CONO and A. Bortnick
May 16, 2022
Exhibit 5

DISCIPLINE COMMITTEE OF
THE COLLEGE OF NATUROPATHS OF ONTARIO

B E T W E E N :

COLLEGE OF NATUROPATHS OF ONTARIO

- and -

ALLAN BORTNICK

ACKNOWLEDGEMENT AND UNDERTAKING

I, **ALLAN BORTNICK**, hereby acknowledge and undertake as follows:

1. I acknowledge that for the relevant periods of time, I was a Registrant of the College of Naturopaths of Ontario (the "College").
2. I acknowledge that I have entered into an agreement with the College and admitted to, or pled no contest to, allegations of misconduct as outlined in an Agreed and Uncontested Statement of Facts signed on April 13, 2022. A copy which is attached hereto as **Appendix "A"**.
3. In light of my admissions in the Agreed and Uncontested Statement of Facts, and pending the acceptance of the Agreed and Uncontested Statement of Facts by a panel of the Discipline Committee and a finding of misconduct, I undertake to attend virtually before a panel of the Discipline Committee to receive an oral caution, immediately following the Discipline Hearing, or on a date and time that is set by the panel.
4. I acknowledge that I have had the opportunity to obtain legal advice prior to entering into this undertaking and I have either done so or I have chosen not to do so.

5. I acknowledge that I am entering into this undertaking freely, voluntarily and without duress.

Signed this 13 day of Apr. 1, 2022.

ALLAN BORTNICK **Witness Signature**

Signed this 28 day of April, 2022.

Andrew Parr, CAE
Chief Executive Officer
College of Naturopaths of Ontario

TAB A

DISCIPLINE COMMITTEE OF

THE COLLEGE OF NATUROPATHS OF ONTARIO

B E T W E E N:

COLLEGE OF NATUROPATHS OF ONTARIO

and

ALLAN BORTNICK

AGREED AND UNCONTESTED STATEMENT OF FACTS

The parties hereby agree that the following facts and attachments may be accepted as true by the Discipline Committee of the College of Naturopaths of Ontario:

The Registrant

1) Allan Bortnick (the "Registrant") initially registered with the Board of Directors of Drugless Therapy – Naturopathy (the "Board") on or about June 14, 1978. The Registrant became a registrant of the College of Naturopaths of Ontario (the "College") in the General class of registration on or about July 1, 2015 as a result of the proclamation of the *Naturopathy Act, 2007*. Attached as **Tab "A"** is a printout from the College's Naturopathic Doctor Register.

2) The Registrant was also a chiropractor registered with the College of Chiropractors of Ontario (CCO). He was registered as a chiropractor from approximately 1977 to 2022. Attached as **Tab "B"** is a printout from the CCO's Public Register.

Notices of Hearing

3) The College and the Registrant consent to the two Notices of Hearing dated December 10, 2020 to be heard together pursuant to s 9.1(1)(a) of the *Statutory Powers Procedure Act.*

4) The College and the Registrant agree that the following allegations and particulars should be withdrawn:

   a) Patient 3 – Paragraphs 17 – 22;

b) Patient 4 – Paragraphs 23-28; and

c) Patient 5 – Paragraphs 29-35.

Patient 1

5) On or about December 9, 2014 Patient 1 visited the Registrant for allergy testing.

6) However, during the appointment, the Registrant told Patient 1 that something was wrong with her back. He asked Patient 1 to stand up in front of him.

7) When Patient 1 stood up to allow the Registrant to check out her back (as the Registrant expressed concern) the Registrant grazed her breasts. If the Registrant were to testify, he would deny grazing her breasts but would state that if it did occur, it was inadvertent. The Registrant agrees that during this procedure inadvertent touching can occur. The Registrant also admits that he never disclosed this to Patient 1 when seeking consent.

8) The Registrant then told Patient 1 that she required a bladder or abdominal lift and a diaphragm examination.

9) It is agreed that during the appointment, the Registrant performed a bladder lift and a diaphragm examination on Patient 1. He also assessed Patient 1 for orthotics.

Bladder/Abdominal Lift

10) The bladder lift required Patient 1 to lie face down on the treatment table. Patient 1 was fully dressed. The Registrant placed his right hand on her abdomen below her belly button. During the bladder lift, Patient 1 felt a sensation in her clitoral area. If he were to testify, the Registrant would advise the panel that any touching of this area was of a clinical and not a sexual nature and he did not touch the pubis or the clitoris during the bladder lift. However, he concedes that a patient may feel a tug at the pubic symphysis as this is where the rectus abdominus muscle attaches. If he were to testify, the Registrant would state that he advised Patient 1 that she may feel a "tug" sensation at the pubic symphysis. If Patient 1 were to testify, she would state that he never disclosed this to her when seeking consent.

11) If he were to testify, the Registrant would advise the panel that he believed that he had obtained informed consent from Patient 1. He now concedes that he did not as he did not provide the necessary information to Patient 1 to obtain informed consent. He also admits that he did not document any aspect of the consent in the patient record.

Diaphragm Examination

12) The Registrant concedes that this procedure may not have been required. However, if he were to testify, he would state he believed that it was warranted in light of his assessment of the patient's symptoms.

13) The Registrant asked Patient 1 to sit down. He was behind her and reached around Patient 1 to examine her xiphoid area located where the lower ribs attach to the breastbone.

14) While doing so, Patient 1 states that the Registrant again grazed her breasts.

15) If he were to testify, the Registrant would advise the panel that he does not recall grazing her breasts. However, he concedes that grazing may occur in light of the fact that he was behind Patient 1 and placed his hands in the xiphoid area to determine if the joint was fixated or mobile. The Registrant admits that during the consent process, he did not disclose to Patient 1 that her breasts may be touched.

16) If he were to testify, the Registrant would advise the panel that he believed that he had obtained informed consent from Patient 1. He now concedes that he did not as he did not provide the necessary information to Patient 1 to obtain informed consent. He admits that he did not document any aspect of the consent in the patient record.

Orthotics

17) The Registrant was concerned about possible pelvis misalignment and asked Patient 1 to stand. Patient 1 stated that the Registrant then took both of his hands and rubbed them down her legs, cupping the underside of her buttocks as he passed that area. She stated that he repeated this movement and again cupped the underside of her buttocks. The Registrant denies cupping the underside of her buttocks.

18) The Registrant concedes that some touching may occur during the assessment and if it did, any touching of this area was not sexual in nature. The Registrant admits that he never disclosed to Patient 1 that he may touch the buttocks when assessing for orthotics.

19) Patient 1 was concerned that the Registrant recommended and ordered orthotics for her. If he were to testify, the Registrant would advise the panel that he did so as he believed it was warranted. However, he concedes that he did not conduct a proper foot/gait examination, did not palpate the region and did not obtain a proper medical history and that this should have occurred before any recommendation or ordering.

20) If he were to testify, the Registrant would advise the panel that he believed he had obtained informed consent from Patient 1. He now concedes that he did not as he did not provide the necessary information to Patient 1 to obtain informed consent. He admits that he did not document any aspect of the consent in the patient record.

Patient 2

21) On or about June 29, 2015, Patient 2 visited the Registrant for orthotics, spine curvature and clenching of the jaw.

22) It is agreed that the Registrant proposed and performed a bladder/abdominal lift and a spinal examination on Patient 2.

Spinal Examination/Jaw Assessment

23) It is agreed that during the spinal examination, the Registrant asked Patient 2 to stand. He tapped her body, including her buttocks. It is the position of the Registrant that this touching was of a clinical and not sexual nature. The Registrant admits that he never disclosed that he would palpate (or tap) her buttocks to Patient 2 when seeking informed consent.

24) It is also agreed that that in assessing her jaw, he palpated and touched the mouth and lips of Patient 2. If she were to testify, Patient 2 would state that he placed his hands in her mouth and on the wet part of her lips. If he were to testify he would deny touching any wet part of her lips. The Registrant admits that he never disclosed that he would palpate and touch her mouth and lips to Patient 2 when seeking informed consent.

25) The Registrant asked Patient 2 to sit down. He admits that he reached across Patient 2 to assess her diaphragm area. During this assessment, Patient 2 states that the Registrant moved both hands over her shoulders, down her chest, under her shirt and bra and cupped her breasts.

26) If he were to testify, the Registrant would advise the panel that he has no recollection of touching her breasts. He concedes that grazing of the breasts may occur in light of the fact that he was behind Patient 2 and placed his hands in the xiphoid area. The Registrant admits that he never disclosed this possibility to Patient 2 when seeking consent. The Registrant also admits that he did not alert Patient 2 that he would stand behind her and move his hands over her shoulders and down her chest when seeking informed consent.

27) If he were to testify, the Registrant would advise the panel that he believed he had obtained informed consent from Patient 2 to perform the spinal assessment. He now concedes that he did not as he did not provide the necessary information to Patient 2 to obtain informed consent. He admits that he did not document any aspect of the consent in the patient record.

Orthotics

28) It is agreed that the Registrant assessed and proposed and recommended new orthotics to Patient 2. If he were to testify, the Registrant would advise the panel he did so as he believed it was warranted. However, he concedes that he did not conduct a proper foot/gait examination, did not palpate the region and did not obtain a proper medical history and that this should have occurred before any recommendation or ordering.

29) If he were to testify, the Registrant would advise the panel that he believed he had obtained informed consent from Patient 2 to perform the orthotics assessment and the ordering thereof. However, he admits that he did not document any aspect of the consent in the patient record.

Patient 6

30) On or about April 7, 2013 the Registrant attended the home of Patient 6 as she wished to obtain naturopathic treatment and recommendations related to her falling.

31) It is agreed that the Registrant provided a naturopathic diagnosis and offered to provide treatment and provided treatment for an alleged fallen bladder and backed up kidneys.

32) It is agreed that the Registrant proposed and performed a bladder lift and a diaphragm examination.

Bladder Lift

33) At the outset of the bladder lift, the Registrant asked Patient 6 to lie down on the treatment table. Patient 6 was on her back and was fully clothed.

34) If she were to testify, Patient 6 would state the following:

a) The Registrant started massaging her head and then moved to her neck. He advised Patient 6 that he would use a laser to relax the muscles.

b) The Registrant then moved down to her breasts and massaged them. Patient 6 thought he was checking for lumps.

c) The Registrant then moved down her body but then moved up to her breasts again. He felt (cupped or held) them again.

d) The Registrant then went back up to her neck and massaged it.

e) The Registrant then returned to her breasts. He touched (cupped or held) them. At this point in time, Patient 6 asked the Registrant what he was doing.

35) If he were to testify, the Registrant would advise the panel that he has no recollection of touching her breasts. He concedes that grazing of the breasts may occur during this procedure. The Registrant admits that he never disclosed this possibility to Patient 6 when seeking informed consent.

36) If he were to testify, the Registrant would advise the panel that he believed he had obtained informed consent from Patient 6 to perform the bladder lift and any touching of this area was of a clinical and not sexual nature. He now concedes that he did not as he did not provide the necessary information to Patient 6 to obtain informed consent. He admits that he did not document any aspect of the consent in the patient record.

Orthotics

37) It is also agreed that during this appointment, the Registrant recommended orthotics to Patient 6. Patient 6 had not requested orthotics. Despite this, the Registrant proceeded to assess,

recommend and order orthotics for Patient 6. It is agreed that orthotics were not warranted for Patient 6.

Touching of Sensitive Body Parts and Sexual Impropriety

38) If he were to testify, the Registrant would acknowledge that any touching of the breasts or buttocks, inadvertent or not, can be stressful for patients. The Registrant would agree that registrants need to reassure patients that they will always be mindful of boundary concerns and that this includes avoiding any unnecessary touching of sensitive body parts. Further, the Registrant admits that if any inadvertent touching of any sensitive body parts (including but not limited to the breasts, buttocks, vulva or vagina) may occur, it is important to alert the patient in advance and ensure that this is acceptable to the patient before any treatment occurs. This ensures that the care is patient centred and does not cause any unnecessary stress or discomfort to the patient. It also ensures that patients have all relevant information before deciding to consent to a treatment.

39) The Registrant admits that if the recollections of Patient 1, 2 and/or 6 are correct with regard to touching of their breasts, it would constitute misconduct and pleads no contest to the allegations of sexual impropriety.

Standards and Guidelines of the Board

40) During the relevant periods of time, it is agreed that the following written standards and guidelines applied to the Registrant (all of which are attached at **Tab "C"**):
    a) General Standards of Practice
    b) Consent to Treatment Standard;
    c) Ethical Conduct Standard; and
    d) Record Keeping Standard.

Admissions of misconduct

41) The College and the Registrant agree that the above conduct constitutes misconduct pursuant to subsection of 30(1) of Ontario Regulation 278, R.R.O. 1990, as defined in Professional Misconduct/Incompetence established by the Board:

    a) **Paragraph 2(a)** - Failure to maintain adequate records in accordance with Board policy;

    b) **Paragraph 2(r)** – Conduct or an act relevant to the practice of naturopathic medicine that, having regard to all the circumstances, would reasonably be regarded by naturopathic doctors as unprofessional or incompetent;

    c) **Paragraph 2(u)** - Failure to obtain informed consent for diagnostic or treatment procedures or plan of treatment; and

d) **Paragraph 2(w)** - Contravening standards of practice or guidelines of practice set by the Board, specifically:

i) 2.6 – Deal honestly with all patients, colleagues, public institutions and legal bodies, and refrain from giving any false, incomplete or misleading information;

ii) 2.9 – Formulate an assessment/diagnosis to a level consistent with the patient based on knowledge, training and expertise of the naturopathic doctor and the technology and tools available to the professions;

iii) 2.10 – Communicate the appropriate assessment to the patient and only communicate a diagnosis to the patient which has been conclusively determined using the training and tools available to the naturopathic profession;

iv)4.6 – Implement the plan of treatment with informed consent;

iv) Consent to Treatment Standard;

v) Ethical Conduct Standard; and

vi) Record Keeping Standard.

No Contest

42) The Registrant pleads no contest (i.e., he neither admits nor denies) to the particulars and allegations of sexual impropriety. The Discipline Committee has sufficient evidence to make this finding of misconduct to subsection of 30(1) of Ontario Regulation 278, R.R.O. 1990, paragraph 2(h) as defined in Professional Misconduct/Incompetence established by the Board.

Acknowledgement

43) By this document, the Registrant states that:

a) He understands fully the nature of the allegations made against him;

b) He has no questions with respect to the allegations against him;

c) He admits to the truth of the facts contained in this document and that the facts constitute professional misconduct;

d) He understands that by signing this document he is consenting to the evidence as set out in this document being presented to the Discipline Committee;

e) He understands that by admitting to certain allegations and not contesting the allegations of sexual impropriety, he is waiving his right to require the College to prove the allegations against him at a contested hearing;

f) He understands that the decision of the Committee and a summary of its reasons, including reference to his name, will be published in the College's annual report and any other publication or website of the College;

g) He understands that any agreement between him and the College with respect to the penalty proposed does not bind the Discipline Committee; and

h) He understands and acknowledges that he is executing this document voluntarily, unequivocally, free of duress, and free of bribe and that he has been advised of his right to seek legal advice.

All of which is respectfully submitted:

Signed this 13 day of Apr. 1, 2022

Allan Bortnick
Registrant

Signed this 28 day of April, 2022

Andrew Parr, CAE
Chief Executive Officer
College of Naturopaths of Ontario

TAB A

College of Naturopaths of Ontario

Status as of: 28-Apr-2022 11:45
NOT A PRACTICE PERMIT

Allan Bortnick

Registrant Number: 0485
Initial registration: 14-Jun-1978 (Initial Registration with the BDDT-N)
Nickname / abbreviation: N/A
Previous name: N/A

Current Registration

Class
General
(By order of the ICRC)

Status
Suspended
Effective
24-Mar-2022

Expiry

Terms, Conditions and Limitations

Limitation (Effective: 24-Mar-2022)

On March 24, 2022, a panel of the Inquiries, Complaints and Reports Committee (ICRC) made an interim order directing the Chief Executive Officer to immediately suspend the certificate of registration of Allan Bortnick.

The interim suspension will continue until it is varied by the ICRC, or until the matter is disposed of by a panel of the ICRC or the Discipline Committee.

Undertaking (Effective: 02-Aug-2018)
The Registrant has entered an agreement with the College to:

a. Notify in writing the College of the identity of any and all of employers, and shall notify the College if there is any change in personal or employment circumstances that may affect the terms of this Undertaking and shall do so within 48 hours of any such change;
b. Provide any and all of his employers with a copy of this Undertaking within 48 hours of signing this undertaking and within 48 hours of entering into any new employment;
c. Abstain from conducting any naturopathic examinations or procedures except with another adult (who is over 18 years of age hereinafter known as the Third party) present during the examinations and procedures;
d. Ensure that the Third Party signs the patient's chart to confirm his/her presence during the examination or procedure; and
e. Not treat or see any patients who do not consent to being seen with the Third Party being present.

Undertaking (Effective: 16-Feb-2016, Expiry: 01-Aug-2018)

This Undertaking is no longer in effect and is available for historical purposes only.

The member was charged with five (5) counts of sexual assault contrary to s. 271(1) of the Criminal Code of Canada. These charges were not proven. The member entered into an agreement with the College that was in effect until August 1, 2018 and in which he undertook to:

a. Notify in writing the College of the identity of any and all of employers, and shall notify the College if there is any change in personal or employment circumstances and shall do so within 48 hours of any such change;
b. Provide any and all of his employers with a copy of this Undertaking within 48 hours of signing this undertaking and within 48 hours of entering into any new employment;
c. Abstain from conducting any naturopathic examinations or procedures on patients except with another adult (who is over 18 years of age hereinafter known as the Third Party) present during the examinations and procedures;
d. Ensure that the Third Party signs the patient's chart to confirm his/her presence during the examination or procedure;
e. Post a sign, acceptable to the College, in a prominent and visible location in the waiting room and each of the examination/treatment rooms that the Members uses that states: "Dr. Allan Bortnick, ND, DC will have an adult (who is over the age of 18 years of age) present in the room during all examinations and procedures" and shall not have any professional encounters with patients until the signs have been posted;
f. Not treat or see any patients who do not consent to being seen with the Third Party being present; and
g. Regularly (at least once per month) advise the College of the status of the criminal matters, including any changes to the terms of his release, dates for trial and other court appearances, and any resolution of the charges.

ICRC Referrals

Referred To: Discipline Committee
Referral Date: December 3, 2020
Hearing Dates: May 16, 17 & June 2, 2022

Notices of Hearing

STATEMENT OF SPECIFIED ALLEGATIONS

Dr. Allan Bortnick, ND (the "Registrant") initially registered with the Board of Directors of Drugless Therapy – Naturopathy (the "Board") on or about June 14, 1978. The Registrant became a registrant of the College of Naturopaths of Ontario (the "College") in the General class of registration on or about July 1, 2015 as a result of the proclamation of the *Naturopathy Act, 2007*.

Patient 1

1. On or about December 9, 2014 Patient 1 visited the Registrant for allergy testing.
2. It is alleged that the Registrant proposed and/or performed a bladder lift and/or a diaphragm examination on Patient 1.
3. It is alleged that a diaphragm examination was not warranted for Patient 1.
4. It is alleged that the Registrant assessed and/or recommended orthotics that were not warranted for Patient 1.
5. It is alleged that the Registrant failed to do the following:
    a. Disclose all relevant information prior to assessments, treatments, examinations and/or recommendations;

b. Obtain informed consent for the assessment and/or recommendations of orthotics;
c. Obtain informed consent for the bladder lift and/or diaphragm examination;
d. Document the informed consent of Patient 1; and/or
e. Document the appointment in accordance with Board requirements.

6. It is alleged that the Registrant did the following during the bladder lift and/or diaphragm examination without clinical rationale:
    a. Grazed, cupped and/or held the breasts of Patient 1; and/or
    b. Grazed, and/or cupped the buttocks of Patient 1.
7. It is alleged that the Registrant did not perform the above in accordance with the standards of practice of the Board.

Patient 2

1. On or about June 29, 2015, Patient 2 visited the Registrant for orthotics, spine curvature and/or clenching of the jaw.
2. It is alleged that the Registrant proposed and/or performed a bladder lift and/or a spinal examination on Patient 2.
3. It is alleged that the Registrant assessed and/or proposed and/or recommended new orthotics to Patient 2.
4. It is alleged that the Registrant failed to do the following:
    a. Disclose all relevant information prior to assessments, treatments, examinations and/or recommendations;
    b. Assess Patient 2 for orthotics in accordance with standards of the profession;
    c. Obtain informed consent for assessing and/or recommending orthotics;
    d. Obtain informed consent for the bladder lift;
    e. Obtain informed consent for the spinal examination;
    f. Document the informed consent of Patient 2; and/or
    g. Document the appointment in accordance with Board requirements.
5. It is alleged that the Registrant did the following during the bladder lift and/or spinal examination without clinical rationale:
    a. Grazed, cupped and/or held the breasts of Patient 2.
6. It is alleged that the Registrant did not perform the above in accordance with the standards of practice of the Board.

Patient 3

1. In or about March 2011, Patient 3 visited the Registrant for low back pain.
2. It is alleged that the Registrant provided treatment to Patient 3 including an abdominal examination and/or abdominal lift.
3. It is alleged that the Registrant failed to do the following:
    a. Disclose all relevant information prior to assessments, treatments, and/or examinations;
    b. Obtain informed consent for an examination and/or treatment;
        a. Document the informed consent of Patient 3; and/or
        b. Document the appointment in accordance with Board requirements.
4. It is alleged that the Registrant did the following during the abdominal examination and/or bladder lift without clinical rationale:
    a. Touch Patient 3 in the public region and/or apply pressure to the pubic region.
5. It is alleged that the Registrant did not perform the above in accordance with the standards of practice of the Board.

Patient 4

1. In or about 2007, Patient 4 visited the Registrant for lower back pain. It is alleged that Patient 4 had 2-3 appointments with the Registrant.
2. It is alleged that during the appointments, the Registrant would treat, assess and/or examine Patient 4 by massaging her breasts, touching her breasts, squeezing her buttocks and/or massaging her buttocks.
3. It is alleged that the Registrant failed to do the following:
    a. Disclose all relevant information prior to assessments, treatments, and/or examinations;
    b. Obtain informed consent for the treatments, assessments and/or examinations.
4. It is alleged that the Registrant did the following during the treatment without clinical rationale:
    a. Massage the breasts, touch the breasts, squeeze the buttocks and/or massage the buttocks of Patient 4.
5. It is alleged that the Registrant did not perform the above in accordance with the standards of practice of the Board.

Patient 5

1. In or about 2003, Patient 5 visited the Registrant for lower back pain.
2. It is alleged that during the appointment, the Registrant performed a diaphragm/xiphoid examination on Patient 5 and grazed and/or touched her breasts.
3. It is alleged that the Registrant assessed and/or proposed and/or recommended orthotics to Patient 5.
4. It is alleged that the Registrant failed to do the following:
    a. Disclose all relevant information prior to assessments, treatments, examinations and/or recommendations;
    b. Assess and/or propose and/or recommend orthotics for Patient 5 in accordance with standards of the profession;
    c. Obtain informed consent for proposing, and/or recommending orthotics;
    d. Obtain informed consent for the examination.
5. It is alleged that the Registrant did the following during the examination and/or treatment without clinical rationale:
    a. Grazed and/or touched the breasts of Patient 5.
6. It is alleged that the Registrant did not perform the above in accordance with the standards of practice of the Board.

Patient 6

1. On or about April 7, 2013 the Registrant attended the home of Patient 6 to provide treatment and/or recommendations related to her falling.
2. It is alleged that the Registrant provided a naturopathic diagnosis and/or offered to provide treatment and/or provided treatment for an alleged fallen bladder and/or backed up kidneys.
3. It is alleged that the Registrant assessed and/or recommended orthotics that were not warranted for Patient 6.
4. It is alleged that the Registrant proposed and/or performed a bladder lift and/or a diaphragm examination.
5. It is alleged that the Registrant failed to do the following:
    a. Disclose all relevant information prior to treatments;
    b. Obtain informed consent for a bladder lift and/or diaphragm examination, including but not limited to the following:
        i. The Registrant failed to alert Patient 6 about the nature of the examination and/or treatment, including but not limited to the following:
            1. The Registrant would or may graze and/or touch her breasts; and/or
            2. The Registrant would or may graze and/or touch her buttocks;

c. Obtain informed consent for assessing and/or recommending orthotics;
d. Document the informed consent of Patient 6; and/or
a. e. Document the appointment in accordance with Board requirements.
1. It is alleged that the Registrant did the following during the bladder lift and/or diaphragm examination, without any clinical rationale:
a. Grazed, cupped and/or held the breasts of Patient 6.
2. It is alleged that the Registrant did not perform the above in accordance with the standards of practice of the Board.

Allegations of professional misconduct as a Registrant of the Board

It is alleged that the above noted conduct constitutes misconduct pursuant to subsection of 30(1) of Ontario Regulation 278, R.R.O. 1990, as defined in Professional Misconduct/Incompetence established by the Board:

a. **Paragraph 2(a)** - Failure to maintain adequate records in accordance with Board policy;
b. **Paragraph 2(h)** – Sexual impropriety with a patient;
c. **Paragraph 2(r)** – Conduct or an act relevant to the practice of naturopathic medicine that, having regard to all the circumstances, would reasonably be regarded by naturopathic doctors as unprofessional or incompetent;
d. **Paragraph 2(u)** - Failure to obtain informed consent for diagnostic or treatment procedures or plan of treatment; and/or
e. **Paragraph 2(w)** - Contravening standards of practice or guidelines of practice set by the Board.

Show: Registration History | Employment

Registration History

Class	Status	Effective
● Suspended (By order of the ICRC)	General	24-Mar-2022
● General	In Good Standing	01-Apr-2021
● General	In Good Standing	01-Apr-2020
● General	In Good Standing	01-Apr-2019
● General	In Good Standing	01-Apr-2018

« ‹ 1 2 3 4 ... › »

Employment

Employer	Address	Phone

Employer	Address	Phone
Dr Allan Bortnick N.D.D.C. Start: 27-Oct-2019	downstairs 1198 Eglinton Ave W Toronto, ON M6C 2E3 CAN	416-782-2113

TAB B

TAB B HAS BEEN EXCLUDED AS THE REGISTRANT'S CCO REGISTRY PROFILE IS NO LONGER AVAILABLE

TAB C

Standards of Practice

Developed and distributed by the
Canadian Naturopathic Association and
the Board of Directors of Drugless Therapy – Naturopathy
Province of Ontario, Developed 1989
Revised January, 2000.

Table of Contents:

1.0. Introduction

2.0 Basic Standards of Practice

3.0 Case Specific Standards – General Considerations

4.0 Case Specific Standards to be Applied by the Naturopathic Doctor to Each Patient

5.0 Application of Standards of Practice

6.0 Modification of Standards of Practice

7.0 Publication and Distribution of Standards of Practice

8.0 Definitions

1.0 INTRODUCTION

STANDARDS OF PRACTICE are the criteria which guide the day to day actions of naturopathic doctors in the delivery of care and service to the patient and the community. They also serve as the basis for the evaluation of the behaviour of practitioners by disciplinary and judicial functions.

This document provides basic standards for the most predictable circumstances, means for developing standards for specific conditions, methods for applying them in the assessment of the actions of practitioners, ways they can be modified and, finally, the necessity for disseminating them to regulated practitioners.

All standards are derived from the same body of knowledge that practitioners use to provide service. Methods of identifying this body of knowledge in a concise and universally accepted form are described herein.

The objectives of this document are to identify the responsibilities of naturopathic doctors to the public and to establish a means for evaluating their professional actions.

The purpose of this document is to provide a clear, unambiguous and consistent format for the identification, development and implementation of standards of practice that apply to naturopathic doctors in the delivery of direct patient care services and other times where the practitioner is in a position of public trust.

2.0 BASIC STANDARDS OF PRACTICE

Each naturopathic doctor shall:

2.1 Have knowledge of and comply with the laws and regulations governing the practice of naturopathic medicine in the jurisdiction of practice.

2.2 Provide a level of care consistent with each patient's individual condition.

2.3 Actively consult and/or refer as appropriate to other health professionals when the patient's condition so warrants in providing optimal care.

Referral is so warranted when:

a) a life-threatening situation occurs or is suspected
b) the diagnosis or the treatment of a patient or of a specific condition is not within the scope of naturopathic practice
c) the diagnosis or treatment of a patient or specific treatment requires expertise or technology that is not available to the naturopathic doctor
d) a diagnosis is required but cannot be confirmed with the training and technology that is available to the naturopathic doctor
e) response to treatment is not adequate or the patient's condition deteriorates
f) a second opinion is desired

2.4 Treat each patient with respect and human dignity regardless of the individual's health condition, personal attributes, national origin or handicap and shall not discriminate on the basis of age, sex, race, religion, economic or social status, or sexual preferences in the rendering of naturopathic medical services.

2.5 Respect the patient's right to privacy by protecting all confidential information.

2.6 Deal honestly with all patients, colleagues, public institutions and legal bodies, and refrain from giving any false, incomplete or misleading information.

2.7 Report any health care provider whose character or competence are deficient or who is grossly negligent or reckless.

2.8 Maintain clear and adequate patient care and billing records for at least seven (7) years after the last visit by the patient.

2.9 Formulate an assessment/diagnosis to a level consistent with the patient based on knowledge, training, and expertise of the naturopathic doctor and the technology and tools available to the profession.

2.10 Communicate the appropriate assessment to the patient and only communicate a diagnosis to the patient which has been conclusively determined using the training and tools available to the naturopathic profession.

2.11 Advise the patient regarding significant side effects from the treatment plan.

2.12 Monitor each patient at a level consistent with the degree of management being exercised.

2.13 Refrain from providing primary care management for any patient where the relationship with the patient (such as family member, close personal friend) would serve to interfere with the doctor's objective judgment.

3.0 CASE SPECIFIC STANDARDS "GENERAL CONSIDERATIONS"

It is recognized that the basic standards cannot anticipate every potential situation faced by a practitioner, nor predict the changes in technology and knowledge with time. This section is a guide for the development of standards of practice for a particular incident or presentation.

3.1 Identify the scope of the doctor, i.e. primary care management, co-treatment, consulting treatment, expert testimony, etc.

3.2 Identify the scope of the problem i.e. the complaint, the specific naturopathic medical area of concern, (e.g. manual manipulation, allergy, diagnostic radiology, etc.) and all other pertinent data such as history, diagnosis, other diagnostic data, etc.

3.3 Identify the body of knowledge to be used in assessing the problem in accordance with the following criteria:

a) Clearly and concisely cover the problem. While it is rare to find a particular situation specifically addressed in the literature, the entirety of the problem must be dealt with in such a manner that all conclusions reached are clearly and concisely drawn from a body of information that is applicable to the problem with no possibility of an incorrect conclusion being drawn by material out of context.

b) Universally accepted by the naturopathic profession. The information used must be from sources accessible and generally accepted by the profession. Such sources include textbooks, journals, information taught in naturopathic colleges and recognized experts in the naturopathic community or in the specialty in question. As with all health care professions, reliable expert data and testimony from sources outside of the naturopathic community is acceptable.

c) Verify in writing when testimony from experts or consultants is used and by specific citation with literature.

3.4 Basis for a decision. Each decision shall be based on the following:

a) Protection of the public and the public interest. This includes risk of physical or mental harm, misrepresentation to the public, billing or costs not consistent with fair and accepted practices, full disclosure of treatment and its effects, appropriateness of referral, etc.

b) Compliance with applicable law.

4.0 CASE SPECIFIC STANDARDS TO BE APPLIED BY THE NATUROPATHIC DOCTOR TO EACH PATIENT

4.1 Identify the naturopathic doctor's role for this specific case.

4.2 Identify the extent of the patient's problem:

a) Obtain a relevant and complete case history to the need of the specific case and presentation.
b) Perform a relevant and complete physical examination.
c) Obtain or perform relevant and approved screening or diagnostic tests.
d) Collect and evaluate all data.
e) Make appropriate referral if indicated at this point to the need of the specific case.
f) Make appropriate communications with other involved health professionals.

4.3 Formulate a relevant assessment and/or diagnosis where possible, based on the history, examination findings, data collected, training and expertise of the naturopathic doctor and the legal scope of practice of the profession.

4.4 Communicate the assessment or diagnosis to the patient.

4.5 Formulate a plan of treatment for the patient based on the best interests of the patient's welfare, need for and appropriateness of referral, accepted practices and naturopathic body of knowledge.

4.6 Implement the plan of treatment with informed consent.

4.7 Amend the plan of treatment as appropriate and implement with informed consent.

5.0 APPLICATION OF STANDARDS OF PRACTICE

Standards of practice must be evaluated in every case to be certain that they are appropriate and complete. The Board or judicial function must also ensure that the standards being used are chronologically consistent with the case being evaluated, since technology procedures and treatment protocols can change rapidly.

6.0 MODIFICATION OF STANDARDS OF PRACTICE

As noted, standards of practice are designed to be modified to suit the conditions of the case and the current state of the art of naturopathic medicine. Each time such a change is made, the reasons for the change must be documented in the same manner used for the development of new standards, for the purpose of allowing a transparent record for appeal as well as ensuring clear precedent for ensuing cases. Changes will be distributed to all other jurisdictions by the Board of Directors of Drugless Therapy - Naturopathy as they are received.

7.0 PUBLICATION AND DISTRIBUTION OF STANDARDS OF PRACTICE

The standards of practice and case specific standards of practice shall be distributed to all registrants in a timely manner. Care shall be taken with the case specific standards to protect the privacy of all involved in their development.

8.0 DEFINITIONS

Body of Knowledge: The clear, concise information, generally accepted by the naturopathic profession, from which standards of practice are derived.

Co-Treatment: Treatment of a patient in concert with the doctor providing primary care management of the patient.

Consulting Treatment: Providing a second opinion or ancillary care for a patient whose primary care management is being provided by another doctor.

Disciplinary Authority: Any Licencing Board, Disciplinary Board or other governmental function having jurisdiction over the practitioner and acts being investigated.

Judicial Function: Any court or other judicial forum with legal jurisdiction over the practitioner and acts being investigated.

Primary Care Management: Provision of a patient's overall health care management including the monitoring of all treatments in progress with other providers as appropriate.

(2000/01-R)

Standard of Practice and Performance Expectations for Consent

Effective date: February 1, 2011
Initial Policy issue date: unknown

Purpose: The BDDT-N has established this standard of practice to assist Registrants to fulfil their consent obligations. The duty to obtain consent for treatment is a professional obligation. Failure to do so can lead to complaints and, in certain cases, discipline.

The purpose of this document is to identify the professional standards related to informed consent, not just to describe the *Health Care Consent Act 1996 (HCCA).* *(To view the HCCA go to http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_96h02_e.htm) or click on the link or click here:* HCCA)

This document deals primarily with consent for treatment. There is a brief outline under sections 7.0 and 8.0 at the end of this policy dealing with consent to collect, use and disclose personal health information and consent for billing purposes. Consent is generally required for these activities and similar principles apply.

Intent: Obtaining consent to treatment is a fundamental obligation for all health care practitioners. This requirement is based upon the Naturopathic Doctor's duty to serve the interests of his or her patient, the patient's autonomy over his or her body and health and the Registrant's professional obligations and duties. Failure to obtain informed consent can result in professional, civil and, in some cases, criminal liability.

This document is not intended to provide legal advice and if faced with a specific situation, Registrants are urged to obtain professional advice.

Definition of Standard of Practice: An approach to a professional issue that is generally accepted as appropriate by informed and competent Registrants.
Definition of Performance Expectation: The manner in which a Registrant typically achieves the corresponding standard of practice.

Standard of Practice	Performance Expectation
1.0 CONSENT	**1.0 CONSENT**
Consent is a legal requirement and a professional obligation.	Consent is expected by the patient and is respectful of the patient.

Except for emergencies and certain legislated exceptions under the Health Care Consent Act, 1996 and the Health Protection and Promotion Act, consent is required for all interventions.

The person administering the treatment generally obtains consent.

The patient has the right to withdraw consent at any time. If consent is withdrawn, the Registrant must cease the intervention as soon as possible (it may be necessary to take certain steps to terminate the procedure safely).

2.0 INFORMED CONSENT

Consent is an ongoing process and not a singular event.
To be valid, consent must be informed. Registrants have a duty to ensure the patient has sufficient information in order to make valid decisions about their care. Consent for the step is obtained prior to:

- obtaining a case history,
- performing a physical examination/testing,
- initiating treatment
- collecting personal health information - see 7.0
- billing the patient – see 8.0

The Registrant appropriately

To be valid, consent:

1. relates to the proposed intervention,
2. is informed,
3. is voluntary, and
4. is not obtained through fear, misrepresentation or fraud.

Consent can be express (written or verbal) or implied. Either way, the file is documented to indicate that consent was obtained.
Consent need not be obtained individually for each procedure. Consent can be obtained for a course of treatment or a plan of treatment; however Registrants will confirm consent when initiating each step in the course or plan of treatment.

A Registrant takes a risk when assigning the duty to obtain informed consent to another person who is not qualified to administer the treatment, especially if the other person does not know enough about the risks, side-effects and benefits of the intervention to obtain informed consent.

2.0 INFORMED CONSENT

Patients need to understand and appreciate the reasonable foreseeable consequences of their decisions, in order to give informed consent.

The Registrant ensures that the patient understands the following with respect to the proposed course of action:

- the nature of the intervention,
- its expected benefits,
- the material risks and side effects
- available reasonable alternatives, and
- the likely consequences of not receiving the intervention.

The Registrant discloses non-trivial risks or

documents the discussion in the patient file.	side effects that are likely to occur as well as risks and side effects that can result in significant harm or death even though they are unlikely to occur. For example, a reasonable person might consider the risk of allergic reaction (both the likelihood of the reaction occurring and the potential severity of the reaction) relevant to their decision whether to undergo the treatment. The Registrant answers questions or addresses any special concerns of the patient. For example, if a patient expresses concerns about spinal manipulation, the Registrant should take extra time explaining current knowledge about the risks of such therapy and outlining the alternative approaches in more detail. The Registrant ensures that the patient understands the professional status of those providing professional services (e.g., Registrant, naturopathic student, assistant). A guideline to assist Registrants in obtaining informed consent is set out in Appendix I of this document. The Registrant ensures the patient's consent is fully informed through the use of handouts, formal discussion, a written consent form for more significant decisions and ongoing communication with patients. Confirming consent in writing is useful, however a signed consent form without dialogue is not informed consent. Signing a consent form following discussion reinforces in the mind of the patient the seriousness of the decision and provides evidence of the consent process should there be a question later. Sample consent forms are provided at the end of this document at Appendix II, but should be modified to address particular circumstances, where appropriate.

2.1 Consent for Specific Modalities

In addition to the requirements set out in 2.0, written consent is obtained for modalities that require additional certification, e.g. Parenteral Therapy.

3.0 CAPACITY TO CONSENT

The Registrant ensures that the patient is capable of providing consent.

The Registrant assesses each patient's ability to understand and appreciate the significance of the information.

2.1 Consent for Specific Modalities

Registrants are advised to review the Parenteral Therapy policy.

3.0 CAPACITY TO CONSENT

In order to be capable of making a consent decision, the patient must both:

1. understand the relevant information and
2. appreciate the reasonable foreseeable consequences of the decision.

The patient's ability to provide consent depends on the circumstances, the complexity of the matter and the timing of the decision.

In determining capacity, the Registrant cannot assume that a patient is unable to provide informed consent simply because of any of the following:

- a psychiatric diagnosis,
- a patient's disability,
- the patient's age, or
- the patient declines to accept a recommendation made by the Registrant.

Examples of observations that may, in some circumstances, lead to a determination of incapacity include the following:

1. The person shows evidence of non-rational, confused or delusional thinking.
2. The person's behaviour, actions or

	means of communication suggest that s/he does not understand the information presented by the Registrant, or is unable to communicate. 3. The person appears unable to decide about the treatment proposed. 4. The person is experiencing shock or severe pain, fear or anxiety. 5. The person appears to be impaired by alcohol or drugs.
3.1 Age of Consent	**3.1 Age of Consent**
There is no minimum age of consent.	While there is no minimum age of consent, Registrants must use professional judgement when determining whether or not the patient is capable of making his/her own decisions with respect to care. Registrants may consider the following informal suggestion in determining capacity to consent: • be cautious in finding that children under the age of 12 are capable, • carefully assess the capacity of children between the ages of 12 and 15, and • be generous in assessing the capacity of patients 16 or 17 years of age. Individuals 18 years of age and older are presumed to be old enough to consent to treatment unless there are specific concerns with respect to capacity.
4.0 MAKING A FINDING OF INCAPACITY	**4.0 MAKING A FINDING OF INCAPACITY**
If a Registrant determines that a patient is incapable of providing informed consent a substitute decision maker is required.	A Registrant who determines that a patient is incapable is advised to adhere to the following guidelines: 1. Where feasible the patient is informed that the substitute decision maker will be assisting the patient in making the decision and

will make the final decision if there is no consensus.
2. Registrants involve the patient in decision making to the extent reasonably possible.
3. If the patient disagrees with the need for a substitute decision maker to be involved or the treatment decision reached, the Registrant advises the patient of his or her rights including the right of the patient to make an application to the Consent and Capacity Board to review the finding of incapacity or the treatment decision.

The Consent and Capacity Board is an independent agency that deals with disputes over treatment decisions where a patient has been deemed not to be capable. For more information about the Consent and Capacity Board, see: www.ccboard.on.ca.

Registrants are reminded that consent is still required for any intervention, despite the incapacity of the patient, unless there is an emergency.

5.0 EMERGENCIES

A Registrant may provide treatment without consent in the case of an emergency.

5.0 EMERGENCIES

An emergency exists if the person for whom the treatment is proposed is apparently experiencing severe suffering or is at risk of sustaining serious bodily harm if the treatment is not administered promptly.

According to the *Health Care Consent Act,* the following are examples of emergency situations in which a Registrant may treat without consent:

1. The delay in obtaining consent will prolong the suffering that the person is apparently experiencing or will put the person at risk of

sustaining serious bodily harm or

2. If there is a communication barrier (e.g., because of a language barrier or a disability) that despite efforts cannot be addressed promptly and where the delay in dealing with the barrier will prolong the suffering or will put the person at risk of sustaining serious bodily harm unless there is reason to believe that the person does not want the treatment (e.g., a prior expressed wish applicable to the situation).

Even where the Registrant provides treatment in an emergency, he or she needs to attempt to locate a substitute decision maker (or address the communication barrier) as soon as possible.

6.0 SUBSTITUTE DECISION MAKERS

Where a patient is incapable, the Registrant obtains consent from the patient's substitute decision maker.

6.0 SUBSTITUTE DECISION MAKERS

The identity of the substitute decision maker is usually obvious. In some circumstances inquiries may need to be made. When in doubt, the Registrant should ask the person proposing to speak on behalf of the patient if he or she believes anyone else would want to or feel entitled to make the decision.

The hierarchy of substitute decision makers is as follows:

1. The incapable person's guardian of the person, if the guardian has authority to give or refuse consent to the treatment.
2. The incapable person's attorney for personal care, if the power of attorney confers authority to give or refuse consent to the treatment.
3. The incapable person's representative appointed by the Consent and Capacity Board if the representative has authority to give

or refuse consent to the treatment.
4. The incapable person's spouse or partner (which need not be a sexual partner).
5. A child or parent of the incapable person, or a children's aid society or other person who is lawfully entitled to give or refuse consent to the treatment in the place of the parent. This does not include a parent who has only a right of access and is not lawfully entitled to give or refuse consent to treatment. If a children's aid society or other person is lawfully entitled to give or refuse consent to the treatment in the place of the parent, this paragraph does not include the parent.
6. A parent of the incapable person who has only a right of access.
7. A brother or sister of the incapable person.
8. Any other relative of the incapable person.
9. As a last resort, the Public Guardian and Trustee.

The substitute decision maker who is highest on the list makes the decision unless he or she is not willing or able to make the decision, is not capable themselves, or is not at least 16 years of age (unless that person is also the parent of the patient). If two equally ranked substitutes cannot agree on a decision, then the Public Guardian and Trustee (a civil servant) makes the decision. For more information on the Public Guardian and Trustee, see: www.attorneygeneral.jus.gov.on.ca.

The substitute acts as if he or she were the patient. The substitute is entitled to all of the information for making the decision just as the patient would be. The substitute is required to act in the patient's best interests taking into account any wishes

expressed by the patient while he or she was capable.

The Registrant is not required to monitor whether the substitute is actually fulfilling his or her obligations. However, where it becomes apparent that the substitute is not following the above requirements, the Registrant should intervene. This intervention may be as simple as reminding the substitute of his or her obligations or it could be as significant as reporting the concern to the Public Guardian and Trustee.

7.0 CONSENT FOR THE COLLECTION USE AND RELEASE OF PERSONAL HEALTH INFORMATION

The *Personal Health Information Protection Act, 2004 (PHIPA)* applies to Registrants. It sets out detailed rules for the collection, use and disclosure of personal health information. It also requires the safeguarding of personal health information. In this context, PHIPA requires health information custodians to obtain consent from patients or their substitutes for any collection, use and disclosure of personal health information.

PHIPA is administered by the Information and Privacy Commissioner of Ontario and more detailed information can be located at the IPC website at: www.ipc.on.ca.

7.0 CONSENT FOR THE COLLECTION USE AND RELEASE OF PERSONAL HEALTH INFORMATION

Consent for the collection, use and release of personal health information can be either implied or express.

Sometimes consent can be implied (e.g., for health care purposes) and sometimes it must be express (e.g., when disclosing information to an insurance company paying for the service). There are also a number of exceptions where consent may not be required (e.g., disclosure to prevent a significant risk of serious bodily harm to self or others; disclosure to the BDDT-N).

8.0 CONSENT FOR BILLING

Patients are entitled to know and agree to the billing arrangements

8.0 CONSENT FOR BILLING

Patients are entitled to know the following with regard to billing:

prior to receiving services. A prudent Registrant will discuss this explicitly with the patient and not rely just on signs or handouts or wait for the patient to raise the topic.

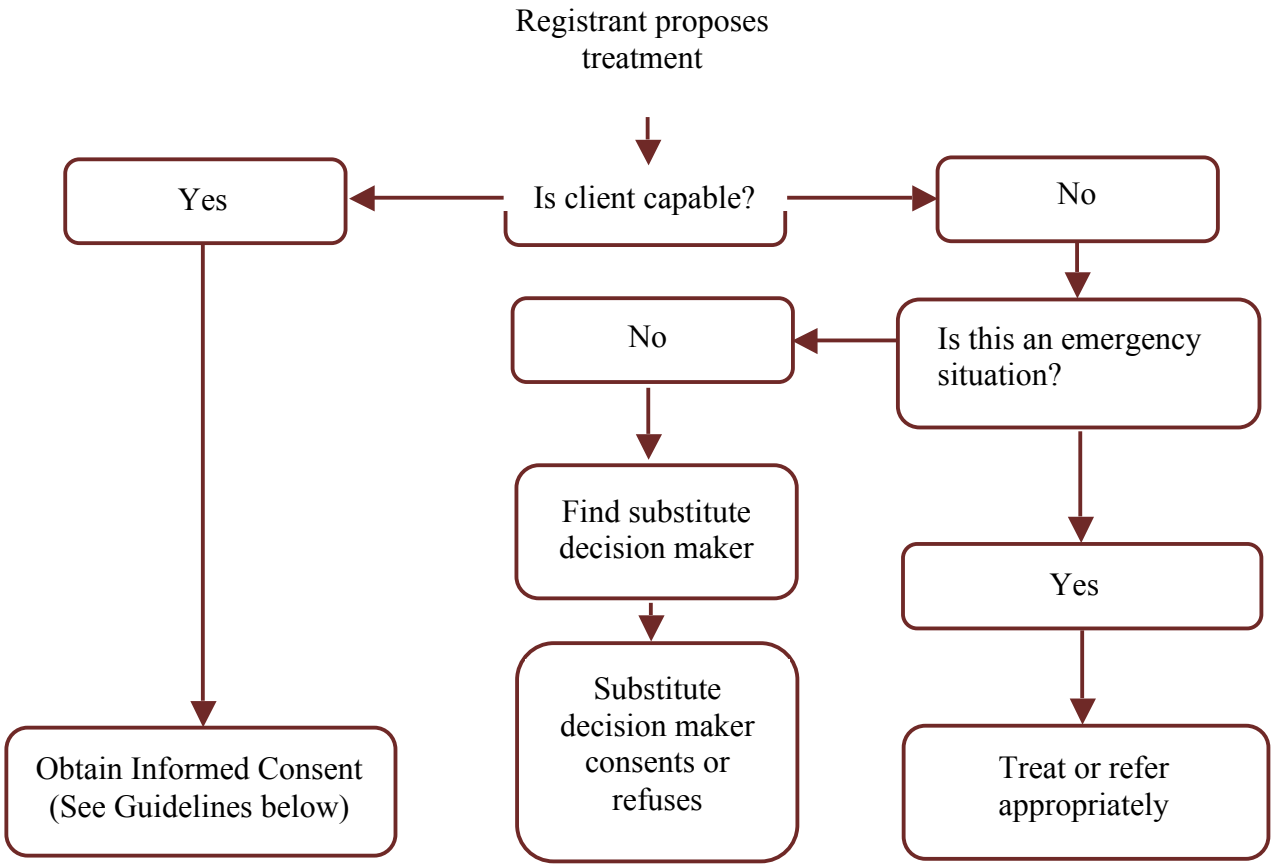
1. The basis upon which the fees will be calculated (e.g., time related, a set fee for service);
2. The amount of the fees per time unit or for the anticipated services;
3. When it is expected that fees should be paid;
4. Acceptable methods of payment;
5. Any interest charges or related service charges;
6. If services are going to be provided in stages, the best estimate possible as to what the total fees will be for each stage and, once the assessment has been completed, an estimate of the total services;
7. If an estimate appears to be materially inaccurate (more than 10%), notification of this fact and an updated estimate as soon as possible;
8. If a third party payer is billed directly, any amount not covered that will be billed by the Registrant to the patient and the amount of coverage remaining after each treatment.

Related Policies:

Standard of Practice and Performance Expectations for Acupuncture
Standard of Practice for Naturopathic Manipulation
Parenteral Therapy Policy
Record Keeping Standard of Practice

APPENDIX I

Consent Algorithm



Guidelines for Obtaining Patients' Informed Consent

In order for a patient's consent for examination, testing or treatment to be informed, the patient must have a clear understanding of the procedure and/or treatment to be administered and the risks, benefits, and alternatives thereof. For this to be achieved, the following components are recommended:

1. The Registrant provides the patient with a verbal and/or written explanation of the clinical findings, the assessment and diagnosis, the recommended treatment plan, as well as the foreseeable risks and benefits, including those risks that may be less likely or even rare but more severe. The Registrant records confirmation of this discussion in the patient file.

2. The Registrant describes the nature of the proposed diagnostic procedure or treatment, to the extent necessary to ensure that the patient will reasonably know what to expect, e.g. where s/he will be touched, who will administer the treatment, etc.

3. The Registrant explains all technical terminology in language that is familiar to and readily understood by the patient. The Registrant speaks at a pace that allows the patient a reasonable opportunity to understand the information provided.

4. Written materials can be used to supplement and/or clarify the Registrant's verbal communications with patients. This is particularly advisable when there may be communication or language barriers. Again, patients should be provided with a reasonable opportunity to read and digest any such written information.

5. The Registrant provides patients with a reasonable opportunity to ask questions about and/or discuss any of the verbal or written information provided.

6. The Registrant explains to patients that they are free to voice concerns at any time during the procedure, for example, should they feel discomfort or pain.

7. The Registrant requests and obtains patients' informed consent only after the completion of the above requirements and only then proceeds with treatment.

8. The Registrant develops and integrates into his or her practice a Consent form that is signed by the patient following discussion indicating that consent has been given voluntarily and that the patient has been informed, understands, and has no further questions concerning each of the following:

    - the nature of the treatment,
    - who will administer the treatment,
    - the reasons for treatment,
    - the risks of treatment,
    - alternatives to undergoing treatment and associated risks,
    - the risks of not undergoing treatment,
    - that s/he has the power to terminate treatment at any time.

APPENDIX II

Explanatory Notes for the use of Consent Forms

1. The attached forms are provided as a suggestion only. Registrants need not use these particular forms.
2. Written forms need not be used for every diagnostic or therapeutic procedure. However, where the procedure requires additional certification, e.g. Parenteral Therapy, use of a form is expected.
3. It is appropriate to use forms to document new decisions made throughout the therapeutic relationship.
4. Refusal of consent or withdrawal of consent is just as significant as the giving of consent. Where a patient refuses or withdraws consent contrary to the recommendations of the Registrant, use of a form is highly recommended.
5. It is important to describe the procedure fully and accurately on the consent form. Otherwise the form may be of little value if there is a question later.
6. The use of form is intended to assist Registrants meet their professional obligations to the Board. It is not intended to deal with other types of accountability (e.g., in the courts). Legal advice should be sought for use of any forms for those purposes.

CONSENT TO NATUROPATHIC
DIAGNOSTIC / THERAPEUTIC PROCEDURES

Patient Name _____ File No. _____

Phone No. _____

Address _____

City/Town _____Postal Code _____

Attending N.D._____ Assistant _____

RECOMMENDED DIAGNOSTIC / THERAPEUTIC PROCEDURE(S)
(including those by referral to another practitioner)

_____
_____
_____
_____
_____

I, the undersigned, do hereby acknowledge that I have been informed of and understand the recommended diagnostic / therapeutic procedure(s) described above and have discussed to my satisfaction this and any requests for related information with the Naturopathic Doctor named above and/or with his/her office or clinical assistant(s). I further acknowledge and confirm that I have been informed of, and understand the procedure(s) with respect to the nature of the procedure, expected benefits, potential risks, side effects and financial cost; the likely consequences of not having the procedure(s), and what alternative course(s) of action are available to me. I understand that I can withdraw my consent at any time.

As a result, I do hereby voluntarily provide my informed consent for the recommended procedure(s) specified above.

Patient or Lawful Representative Signature _____

Date Signed _____

Witness Signature* _____ Relation to Patient _____

Address _____ Phone No. _____

*Witness signature is advised but not necessary

REFUSAL OF CONSENT TO NATUROPATHIC DIAGNOSTIC / THERAPEUTIC PROCEDURES

Patient Name _____ File No. _____

Phone No. _____

Address _____

City/Town _____Postal Code _____

Attending N.D._____ Assistant _____

RECOMMENDED DIAGNOSTIC / THERAPEUTIC PROCEDURE(S) (including those by referral to another practitioner)

_____
_____
_____
_____

I do hereby voluntarily and on an informed basis refuse to provide consent for the recommended diagnostic / therapeutic procedure(s) specified above.

I, the undersigned, do hereby acknowledge that I have been informed of and understand the recommended diagnostic / therapeutic procedure(s) described above and have discussed to my satisfaction this and any requests for related information with the Naturopathic Doctor named above and/or with his/her office or clinical assistant(s). I further acknowledge and confirm that I have been informed of, and understand the procedure(s) with respect to the nature of the procedure, expected benefits, potential risks, side effects and the financial cost; the likely consequences of not having the procedure(s), and what alternative course(s) of action are available to me. I understand that I can withdraw my refusal of consent.

I also understand that my refusal of the above consent is contrary to the recommendations of my Naturopathic Doctor.

As a result, I do hereby voluntarily and on an informed basis refuse consent for the recommended procedure(s) specified above.

Patient or Lawful Representative Signature _____

Date Signed _____

Witness Signature* _____ Relation to Patient _____

Address _____ Phone No. _____

*Witness signature is advised but not necessary

WITHDRAWAL OF CONSENT TO NATUROPATHIC DIAGNOSTIC / THERAPEUTIC PROCEDURES

Patient Name _____ File No. _____

Phone No. _____

Address _____

City/Town _____Postal Code _____

Attending N.D._____ Assistant _____

RECOMMENDED DIAGNOSTIC / THERAPEUTIC PROCEDURE(S)
(including those by referral to another practitioner)

_____
_____
_____
_____

I do hereby voluntarily and on an informed basis withdraw the consent I gave previously for the recommended diagnostic / therapeutic procedure(s) specified above.

I, the undersigned, do hereby acknowledge that I have been informed of and understand the recommended diagnostic / therapeutic procedure(s) described above and have discussed to my satisfaction this and any requests for related information with the Naturopathic Doctor named above and/or with his/her office or clinical assistant(s). I further acknowledge and confirm that I have been informed of, and understand the procedure(s) with respect to the financial costs, nature of the procedure, expected benefits, potential risks and side effects; the likely consequences of not having the procedure(s), and what alternative course(s) of action are available to me. I understand that I can renew consent at any time.

I also understand that my withdrawal of consent is contrary to the recommendations of my Naturopathic Doctor.

As a result, I do hereby voluntarily and on an informed basis withdraw consent for the recommended procedure(s) specified above.

Patient or Lawful Representative Signature _____

Date Signed _____

Witness Signature* _____ Relation to Patient _____

Address _____ Phone No. _____

*Witness signature is advised but not necessary

Guide to the Ethical Conduct of Naturopathic Doctors

Developed and distributed by the Canadian Naturopathic Association
May 1994

Adopted by the Board of Directors of Drugless Therapy – Naturopathy March 2000

Primary Purpose

The Naturopathic Doctor's primary purpose is to prevent disease, to promote health, and to restore, maintain and optimize health and well-being through individualized patient care and public education.

Principles of Naturopathic Medicine

The Naturopathic Doctor will practice the art, science and spirit of the profession to the best of his/her ability and judgment following these principles of naturopathic medicine.

1. The Naturopathic Doctor shall endeavor to first, do no harm; to provide the most effective health care available with the least risk to his/her patients at all times (Primum Non Nocere).
2. The Naturopathic Doctor shall recognize, respect and promote the self-healing power of nature inherent in each individual human being. (Vis Medicatrix Naturae).
3. The Naturopathic Doctor shall strive to identify and remove the causes of illness, rather than to eliminate or suppress symptoms (Tolle Causum).
4. The Naturopathic Doctor shall educate his/her patients, inspire rational hope and encourage self-responsibility for health (Doctor as Teacher).
5. The Naturopathic Doctor shall treat each person by considering all individual health factors and influences. (Treat the Whole Person).
6. The Naturopathic Doctor shall emphasize the condition of health to promote well-being and to prevent diseases for the individual, each community and our world. (Health Promotion, the Best Prevention)

Responsibilities to the Patient

The Naturopathic Doctor:

1. will practice in a manner that is above reproach and will take neither physical, emotional nor financial advantage of the patient.
2. shall maintain competence in naturopathic medicine and strive for professional excellence through constant assessment of personal strengths, limitations and effectiveness and by the advancement of professional knowledge.

3. will recognize his/her professional limitations and when indicated recommend to the patient that additional opinions and/or services be obtained.
4. will agree that a patient has the right to accept or reject any health care recommended.
5. shall safeguard a patient's right to privacy and only disclose confidential information when either authorized by the patient or mandated to do so by law.
6. will ensure, when acting on behalf of a third party, that the patient understands the naturopathic doctor's legal responsibilities to the third party before proceeding with the examination.
7. will recommend only diagnostic procedures and treatment that is believed necessary for the well-being of the patient. The naturopathic doctor will exchange such information concerning these findings that is necessary for the patient to reach a decision.
8. will, upon a patient's request, supply the information that is required to enable a patient to receive any benefits to which the patient may be entitled.
9. will be considerate of the anxiety of the patient's next-of-kin and cooperate with them in the patient's interest.
10. will recognize the responsibility of a naturopathic doctor to render care to any person regardless of colour, religion, sexual orientation or political belief.
11. shall, except in an emergency or as required by law, have the right to refuse to accept a patient.
12. will render all possible assistance to any patient where an urgent need for naturopathic care exists.
13. will when the patient is unable to give consent and an agent of the patient is not available to give consent render such therapy, as the naturopathic doctor believes to be in the patient's best interest.
14. will, if absent, ensure the availability of care to his/her patients if possible.
15. will, once having accepted a patient, continue to provide services until they are no longer required or until arrangements have been made for the services of another suitable practitioner.
16. may withdraw from the responsibility for the care of a patient provided that the patient is given adequate notice of that intention.
17. will inform the patient when personal morality or religious conscience prevents the naturopathic doctor from recommending some forms of therapy.
18. will ensure, before initiating clinical research involving humans, that proper recognized ethical protocol is followed.
19. will consider, in determining professional fees both the nature of the service provided and the ability of the patient to pay, and will be prepared to discuss the fee with the patient.

Responsibilities to the Profession

The Naturopathic Doctor:

1. will recognize that the profession demands integrity and dedication from all its members.

2. will strive to participate in professional activities at the national, provincial and local level in order to advance the standards of care, the body of knowledge and the public awareness of naturopathic medicine.
3. will recognize that self-discipline of the profession is a privilege and that each practitioner has a continuing responsibility to merit the retention of that privilege.
4. will behave in a way beyond reproach and will report to the appropriate professional body any conduct of a colleague which might generally be considered unbecoming to the profession.
5. will enter into a contract with an organization only if it will allow maintenance of professional integrity.
6. will only offer to a colleague a contract which has terms and conditions equitable to both parties.
7. will recognize a responsibility to give the generally held opinions of the profession when interpreting knowledge of a scientific nature to the public.
8. will, when professing an opinion which is contrary to the generally held opinion of the profession, so indicate and will avoid any attempt to enhance his/her own professional reputation.
9. will build a professional reputation based on ability and integrity and will only advertise professional services or make professional announcements as permitted by legislation or by the provincial naturopathic licensing authority.
10. will avoid advocacy of any product when identified as a member of the naturopathic medical profession.
11. will avoid the use of secret remedies.
12. will request the opinion of an appropriate practitioner acceptable to the patient when diagnosis or treatment is difficult or obscure or when the patient requests it.
13. will, having requested the opinion of a colleague, make available all relevant information and providing the patient consents indicate clearly if the consultant is to continue with the care of the patient.
14. will co-operate with those individuals who in the opinion of the naturopathic doctor may assist in the care of the patient.
15. will make available to appropriate practitioners, upon the request of the patient a report of pertinent findings and treatment of the patient.

Responsibilities to Society

The Naturopathic Doctor:

1. will strive to improve the standards of medical care and promote health and safety for the individual, the public and the global community.
2. will recognize the responsibility as a witness to assist the court in arriving at a just decision.

Record Keeping Standard of Practice For Naturopathic Doctors

Revised October 2009. Effective date January 1, 2010
Initial Policy: January, 1999

Board publications contain practice considerations and standards that, in the absence of extenuating circumstances, must be adopted by all Registrants in the care of their clients and in the practice of the profession. Board standards and guidelines are developed in consultation with professional practice leaders and describe current professional expectations. It is important to note that these publications may be used by the Board or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

Definition of Standard of Practice: An approach to a professional issue that is generally accepted as appropriate by informed and competent Registrants.
Definition of Performance Expectation: The manner in which a Registrant typically achieves the corresponding standard of practice.

PURPOSE: The BDDT-N has established the following standard of practice and performance expectations regarding the proper recording, maintenance and retention of all records in a naturopathic practice. This document will delineate Registrants' obligations and patients' rights regarding naturopathic records.

INTENT: To assist Registrants in developing, achieving and maintaining best practices in record keeping in naturopathic practice.

The patient record consists of the patient chart, appointment book and financial records. The patient chart is an essential chronicle of the history of medical care and a guide for the direction of future care. It is often the Registrant's most important evidence in a complaint or a lawsuit.

Registrants will take all reasonable steps to ensure written and electronic records are kept in accordance with this standard. Unless otherwise indicated, these standards pertain to written records. For electronic records specifically refer to section 5.

Good records help Registrants to provide effective, progressive and organized care. They also assist in providing continuity of services if the care of the patient is transferred to another practitioner for any reason. Concise, accurate, legible records should provide a full account of the patient's past and current health status and concerns, the treatment provided and the patient's response to treatment.

Standard of Practice	Practice Expectations
1.0 APPOINTMENT RECORDS Appointment records – hard copy or electronic – are maintained and retained for a period of at least 10 years after the date of the last entry. In the case of a minor, records are retained for at least 10 years following the patient's 18th birthday. Each Registrant is able to produce a hard copy of the original appointment record if legally required.	**1.0 APPOINTMENT RECORDS** The Registrant maintains an appointment record that clearly and legibly identifies the following: • ND name, clinic name, address and telephone number, • date and time of appointment, • name of patient (minimum of last name and first initial), • duration and type of appointment Abbreviations/codes may be used for appointments, cancellations, missed appointments, re-booked appointments, new patients, special techniques, tests etc. A legend of abbreviations/codes is in the appointment record and/or accessible elsewhere in the office. Each Registrant in a clinic maintains his/her own appointment record or has his/her appointments recorded on separate pages, or at a minimum in separate columns.
2.0 FINANCIAL RECORDS Financial records - written or electronic - are maintained and retained for a period of at least 10 years after the date of the last entry for the patient. In the case of a minor, records are retained for at least 10 years following the patient's 18th birthday, regardless of the date of the last entry in the file. **2.1 Receipts** A receipt is issued for each payment if requested.	**2.0 FINANCIAL RECORDS** Financial records clearly and legibly record the following: • name of treating ND, clinic name, address, telephone number, • patient's name, address, telephone number, • date of service, • services billed, • payment and method of payment, • balance of account. **2.1 Receipts** Receipts clearly and legibly record the following information: • name of treating ND, clinic name, address, telephone number, • ND's registration number, • patient's name and address, • date of service, • services billed, • payment received,

Standard of Practice	Practice Expectations
	• GST registration number (if GST charged). If a replacement receipt is issued it is clearly marked 'COPY'. Fees are properly itemized. For example, fees for naturopathic consultation are separated from all other fees. Fees for supplements, PT injectibles, devices, special testing etc., are listed separately, either on the same or another receipt. Charges for supplements are billed as such. The purchase and redemption of vouchers or gift certificates are clearly documented as such.
3.0 PATIENT CHARTS Patient charts – written or electronic – are maintained and retained for a period of at least 10 years following the last entry in the chart. In the case of a minor, the chart is retained for a period of at least 10 years following the patient's 18th birthday, regardless of the date of the last entry in the file.	**3.0 PATIENT CHARTS** All patient charts meet the following criteria: • All written entries are made in indelible ink. • Highlighting over writing is not used as it accelerates ink fading and may not be legible when photocopied; underscoring is permitted. • All written records are clearly legible. • There are no blank spaces between entries. • All pages are in chronological order, consecutively numbered and dated. • A consistent format is used throughout the chart for recording the date e.g. dd/mm/yy, OR mm/dd/yy. • All chart entries are recorded as soon as possible after the patient encounter while the details are fresh in the Registrant's mind. • Generally accepted medical abbreviations may be used. A legend of abbreviations/codes is in the appointment record and/or accessible elsewhere in the office. Recording derogatory, judgmental or otherwise inappropriate comments about patients is inadvisable. Use factual terms e.g. patient shouting, shaking fists vs. difficult, non-cooperative, rude. Always assume the patient will read their chart. The attending Registrant signs his/her chart notes and includes his/her registration number so that the treating ND (e.g. primary, locum or other) is clearly identified.

Standard of Practice	Practice Expectations
3.1 Storage of Charts All patient charts are stored in an area accessible only to authorized staff as per the (Ontario) *Personal Health Information Protection Act 2004* (PHIPA). All patient charts are securely stored and organized in a way that the chart can be extracted for each individual patient when required.	*For detailed record keeping practices and S.O.A.P. format please see Appendix I and II **3.1 Storage of Charts** When storing patient charts, the Registrant will: • Ensure all patient charts are secured when the office is closed, e.g. in a locked filing cabinet. • Ensure sensitive information is never left unattended in an unsecure location. • Store all patient charts alphabetically or numerically, such that a specific file can be easily identified and retrieved. Registrants maintain a separate chart for each patient. In multi-disciplinary clinics, naturopathic patient charts may be filed with other charts in the clinic as long as they can be readily identified e.g. different colored file folders. Registrants maintain a chart for each patient so that the information can be extracted individually when required. If other practitioners also see the same patient, their notes are kept in a separate file. Charts for patients receiving Parenteral Therapy are easily identifiable for retrieval for inspection purposes.
3.2 Corrections to Patient Records Necessary corrections to the patient chart are acceptable as long as the change is clearly indicated as such and is dated and initialed. Corrections are only to be in the form of additions and not erasure or overwriting. At all times the original entry is available and legible. A patient's chart must never be re-written.	
4.0 PRIVACY ASPECTS OF RECORD KEEPING Registrants adhere to the (Ontario) *Personal Health Information Protection Act, 2004* (*PHIPA*). The Registrant identifies a Health Information Custodian (HIC) who establishes written policies and procedures relating to the collection, use, and disclosure of all personal health	**4.0 PRIVACY ASPECTS OF RECORD KEEPING** In a single-practitioner private naturopathic practice, the owner of the practice is generally the HIC and often serves as its privacy information officer. In a shared practice/partnership/associateship, the terms of the written agreement made between or among the Registrants specifies that the patient charts are the responsibility of the HIC of the practice. Regardless of the agreement, all treating Registrants are given access to the chart where necessary to fulfill their professional obligations, including their obligations to the BDDT-N.

Standard of Practice	Practice Expectations
information. See Appendix III for more information.	All patients are made aware that other practitioners may have access to their charts and patients may choose to decline that access in accordance with PHIPA. See **www.ipc.on.ca.**
5.0 ELECTRONIC RECORD KEEPING Patient charts – written or electronic – are maintained and retained for a period of at least 10 years following the last entry in the chart. In the case of a minor, the chart is retained for a period of at least 10 years following the patient's 18th birthday, regardless of the date of the last entry in the file. Electronic records are backed up each practice day and separate copies of the back-up are kept in a safe place, off-site.	**5.0 ELECTRONIC RECORD KEEPING** Patient records may be maintained in an electronic system as long as the following criteria are met: • The system provides a visual display of the recorded information. • The system provides a means of accessing the record of each patient by the patient's name. • The system is capable of printing promptly the recorded information in chronological order for each patient. • The system maintains an audit trail that: i. records the date and time of each entry for each patient, ii. preserves the original content of the record if changed or updated, iii. identifies the person making each entry, iv. is capable of printing each patient record separately. • The system provides reasonable protection against unauthorized access, such as requiring person specific passwords to access the system and a separate password for the patient management software. • The system is backed up at least each practice day and allows for the recovery of backed-up files or otherwise provides reasonable protection against loss of, damage to and inaccessibility of records. • Files are encrypted if they are transferred or transported outside of the facility.
6.0 RETENTION AND TRANSFER OF PATIENT RECORDS	**6.0 RETENTION AND TRANSFER OF PATIENT RECORDS** • Under PHIPA, patients or their legal representatives are generally entitled to copies of

Standard of Practice	Practice Expectations
All records are retained for **at least ten (10) years** following the date of the last entry in the chart. In the case of a minor, records are retained for at least 10 years following the patient's 18th birthday, regardless of the date of the last entry in the file. Records are transferred in a manner ensuring continuing access by patients and the Board.	their "medical record." The Registrant always maintains the original file unless it is requested by the BDDT-N for a regulatory purpose or is required for legal purposes. Except as authorized by PHIPA, the Registrant may not provide any information concerning the patient to a person other than the patient or his/her authorized representative(s) without the express consent of the patient, an authorized representative, or as otherwise authorized by law. • The Registrant may charge a reasonable fee to reflect the actual cost of reproduction, the time required to prepare the material and the direct cost of sending the material to the authorized party. The Registrant may not require prepayment of this fee. Non-payment of the fee is not reason for the Registrant to withhold the information. • In the event of death of the Registrant, the responsibility for the maintenance of the records lies with the estate, which is obliged to maintain those records as defined above. If the estate sells the practice to another Registrant, all records are transferred to the purchasing Registrant and are maintained as above. It is each Registrant's responsibility to ensure there is an orderly preservation of patient records in the event of his/her death and to ensure that the Registrant's authorized representative notifies the BDDT-N of the Registrant's death within a reasonable period. PHIPA has additional requirements in respect of the transfer of health records (e.g., notice to patients). • If a Registrant relocates a practice s/he may take the patient records to the new location. If the practice ceases operation, the Registrant either appropriately transfers or maintains the original of all patient records as described above. Patients are notified, in writing, as to how they can obtain access to their patient records. The BDDT-N is also notified and provided with a forwarding address for a minimum of ten (10) years. • In the event of a sale of the practice, all of the original records are transferred to the purchasing Registrant who maintains those records as described above. Where feasible, (in some cases by newspaper notice) patients are notified, in

Standard of Practice	Practice Expectations
	writing, of the practice sale so that any patient who requires a copy of his/her record may obtain it. The BDDT-N is also informed of the sale in writing and in whose care and control the original records will be maintained. • In all cases, the BDDT-N is notified, in writing, of the forwarding address where the records are kept for a minimum of ten (10) years from the date of the last day of practice of the Registrant. • Any records that are destroyed after the minimum period of retention are destroyed by shredding, burning, overwriting software or some other method to render them illegible and irretrievable. A record is kept of disposal dates and the names of patients whose records were disposed of.
7.0 OFF-SITE STORAGE OF HEALTH RECORDS Section 14 of PHIPA permits practitioners to store records at a patient's home (e.g. for homecare, a long term care home or retirement home) or a third party storage site if the patient consents, reasonable safeguards are taken and all applicable Board regulations or guidelines are complied with. Refer to Appendix IV.	**7.0 OFF-SITE STORAGE OF HEALTH RECORDS** Please follow the guidelines outlined in Appendix IV.

Related Policies:

Standards of Practice
Consent to Treatment
Definition of Professional Misconduct and/or Incompetence
Guide to Ethical Conduct of Naturopathic Doctors
Parenteral Therapy Policy
Research Devices, Appliances, Instruments or Techniques
***Ontario's Health Information and Protection Act* (2004)**

APPENDIX I

DETAILS OF RECORD KEEPING

All patient charts are expected to contain the following:

a. patient's name, address, telephone number, date of birth and gender,
b. treating ND's name, clinic name and patient's name and date on each page,
c. contact information for any parent or substitute decision maker and copy of authority for substitute decision maker where applicable,
d. the identity of anyone in attendance during the patient visit, including an interpreter
e. a copy of the office privacy policy signed by the patient or his or her substitute decision maker,
f. documentation of any disability or special needs the patient has,
g. a complete case history including modalities and concomitants of the chief concerns, secondary concerns, medical history, relevant family history, prior diagnoses, results of diagnostic testing, prior treatment and medication history,
h. positive and negative results of a complete and/or relevant physical exam,
i. copies of results of any testing performed by the Registrant,
j. copies of all relevant written reports received from tests, examinations, consultations or treatments performed by other health care providers,
k. diagnosis (naturopathic/medical/differential),
l. a record of consent for an assessment or treatment including any signed consent forms e.g. history taking, physical exam, parenteral therapy, manipulation, research devices, acupuncture, (refer to the Consent Policy),
m. treatment plan, future plan and prognosis
n. all prescriptions or refills, including dosage, frequency and duration
o. discussion of potential risks and side effects of any treatment
p. identity of all other health care providers involved in the patient's assessment or treatment,
q. patient's or Registrant's refusal of any or all aspects of physical exam, lab tests, or treatment plan and reasons given,
r. re-assessments, re-examinations, changes to treatment plan and rationale for changes,
s. documentation of requests for information and the response provided
t. documentation regarding all professional communications including office consultations and new information provided by email or telephone
u. record of all professional recommendations
v. a copy of all reports issued by the Registrant in respect of the patient,
w. a copy or identification of all handouts (which should be dated and contain the Registrant's name/clinic name and telephone number). Standard handouts can be named in the file provided copies are easily obtainable in the event of an inquiry.
x. a note of all referrals to other health care practitioners with an explanation of the reasons for the referral,
y. record of discharge of patient with reasons and recommendations,
z. record of early termination of treatment by Registrant or patient with reasons for and recommendations,

APPENDIX II
S.O.A.P. FORMAT RECORD KEEPING

S.O.A.P. is the acronym for Subjective, Objective, Assessment and Plan. Use of this system simplifies record keeping, clarifies what occurs at each appointment and makes it easier for the Registrant, an investigator or a subsequent ND to follow the patient's progress.

Subjective – This is a report of what the patient reports to the ND, often recorded in the patient's own words. This includes the following:

- complete case history
- changes in patient's health status since the last visit
- response to treatment

Objective – This is the report of what the Registrant observes about the patient including the following:

- positive and negative findings of a complete or relative physical examination
- results of laboratory and other diagnostic testing
- reports from other health care providers
- observations of the patient's behavior and apparent mental/emotional state
- timely re-assessments of all relevant findings

Assessment – This is the analysis of gathered subjective and objective data which will result in a definitive diagnosis, a differential diagnosis, a working diagnosis, or a need for further investigation. It is important that the reasoning process from the subjective and objective information to the plan for the patient be evident.
Also included are the following:

- patient risk factors
- review of current supplements and medications
- re-assessment of previous diagnoses

Plan – This is the development of a plan of treatment based on the subjective, objective and assessment information recorded. The plan will include the following:

- all patient advice and treatment recommendations
- tests or procedures ordered,
- consultation requests or referrals including rationale
- future considerations for follow-up and treatment
- specific concerns including any refusal of examination or refusal to comply with recommendations,
- informed consent notations

APPENDIX III
PRIVACY ASPECTS OF RECORD KEEPING

Generally, patient consent is required for the collection, use and disclosure of personal health information. Consent can be implied, particularly if the information is only used for the provision of health care. Unless a patient directs otherwise, information can be shared with others on the health care team (i.e., within the circle of care) where obtaining consent is not practical. There are some other exceptions where consent is not required. For example, consent is not needed to use the information to collect an unpaid account. Disclosure can be made without consent for a number of reasons including to protect another person from serious bodily harm or for certain legal proceedings. For example, disclosure of charts to assist the Board in performing its regulatory functions does not need patient consent.

Where a patient is incapable of giving consent, it can be obtained from a substitute decision maker (generally a power of attorney or a relative). Patients, or their substitutes, can prohibit Registrants from disclosing certain information to others (unless *PHIPA* permits disclosure without consent). This is called a "lock box". Where a record is transferred, but the patient refuses to permit another health provider in the circle of care from receiving part of the information that the practitioner will likely need for treatment, the Registrant must notify the other practitioner that some of the information has been withheld.

Under ***PHIPA*** the patient has a right to review or obtain a copy of his/her patient chart. That right of access includes any portions of the chart provided by others, such as consultation reports and lab results. Generally the Registrant may only decline access to information for legally permitted reasons like the following:

- the information is raw data from standardized psychological tests or assessments,
- there is a risk of serious harm to the treatment or recovery of the patient or of serious bodily harm to another person, or
- providing access to the patient would reveal the identity of a confidential source of information (assuming that the case was a suitable one for the Registrant to collect information in this way, e.g., for a medico-legal report).

An individual also has the right to request the correction of erroneous personal information held by the Registrant. If the Registrant agrees that an error has been made, s/he must correct the error. Where the individual and the Registrant cannot agree, then the Registrant must note the disagreement in the file. Some grounds for refusing to correct information include the following:

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

For more detailed information about the implications of ***PHIPA*** on record keeping, see the website of the Information and Privacy Commissioner of Ontario at: www.ipc.on.ca.

APPENDIX IV
OFF-SITE STORAGE OF HEALTH RECORDS GUIDELINES

Section 14 of the Personal Health Information Protection Act, 2004 permits practitioners to store records at a patient's home (e.g., for homecare, a long term care facility) or a third party storage site if the patient consents, reasonable safeguards are taken and any Board regulations or guidelines are complied with. The following guideline balances the interests of the Registrant and the patient while maintaining appropriate accountability.

1(1) A Registrant may store personal health information (the "chart") at a patient's residence, including an institutional residence so long as the following criteria are met:

(a) the patient, or the patient's substitute, consents,
(b) the patient, or patient's substitute, understands and appreciates the reasonably foreseeable consequences of maintaining the chart at the patient's residence and has identified a reasonable plan for safeguarding the chart,
(c) the patient, or the patient's substitute, agrees that the Registrant has access to the chart or, in the alternative, the Registrant shall keep an up-to-date copy of the complete chart with the Registrant's other records,
(d) the patient, or the patient's substitute, agrees to retain the chart for the period required under this policy or, in the alternative, the Registrant keeps an up-to-date copy of the complete chart with the Registrant's other records,
(e) a reasonable clinical purpose is served by keeping the chart there,
(f) either the chart kept at the patient's residence or the record kept with the Registrant's other records, or both, is a complete and up-to-date copy of the record and both records indicate which is the complete, up-to-date copy of the record, and
(g) unless the Registrant keeps an up-to-date copy of the complete chart with the Registrant's other records, the Registrant shall keep a copy of the following information with the Registrant's other records:
    a. the name and contact information for the patient,
    b. the location of the chart,
    c. the essential, up-to-date, clinical information about the patient including significant assessment results, a summary of the treatment plan and the major milestones in the implementation of the treatment plan, and
    d. documentation of compliance with clauses (a) to (f).

(2) A Registrant may store personal health information at a storage facility other than one under the control of the Registrant or the Registrant's employing custodian or the patient's residence so long as the following criteria are met:

(a) the patient, or the patient's substitute, consents,
(b) the storage facility has a privacy policy consistent with the *Personal Health Information Protection Act, 2004* and the Board's record keeping policy,
(c) the storage facility provides the Registrant with a written privacy assurance that it will safeguard the chart and will only use or disclose it at the express direction of the Registrant,
(d) the Registrant describes the fact that he or she uses a storage facility in his or her privacy policy,
(e) the storage facility is not a private residence

(f) the Registrant contracts with the storage facility to retain the chart for the period of time specified in the Board's record keeping policy before it will destroy the chart in a secure manner,
(g) the Registrant keeps the account with the storage facility current at all times so that the charts are not discarded or destroyed prematurely, and
(h) the Registrant keeps, with his or her other records, a list identifying the patient, the nature of the record kept at the storage facility, the location of the file in the storage facility (e.g., file box number), documentation of compliance with clauses (a) to (g) and the contact information for the storage facility.

(3) If the Registrant is an agent of a health information custodian as defined in the *Personal Health Information Protection Act, 2004*, the Registrant may comply with the custodian's privacy policies on storing records at a patient's residence or a storage facility rather than this policy so long as the policies are substantially similar to this policy.

COLLEGE OF NATUROPATHS OF ONTARIO - and - ALLAN BORTNICK

DISCIPLINE COMMITTEE OF THE
COLLEGE OF NATUROPATHS
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AGREED AND UNCONTESTED STATEMENT OF FACTS

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