COMMUNICATING A DIAGNOSIS

Standard of Practice S-008
Quality Assurance Committee
Approved by Council: February 28, 1998
Amended: April 16, 2013

Note to readers: In the event of any inconsistency between this document and the legislation that affects chiropractic practice, the legislation governs.

INTENT

To advise members of their legislative authority of communicating a diagnosis, under the *Regulated Health Professions Act, 1991* and the *Chiropractic Act, 1991*

To advise members of the procedures to be followed in communicating a diagnosis

OBJECTIVES

- To delineate the authority and describe the process for members when establishing, communicating and documenting a diagnosis.
- To ensure members provide patients with an appropriate evaluation, including a history, examination and other diagnostic procedures, as a prerequisite for the delivery of treatment/care.
- To describe for members that when a diagnosis is not made, a clinical impression must be established, communicated and documented prior to the delivery of treatment/care.
- To describe for members the inter-relationship between a diagnosis and a clinical impression.
- To ensure members respond to the clinical situation in a manner consistent with the best interests of their patients.

DESCRIPTION OF STANDARD

A member is authorized to communicate a diagnosis in accordance with section 4(1) of the *Chiropractic Act, 1991*:

> In the course of engaging in the practice of chiropractic, a member is authorized, subject to the terms, conditions and limitations imposed on his/her certificate of registration, to perform the following:
>
> Communicating a diagnosis identifying, as the cause of a person's symptoms,

i. a disorder arising from the structures or functions of the spine and their effects on the nervous system; or
ii. a disorder arising from the structures or functions of the joints of the extremities."

Diagnosis

When a diagnosis is made, a member shall:

- ensure he/she has performed an initial consultation and examination that is sufficiently comprehensive to determine or establish the patient's condition and form a diagnosis;
- communicate the diagnosis to the patient, or a substitute decision-maker in accordance with the *Health Care Consent Act, 1991*;
- provide an opportunity for the patient to ask questions concerning the diagnosis;
- propose and discuss treatment/care or a plan of treatment/care with the patient;
- obtain consent for the proposed treatment/care or plan of treatment/care, consistent with Standard of Practice S-013: Consent; and
- record the diagnosis in the patient health record, consistent with Standard of Practice S-002: Record Keeping, prior to any treatment/care or plan of treatment/care.

Clinical Impression

The term "diagnosis" suggests a greater degree of certainty than a clinical impression. A clinical impression may include a differential diagnosis, a preliminary or working diagnosis, or an idea or analysis of the patient's condition.

When a diagnosis has not been made, a member shall establish, communicate and document a clinical impression prior to the delivery of treatment/care, consistent with the procedures as outlined above for a diagnosis.

When more than one reasonable diagnosis or clinical impression exists (i.e. a differential diagnosis), the member shall consider:

- the potential causes of the patient's complaint;
- whether additional examination or diagnostic procedures are appropriate; and
- whether there is a need for the patient to consult with another health professional.

When the member advises the patient to consult with another health professional, which may include the performance of additional tests or advanced diagnostic tests, the member shall:

- fully inform the patient, or a substitute decision-maker in accordance with the *Health Care Consent Act, 1996*; and
- record the course of action in the patient health record.

Terminology

Diagnostic terms shall be used in a manner consistent with the generally accepted usage in the chiropractic profession; for example, vertebral subluxation complex, posterior joint syndrome, sacroiliac joint syndrome, rotator cuff tendinitis, etc.

The member shall explain the diagnostic term(s) to the patient in easily understood and patient-centred language.

This standard of practice should be read in conjunction with:

- *Ontario Regulation 852/93: Professional Misconduct*
- Standard of Practice S-001: Chiropractic Scope of Practice
- Standard of Practice S-002: Record Keeping
- Standard of Practice S-013: Consent
- *Health Care Consent Act, 1996*

LEGISLATIVE CONTEXT

Chiropractic Act, 1991

Scope of Practice

The scope of practice of chiropractic is outlined in section 3 of the *Chiropractic Act, 1991*, and includes 'diagnosis' as follows:

"The practice of chiropractic is the assessment of conditions related to the spine, nervous system and joints and the diagnosis, prevention and treatment, primarily by adjustment, of,

- dysfunctions or disorders arising from the structures or functions of the spine and the effects of those dysfunctions or disorders on the nervous system; and

- dysfunctions or disorders arising from the structures or functions of the joints."

Authorized Acts

The authorized acts for chiropractors are outlined in section 4 of the *Chiropractic Act, 1991*, and include 'communicating a diagnosis' as follows:

"In the course of engaging in the practice of chiropractic, a member is authorized, subject to the terms, conditions and limitations imposed on his/her certificate of registration, to perform the following:

communicating a diagnosis identifying, as the cause of a person's symptoms,

i. a disorder arising from the structures or functions of the spine and their effects on the nervous system; or

ii. a disorder arising from the structures or functions of the joints of the extremities."

Ontario Regulation 852/93 under the *Chiropractic Act, 1991*[1]

The following are acts of professional misconduct for the purposes of clause 51.1(c) of the *Health Professional Procedural Code*:

2. Contravening a standard of practice of the profession or failing to maintain the standard of practice expected of members of the profession.
3. Doing anything to a patient for therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purposes in a situation in which consent is required by law, without such consent.
13. Failing to advise a patient to consult with another health professional when the member knows or ought to know that,
    - The patient's condition is beyond the scope of practice and competence for the member;
    - The patient requires the care of another health professional;
    - The patient would be most appropriately treated by another health professional.
14. Providing a diagnostic or therapeutic service that is not necessary
19. Failing to keep records as required by the regulations.
28. Contravening the *Act*, the *Regulated Health Professions Act, 1991* or the regulations under either of those *Acts*.
33. Engaging in conduct or performing an act that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

Health Care Consent Act, 1996

Section 9: "substitute decision-maker" means a person who is authorized under section 20 to give or refuse consent to a treatment on behalf of a person who is incapable with respect to treatment.[2]

[1] See https://www.cco.on.ca/wp-content/uploads/2017/10/R-008.pdf for a full copy of Ontario Regulation 852/93
[2] See section 20 of the *Health Care Consent Act, 1996* for more information at http://canlii.org/en/on/laws/stat/so-1996-c-2-sch-a/latest/so-1996-c-2-sch-a.html