one of the Colleges of a health profession?**  
If you are uncertain whether the person is registered with a College, you may call the Registrar of the College that regulates the person's health profession.
- (3) **Was the other person involved a patient of the alleged sexual abuser?**  
The purpose of the sexual abuse amendments was to deal with sexual abuse of patients and not to pry into the private activities of practitioners.
- (4) **Did the conduct involve one or more of the following:**
  - (a) **sexual intercourse or other form of physical sexual relations;**
  - (b) **touching of a sexual nature; or**
  - (c) **behaviour or remarks of a sexual nature?**

The term "sexual nature" does not include touching, behaviour or remarks of a clinical nature appropriate to the service provided. Appropriate sexual histories or physical examinations do not constitute sexual abuse.
- (5) **Was the information of the alleged sexual abuse obtained in the course of practising your profession?**  
The reporting requirement is not intended to cover information learned through your private life (e.g. at a cocktail party). However, the information may be obtained from any aspect of your professional practice including information from a patient, from your coworkers or staff or from personal observations made during the course of practising your profession (e.g. overheard conversations). The fact that other registered practitioners were present and may have made reports on their own does not relieve you of your obligation to make your own report.
- (6) **Does your information constitute "reasonable grounds"?**  
This question sometimes involves a judgment call. Mere rumour or innuendo (e.g. when someone who barely knows X says "everyone knows that X sleeps with his patients" but can provide no particulars) does not constitute reasonable grounds. However, concrete information from a normally reliable source (e.g. a colleague reports to you that patient Y reported that practitioner X needlessly fondled Y's breasts) would normally constitute reasonable grounds even though you have not spoken to a direct participant to the incident. Most reports to you from a patient of a specific incident constituting sexual abuse of that patient would constitute reasonable and probable grounds.

## **(b) Termination Reports**

A second kind of mandatory report is called a termination report. As indicated by Table 1, termination reports are required whenever a person:

- terminates the employment of a practitioner;
- revokes, suspends or imposes restrictions on the privileges of a practitioner;
- dissolves a partnership or association with a practitioner; or
- resolves a case leading to termination of employment or revocation of privileges by a resignation voluntarily relinquishing privileges.<sup>4</sup>

There is some debate over what constitute “privileges”. They certainly include hospital privileges afforded to physicians, dentists and midwives. There is some doubt that disciplinary measures against employees short of dismissal, such as a suspension without pay, are captured by the provision, although the matter is not certain.

Employers, managers and partners must be particularly careful when resolving concerns with practitioners. Many Colleges have noted that these resolutions have not been reported as required. All too often, practitioners are offered the option of resigning or voluntarily relinquishing their privileges as an alternative to mandatory action. In the hope of avoiding a lengthy and expensive hearing or dispute, employers, managers and partners offer the practitioner a quiet exit. While always of questionable ethics, this action is now illegal; a mandatory report must be made.

## **(c) Confidentiality Concerns**

The duty to make a mandatory report overrides other duties of confidentiality. For example, a report must be made even if the patient requests that the information about the sexual abuse be kept confidential. Indeed, even if the abuser is a regulated health practitioner who discloses the abuse in order to receive help, one is obliged to make a mandatory report.

However, having to make a report does not mean that patient information must always be included in the report. In sexual abuse cases, a mandatory report cannot identify the name of the patient who appears to have been sexually abused unless he or she consents in writing to the disclosure. If the patient who was apparently abused is incapable, his or her personal representative (e.g., parent or guardian) may give the consent in writing. There may even be a duty upon employees, managers and partners to attempt to obtain the written consent of the patient who was apparently abused (the statute is not clear). Presumably, the consent must be an informed consent requiring an explanation as to why a report must be made, why the consent is sought and the likely results of giving the consent. A sample consent form is found at Table 4.

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<sup>4</sup> Section 85.5 of the *Health Professions Procedural Code*.

TABLE 4

**PATIENT CONSENT FORM**

**PLEASE READ THIS IMPORTANT MESSAGE BEFORE YOU SIGN THIS DOCUMENT**

By law, every regulated health care practitioner must report sexual abuse by another practitioner. He or she has no choice.

You have a choice. You can put your name in the report or you can remain anonymous. If you decide not to sign this consent form, your name will not be included in the report.

To help you decide whether to allow your name to be included in the report, please consider the following points.

- The report will be sent to the regulator (called the "College") of the health care practitioner who abused you.
- By disclosing your name, it may be possible to take some action to prevent the practitioner from abusing other patients. For example, the practitioner can be disciplined.
- If you do not disclose your name, it will be very difficult for the College to act on the report because there will be no evidence.
- If you consent to your name being disclosed, you will likely be approached by a representative of the College who will explain what can be done about the practitioner who abused you. He or she will also ask you if you would be willing to help the College deal with the person who abused you. This may result in your being asked to testify in legal proceedings. You can ask him or her any questions you might have.

If you have any questions before deciding whether to sign this consent form, please call:

**[insert name and phone number of contact person from College of practitioner being reported]**

If you wish to give your consent for your name being included in the report please sign below. The choice is yours.

**INFORMED CONSENT**

I was a patient of **[insert name of practitioner being reported]** (the practitioner). **[Insert name of reporting person]** has told me that he or she must report the practitioner for his or her sexual abuse of me. I consent to my name being included in the report.

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(signature of witness)

\_\_\_\_\_  
(print name)

\_\_\_\_\_  
(signature of patient)

\_\_\_\_\_  
(print name)

In termination reports, the statute is silent about the inclusion of patient information. Colleges will inevitably be seeking the information. Employers, managers and partners are well advised to seek patient consent for the disclosure of the information in the report itself. If such consent cannot be readily obtained, the report should state so and provide sufficient details of the concerns so that the College can decide whether to initiate a formal investigation to obtain the information without consent.

#### **(d) How to Make a Mandatory Report**

The mandatory report must be made in writing to the Registrar of the College to which the practitioner of concern belongs. Normally, the report must be filed within 30 days of one's obtaining the reasonable and probable grounds or taking the disciplinary action. However, in sexual abuse cases, if one has reasonable grounds to believe the practitioner will continue to abuse the patient or will sexually abuse other patients, one must file the report immediately.

For sexual abuse reports, the report must contain the reporter's name, the name of the alleged abuser and details of the alleged abuse. If the patient consents in writing to the inclusion of his or her name, it must be included. Otherwise, the patient's name cannot be included in the report.

Where possible, full details of the concern should be included with the report. Also, backup documents are also quite helpful. The report should contain the following details:

- a summary of the nature of the concern;
- a description of the details of the conduct in issue;
- a list of the witnesses to the conduct;
- a copy of the policies or directives of the employer, manager or partner that apply to the conduct;
- the response of the practitioner to the concern; and
- the action taken to date by the employer, manager or partner.

Otherwise, the College will be requesting these details from you. Employers, managers and partners are more likely to avoid unnecessary administrative disruption by College investigations by providing the information Colleges are likely to need in order to determine how to dispose of the matter at the start. See the discussion of College investigations below for more information.

Special rules apply if you make a mandatory report and one is also providing "psychotherapy" to the alleged abuser. The report must also contain one's opinion, if one is able to form one, as to whether the alleged abuser is likely to sexually abuse patients in

the future. One must also file an additional report immediately after the alleged abuser ceases to receive psychotherapy.

**(e) Immunity for Mandatory Reports**

Reporters are given legal protection, known as immunity, for making a mandatory report. If the report is made in good faith, no action or other proceeding shall be instituted against the person making the report. There is also case law that appears to provide similar protection for voluntary reports as well. Presumably, other retaliatory action by the abuser, such as disrupting one's operations, would constitute professional misconduct as well.

**(f) Consequences of Failing to Make a Mandatory Report**

Failure to make a mandatory report is an offence punishable by a fine of up to \$25,000. It also constitutes professional misconduct if the employer, manager or partner is a regulated health practitioner. In addition, if the practitioner later abuses or harms other patients, those patients could sue for failing to report the practitioner before he or she abused or harmed them. For that reason, employers, managers and partners will want to be aware of the precise nature of mandatory reporting requirements. If the patient later does report the other practitioner to the College on his or her own, one of the questions investigators will ask the patient is who else did he or she tell about the abuse. A failure to make a mandatory report will, therefore, often be discovered afterwards.

**(g) Handling of Mandatory Reports by the College**

Mandatory reports are not complaints. Generally, such reports will be treated confidentially as a basis for initiating investigations against practitioners. Normally, the reporter's name will not be disclosed unless absolutely necessary for the investigation or for any disciplinary hearing.

In sexual abuse cases, the most common continuing contact with the College will be requests from College investigators to contact the patient on the College's behalf. This will occur most frequently where the patient has refused to disclose his or her identity in the report. See the discussion below about the duty of employers, managers and partners to cooperate with a College's investigation.

Normally, the reporter will not be a witness at any discipline hearing because his or her information is second-hand or "hearsay". However, there will be some occasions where one will be asked or summoned to give evidence at a discipline hearing. For example, where the defence claims that the statement made by a witness to the employer, manager or partner is different from what the witness said at the hearing, the employer, manager or partner may be asked to clarify what the witness said to him or her. For this reason, employers, managers and partners are well advised to take detailed notes of any information that may lead to a mandatory report at the time the information is first given.

## UNAUTHORIZED PRACTICE AND IMPROPER USE OF TITLES

Employers, managers and partners often do not concern themselves with the various rules prohibiting persons from practising certain aspects of health care or using improper terms, titles and designations. Often the assumption is made that only the persons actually engaging in the prohibited conduct are affected and that employers, managers and partners are not at risk. In fact, this is far from the truth. Aiding and abetting a person to engage in that sort of conduct is also an offence, which can result in prosecution. Restraining orders by a court, sometimes called an injunction, are available. Such a court order would almost certainly apply to the employers, managers and partners as well. Even if legal action is taken only against the employee who does the prohibited act, the reputation of the employer, manager or partner will be tarnished as well. Thus, it is incumbent upon employers, managers and partners to be familiar with the various rules that apply. A brief overview of these requirements is set out below.

Employers, managers and partners are well advised to do the following:

- understand the basic outlines of the *Regulated Health Professions Act* rules;
- educate their staff on these rules;
- include a section in the staff manual about these rules;
- have a process in place for answering staff requests as to whether proposed conduct is in compliance with the *Regulated Health Professions Act*;
- establish a policy requiring compliance with the rules and the reporting to senior management any apparent breach of them; and
- maintain a mechanism for investigating and dealing with apparent breaches of these rules.

One word of warning. Some practitioners experiencing conflict with members of other professions use the complex rules in the *Regulated Health Professions Act* regarding unauthorized practice and improper use of title to conduct their turf battles. Employers, managers and partners may have to distinguish between true threats to the public interest and self-interest advocacy.

### (a) **Controlled Acts**

The *Regulated Health Professions Act* prohibits any person from performing a controlled act (in the course of providing health care services to an individual) unless:

- (1) the person doing the act is registered to a profession that is authorized to perform that act, or

- (2) the performance of the controlled act has been delegated by a registered person.<sup>5</sup>

This rule implies that the provision of health care services that do not involve a controlled act is in the public domain and may be performed by anyone (subject to the harm provision discussed below).

Even registered practitioners can only perform or delegate a controlled act if it is specifically authorized, or listed, in its profession specific statute. Some professions, like dietetics, are not authorized to perform any controlled acts.<sup>6</sup> Others, like medicine, are authorized to perform many controlled acts.<sup>7</sup> No profession can perform all of the controlled acts.

There are thirteen controlled acts. They are as follows:

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

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<sup>5</sup> *Regulated Health Professions Act*, subsection 27(1).

<sup>6</sup> *Dietetics Act*, S.O. 1991, c.26.

<sup>7</sup> *Medicine Act*, S.O. 1991, c.30, section 4.

- (8) Prescribing, dispensing, selling or compounding a drug as defined in subsection 117(1) of the *Drug and Pharmacies Regulation Act*, or supervising the part of a pharmacy where such drugs are kept.
- (9) Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.
- (10) Prescribing a hearing aid for a hearing impaired person.
- (11) Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or a device used inside the mouth to protect teeth from abnormal functioning.
- (12) Managing labour or conducting the delivery of a baby.
- (13) Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response.<sup>8</sup>

The first controlled act, communicating a diagnosis, must be interpreted in light of the scope of practice statements contained in the profession specific acts. For example, respiratory therapists are not authorized to communicate a diagnosis. However, their scope of practice statement suggests that they do assess and treat patients. Given the obligation to obtain an informed consent from patients, this means that one must be able to assess a patient and communicate the results of that assessment without communicating a diagnosis.<sup>9</sup>

The second controlled act prohibits performing a procedure on tissue below the dermis. This will be interpreted in light of cases that indicate that bone is tissue below the deep fascia layer of the dermis<sup>10</sup>.

The profession specific statutes authorizing the performance of controlled acts do not always follow the language of the *Regulated Health Professions Act*. For example, the *Dental Hygiene Act* authorizes dental hygienists to perform “orthodontic and restorative procedures”<sup>11</sup>. This wording is not used in any of the controlled acts and probably includes a combination of the second (procedures in or below the surfaces of the teeth) and eleventh (fitting and dispensing dental prosthesis or orthodontic appliances) controlled acts.

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<sup>8</sup> *Regulated Health Professions Act*, subsection 27(2).

<sup>9</sup> *Respiratory Therapy Act*, S.O. 1991, c.39, section 3.

<sup>10</sup> *Re College of Physicians and Surgeons of Ontario and Larsen* (1987), 62 O.R. (2d) 545 (H.C.).

<sup>11</sup> *Dental Hygiene Act*, s.4.

## (b) Delegation of Controlled Acts

A practitioner whose profession has been authorized to perform a controlled act can delegate the performance of that act to someone else<sup>12</sup>. For example, a midwife can delegate the taking of a blood sample from a woman<sup>13</sup>. The delegation can be to another regulated practitioner whose profession is not authorized to perform the controlled act or to a completely unregulated person.

However, the delegation must be in accordance with any applicable regulations. The regulations could apply to the delegating practitioner, restricting how he or she can make a delegation. Alternatively, if a regulated practitioner receives the delegation, he or she can be restricted by a regulation made by his or her own College as to the performance of the delegation. It appears that, if there are no regulations dealing with the delegation, it can be made and received without restriction.<sup>14</sup> To date, virtually no regulations have been made dealing with the delegation of controlled acts. A few Colleges, such as the Royal College of Dental Surgeons, have made regulations prohibiting their members from making any delegation at all. The Ministry of Health has deferred the thorny issue of how these regulations should work and is expected to deal with the matter in 1999.

The *Regulated Health Professions Act* does not define the delegation of a controlled act. It would appear to be different from ordering the performance of a controlled act because there are some controlled acts that must be ordered by another profession to be performed<sup>15</sup>. Ordering the performance of a controlled act implies that the orderer does not have to know who will be performing a controlled act so long as the performer has certain qualifications, such as registration in another profession. The orderer does not normally take responsibility for the performance of the act.

Delegation, on the other hand, suggests that the delegator takes responsibility for the proper performance of the act. Therefore, the delegator must be confident that the performer of the act is competent to perform the act. This confidence must come from either personal knowledge of the performer, or knowledge of a process that evaluates and ensures the continuing competence of the performer.

Other provisions in the *Regulated Health Professions Act* refer to supervising an unauthorized person to perform a certain act<sup>16</sup>. This suggests that delegation is different from supervising. Supervising implies a more intense control over the performance of the act than does delegation. Supervisors would likely be physically present and would probably review the results of the act on each occasion. Delegation would not require such intense control.

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<sup>12</sup> *Regulated Health Professions Act*, subsection 27(1).

<sup>13</sup> *Midwifery Act*, S.O. 1991, c.31, paragraph 4.5.

<sup>14</sup> *Regulated Health Professions Act*, section 28.

<sup>15</sup> *Respiratory Therapy Act*, S.O. 1991, c.39, subsection 5(1).

<sup>16</sup> *Regulated Health Professions Act*, clauses 29(1)(b), 30(5)(b), 32(1)(a) and subsection 32(3).

### (c) Exceptions to Controlled Acts

There are a number of exceptions to the prohibition against an unregistered person performing a controlled act. They include the following:

- (1) One can render first aid or temporary assistance in an emergency<sup>17</sup>.
- (2) A trainee can perform controlled acts within the scope of his or her future profession if done under the direction and supervision of a member of the profession<sup>18</sup>.
- (3) One can treat a person by prayer or spiritual means in accordance with the tenets of the religion of the treating person<sup>19</sup>.
- (4) One can treat a member of one's household by communicating a diagnosis, administering a substance by inhalation or injection and by internal procedures<sup>20</sup>.
- (5) One can assist a person with his or her routine activities of living by administering a substance by inhalation or injection and by internal procedures<sup>21</sup>.
- (6) Aboriginal healers or midwives can provide traditional services to aboriginal persons or members of an aboriginal community<sup>22</sup>.
- (7) Other exceptions are contained in the regulations. Currently, the regulations permit the performance of such acts as acupuncture, tattooing and ear piercing.<sup>23</sup>

Another provision, dealing with counsellors, is more of a clarification than an exception. The prohibition against performing a controlled act does not apply to communications made in the course of counselling about emotional, social, educational or spiritual matters as long as the communication is not an authorized act for any health profession.<sup>24</sup> It is difficult to understand what this last phrase means as communicating a diagnosis is an authorized act for some professions.

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<sup>17</sup> *Regulated Health Professions Act*, clause 29(1)(a).

<sup>18</sup> *Regulated Health Professions Act*, clause 29(1)(b).

<sup>19</sup> *Regulated Health Professions Act*, clause 29(1)(c).

<sup>20</sup> *Regulated Health Professions Act*, clause 29(1)(d).

<sup>21</sup> *Regulated Health Professions Act*, clause 29(1)(e).

<sup>22</sup> *Regulated Health Professions Act*, subsection 35(1).

<sup>23</sup> Ontario Regulation 107/96.

<sup>24</sup> *Regulated Health Professions Act*, subsection 29(2).

**(d) Almost Controlled Acts in the *Regulated Health Professions Act***

There are some additional acts that are prohibited independently of the controlled acts scheme. These relate to hearing aids and dental appliances. It is not clear why these acts are not included in the list of controlled acts. In any event, because these acts are listed separately, they are not covered by the delegation provision. Also, most of the exceptions do not apply to them.

The first provision prohibits the dispensing of a hearing aid for a hearing impaired person except under a properly given prescription<sup>25</sup>. This prohibition is in addition to the controlled act of prescribing a hearing aid.

The second provision prohibits the design, construction, repair or alteration of a dental device except by a dental technologist or a dentist. Even here, the technical aspects are supervised by a dental technologist or dentist, by a denture made by a denturist and for procedures done in a public hospital, a faculty of dentistry clinic or a denturist program at a community college.<sup>26</sup> This prohibition is in addition to the controlled act of fitting or dispensing a dental appliance.

**(e) Harm Clause**

The "harm clause" of the *Code* prohibits a person from treating or advising a person about his or her health in circumstances in which it is reasonably foreseeable that serious physical harm may result<sup>27</sup>. The purpose of the harm clause is to capture dangerous actions that may not be specifically prohibited by the controlled acts scheme. In other words, it is intended to capture unforeseeable risky conduct.

However, the harm clause is intended primarily to capture conduct by unregistered practitioners. Therefore, exceptions have been made for the following:

- (1) registered practitioners acting within the scope of their profession;
- (2) persons acting under the direction or in collaboration with a registered practitioner acting within the scope of his or her profession; and
- (3) persons acting pursuant to a properly given delegation.

The harm clause also does not apply to counselling for emotional, social, educational or spiritual matters. This exception was created because of the subjective nature of the difficult to distinguish harmful counselling from harmless counselling.

The usual exceptions for the controlled acts scheme also apply to the harm clause. Thus, the following exceptions apply:

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<sup>25</sup> *Regulated Health Professions Act*, section 31.

<sup>26</sup> *Regulated Health Professions Act*, section 32.

<sup>27</sup> *Regulated Health Professions Act*, section 30.

- (1) One can render first aid or temporary assistance in an emergency.
- (2) A trainee can perform controlled acts within the scope of his or her future profession if done under the direction and supervision of a member of the profession.
- (3) One can treat a person by prayer or spiritual means in accordance with the tenets of the religion of the treating person.
- (4) One can treat a member of one's household.
- (5) One can assist a person with his or her routine activities of living.
- (6) Aboriginal healers or midwives can provide traditional services to aboriginal persons or members of an aboriginal community.
- (7) Other exceptions can be set out in the regulations.

The harm clause will create significant issues of statutory interpretation. For example, courts will have to interpret the phrase "serious physical harm" in all cases. Also, courts will have to determine the boundaries of the scope of practice of the professions in some cases. Many scope of practice statements in the profession specific acts are drafted in technical language. In other cases, courts will have to interpret what it means for a person to act in "collaboration with a member". These phrases did not exist in prior statutes. The boundaries of the counselling exception will also have to be construed in some cases.

However, the end result is that employers, managers and partners will need to be careful in authorizing unregistered practitioners to do potentially harmful procedures. Some care will also have to be taken before registered practitioners are required to perform procedures outside of their scope of practice.

#### **(f) Misrepresentations of Titles or Status**

Given the emphasis on freedom of choice inherent in the controlled acts scheme, one could assume that the *Regulated Health Professions Act* would contain increased protection from misleading use of titles or a misrepresentation of one's regulated status. However, that does not appear to be the case. Protection from misrepresentation appears to be about the same or perhaps even a little less than it was in the *Health Disciplines Act*. It is difficult to compare the level of protection because the provisions have been reworded so significantly.

#### **(g) Use of the Title "Doctor"**

Under the *Health Disciplines Act*, only members of the dental, medical or optometry professions were permitted to call themselves "doctor" as an occupational designation. Under the *Regulated Health Professions Act*, the right to use the title has been extended

to chiropractors and psychologists as well. In addition, further categories of people can use the title if permitted by the regulations.<sup>28</sup>

The prohibition applies to variations or abbreviations of the title or to an equivalent in another language

The prohibition now applies to the use of the title in the course of providing or offering to provide, in Ontario, health care to individuals. Thus, use of the title outside of a clinical context appears to remain acceptable. Under the current wording, a practitioner may not be able to refer to a doctoral degree in a clinical context if the practitioner is not from one of the listed professions.

### **(i) Use of Prohibited Title**

Each profession has specific title protection. The protection is absolute for the titles actually protected. For example, no person other than a member of the College of Opticians of Ontario can use the title "optician". The protection applies to variations or abbreviations, including abbreviations of a variation, or an equivalent in another language.<sup>29</sup> For example, R.Opt. is a variation of the abbreviation Opt.

The protection of the title is absolute. There is no requirement to prove that the use occurred in the course of providing health care to individuals (as in the case of the prohibition of the title "doctor").

One cannot escape the prohibition by inserting an adjective before the prohibited word. For example, where "surgeon" and "physician" are protected, the use of the phrases "manipulative surgeon" or "osteopathic physician" breaches the prohibition.

### **(j) Holding Out**

Each profession also has a "holding out" or "passing off" provision. It prohibits any person from holding himself or herself out as a person who is qualified to practise in Ontario as a practitioner or in a specialty of the profession. The purpose of the provision is to prevent persons who are not practitioners from passing themselves off as such.

The wording of the provision in the *Regulated Health Professions Act* is quite different from the *Health Disciplines Act*. However, its general approach seems to be similar. The provision creates an objective test of whether there was passing off; the intent of the person is irrelevant. The court will look to the entire conduct of the person to see whether a reasonable member of the public would infer that the person was qualified to practise in Ontario. In assessing the conduct, the court will examine how a layperson would interpret the representation even though members of the profession may well understand what the qualifications of the person really are.

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<sup>28</sup> *Regulated Health Professions Act* section 33.

<sup>29</sup> *Opticianry Act*, S.O. 1991, c.34, section 8.

The object of the holding out must be that the person is "qualified to practise in Ontario as a practitioner". This phrase probably does not require a holding out that the person is registered with the College. Conveying the sense that the person is a member of the profession may be sufficient. There probably does not need to be a positive assertion of the legal right to practise.

Merely practising the profession may not, by itself, constitute a holding out. However, where the practice of the profession is open or public, it will likely constitute a holding out.

On the other hand, holding out can occur even where there is no evidence that the person was, in fact, practising. It can also occur even where the person tells people that he or she is not authorized to do what he or she does.

### **(k) Methods of Enforcement**

The College has a number of options available to it when it decides to take action against someone breaching the law. Choosing the most effective option can have a significant impact on the success and the cost of the enforcement proceeding.

**Discipline Proceedings.** Where the conduct is permitted or carried out by a registered practitioner, he or she can often be disciplined. If the practitioner is a member of the College, discipline proceedings are probably the most effective method of enforcing the law. Where the practitioner is a member of another College, the matter can be reported to that College. However, other Colleges may have different priorities and may not view the conduct with the same seriousness.

**Provincial Offences Prosecution.** Most of the prohibitions contained in the *Regulated Health Professions Act* are also provincial offences. The College may prosecute these offences in Provincial Offences Court unless the Crown intervenes. Provincial offences prosecutions are similar to criminal prosecutions. The person is charged with an offence. Once a court date is set, a plea is taken and the prosecutor must prove the charge through witnesses. A judge or justice of the peace decides the case and may impose a fine if the person is convicted.

**Restraining Order.** The *Health Professions Procedural Code* permits the College to bring an application asking a judge to direct the person to comply with the legislation. The order is similar to an injunction requiring a person to comply with the law. A failure to comply with the order would place the person in contempt of court, which is a very serious matter.<sup>30</sup>

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<sup>30</sup> *Health Professions Procedural Code*, section 87.

## RECORD KEEPING REQUIREMENTS

Employers, managers and partners sometimes assume that since they own or operate the facility or clinic, the records belong to them. Similarly, employers, managers and partners have special provisions in their legislation<sup>31</sup> dealing with their records and assume that these are the only applicable rules. However, the situation is not that simple. All regulated health practitioners have record keeping requirements that apply to them, either through the unwritten standards of practice of their profession or in the regulations made by their College. (Additional regulations respecting record keeping are expected to be finalized for most professions in the next year). To the extent that these record keeping requirements are inconsistent with the policies of the employers, managers and partners, there will be conflicts. This situation is not helped by the fact that the record keeping rules for each profession are slightly different.

Ordinarily, the problem does not reveal itself until after the relationship with the practitioner ends. The practitioner then may wish to take the record with him or her to facilitate the continuity of care or to help establish his or her own practice. In addition, the practitioner almost certainly has a professional obligation to maintain the record for a number of years. Failing to do so is professional misconduct. The treating practitioner can fulfil his or her professional obligation in a number of ways, including:

- having the employer, manager or partner agree that the treating practitioner can take the record;
- having the employer, manager or partner agree that he or she can take a copy of the record; or
- having the employer, manager or partner agree that the record will be left with the employer, manager or partner, that the employer, manager or partner will maintain the record and that the treating practitioner will be given access to the record whenever required.

Obviously, it is better if these sorts of matters are agreed to before the departure of the treating practitioner, when the relationship may not be at its best.

While record keeping problems are most likely to arise on the departure of the treating practitioner, they can occur earlier. For example, if the employer, manager or partner attempts to impose lower record keeping requirements upon the treating practitioner, conflict will arise. To the extent that the employer, manager or partner attempts to impose what would be an illegal requirement on the treating practitioner, the treating practitioner would probably be able to successfully resist the request of the employer, manager or partner. Most Colleges would also likely intervene if employers, managers and partners seek to impose requirements that would force a practitioner to engage in substandard practice.

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<sup>31</sup> See, for example, the *Public Hospitals Act* and regulations.

Where employers, managers and partners have strict control over the records, such as in an institutional setting, practitioners may develop a practice of maintaining their own private records. Private records may consist of a copy of portions of the institution's record. They may also include additional notes by the practitioner of matters that the practitioner believes are not welcome by the employer, manager or partner. Sometimes the additional notes are those to which the practitioner does not want the patient to have access. A number of problems arise with private records made by the practitioner, including:

- care to the patient may not be based on a uniform information base;
- a patient's request for access to their record may not be answered appropriately;
- security of the record may not be properly maintained; and
- in legal proceedings, the additional record may cause administrative or tactical difficulties.

There are a number of reasons why a practitioner may feel the need to keep private records. Distrust of the employer's, manager's or partner's policies and record keeping practices, a feeling that access may not be provided to the practitioner when needed, legal concerns about a particular patient, the practitioner's perceived financial or legal need for the records once he or she leaves the practice are all possible explanations. Employers, managers and partners would be wise to not simply ban the practice. Rather, they should attempt to address the reasons why such records are kept. In particular, employers, managers and partners should assure the practitioner that he or she can document what they believe needs to be documented without sanction and that the practitioner will be given legitimate access to them, even after he or she leaves.

## **PROFESSIONAL MISCONDUCT CONSIDERATIONS**

Just as practitioners cannot engage in improper record keeping practices simply because their employer, manager or partner requires it, so practitioners cannot engage in other forms of unprofessional behaviour at the request of their employers, managers or partners. The practitioner has a professional and legal obligation to refuse to engage in such behaviour. In addition, most contracts with practitioners have an express or implied term that the practitioner must fulfil his or her professional duties. Failing that, the practitioner has an obligation to quit the position or else face disciplinary proceedings.

For this reason, most employers, managers and partners should attempt to be familiar with these professional obligations and manage the facility in a manner that is consistent with them. Again, it does not help that each profession has slightly differing professional obligations, although there are many similarities.

Some of the recurring trouble areas include the following:

- The duty to maintain the **standard of practice** of the profession. Standards of practice can be written or unwritten. However, in either case, they generally refer to the requirements that most right thinking members of the profession would bring to a particular situation. For example, certain minimum standards of assessment are generally required before treatment can commence. Re-assessment on a regular basis is also generally required for ongoing care. Conflicts might arise when these interfere with the efficiencies that employers, managers and partners are being pressured to achieve by the funders of health care.
- the duty to only perform assessments or **procedures within the practitioner's skills and abilities**. Employers, managers and partners are frequently seeking multiskilling as a means to reduce costs. Conflicts can arise where practitioners do not have the skills necessary to do an adequate job. The practitioner can be held accountable by the College and may attempt to divert responsibility to their employer, manager or partner. This scrutiny of responsibility can be uncomfortable for all concerned.
- The duty to **obtain informed consent** is imposed on all health care practitioners. Conflicts can arise when employers, managers and partners develop a procedure for one part of the health care team to obtain the consent for the procedures performed by the remainder of the team. While there is nothing wrong with this concept in principle, the person obtaining the consent must have sufficient knowledge of the practice of the others in the team so as to obtain truly informed consent. Also, cautious practitioners may review the actual understanding of the patient because the practitioner will be held accountable to their College if informed consent is not in fact obtained. One of the most frequent complaints to Colleges is in respect of inadequate communication between practitioners and their patients. Because of the civil liability that flows from a lack of informed consent, most employers, managers and partners actively promote the obtaining of such consent by practitioners at their institution or facility.
- The duty to avoid a **conflict of interest**. Conflicts of interest are an area in which employers, managers and partners and practitioners can have divergent views. Practitioners of many professions have the duty to ensure that no direct or indirect benefit accrues to them or their employers or partners for their treatment recommendations. Practitioners certainly have an obligation to ensure that only necessary services are provided. With the financial squeeze in which most health institutions and facilities find themselves, many are seeking alternate sources of revenue. Questionable arrangements should be checked out with the relevant Colleges beforehand or else the practitioners involved may find themselves in some jeopardy.
- The duty to refrain from **splitting fees** with a person who referred the patient is a special form of conflict of interest that has been prohibited by most health professions for decades. The difficulty usually arises with creative means for disguising such fees. Recently, a managing physiotherapist was suspended for 4 months for instituting a policy of paying physicians an excessive amount for medical

reports upon the referral of a patient. The Discipline Committee viewed this as a form of fee splitting.

- The duty to **continue with “necessary” treatment** until proper arrangements can be made to transfer the care of the patient. Most Colleges have rules about the timing and manner in which treatment can be terminated. Discontinuance of treatment is also a frequent area of complaint to Colleges by patients. The rules of the various Colleges differ between themselves and according to the circumstances. For example, refusing the take on a new patient is usually treated differently than discontinuing treatment of an existing patient. Similarly, even when discontinuing treatment for an existing patient, the necessity of the treatment and the availability of alternative care may affect the extent of the obligation. Some Colleges recognize the restrictions imposed by employers, managers and partners as a legitimate reason for refusing or discontinuing treatment while others do not. What is considered a necessary service is also variable from profession to profession. Necessity likely goes beyond saving the life or limb of the patient in most cases. Employers, managers and partners need to develop sensitive and flexible policies in this area.
- The duty to perform necessary services even if the **patient cannot pay** for it beforehand or at all (an obligation that may become increasingly important as OHIP insists upon valid coverage before it will pay for treatment). Again, rules vary from profession to profession and circumstance to circumstance. Generally, if the service is “necessary”, the practitioner must provide the service, at least to an existing patient. Some professions define “necessary” as what is covered by OHIP, while many, particularly those services that are not covered by OHIP, generally do not. A recurring problem area is whether a legal report can be withheld pending payment. Colleges take very different positions on this issue; check with the College of the affected profession.
- The duty to keep all **client information confidential** is central to most professions. However, the exceptions vary from profession to profession. Can information be shared with others in the health care team without explicit client consent? In most cases, the question is answered by the reasonable expectations of the client in the circumstances. Most conflicts between employers, managers and partners and practitioners arise over the disclosure of confidential health information for management purposes. Hospitals tend to have the broadest access to such information for management purposes (e.g., for monitoring quality and legal issues) but even here there are some limits (e.g., access to health information from hospital staff for human resources purposes). Other institutions do not expect to have access to such information from the practitioner’s files without explicit consent (e.g., homes for the aged for admission or discharge purposes).
- The duty to ensure that all **statements and documents are accurate** appears to be indisputable. However, this issue arises more frequently than one would suppose. For example, many practitioners are learning that they have a responsibility to ensure that the billing of services in their name be accurate. Some

employers, managers and partners appear to take billing the services of other practitioners in a misleading manner resulting in the investigation and, occasionally, the discipline of the practitioner. As a result, practitioners are demanding access to administrative and billing records from their employers, managers and partners to ensure that they are accurate. Another source of conflict is the preparing of reports to insurers as to treatment of patients by employers, managers and partners without the approval of practitioners.

- The duty to avoid **misleading advertising** or to refrain from **personal solicitation** of patients is accepted by most practitioners. However, where employers, managers and partners conduct the advertising and solicitation, difficulties arise. Many Colleges hold practitioners responsible for the advertising or solicitation on their behalf by employers, managers and partners. Employers, managers and partners should check with the practitioners affiliated with their institution or facility before engaging in potentially controversial marketing of the practitioners' services.
- The duty to charge **reasonable fees and to itemize fees**, at least when requested, is common to most health professions. Employers, managers and partners should not assume that this is solely a management issue for which the practitioner need not be consulted. Disguising the fees as administrative charges seems to be a sure way to create a complaint. Even charging an unreasonable fee for access to or a copy of the patient's chart is not just a management function, but could get the practitioner into trouble.
- The duty to refrain from selling fees to **collection agents**. Most professions will allow the use of a collection agent to collect an unpaid fee so long as the control over the account is maintained with the practitioner. However, when an account is sold to a collection agent, control is lost and the College may hold the practitioner accountable for the improper collection tactics of the agent.
- The duty not to assist in the **improper delegation** of patient care is discussed above, under the topic of unauthorized practice. Employers, managers and partners can themselves get into legal difficulty for permitting an improper delegation of a controlled act. However, even if the act is not controlled, there may be standards of practice that apply to improperly assigning those acts to unregulated practitioners (or even, in some cases, inappropriate assignment to other regulated practitioners). Employers, managers and partners should be careful about setting up systems that result in the treatment of a patient by an inappropriate person. A College could investigate one of their members affiliated with the institution or facility for associating themselves with the practice.
- The duty to **cooperate with a College investigation** is discussed below. Employers, managers and partners can create significant difficulties for their employees and themselves by interfering with a proper College investigation.
- The duty to avoid using one's **influence with a patient to obtain financial advantage** is fundamental to the ethics of all health professions. However, in this

age of health care cuts, many institutions and facilities are looking for innovative ways to obtain alternative funding. Some methods may be improper for regulated practitioners. For example, seeking a charitable contribution may in some circumstances be improper for a practitioner. Using client information for creating a mailing list for fund raising is also quite controversial.

- The duty to act ethically and honestly at all times, even **when not actually practising**, has become an accepted part of professional regulation for most professions. Thus, employers, managers and partners should not assume that practitioners, when they are off-duty, could engage in any sort of conduct. For example, many Colleges have rules about practitioners sponsoring health products or services.

These are just examples of the broader principle. As a general rule, employers, managers and partners cannot assume that their management prerogative overrides the professional obligations of their staff. Practitioners have the duty to inquire of certain management practices because these can impact on the practitioners' duties to their College.

Most ethical employers, managers and partners share the same values as registered practitioners and many of these obligations will not pose a problem. However, even ethical employers, managers and partners may have honest differences of opinion about the management of the practice. For example, the pressures of efficiency may, in the opinion of some employers, managers and partners, require the practitioner to see more patients or samples per day than the practitioner feels he or she can comfortably accommodate. At what point does the prerogative of management end and the requirement to maintain professional standards begin? Practitioners may sometimes use the rubric of professional obligation to resist management changes they dislike. Employers, managers and partners may use their immediate authority over the practitioner to force changes that will only remotely lead to professional sanction (which, of course, is unfair to the practitioner and may result in unexpected legal consequences for the employer, manager or partner).

There is no doubt that fair discussion between employers, managers and partners and practitioners is necessary. Sometimes, the regulatory College should be part of those discussions.

## **DUTY TO COOPERATE IN COLLEGE INVESTIGATIONS**

All regulated health practitioners are subject to investigation by their College. Where a practitioner works with an employer, manager or partner, the employer, manager or partner will often become involved in the investigation. Because of the powers conferred by the *Regulated Health Professions Act* upon College investigators, employers, managers and partners cannot absolve themselves of any involvement in the investigation. They can be required to provide access to records and other information and to have their staff interviewed. It is important, therefore, for employers, managers and partners to be aware of the investigative powers of Colleges and to develop a working

relationship with such investigators that will provide the minimum disruption to the operation of the facility.

### **(a) Entry and Inspection of Business Premises**

One of the more important powers of an investigator is that he or she may enter the business premises of the member to inspect the premises and records of the member<sup>32</sup>. The following are the requirements for entry:

- (1) the investigator must produce his or her appointment (which presumes that the appointment has been made in writing);
- (2) entry must be sought at a reasonable time (which presumably includes normal office hours); and
- (3) the premises must be the "business premises of the member".

As the role of the investigator is to gather facts and not to make findings against the practitioner, he or she likely does not have any additional procedural obligations. For example, it does not appear that the investigator must give prior notice of his or her visit, give particulars of the allegations being investigated or make disclosure of the evidence gathered to date. Often, however, investigators provide some notice and disclosure to assist in the effective and cooperative investigation.

The business premises of the member probably includes any location of practice belonging to the practitioner where he or she sees patients. For example, it likely includes a home office if patients are seen there. The business premises probably does not include a place used only to store charts or records such as the basement of the practitioner's home.

An interesting issue is whether the investigator can enter the work premises of a practitioner who is employed by another health practitioner. For example, can an inspector for the College of Physiotherapists enter and inspect the records and equipment of a therapy clinic owned and operated by a physician?

Another question is whether the investigator can enter an institution where health services are provided. The provision seems to authorize entry into a designated office located in an institution, such as a hospital or nursing home, where a member sees patients. This provision overrides confidentiality provisions for health records contained in other statutes. However, where the practitioner does not have a designated space from which to practise, it is not clear whether the institution as a whole constitutes the "business premises of the member".

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<sup>32</sup> *Health Professions Procedural Code*, section 76.

Where there is a right of entry, no person shall obstruct the investigator or withhold, conceal or destroy relevant records or things. The obstruction provision is discussed in more detail below.

Colleges do not always give employers, managers and partners prior warning of their investigations. Sometimes prior warning can jeopardize the investigation itself by leading to the altering of evidence. Sometimes the duty of confidentiality imposed upon the College prevents employers, managers and partners from being notified.<sup>33</sup> The issue of prior notification of employers, managers and partners is clearly an area that requires more consideration by all sides, including Colleges. What employers, managers and partners can do is develop a policy requiring practitioners to inform them of College investigations so that employers, managers and partners are not caught off guard or their operations unduly disrupted.

### **(b) Search Warrant Powers**

An investigator may also apply to a justice of the peace for a search warrant<sup>34</sup>. The advantages of a search warrant include the following:

- (1) a search warrant authorizes the investigator to enter any premises named in the warrant, not just the business premises of the member;
- (2) a search warrant authorizes entry by means of force, if necessary (an investigator without a search warrant will generally withdraw if denied entry into the business premises of the member); and
- (3) an investigator with a search warrant is more likely to be able to obtain police assistance for difficult investigations.

### **(c) Copying and Removal of Records**

The procedure for the removal and copying of records by investigators is as follows:

- (1) the investigator must first attempt to copy, at the College's expense, the document or object at the place it is found;
- (2) the investigator may only remove the document or object if it is not practical to copy it on the premises or if a copy is insufficient for the investigation;
- (3) where the document or object is removed in order to copy it, the original must be returned within a reasonable time;

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<sup>33</sup> *Regulated Health Professions Act*, section 36.

<sup>34</sup> *Health Professions Procedural Code*, section 77.

- (4) where the document or object is removed because a copy is insufficient for the purposes of the investigation, a copy must be returned to the person from whom it was removed within a reasonable time;
- (5) the investigator should "certify" the copy as a true copy before returning it; and
- (6) a certified copy shall be received in evidence in any proceeding as if it were an original.<sup>35</sup>

Copying documents at the College's expense means that the practitioner need not pay for the copying to be done (e.g., at a photocopy store in the practitioner's office building). However, if the practitioner's copying facilities are used, it is unclear how the practitioner's expense ought to be calculated.

Some examples of where it may not be practical to copy documents or objects on the premises are as follows:

- (1) where the volume of documents is large;
- (2) where there is a lack of copying facilities on the premises; or
- (3) where the disruption to the member's practice of copying the documents there outweighs the disruption of removing the documents for a brief period of time.

Some examples of where a copy may not be sufficient for the purposes of the investigation are as follows:

- (1) where there is a concern as to the authenticity of the record and expert document examination of the original is required;
- (2) where copies are illegible or of poor quality (e.g., x-rays); or
- (3) where the object cannot be properly duplicated (e.g., a dental appliance).

Prudent investigators will leave a receipt for the objects removed and attempt to obtain the practitioner's signature indicating that the receipt is accurate and complete. A prudent investigator will also ask the practitioner whether the charts or other documents being removed are complete.

An investigator can certify a copy as being a true copy by comparing the copy to the original before the original is returned and then signing and dating the copy.

For investigations, documents are defined as a record of information in any form. This would include electronic records. Documents also include a part of a document which clarifies that an investigator can, in appropriate cases, certify as a true copy the relevant portion of a large document.

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<sup>35</sup> *Health Professions Procedural Code*, section 78.

#### (d) Summoning Witnesses and Documents

An increasingly frequently used power is the summoning of witnesses and documents<sup>36</sup>. In effect, the investigator would hold an inquiry or investigative hearing. For the inquiry, the investigator could serve a summons on the appropriate witnesses, receive documents summoned to the inquiry and take evidence of witnesses under oath. The inquiry is not open to the public.

The summoning power would be useful where:

- (1) an important witness was reluctant to give a statement voluntarily (e.g., an employer or employee of the practitioner); and
- (2) important documents are held by third parties who are reluctant to disclose them voluntarily (e.g., an institution like a hospital or nursing home, or a business such as Bell Canada or OHIP).

Table 5 is an example of the summons that might be used. The summons is often served with conduct money.

It appears that the practitioner could be summoned to give a statement on the allegations being investigated against him or her. It also seems that in some circumstances the statement could be used at a subsequent discipline hearing involving that practitioner. However, many Colleges are reluctant to require a practitioner to give a statement against his or her will.

When the inquiry procedure is used, the investigator must act with procedural fairness. For instance, the witness is probably entitled to have counsel while giving evidence and ought to be informed of the matters under investigation. However, since the inquiry is only investigative in nature, the full procedural protections of a hearing do not apply. Therefore, the investigator probably does not have to do any of the following:

- (1) give full particulars of the allegations;
- (2) make disclosure of the sources of the allegations;
- (3) make disclosure of the evidence gathered to date in the investigation; or
- (4) permit attendance at the giving of evidence of other witnesses or permit cross-examination of other witnesses or of the investigator.

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<sup>36</sup> *Health Professions Procedural Code*, subsection 76(1).

**TABLE 5****SUMMONS**

(Name of Act under which proceeding arises)

SUMMONS TO A WITNESS BEFORE (name of tribunal)

TO: (name and address of witness)

(For oral hearing)

YOU ARE REQUIRED TO ATTEND TO GIVE EVIDENCE at the hearing of this proceeding on (day) , (date) , at (time) , at (place) , and to remain until your attendance is no longer required.

YOU ARE REQUIRED TO BRING WITH YOU and produce at the hearing the following documents and things: (Set out the nature and date of each document and give sufficient particulars to identify each document and thing.)

IF YOU FAIL TO ATTEND OR TO REMAIN IN ATTENDANCE AS THIS SUMMONS REQUIRES, THE ONTARIO COURT (GENERAL DIVISION) MAY ORDER THAT A WARRANT FOR YOUR ARREST BE ISSUED, OR THAT YOU BE PUNISHED IN THE SAME WAY AS FOR CONTEMPT OF THAT COURT.

(For electronic hearing)

YOU ARE REQUIRED TO PARTICIPATE IN AN ELECTRONIC HEARING on (day) , (date) , at (time) , in the following manner: (Give sufficient particulars to enable witness to participate.)

IF YOU FAIL TO PARTICIPATE IN THE HEARING IN ACCORDANCE WITH THE SUMMONS, THE ONTARIO COURT (GENERAL DIVISION) MAY ORDER THAT A WARRANT FOR YOUR ARREST BE ISSUED, OR THAT YOU BE PUNISHED IN THE SAME WAY AS FOR CONTEMPT OF THAT COURT.

Date: \_\_\_\_\_ (Name of tribunal)

\_\_\_\_\_  
(Signature by or on behalf of tribunal)

NOTE: You are entitled to be paid the same fees or allowances for attending at or otherwise participating in the hearing as are paid to a person summoned to attend before the Ontario Court (General Division).

### **(e) Powers Under Other Statutes**

Other statutes may give the investigator access to information for an investigation. Some examples are set out below.

The regulations of some Colleges require its members to cooperate with the investigators of other Colleges. This provision is particularly useful in investigations where the practitioner being investigated is employed by another regulated health practitioner.

The regulations made under the *Public Hospitals Act* permit the Registrar of the College of Physicians and Surgeons of Ontario to inspect medical records and interview hospital staff after giving written notice to the administrator of the hospital.

The *Freedom of Information and Protection of Privacy Act* and the *Municipal Freedom of Information and Protection of Privacy Act* set out detailed rules for the handling of information by government agencies. Government agencies are permitted to disclose confidential information to a "law enforcement agency". Colleges likely constitute a law enforcement agency. Government agencies are also permitted to disclose personal information "in compelling circumstances affecting the health or safety of an individual".

The *Criminal Code of Canada* contains provisions permitting interested parties to obtain access to documents seized under a criminal search warrant. Colleges investigating a member appear to constitute an interested party and may be given access to the seized things.

### **(f) Obstruction of an Investigator**

The *Code* prohibits any person, not just a practitioner, from:

- (1) obstructing an investigator;
- (2) withholding or concealing anything relevant to the investigation; or
- (3) destroying anything relevant to the investigation.<sup>37</sup>

Such conduct constitutes an offence punishable by a fine of up to \$10,000<sup>38</sup>.

The type of conduct that would constitute obstruction will depend on the circumstances. The following likely constitutes obstruction:

- (1) an act, even if not unlawful in itself, that frustrates or makes the investigation more difficult (e.g., hiding a chart);

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<sup>37</sup> *Health Professions Procedural Code*, subsection 76(3).

<sup>38</sup> *Health Professions Procedural Code*, subsection 93(2).

- (2) a passive default that frustrates or makes the investigation more difficult (e.g., refusing to permit entry to investigators); or
- (3) lying to investigators.

In addition, depending on the circumstances, it is professional misconduct for a registered practitioner to fail to cooperate with his or her College during an investigation. Therefore, where there is obstruction, the College may choose to deal with the matter internally without having to go to the courts first.

## **CONCLUSION**

Employers, managers and partners need to be aware of the implications of the *Regulated Health Professions Act* upon their operations. It is insufficient to assume that it applies just to regulated health practitioners. Employers, managers and partners who take an informed approach to these issues will be able to avoid many disruptive and costly challenges by practitioners and investigations by Colleges.

When in doubt, contact the applicable College. The addresses and telephone numbers of the 21 health Colleges are listed in Appendix 1.

For more information, see the additional resources listed in Appendix 2.

Appendix 3 contains relevant excerpts from the *Regulated Health Professions Act* and its accompanying *Health Professions Procedural Code*.

## APPENDIX 1

### ADDRESSES AND TELEPHONE NUMBERS OF THE HEALTH COLLEGES

1. College of Audiologists and Speech Language Pathologists of Ontario  
Suite 1125  
160 Bloor Street East  
Toronto, ON M4W 1B9  
  
(416) 975-5347
2. College of Chiropodists of Ontario  
Suite 2102  
180 Dundas Street West  
Toronto, ON M5G 1Z8  
  
(416) 542-1333
3. College of Chiropractors of Ontario  
Suite 902  
130 Bloor Street West  
Toronto, ON M5S 1N5  
  
(416) 922-6355
4. College of Dental Hygienists of Ontario  
Suite 300  
69 Bloor Street East  
Toronto, ON M4W 1A9  
  
(416) 961-6234
5. College of Dental Technologists of Ontario  
Suite 321  
2100 Ellesmere Road  
Scarborough, ON M1H 3B7  
  
(416) 438-5003
6. Royal College of Dental Surgeons  
Fifth Floor  
6 Crescent Road  
Toronto, ON M4W 1T1  
  
(416) 961-6555

7. College of Denturists of Ontario  
Suite 903  
180 Bloor Street West  
Toronto, ON M5S 2V6  
(416) 925-6331
8. College of Dietitians of Ontario  
Suite 1810  
438 University Avenue  
Toronto, ON M5G 2K8  
(416) 598-1725
9. College of Massage Therapists of Ontario  
Suite 810  
1867 Yonge Street  
Toronto, ON M4S 1Y5  
(416) 489-2626
10. College of Medical Laboratory Technologists of Ontario  
Suite 330  
10 Bay Street  
Toronto, ON M5J 2R8  
(416) 861-9605
11. College of Medical Radiation Technologists of Ontario  
Suite 1001  
170 Bloor Street West  
Toronto, ON M5S 1P9  
(416) 975-4353
12. College of Midwives of Ontario  
4th Floor  
2195 Yonge Street  
Toronto, ON M4S 2B2  
(416) 327-0874
13. College of Nurses of Ontario  
101 Davenport Road  
Toronto, ON M5R 3P1  
(416) 928-0900

14. College of Occupational Therapists of Ontario  
Suite 340  
10 Bay Street  
Toronto, ON M5J 2R8  
(416) 214-1177
15. College of Opticians of Ontario  
Suite 902  
85 Richmond Street West  
Toronto, ON M5H 2C9  
(416) 368-3616
16. College of Optometrists of Ontario  
Third Floor  
6 Crescent Road  
Toronto, ON M4W 1T1  
(416) 962-4071
17. Ontario College of Pharmacists  
483 Huron Street  
Toronto, ON M5R 2R4  
(416) 962-4861
18. College of Physicians and Surgeons of Ontario  
80 College Street  
Toronto, ON M5G 2E2  
(416) 961-3330
19. College of Physiotherapists of Ontario  
10th Floor  
230 Richmond Street West  
Toronto, ON M5V 1V6  
(416) 591-3828
20. College of Psychologists of Ontario  
Suite 201  
1246 Yonge Street  
Toronto, ON M4T 1W5  
(416) 961-8817

21. College of Respiratory Therapists of Ontario  
Suite 2103  
180 Dundas Street West  
Toronto, ON M5G 1Z8  
(416) 591-7800

## APPENDIX 2

### ADDITIONAL RESOURCES

1. Linda S. Bohnen, *Regulated Health Professions Act A Practical Guide* (Toronto: Canada Law Book, 1994).
2. Richard Steinecke, *A Complete Guide to the Regulated Health Professions Act*, (Toronto, Canada Law Book, 1995, updated annually).

## APPENDIX 3

### EXCERPTS FROM *REGULATED HEALTH PROFESSIONS ACT*

#### PROHIBITIONS

##### Controlled acts restricted

27.-(1) No person shall perform a controlled act set out in subsection (2) in the course of providing health care services to an individual unless,

- (a) the person is a member authorized by a health profession Act to perform the controlled act; or
- (b) the performance of the controlled act has been delegated in accordance with section 28 to the person by a member described in clause (a).

##### Controlled acts

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

1. Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.
2. Performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.
3. Setting or casting a fracture of a bone or a dislocation of a joint.
4. Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust.
5. Administering a substance by injection or inhalation.
6. Putting an instrument, hand or finger,
  - i. beyond the external ear canal,
  - ii. beyond the point in the nasal passages where they normally narrow,
  - iii. beyond the larynx,
  - iv. beyond the opening of the urethra,
  - v. beyond the labia majora,
  - vi. beyond the anal verge, or
  - vii. into an artificial opening into the body.
7. Applying or ordering the application of a form of energy prescribed by the regulations under this Act.
8. Prescribing, dispensing, selling or compounding a drug as defined in subsection 117(1) of the *Drug and Pharmacies Regulation Act*, or supervising the part of a pharmacy where such drugs are kept.
9. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.
10. Prescribing a hearing aid for a hearing impaired person.
11. Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or a device used inside the mouth to protect teeth from abnormal functioning.
12. Managing labour or conducting the delivery of a baby.
13. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response.

##### Exemptions

(3) An act by a person is not a contravention of subsection (1) if the person is exempted by the regulations under this Act or if

the act is done in the course of an activity exempted by the regulations under this Act.

#### **Delegation of controlled act**

**28.**-(1) The delegation of a controlled act by a member must be in accordance with any applicable regulations under the health profession Act governing the member's profession.

#### **Idem**

(2) The delegation of a controlled act to a member must be in accordance with any applicable regulations under the health profession Act governing the member's profession.

#### **Exceptions**

**29.**-(1) An act by a person is not a contravention of subsection 27(1) if it is done in the course of,

- (a) rendering first aid or temporary assistance in an emergency;
- (b) fulfilling the requirements to become a member of a health profession and the act is within the scope of practice of the profession and is done under the supervision or direction of a member of the profession;
- (c) treating a person by prayer or spiritual means in accordance with the tenets of the religion of the person giving the treatment;
- (d) treating a member of the person's household and the act is a controlled act set out in paragraph 1, 5 or 6 of subsection 27(2); or
- (e) assisting a person with his or her routine activities of living and the act is a controlled act set out in paragraph 5 or 6 of subsection 27(2).

#### **Counselling**

(2) Subsection 27(1) does not apply with respect to a communication made in the course of counselling about emotional, social, educational or spiritual matters as long as it is not a communication that a health profession Act authorizes members to make.

#### **Treatment, etc., where risk of harm**

**30.**-(1) No person, other than a member treating or advising within the scope of practice of

his or her profession, shall treat or advise a person with respect to his or her health in circumstances in which it is reasonably foreseeable that serious physical harm may result from the treatment or advice or from an omission from them.

#### **Supervision by member**

(2) Subsection (1) does not apply with respect to treatment by a person who is acting under the direction of or in collaboration with a member if the treatment is within the scope of practice of the member's profession.

#### **Delegation**

(3) Subsection (1) does not apply with respect to an act by a person if the act is a controlled act that was delegated under section 28 to the person by a member authorized by a health profession Act to do the controlled act.

#### **Counselling**

(4) Subsection (1) does not apply with respect to counselling about emotional, social, educational or spiritual matters.

#### **Exceptions**

(5) Subsection (1) does not apply with respect to anything done by a person in the course of,

- (a) rendering first aid or temporary assistance in an emergency;
- (b) fulfilling the requirements to become a member of a health profession if the person is acting within the scope of practice of the profession under the supervision or direction of a member of the profession;
- (c) treating a person by prayer or spiritual means in accordance with the tenets of the religion of the person giving the treatment;
- (d) treating a member of the person's household; or
- (e) assisting a person with his or her routine activities of living.

#### **Exemption**

(6) Subsection (1) does not apply with respect to an activity or person that is exempted by the regulations.

**Dispensing hearing aids**

**31.** No person shall dispense a hearing aid for a hearing impaired person except under a prescription by a member authorized by a health profession Act to prescribe a hearing aid for a hearing impaired person.

**Dental devices, etc.**

**32.-(1)** No person shall design, construct, repair or alter a dental prosthetic, restorative or orthodontic device unless,

- (a) the technical aspects of the design, construction, repair or alteration are supervised by a member of the College of Dental Technologists of Ontario or the Royal College of Dental Surgeons of Ontario; or
- (b) the person is a member of a College mentioned in clause (a).

**Employers**

(2) A person who employs a person to design, construct, repair or alter a dental prosthetic, restorative or orthodontic device shall ensure that subsection (1) is complied with.

**Supervisors**

(3) No person shall supervise the technical aspects of the design, construction, repair or alteration of a dental prosthetic, restorative or orthodontic device unless he or she is a member of the College of Dental Technologists of Ontario or the Royal College of Dental Surgeons of Ontario.

**Denturists**

(4) This section does not apply with respect to the design, construction, repair or alteration of removable dentures for the patients of a member of the College of Denturists of Ontario if the member does the designing, construction, repair or alteration or supervises their technical aspects.

**Exceptions**

(5) This section does not apply with respect to anything done in a hospital as defined in the *Public Hospitals Act* or in a clinic associated with a university's faculty of dentistry or the denturism program of a college of applied arts and technology.

**Restriction of title "doctor"**

**33.-(1)** Except as allowed in the regulations under this Act, no person shall use the title "doctor", a variation or abbreviation or an equivalent in another language in the course of providing or offering to provide, in Ontario, health care to individuals.

**Idem**

(2) Subsection (1) does not apply to a person who is a member of,

- (a) the College of Chiropractors of Ontario;
- (b) the College of Optometrists of Ontario;
- (c) the College of Physicians and Surgeons of Ontario;
- (d) the College of Psychologists of Ontario; or
- (e) the Royal College of Dental Surgeons of Ontario.

**Definition**

(3) In this section, "abbreviation" includes an abbreviation of a variation.

**Holding out as a College**

**34.-(1)** No corporation shall falsely hold itself out as a body that regulates, under statutory authority, individuals who provide health care.

**Idem**

(2) No individual shall hold himself or herself out as a member, employee or agent of a body that the individual falsely represents as or knows is falsely represented as regulating, under statutory authority, individuals who provide health care.

**MISCELLANEOUS****Exemption, aboriginal healers and midwives**

**35.-(1)** This Act does not apply to,

- (a) aboriginal healers providing traditional healing services to aboriginal persons or members of an aboriginal community; or
- (b) aboriginal midwives providing traditional midwifery services to aboriginal persons or members of an aboriginal community.

### Jurisdictions of Colleges

(2) Despite subsection (1), an aboriginal healer or aboriginal midwife who is a member of a College is subject to the jurisdiction of the College.

### Definitions

(3) In this section,

"aboriginal healer" means an aboriginal person who provides traditional healing services; ("guérisseur autochtone")

"aboriginal midwife" means an aboriginal person who provides traditional midwifery services. ("sage-femme autochtone")

### Confidentiality

36.-(1) Every person employed, retained or appointed for the purpose of the administration of this Act, a health profession Act or the *Drug and Pharmacies Regulation Act* and every member of a Council or committee of a College shall preserve secrecy with respect to all information that comes to his or her knowledge in the course of his or her duties and shall not communicate any information to any other person except,

- (a) to the extent that the information is available to the public under this Act, a health profession Act or the *Drug and Pharmacies Regulation Act*;
- (b) in connection with the administration of this Act, a health profession Act or the *Drug and Pharmacies Regulation Act*, including, without limiting the generality of this, in connection with anything relating to the registration of members, complaints about members, allegations of members' incapacity, incompetence or acts of professional misconduct or the governing of the profession;
- (c) to a body that governs a health profession in a jurisdiction other than Ontario;
- (d) as may be required for the administration of the *Drug Interchangeability and Dispensing Fee Act*, the *Health Insurance Act*, the *Independent Health Facilities Act*, the *Ontario Drug Benefit Act*, the *Narcotic Control Act* (Canada) and the *Food and Drugs Act* (Canada);

(e) to the counsel of the person who is required to preserve secrecy; or

(f) with the written consent of the person to whom the information relates.

### Reports required under Code

(1.1) Clauses (1)(c) and (d) do not apply with respect to reports required under section 85.1 or 85.2 of the Code.

### Not compellable

(2) No person or member described in subsection (1) shall be compelled to give testimony in a civil proceeding with regard to matters that come to his or her knowledge in the course of his or her duties.

### Evidence in civil proceedings

(3) No record of a proceeding under this Act, a health profession Act or the *Drug and Pharmacies Regulation Act*, no report, document or thing prepared for or statement given at such a proceeding and no order or decision made in such a proceeding is admissible in a civil proceeding other than a proceeding under this Act, a health profession Act or the *Drug and Pharmacies Regulation Act* or a proceeding relating to an order under section 11.1 or 11.2 of the *Ontario Drug Benefit Act*.

### Onus of proof to show registration

37. A person who is charged with an offence to which registration under a health profession Act would be a defence shall be deemed, in the absence of evidence to the contrary, to have not been registered.

### Immunity

38. No action or other proceeding for damages shall be instituted against the Advisory Council, the Board, a College, a Council, or a member, officer, employee, agent or appointee of the Advisory Council, the Board, a College, a Council, a committee of a Council or a panel of a committee of a Council for an act done in good faith in the performance or intended performance of a duty or in the exercise or the intended exercise of a power under this Act, a health profession Act, the *Drug and Pharmacies Regulation Act* or a regulation or a by-law under those Acts or for any neglect or default in the performance or exercise in good faith of the duty or power.

**Service by mail**

39.-(1) A notice to be given under this Act to a person may be given by mail.

**Idem**

(2) If a notice under this Act is sent by prepaid first class mail addressed to the person at the person's last known address there is a rebuttable presumption that the notice was received by the person on the fifth day after the notice was mailed.

**Offence**

40.-(1) Every person who contravenes subsection 27(1) or 30(1) is guilty of an offence and on conviction is liable to a fine of not more than \$25,000 or to imprisonment for a term of not more than six months, or to both.

**Idem**

(2) Every person who contravenes section 31, 32 or 33 or subsection 34(2) is guilty of an offence and on conviction is liable to a fine of not more than \$5,000 for a first offence and not more than \$10,000 for a subsequent offence.

**Idem**

(3) Every person who contravenes subsection 34(1) is guilty of an offence and on conviction is liable to a fine of not more than \$10,000 for a first offence and not more than \$20,000 for a subsequent offence.

**Same**

(4) Every person who contravenes subsection 36(1) is guilty of an offence and on conviction is liable to a fine of not more than \$25,000.

**Responsibility of employment agencies**

41. Every person who procures employment for an individual and who knows that the individual cannot perform the duties of the position without contravening subsection 27(1) is guilty of an offence and on conviction is liable to a fine of not more than \$25,000.

**Responsibility of employers**

42.-(1) The employer of a person who contravenes subsection 27(1) while acting within the scope of his or her employment is guilty of an offence and on conviction is liable to a fine of not more than \$25,000.

**Responsibility of directors of corporate employers**

(2) In addition, if the employer described in subsection (1) is a corporation, every director of the corporation who approved of, permitted or acquiesced in the contravention is guilty of an offence and on conviction is liable to a fine of not more than \$25,000.

**Exception**

(3) Subsection (2) does not apply with respect to a corporation that operates a public hospital within the meaning of the *Public Hospitals Act* or to a corporation to which Part III of the *Corporations Act* applies.

**Regulations**

43.-(1) Subject to the approval of the Lieutenant Governor in Council, the Minister may make regulations,

- (a) prescribing forms of energy for the purposes of paragraph 7 of subsection 27(2);
- (b) exempting a person or activity from subsection 27(1) or 30(1);
- (c) attaching conditions to an exemption in a regulation made under clause (b);
- (d) allowing the use of the title "doctor", a variation or abbreviation or an equivalent in another language.

**Scope of regulations**

(2) A regulation may be general or particular in its application.

**Definition**

(3) In clause (1)(d), "abbreviation" includes an abbreviation of a variation.

**Regulations**

43.1 Subject to the approval of the Lieutenant Governor in Council, the Minister may make regulations governing funding under programs required under section 85.7 of the Code, including regulations,

- (a) prescribing the maximum amount or a means of establishing the maximum amount of funding that may be provided for a person in respect of a case of sexual abuse;

- (b) prescribing the period of time during which funding may be provided for a person in respect of a case of sexual abuse.

## EXCERPTS FROM *HEALTH PROFESSIONS PROCEDURAL CODE*

### Definitions

1.-(1) In this Code, ...

"incapacitated" means, in relation to a member, that the member is suffering from a physical or mental condition or disorder that makes it desirable in the interest of the public that the member no longer be permitted to practise or that the member's practice be restricted; (frappé d'incapacité")

"member" means a member of the College; ("membre") ...

"Registrar" means the Registrar of the College; ("registrateur")

### Sexual abuse of a patient

(3) In this Code, "sexual abuse" of a patient by a member means,

- (a) sexual intercourse or other forms of physical sexual relations between the member and the patient;
- (b) touching, of a sexual nature, of the patient by the member; or
- (c) behaviour or remarks of a sexual nature by the member towards the patient.

### Exception

(4) For the purposes of subsection (3), "sexual nature" does not include touching, behaviour or remarks of a clinical nature appropriate to the service provided.

### Statement of purpose, sexual abuse provisions

1.1 The purpose of the provisions of this Code with respect to sexual abuse of patients by members is to encourage the reporting of such abuse, to provide funding for therapy and counselling for patients who have been sexually

abused by members and, ultimately, to eradicate the sexual abuse of patients by members.

### COLLEGE

#### College is body corporate

2.-(1) The College is a body corporate without share capital with all the powers of a natural person.

#### Corporations Act

(2) The *Corporations Act* does not apply in respect to the College.

#### Objects of College

3.-(1) The College has the following objects:

1. To regulate the practice of the profession and to govern the members in accordance with the health profession Act, this Code and the *Regulated Health Professions Act, 1991* and the regulations and by-laws.
2. To develop, establish and maintain standards of qualification for persons to be issued certificates of registration.
3. To develop, establish and maintain programs and standards of practice to assure the quality of the practice of the profession.
4. To develop, establish and maintain standards of knowledge and skill and programs to promote continuing competence among the members.
5. To develop, establish and maintain standards of professional ethics for the members.

6. To develop, establish and maintain programs to assist individuals to exercise their rights under this Code and the *Regulated Health Professions Act, 1991*.
7. To administer the health profession Act, this Code and the *Regulated Health Professions Act, 1991* as it relates to the profession and to perform the other duties and exercise the other powers that are imposed or conferred on the College.
8. Any other objects relating to human health care that the Council considers desirable.

#### **Duty**

(2) In carrying out its objects, the College has a duty to serve and protect the public interest.

#### **REGISTRAR'S POWERS OF INVESTIGATION**

##### **Investigators**

**75.** The Registrar may appoint one or more investigators to determine whether a member has committed an act of professional misconduct or is incompetent if,

- (a) the Registrar believes on reasonable and probable grounds that the member has committed an act of professional misconduct or is incompetent and the Executive Committee approves of the appointment;
- (b) the Executive Committee has received a report from the Quality Assurance Committee with respect to the member and has requested the Registrar to conduct an investigation; or
- (c) the Complaints Committee has received a written complaint about the member and has requested the Registrar to conduct an investigation.

##### **Powers of investigators**

**76.**-(1) An investigator may inquire into and examine the practice of the member to be investigated and has, for the purposes of the investigation, all the powers of a commission under Part II of the *Public Inquiries Act*.

##### **Idem**

(2) An investigator may, on the production of his or her appointment, enter at any reasonable time the business premises of the member and may examine anything found there that is relevant to the investigation.

##### **Obstruction prohibited**

(3) No person shall obstruct an investigator or withhold or conceal from him or her or destroy anything that is relevant to the investigation.

##### **Conflicts**

(4) This section applies despite any provision in any Act relating to the confidentiality of health records.

##### **Entries and searches**

**77.**-(1) A justice of the peace may, on the application of the investigator, issue a warrant authorizing an investigator to enter and search a place and examine anything that is relevant to the investigation if the justice of the peace is satisfied that the investigator has been properly appointed and that there are reasonable and probable grounds for believing that,

- (a) the member being investigated has committed an act of professional misconduct or is incompetent; and
- (b) there is something relevant to the investigation at the place.

##### **Searches by day unless stated**

(2) A warrant issued under subsection (1) does not authorize an entry or search after sunset and before sunrise unless it is expressly stated in the warrant.

##### **Assistance and entry by force**

(3) An investigator entering and searching a place under the authority of a warrant issued under subsection (1) may be assisted by other persons and may enter a place by force.

##### **Investigator to show identification**

(4) An investigator entering and searching a place under the authority of a warrant issued under subsection (1) shall produce his or her identification, on request, to any person at the place.

##### **Copying of documents and objects**

**78.**-(1) An investigator may copy, at the College's expense, a document or object that an

investigator may examine under subsection 76(2) or under the authority of a warrant issued under subsection 77(1).

#### **Removal for documents and objects**

(2) An investigator may remove a document or object described in subsection (1) if,

- (a) it is not practicable to copy it in the place where it is examined; or
- (b) a copy of it is not sufficient for the purposes of the investigation.

#### **Return of documents and objects or copies**

(3) If it is practicable to copy a document or object removed under subsection (2), the investigator shall,

- (a) if it was removed under clause (2)(a), return the document or object within a reasonable time; or
- (b) if it was removed under clause (2)(b), provide the person who was in possession of the document or object with a copy of it within a reasonable time.

#### **Copy as evidence**

(4) A copy of a document or object certified by an investigator to be a true copy shall be received in evidence in any proceeding to the same extent and shall have the same evidentiary value as the document or object itself.

#### **Definition**

(5) In this section, "document" means a record of information in any form and includes any part of it.

#### **Report of investigation**

**79.** The Registrar shall report the results of an investigation to,

- (a) the Executive Committee if the investigator was appointed under clause 75(a) or (b);
- (b) the Complaints Committee if the investigator was appointed under clause 75(c), at the request of the Complaints Committee; or
- (c) the Board if the investigator was appointed under clause 75(c) by the

Board exercising the Registrar's powers under subsection 28(4).

### **QUALITY ASSURANCE COMMITTEE**

#### **Reference to Quality Assurance Committee**

**79.1** When the Executive Committee, Complaints Committee or Board receives a report under section 79 of the results of an investigation conducted into a possible act of sexual abuse as defined in clause 1(3)(c), it may refer the matter to the Quality Assurance Committee.

### **REPORTING OF HEALTH PROFESSIONALS**

#### **Reporting by members**

**85.1-(1)** A member shall file a report in accordance with section 85.3 if the member has reasonable grounds, obtained in the course of practising the profession, to believe that another member of the same or a different College has sexually abused a patient.

#### **If name not known**

(2) A member is not required to file a report if the member does not know the name of the member who would be the subject of the report.

#### **If information from a patient**

(3) If a member is required to file a report because of reasonable grounds obtained from one of the member's patients, the member shall use his or her best efforts to advise the patient of the requirement to file the report before doing so.

#### **Reporting by facilities**

**85.2-(1)** A person who operates a facility where one or more members practise shall file a report in accordance with section 85.3 if the person has reasonable grounds to believe that a member who practises at the facility has sexually abused a patient.

#### **When non-individuals have reasonable grounds**

(2) For the purposes of subsection (1), a person who operates a facility but who is not an individual shall be deemed to have reasonable grounds if the individual who is responsible for the operation of the facility has reasonable grounds.

#### **If name not known**

(3) A person who operates a facility is not required to file a report if the person does not know the name of the member who would be the subject of the report.

**Requirements of required reports**

**85.3-**(1) A report required under section 85.1 or 85.2 must be filed in writing with the Registrar of the College of the member who is the subject of the report.

**Timing of report, sexual abuse**

(2) The report must be filed within thirty days after the obligation to report arises unless the person who is required to file the report has reasonable grounds to believe that the member will continue to sexually abuse the patient or will sexually abuse other patients, in which case the report must be filed forthwith.

**Contents of report**

- (3) The report must contain,
- (a) the name of the person filing the report;
  - (b) the name of the member who is the subject of the report;
  - (c) an explanation of the alleged sexual abuse;
  - (d) if the grounds of the person filing the report are related to a particular patient of the member who is the subject of the report, the name of that patient, subject to subsection (4).

**Patients not named without consent**

(4) The name of a patient who may have been sexually abused must not be included in a report unless the patient, or if the patient is incapable, the patient's representative, consents in writing to the inclusion of the patient's name.

**If reporter providing psychotherapy**

(5) If a member who is required to file a report under section 85.1 is providing psychotherapy to the member who would be the subject of the report, the report must also contain the opinion of the member filing the report, if he or she is able to form one, as to whether or not the member who is the subject of the report is likely to sexually abuse patients in the future.

**Additional reports, psychotherapy**

**85.4-**(1) A member who files a report in respect of which subsection 85.3(5) applies, shall file an additional report to the same College if the member ceases to provide psychotherapy to the member who was the subject of the first report.

**Timing of additional report**

(2) The additional report must be filed forthwith.

**Reporting by employers, etc.**

**85.5-**(1) A person who terminates the employment or revokes, suspends or imposes restrictions on the privileges of a member or who dissolves a partnership or association with a member for reasons of professional misconduct, incompetence or incapacity shall file with the Registrar within thirty days after the termination, revocation, suspension, imposition or dissolution a written report setting out the reasons.

**Same**

(2) If a person intended to terminate the employment of a member or to revoke the member's privileges for reasons of professional misconduct, incompetence or incapacity but the person did not do so because the member resigned or voluntarily relinquished his or her privileges, the person shall file with the Registrar within thirty days after the resignation or relinquishment a written report setting out the reasons upon which the person had intended to act.

**Application**

(3) This section applies to every person, other than a patient, who employs or offers privileges to a member or associates in partnership or otherwise with a member for the purpose of offering health services.

**Immunity for reports**

**85.6** No action or other proceeding shall be instituted against a person for filing a report in good faith under section 85.1, 85.2, 85.4 or 85.5.

**FUNDING FOR THERAPY AND COUNSELLING****Funding provided by College**

**85.7-**(1) There shall be a program, established by the College, to provide funding for therapy and counselling for persons who, while patients, were sexually abused by members.

**Funding governed by regulations**

(2) The funding shall be provided in accordance with the regulations made under the *Regulated Health Professions Act, 1991*.

**Administration**

(3) The Patient Relations Committee shall administer the program.

**Eligibility**

- (4) A person is eligible for funding only if,
- (a) there is a finding by a panel of the Discipline Committee that the person, while a patient, was sexually abused by a member; or
  - (b) the alternative requirements prescribed in the regulations made by the Council are satisfied.

**Effect of appeal**

(5) A person's eligibility for funding under clause (4)(a) is not affected by an appeal from the panel's finding.

**No assessment**

(6) A person is not required to undergo a psychological or other assessment before receiving funding.

**Choice of therapist or counsellor**

(7) A person who is eligible for funding is entitled to choose any therapist or counsellor, subject to the following restrictions:

1. The therapist or counsellor must not be a person to whom the eligible person has any family relationship.
2. The therapist or counsellor must not be a person who, to the College's knowledge, has at any time or in any jurisdiction been found guilty of professional misconduct of a sexual nature or been found civilly or criminally liable for an act of a similar nature.
3. If the therapist or counsellor is not a member of a regulated health profession, the College may require the person to sign a document indicating that he or she understands that the therapist or counsellor is not subject to professional discipline.

**Payment**

(8) Funding shall be paid only to the therapist or counsellor chosen by the person.

**Use of funding**

(9) Funding shall be used only to pay for therapy or counselling and shall not be applied directly or indirectly for any other purpose.

**Same**

(10) Funding may be used to pay for therapy or counselling that was provided before the person became eligible under subsection (4) but after the panel began its hearing into the matter.

**Other coverage**

(11) The funding that is provided to a person shall be reduced by the amount that the Ontario Health Insurance Plan or a private insurer is required to pay for therapy or counselling for the person during the period of time during which funding may be provided for him or her under the program.

**Right of recovery**

(12) The College is entitled to recover from the member, in a proceeding brought in a court of competent jurisdiction, money paid in accordance with this section for therapy or counselling for an eligible person referred to in clause (4)(a).

**Person not required to testify**

(13) The eligible person shall not be required to appear or testify in the proceeding.

**MISCELLANEOUS****Right to use French**

**86.-(1)** A person has the right to use French in all dealings with the College.

**Council to ensure right**

(2) The Council shall take all reasonable measures and make all reasonable plans to ensure that persons may use French in all dealings with the College.

**Definition**

(3) In this section, "dealings" means any service or procedure available to the public or to members and includes giving or receiving communications, information or notices, making applications, taking examinations or tests and participating in programs or in hearings or reviews.

**Limitation**

(4) A person's right under subsection (1) is subject to the limits that are reasonable in the circumstances.

**Injunctions**

**87.** The College may apply to the Ontario Court (General Division) for an order directing a person to comply with a provision of the health profession Act, this Code, the *Regulated Health Professions Act, 1991* or the regulations under those Acts.

**Evidence of Registrar**

**88.** A statement purporting to be certified by the Registrar under the seal of the College as a statement of information from the records kept by the Registrar in the course of his or her duties is admissible in court as proof, in the absence of evidence to the contrary, of the information in it without proof of the Registrar's appointment or signature or of the seal of the College.