

HEALTH
PROFESSIONS
COUNCIL

RECOMMENDATIONS
ON THE DESIGNATION
OF DIETETICS

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Application by the
British Columbia
Dietitians' & Nutritionists' Association

October 1999

FOREWORD

This report is the response to an application by the British Columbia Dietitians' and Nutritionists' Association for designation under the *Health Professions Act*, RSBC 1996, c. 183. Under the *Health Professions Act*, the Health Professions Council is a six-person advisory body appointed by the Government of British Columbia to make recommendations to the Minister of Health and Minister Responsible for Seniors about the regulation of health professions. This report is the result of an investigation of the practice of dietitians and nutritionists by a three-member panel of the Health Professions Council.

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EXECUTIVE SUMMARY

In its review of the application for designation of dietetics, the Health Professions Council (Council) applied the Public Interest Criteria as directed by the *Health Professions Act (HPA)*. The Council reviewed the information provided by the applicant and information gathered during the research, written consultation and public hearing phases of its investigation.

The Council first determined that the practice of dietetics meets the definition of health profession as set out in section 1 of the *HPA*.

The Council then reviewed the services provided by dietitians and determined that the applicant met the section 5(1) criteria for designation listed in the Health Professions Regulation (*HPA Regulation*).

The Council next considered the supporting criteria listed in section 5(2) of the *HPA Regulation* and determined that those criteria supported designation.

The Council, finally considered whether any of the activities or services provided by dietitians are activities which present a significant risk of harm such that those activities are encompassed within the Council's reserved acts list or whether a new reserved act was warranted.

The Council made the following recommendations to the Minister of Health and Minister Responsible for Seniors:

1. that the profession of dietetics be designated as a health profession under the *Health Professions Act*.
2. that the services which may be performed by registrants are the practice of dietetics, as defined in the following scope of practice statement:

The practice of dietetics and nutrition is the assessment of nutritional needs, design and implementation of nutrition care plans and therapeutic diets, and dissemination of information about foods and human nutrition to attain, maintain and promote the health of individuals and the community.

3. that the following be reserved acts for registrants of the College:

5(b) designing, compounding or dispensing therapeutic diets where nutrition is administered through enteral or parenteral means. For the purposes of this reserved act, the following definitions shall apply:

"designing": the selection of appropriate ingredients for parenteral or enteral nutrition.

"compounding": mixing ingredients, for parenteral or enteral nutrition.

"dispensing": filling a prescription for parenteral or enteral nutrition.

2(d) administration of a substance by instillation through enteral or parenteral means.

4. that the title "dietitian" be reserved for the exclusive use of registrants of the College.
5. that the college established for the health profession be named the "College of Dietitians."

I. APPLICATION AND PROCESS OF INVESTIGATION

The practice of dietetics is currently unregulated in British Columbia. In Canada, only British Columbia has no established mechanism to regulate the practice of dietetics. In all provinces except British Columbia, dietetics is recognized as an autonomous health profession, with the profession's own distinct legislation and regulations. In Quebec, Ontario and P.E. I., colleges have been established for self-governing status.

This investigation was undertaken because an application was submitted in June 1993 by the British Columbia Dietitians and Nutritionists Association (BCDNA) to have dietetics designated as a self-regulating health profession under the *HPA*.

BCDNA has been the professional organization for dietitians and nutritionists for 70 years, including 38 years as an independent society registered under the *Society Act*. The applicant Association has 831 members, of which 763 are practising, 68 are non-practising.

The Council's investigation included a consultation process with other health professions, regulatory bodies, other provinces and the public. A summary of submissions made by respondents to the written consultation is included as Appendix A.

Since their original submission in June 1993, BCDNA has updated their submission on November 20, 1995. BCDNA met with the Council on May 2, 1997. At that meeting, the Council requested more detail on the risk of harm to the public by unqualified, unethical or incompetent nutrition practitioners who are members of the profession or other groups.

At the request of the Council, the BCDNA re-defined "*therapeutic diet*" in order to identify those therapeutic diets which they are proposing be considered as "*reserved acts*". The BCDNA revised submission on reserved acts was received by the Council on June 5, 1997 and is included as Appendix B.

A public hearing was held February 12, 1998. A list of participants is included in Appendix C.

BCDNA has also requested that their June 5, 1997 proposal for reserved acts for eight categories of therapeutic diets be considered to replace their original exclusive scope of practice request.

II. STATEMENT OF ISSUES

The Council identified three issues involving the regulation of the practice of dietetics. In assessing the public interest in the regulation of this profession, the Council considered:

- (1) the extent to which the practice of dietetics may involve a risk of physical, mental or emotional harm to the health, safety, or well-being of the public according to s.5(1) of the *HPA Regulation*;
- (2) whether designation of a college of dietitians would be in the public interest having regard to the criteria of sections 5(1) and 5(2) of the *HPA Regulation*.
- (3) in the event a college is designated:
 - a) whether members of the college perform any reserved acts as listed in the Council's *Shared Scope of Practice Model Working Paper*; and
 - b) whether any other acts or activities performed by members of the college present such a serious risk of harm that consideration must be given to establishing a new reserved act(s).

III. RECOMMENDATIONS

The Council recommends to the Minister of Health that:

1. that the profession of dietetics be designated as a health profession under the *Health Professions Act*.
2. that the services which may be performed by registrants are the practice of dietetics, as defined in the following scope of practice statement:

The practice of dietetics and nutrition is the assessment of nutritional needs, design and implementation of nutrition care plans and therapeutic diets, and dissemination of information about foods and human nutrition to attain, maintain and promote the health of individuals and the community.

3. that the following be reserved acts for registrants of the College:
 - 5(b) designing, compounding or dispensing therapeutic diets where nutrition is administered through enteral or parenteral means.

For the purposes of this reserved act, the following definitions shall apply:

"designing": the selection of appropriate ingredients for parenteral or enteral nutrition.

"compounding": mixing ingredients, for parenteral or enteral nutrition.

"dispensing": filling a prescription for parenteral or enteral nutrition.

- 2(d) administration of a substance by instillation through enteral or parenteral means.
4. that the title "dietitian" be reserved for the exclusive use of registrants of the College.

5. that the college established for the health profession be named the "College of Dietitians."

IV. RATIONALE FOR THE RECOMMENDATIONS

A. DESIGNATION

In order to proceed under section 7 of the *HPA* to recommend the designation of dietetics, the Council must determine (1) whether the applicant's profession comes within the definition of "*health profession*" as set out in s.1 of the *HPA* and (2) that designation is in the public interest pursuant to section 5 of the *HPA Regulation*.

1. Definition of "Health Profession"

The *HPA* s.1 defines a health profession as

. . . a profession in which a person exercises skill or judgment or provides a service related to (a) the preservation or improvement of the health of individuals, or (b) the treatment or care of individuals who are injured, sick, disabled or infirm.

The applicant BCDNA submits that dietitians and nutritionists are "*uniquely qualified to integrate and apply the principles of food, nutrition and health to promote the nutritional well-being of the public*". The dietitian and nutritionist exercises knowledge and skills and provides services related to the assessment of nutrition and nutritional status as well as the treatment and prevention of nutrition disorders.

The applicant provided the Council with information about the roles of dietitians and nutritionists who practise in institutional settings, including acute care and community care facilities, and in community health settings. As well, dietitians and nutritionists work in business, government and academia. A growing number of practitioners work in private practice. In many cases, dietitians work directly with patients who have been diagnosed with a disease, disorder or condition requiring specific diet therapy or adaptations of their current diet. The Council was satisfied that within these various settings, dietitians assess, plan for and manage individual patients' nutritional needs as well as those of the community at large. Whether the focus is on acute care or health promotion and disease prevention, the Council was convinced that the applicant met the definition of "*health profession*" under the *HPA*.

2. Public Interest Criteria

Section 5 of the *HPA Regulation Part II Public Interest Criteria* states:

5. (1) For the purposes of s. 10(1) of the Act, the Council must consider the extent to which the practice of a health profession may involve a risk of physical, mental or emotional harm to the health, safety or well being of the public, having regard to

(a) the services performed by practitioners of the health profession,

(b) the technology, including instruments and materials, used by practitioners,

(c) the invasiveness of the procedure or mode of treatment used by practitioners, and

(d) the degree to which the health profession is

(i) practised under the supervision of another person who is qualified to practise as a member of a different health profession, or

(ii) practised in a currently regulated environment.

(2) The Council may also consider the following criteria:

(a) the extent to which the health profession has demonstrated that there is a public interest in ensuring the availability of regulated services provided by the health profession;

(b) the extent to which the services of the health profession provide a recognized and demonstrated benefit to the health, safety or well being of the public;

- (c) *the extent to which there exists a body of knowledge that forms the basis of the standards of practice of the health profession;*
- (d) *whether members of the profession are awarded a certificate or degree from a recognized post-secondary educational institution;*
- (e) *whether it is important that continuing competence of the practitioner be monitored;*
- (f) *the extent to which there exists within the health profession recognized leadership which has expressed a commitment to regulate the profession in the public interest;*
- (g) *the likelihood that a college established under the Act would be capable of carrying out the duties imposed by the Act, having regard to factors which in the view of the council may affect the viable operation of the College;*
- (h) *whether designation of the health profession is likely to limit the availability of services contrary to the public interest.*

The Public Interest Criteria contained in s. 5(1) of the *HPA Regulation* provide the context in which the Council will analyze the risk of harm in the applicants' practice. While the Council may also consider the s.5(2) criteria in making its designation decision, these criteria do not address risk of harm. If the Council decides that the profession should be designated, the Council will determine an appropriate scope of practice statement for the profession. The Council will then determine which aspects of the scope of practice have been shown to present a significant risk of harm. These will be defined as reserved acts, as directed in s.10(3)(b)(v) of the *HPA* and the Council's Terms of Reference. Any other aspects of the scope of practice of a health profession are considered to be capable of being shared with other health practitioners and the general public.

There is a distinction between analyzing risk of harm for the purposes of s.5(1) and for reserved acts. The s.5(1) analysis is broadly based and looks at the extent of the risk of physical, mental or emotional harm to the health, safety or well being of the public in the practice of the profession. This analysis looks generally at the services performed by practitioners, the technology used, the invasiveness of procedures or treatments and the degree of regulation or supervision of practitioners, as directed in s.5(1)(a), (b), (c) and (d). The Council will make its determination of whether the profession should be designated on the basis of this analysis together with the analysis of the criteria contained in s.5(2) of the *HPA Regulation*.

After it is determined that the profession should be designated, a more narrowly focused risk of harm analysis is conducted to determine whether the health profession will be granted one or more reserved acts. The Council emphasizes that it is not necessary for a health profession to be granted any reserved acts in order to be designated. However, once the recommendation to designate is made, the Council will look at whether there are acts or activities within the profession's scope of practice which present such a significant risk of harm that they must be designated reserved acts, as directed in s.10(3)(b)(v) of the *HPA*. In the *Shared Scope of Practice Model Working Paper (Working Paper)* issued by the Council in January 1998 and most recently revised in July 1998, reserved acts have been restricted primarily to physical acts which carry a significant risk of harm.

The Council's *Working Paper* will form the basis of the reserved act analysis. Where an act or activity is currently listed as a reserved act, the Council will determine whether members of the applicant profession are trained and qualified to perform such act. Where the applicant requests a reserved act which is not included on the current reserved act list incorporated in the *Working Paper*, the Council will conduct a risk of harm analysis to determine if a new reserved act is warranted or a current reserved act could be expanded or adapted to include that which is requested by the applicant, should it present a significant risk of harm.

The Council applied the Public Interest Criteria set out in section 5 of the *HPA Regulation* in order to determine whether designation of a college of dietitians and nutritionists is in the public interest.

a) Section 5(1): Risk of Harm Criteria

5. (1) For the purposes of section 10(1) of the Act, the Council must consider the extent to which the practice of a health profession may involve a risk of physical, mental or emotional harm to the health, safety or well being of the public, having regard to:

(a) the services performed by practitioners of the health profession

The services performed are set out in the BCDNA application proposed scope of practice section:

The practice of dietetics and nutrition is the translation and application of the scientific knowledge of foods and human nutrition towards the attainment, maintenance, and promotion of the health of the public, and may include but is not limited to:

(i) Establishing and reviewing nutrition guidelines, standards and policies and goals for healthy and ill people throughout their lives;

(ii) Assessing nutritional needs of individuals and developing, implementing and evaluating nutrition care plans, therapeutic diets and other nutrition interventions based on the assessments;

(iii) Assessing the overall nutritional needs of a community, and planning, coordinating, implementing, and evaluating the nutrition component of prevention and health promotion programs;

(iv) Collecting, interpreting, evaluating and disseminating nutrition information for the public and health professionals;

(v) Planning, conducting and evaluating educational programs on nutrition for the public and health professionals;

(vi) Promoting healthy eating, healthy growth and development related to nutritional health, and access to safe, nutritious and culturally acceptable food;

(vii) Consulting to individuals, families, groups and other health professionals on the principles of food and nutrition, and the practical application of those principles;

(viii) Conducting basic and applied research in food, nutrition, and food service.

The applicant submitted that potential risks to the public resulting from incompetent, unethical or impaired practice include:

- *malnutrition*
- *vitamin and mineral deficiency and toxicity*
- *dehydration*
- *adverse reactions to food*
- *compromised health, delayed recovery or death from inappropriate therapeutic assessment and/or recommendations.*

Other examples were submitted by the applicant to support the risk of harm inherent in dietitian services. They included metabolic difficulties resulting in compromised health and diminished quality of life; diet-induced anaphylaxis and potential for death in patients with life-threatening food allergies; choking, aspiration pneumonia, and potential for death in patients with eating and swallowing disorders (dysphagia); and food poisoning and potential for dehydration and death, particularly where there is increased susceptibility to infection.

During the consultation process, the Council received the following comments supporting designation. The Pacific Society of Nutrition Management (PSNM) commented:

It is in the public interest to designate dietetics under the HPA due to the substantial risk of harm . . . to the ill, very young and aged populations who are at greater risk form food borne illnesses caused by improper food handling, as well as, inadequate or damaging diets that may cause medical complications.

The PSNM sent supportive materials and articles dealing with issues of food safety. The Public Health Association of BC, the College of Physicians and Surgeons, The College of Dental Surgeons, the Registered Nurses Association of BC, the BC Home Economics Association, the BC Naturopathic Association, the College of Denturists, the Heart and Stroke Foundation of BC and the Yukon, Vancouver Community College, BC Society of Occupational Therapists and the Dial-A-Dietitian Information Society of BC all support designation in the public interest.

(b) the technology, including instruments and materials, used by practitioners

No evidence was presented of dietetics technology, instruments or materials presenting any direct risk of harm. However, enteral and parenteral feeding technology was presented as one form of technology utilized by practitioners. The risk of harm associated with enteral and parenteral feeding will be discussed more extensively in the reserved acts section of this report.

(c) the invasiveness of the procedure or mode of treatment used by practitioners

Dietitians do not perform invasive procedures or treatments directly, however dietitians' treatment of patients with swallowing disorders and other patients who require enteral or parenteral nutrition requires dietitians to utilize existing invasive appliances or equipment as a means to deliver nutrition to the patient. As pointed out by the College of Physicians and Surgeons of BC:

...with enteral and parenteral feeding, although the dietitian has an expert role in providing nutritional information and ongoing assessment, there are numerous aspects of enteral and parenteral feeding, such as the placement of catheters and lines and the complications thereof, which are outside their realm of expertise .

...

In the Council's view, while dietitians and nutritionists are generally not responsible for placement of interarterial lines or for enteral feeding tube placement, they are responsible in some instances for the proper utilization of

those pieces of equipment and for the safe and effective administration of nutrition by these means. Enteral and parenteral feeding does carry a risk of harm to the patient, either through handling of the equipment or through design, compounding, dispensing or instillation of the feeding. Dietitians are often directly responsible for certain aspects of these feedings. The risks include choking, aspiration, infection and serious metabolic or digestive disturbances. This aspect of dietitian services will be discussed in greater detail in the reserved acts section of this report.

(d) The degree to which the health profession is

(i) practised under the supervision of another person who, is qualified to practise as a member of a different health profession,

The practice of dietitian/nutritionists is not subject to the direct or indirect supervision of other health care practitioners.

At the public hearing on February 12, 1998, a representative from the College of Physicians and Surgeons, Dr. L. Birmingham, commented that dietitians work independently in the community with little or no communication with medical doctors. In an institutional setting, dietitians work as members of the health care team, along with physicians and others. The dietitian is considered the expert in recommending foods for certain specific diets, such as those for inborn errors of metabolism. Dr. T. Handley, Registrar of the College of Physicians and Surgeons of British Columbia, commented in a July 4, 1996 letter to the Council that dietitians do not have expertise to perform medical diagnosis or physical assessment. Dr. Birmingham elaborated on this point at the public hearing and commented that dietitians do make nutritional assessments and teach patients about special diets required for conditions which have been diagnosed previously by medical doctors. This is one example of independent practice. Dr. Birmingham commented that physicians would refer patients to dietitians after making a diagnosis of a disease, disorder or condition which requires diet therapy, however physicians would not supervise dietitians in their practice once the referral is made. Dr. Birmingham commented, for example, "*the average physician could not and should not give diabetic diet advice*". Rather the physician and the dietitian both function as independent health professionals and members of the health care team.

(ii) practised in a currently regulated environment

According to information provided by the applicant, administrative reporting structures vary with the organization and setting in which dietitians work. Dietitians often work autonomously in sole charge positions in institutions or in independent private practice situations and health units. In the Council's view, institutional or administrative structure cannot generally be relied upon to regulate professional practice and standards. Although a dietitian may be practicing within an institution, the administrative structure of that institution does not exist to supervise the professional practice of independent health professional practitioners working within that structure. A health care professional can only be supervised in his or her practice by another qualified health care professional.

Section 5(1): General Risk of Harm Conclusion

The Council was persuaded, primarily by the services provided by dietitians and the type of patients receiving dietitian services, that dietetics meets the general risk of harm criteria for designation. Some life threatening conditions are treated by diet therapy. Diet therapy is often the only, or a significant part of, a treatment plan for management of very serious health conditions. Dietitians design and administer diet therapy sometimes utilizing invasive technology. Dietitians generally practise without supervision by other health professionals. There is a general risk of harm in the practice of dietetics and nutrition which warrants designation as a health profession under the *HPA*.

RECOMMENDATION 1:

The Council recommends that the profession of dietetics be designated as a health profession under the *Health Professions Act*.

b) Section 5(2): Other Criteria

Regulation 5(2) indicates the Council may also consider the following criteria in sections 2(a) to (h):

- (a) the extent to which the health profession has demonstrated that there is a public interest in ensuring the availability of regulated services provided by the health profession.

The applicant association did not include materials specifically demonstrating a public interest in ensuring the availability of regulated services provided by the health profession. However, the Council is not concerned about the lack of demonstrable public interest because dietitian services are well established and the public has access to dietitians throughout the province.

- (b) **the extent to which the services of the health profession provide a recognized and demonstrated benefit to the health, safety or well being of the public**

Submissions were made by the applicant that nutrition and dietetic expertise are essential to vulnerable individuals both in institutions and in the community. Infants, young children, chronically ill, elderly and disabled persons are particularly at risk of compromised health and quality of life should they receive inaccurate or inadequate dietary advice or therapeutic diets. Several participants in the consultation process made submissions which specifically supported these statements by the applicant. Among them were Dial-A-Dietitian Nutrition Information Society of BC, the Public Health Association of BC, and the Pacific Society of Nutrition Management.

Dial-A-Dietitian commented:

Physicians and nurses and other healthcare providers do not typically receive the specific education, training or experience for counselling on such diets and may do physical harm if they provide cursory or inept diet management, or make an error of omission by not referring the patient to a qualified dietitian.

(for example) The dietitian implementing the diet for diabetes and pregnancy must be knowledgeable about the nutrient needs for optimal fetal development; how to adjust the diet to achieve good plasma glucose levels taking into consideration further complicating factors such as allergies, hyperemesis (nausea/vomiting), fevers, exercise, twin pregnancy, renal disease, ... etc.

Parents of infants or children with several allergies, diabetes, renal disease, cancer, HIV, inborn errors of metabolism such as phenylketonuria, cystic fibrosis, or multiple nutrition related disorders need a professional dietitian's help. The dietitian

educates the parent, provides diet guidelines, recipes and support in locating specialized food/supplemental products.

On the basis of all the submissions, the Council concludes that dietitian services provide a recognized and demonstrated benefit to the health, safety or well-being of the public.

(c) the extent to which there exists a body of knowledge that forms the basis of the standards of practice of the health profession

Preparation for entry in the profession of dietetics and nutrition requires completion of academic course work in natural sciences, humanities and social sciences, and dietetics to the Bachelor's degree level as well as documentation of professional competencies, usually through the completion of a dietetic internship program or Master's degree.

The Canadian Dietitians Association Standards of Practice Manual defines the roles of three areas of dietetics practice as clinical dietetics, community dietetics, and administrative dietetics.

Training programs in the U. S. A. are comparable to Canadian programs. Individuals who have completed Bachelor's degrees and dietetic internships in the U. S. A. and are registered members of the American Dietetic Association are eligible for CCDA/BCDNA membership.

Dietitian and nutritionist training programs in the U. K. , New Zealand and Australia differ somewhat from those in Canada. Dietitians and nutritionists who have state licensure in these countries must successfully complete the CDA qualifying examination to be eligible for CDA/BCDNA membership.

Dietitian and nutritionist training programs in other countries may differ considerably from those in Canada. Individuals trained in other countries must have university education assessed for Canadian equivalency by International Credential Evaluation Service and Dietitians of Canada Professional Standards; must successfully complete the Canadian Dietetic Registration Exam (CDRE); and may also be required to complete a prescribed period of supervised experience at the level of a dietitian in Canada or the U. S. for CDA/BCDNA eligibility.

The similarity of training and the equivalency requirements lead the Council to conclude that there is a body of knowledge that forms the underpinning of standards of practice.

(d) whether members of the profession are awarded a certificate or degree from a recognized post-secondary educational institution

Baccalaureate degree programs for dietitians and nutritionists in Canada are available at the following universities: (a single asterisk represents masters program, double asterisk represents doctoral program).

The University of British Columbia	*	**
University of Alberta	*	**
University of Saskatchewan	*	
The University of Manitoba	*	**
The University of Western Ontario		
University of Guelph	*	**
University of Toronto (no baccalaureate)	*	**
Ryerson Polytechnic University		
Université Laval	*	**
McGill University	*	**
Université de Montréal	*	**
Université de Moncton	*	
University of Prince Edward Island		
St. Francis Xavier University		
Acadia University	*	**
Mount St. Vincent University	*	
Memorial University of Newfoundland	*	**

(e) whether it is important that continuing competence of the practitioner be monitored

In the Council's view, monitoring continuing competence is important in the practice of any profession which involves a risk of harm to the health, safety or well-being of the public from incompetent, unethical or impaired practice.

Compulsory continuing education is a BCDNA requirement. Compulsory continuing education is only one part of assuring continuing competence. Members must complete and report continuing education activities worth a minimum of 45 hours of approved

professional education credits every three years. The requirements of the *HPA* under duties and objects of a college will offer further assurance that continuing competence of practitioners is monitored.

- (f) **the extent to which there exists within the health profession recognized leadership which has expressed a commitment to regulate the profession in the public interest**

The BCDNA represents 94 per cent of the estimated 838 dietitians and nutritionists in British Columbia. The society was incorporated in 1957 and is associated with the Dietitians of Canada. The leadership of the society has demonstrated an understanding and commitment to regulate the profession in the public interest. Prior to the enactment of the *HPA*, the BCDNA had sought passage of a separate *Dietitians Act*.

BCDNA operates under a seven-member board of directors with regional representation from practitioners across the province. The BCDNA functions with three councils and seven standing committees, including Professional Action (continuing education), legislation and regulation, professional conduct review and discipline. An estimated 300 dietitians and nutritionists are involved in activities such as ensuring the association is administered effectively, investigating complaints, conducting hearings and monitoring continuing education.

- (g) **the likelihood that a college established under the Act would be capable of carrying out the duties imposed by the Act, having regard to factors which in the view of the Council may affect the viable operation of the college.**

There are currently 831 members of the BCDNA. With membership of this size, and based upon the existence of professional colleges with fewer members, it appears that the BCDNA has more than adequate membership to sustain a viable college.

- (h) **whether designation of the health profession is likely to limit the availability of services contrary to the public interest.**

There is no evidence that designation of the profession under the *HPA* would limit the availability of services. Most employers, including Children's Health Centre, Vancouver General Hospital and Regional Health Boards, require membership in the BCDNA as a requirement for employment. While it would be the responsibility of

the College to determine registration requirements for its members, it appears that the employed members of the profession would meet the requirements for BCDNA membership. BCDNA has fairly detailed and stringent requirements for membership. It is unlikely that a requirement for college membership would limit availability of dietitian services as College membership requirements would not likely be more stringent than those already required by BCDNA.

Section 5(2) Other Criteria Conclusion

The section 5(2) criteria are supportive of the section 5(1) conclusion to designate the profession of dietetics in the public interest. The Council was particularly influenced by the size of the profession, the leadership evident in its professional association and its commitment to regulate in the public interest.

B. SCOPE OF PRACTICE STATEMENT

In determining an appropriate scope of practice statement, the Council considered the applicant's request and reviewed the legislative descriptions of dietetics and nutrition in other provinces.

According to the Council's Terms of Reference for scope of practice review and its policy guidelines, the purpose of the scope of practice statement is to describe what the profession does, the purpose for which it does it and the methods it uses. The statement itself does not grant the profession an exclusive scope of practice. Nonetheless, the statement is important because it defines the area of practice in relation to which the governing body must establish registration requirements and standards of practice; it defines the parameters of the profession for members of the profession, employers, courts and educators; and it informs consumers about the service practitioners are qualified to perform. The Council's *Working Paper*, issued in January 1998, indicates that "*a scope of practice statement will define an individual profession's activities in broad, non-exclusive terms.*"

The following scope of practice statement was submitted by the applicant:

The practice of dietetics and nutrition is the translation and application of the scientific knowledge of foods and human nutrition

towards the attainment, maintenance, and promotion of the health of the public, and may include but is not limited to:

- (i) Establishing and reviewing nutrition guidelines, standards and policies and goals for healthy and ill people throughout their lives;*
- (ii) Assessing nutritional needs of individuals and developing, implementing and evaluating nutrition care plans, therapeutic diets and other nutrition interventions based on the assessments;*
- (iii) Managing and monitoring food service systems to provide nutrition care;*
- (iv) Assessing the overall nutritional needs of a community, and planning, coordinating, implementing, and evaluating the nutrition component of prevention and health promotion programs;*
- (v) Collecting, interpreting, evaluating and disseminating nutrition information for the public and health professionals;*
- (vi) Planning, conducting and evaluating educational programs on nutrition for the public and health professionals;*
- (vii) Promoting healthy eating, healthy growth and development related to nutritional health, and access to safe, nutritious and culturally acceptable food;*
- (viii) Consulting to individuals, families, groups and other health professionals on the principles of food and nutrition, and the practical application of those principles;*
- (ix) Conducting basic and applied research in food, nutrition, and food service.*

The dietitian/nutritionist is an autonomous health professional, exercising specialized skills and judgment related to services within the scope of practice. There should not be any requirement for supervision, nor limits and conditions on the performance of services within the scope of practice outlined.

Based upon the information provided by the applicant the Council proposes that the following scope of practice statement meets the criteria set out in the terms of reference and fulfils the purpose of the scope of practice statement.

RECOMMENDATION 2:

The Council recommends the following scope of practice statement:

The practice of dietetics and nutrition is the assessment of nutritional needs, design and implementation of nutrition care plans and therapeutic diets, and dissemination of information about foods and human nutrition to attain, maintain and promote the health of individuals and the community.

C. RESERVED ACTS

After it is determined that a profession should be designated, the Council conducts a more narrowly focused risk of harm analysis to determine whether the health profession will be granted one or more reserved acts. The Council looks at whether there are acts or activities within the profession's scope of practice which present such a significant risk of harm that they must be designated reserved acts, as directed in s.10(3)(v) of the *HPA*.

In June 1997, following the Council's release of its *Working Paper* and in response to the Council's request for more specific information regarding therapeutic diets, the BCDNA submitted revisions to its original application. The applicant requested that this June 1997 proposal for reserved acts for eight therapeutic diets be considered to replace their original exclusive scope of practice request.

The following is an excerpt from this revised submission:

DEFINITION OF HARM

BCDNA wishes to submit our definition of harm to include consequences other than just increased morbidity and mortality: Harm occurs when the delivery of incompetent health service or the omission of competent services, can result in:

- *death*
- *long term disability*
- *prolongation of recovery from illness or surgery*
- *increased complications*
- *promotion of progression/advancement of a chronic disease*
- *delaying appropriate medical attention*
- *increased pain and suffering.*

PROPOSED "RESERVED ACTS": DIET THERAPY FOR HIGHEST RISK OF HARM

Harm can result from any poorly planned therapeutic diet. However, since we have been asked to present only those areas where significant harm can occur, BCDNA has chosen to identify the following diets/conditions for "reserved acts":

1. *Food Allergies*
2. *Drug: diet interactions*
3. *Ketogenic diets*
4. *Inborn Errors of Metabolism*
5. *Enteral & Parenteral Nutrition*
6. *Renal disease*
7. *Dysphagia*
8. *Diabetes Mellitus/Gestational Diabetes*

The applicant submitted the following definition in the July 1997 submission:

Therapeutic Diet: modification of the nutritional components of a normal diet based on the findings of nutritional assessment, designed to treat identified symptoms, conditions, deficiencies, or altered nutrient needs.

The July 1997 BCDNA submission in full is included as Appendix B.

Upon receipt of the BCDNA revised submission, the Council issued a second consultation letter to inform participants in the consultation process of the changes.

Some of the responses to the second consultation letter supported the BCDNA request for reserved acts.

Marilyn Born, Senior Advisor, Legislation Development, New Brunswick Department of Health and Community Services commented:

The inappropriate administration of any of the therapeutic diets presented by BCDNA for inclusion as reserved acts within the scope of practice of dietitians/nutritionists carries sufficient risk of harm to the public and to the System to warrant this restriction. The content of BCDNA's briefing document on the eight diet therapy categories posing the highest risk of harm is accurate and presented objectively. . . . New Brunswick clinical dietitians continue to report incidents of questionable nutrition treatment (or lack thereof) by other health care professionals (i. e., physicians and nurses) which in their opinion impacted considerably on the need for hospitalization, length of stay, recovery period, complications and/or even death.

The College of Dental Hygienists of BC commented:

With regard to the eight identified therapeutic diets, we believe that inappropriate administration of diets related to food allergies, drug/diet interactions, inborn errors of metabolism, dysphagia and diabetes does pose a significant risk of harm to the public Although we believe that food allergy diets should be reserved acts because of significant risk of harm, we believe that there is some confusion in the public over the definition of the term allergy. True allergic reactions can and do result in death from anaphylaxis, while some food sensitivities, referred to generally as allergies, may not pose a risk of harm sufficient to warrant their restriction. To reduce confusion, we recommend that the term allergy be defined We believe that dietitians and nutritionists are well qualified by their education to perform the proposed reserved acts. Dietitians and

nutritionists receive post-secondary and graduate level science-based education directly related to the reserved acts. In addition, internships provide practical application of the scientific principles. Finally, BC dietitians and nutritionists participate in a program which helps ensure their continuing competence.

The College of Dental Hygienists went on to comment specifically about the proposed reserved acts and the Council's *Working Paper*:

It is not apparent on first reading that the reserved acts proposed by the BCDNA fit within the seven reserved acts described in the working paper. Yet it seems clear that the administration of the specified diets can result in significant harm if carried out inappropriately or by persons not qualified to do so.

For example, we expect that the administration of a therapeutic diet such as a dysphagia diet would fall within the definition of "physically invasive", given the risks of harm identified for the medically compromised client. Similarly, if one agrees that drug/diet interactions can result in significant harm, this should be included in the reserved act relating to drugs. Further, food allergy diet administration is a natural corollary of the reserved act relating to allergy testing (i.e., if testing is reserved, it seems that the therapy resulting from the testing would be equally risky).

While we have heard the argument that diet administration does not fit within the seven reserved acts, we do not see how this can be so. It is true that ordinary diet and nutrient counselling should not be reserved. But when nutrients are ingested as part of therapy for a serious health condition and where a significant risk of harm exists, diet is no longer in the realm of an ordinary food consumption activity. It is a health care therapy, just like drug therapy or any other physically invasive therapy, for which the public deserves protection. [Emphasis in original.]

It is our opinion that significant risk of harm exists for five of the eight specific therapeutic diets identified by the applicant. We are not qualified to comment on the other three (ketogenic diets, enteral/parenteral nutrition, and renal diets).

Dial-A-Dietitian Nutrition Information Society of BC, in addition to its previously quoted submission which outlined instances of specific therapeutic diet problems encountered in its work, submitted a second letter in support of the BCDNA proposal for reserved acts for the following diets: inborn errors of metabolism, renal diets and diabetes controlled by drugs and gestational diabetes. They commented:

In the case of the diets for inborn errors of metabolism and renal conditions, we know of no other health professional group qualified to teach and manage these high risk diets. In the case of diabetes controlled by drugs or gestational diabetes, the public must be offered the best available diet counselling.

The College of Pharmacists of BC has "no objection" to the reserved acts and commented:

the administration of specific therapeutic diets for drug: diet interactions . . . If the designation requested by the BCDNA would not interfere with a pharmacist's ability to provide information and advice to individual patients or to groups of individuals by means of printed materials and information sessions, then there would be no objection to it.

Several groups did not endorse reserved acts for therapeutic diets in any form. Chanchal Cabrera, for the Canadian Herbalists Association of BC, wrote:

The conditions you mention as being proposed for restriction include food allergies and diabetes. Both of these are conditions which are in many cases, amenable to self-treatment through dietary adjustment . . . The practice of natural medicine (herbalism, naturopathy, homeopathy, Ayurveda, TCM) almost always relies heavily on various general and specific therapeutic diets as well as on the materia medica of their particular cultural or philosophical position. It would be deeply distressing to hundreds of existing and upcoming practitioners of various forms of natural medicine if this opportunity to effect healing through diet were to be removed from them . . . potentially thousands of patients would suffer because the over-burdened health care system of this province cannot possibly supply sufficient dietitians for the demand and need.

Alan Burrows, Director of the Ontario Ministry of Health responded to the BCDNA proposal for reserved acts by referring to his initial consultation letter sent July 12, 1996 stating:

. . . the Ontario Regulated Health Professions Act "controlled acts" scope of practice model is based on the concept that non-hazardous health provider services are in the public domain. Only those health care procedures which are potentially harmful to the public are restricted to members of regulated health professions. These potentially harmful procedures are referred to as "controlled acts" in the RHPA (section 27) . . . Although the scope of practice for the profession of dietetics did not include any "controlled acts", the profession provided adequate evidence to satisfy the HPLR that it should be regulated under the RHPA and the government accepted the HPLR's recommendation . . .

In response to the BCDNA proposal of reservation of therapeutic diets, Mr. Burrows commented:

If a person needs to have a nutritional assessment, a therapeutic diet or nutrition counselling, a physician may refer the person to a registered dietitian. However, this person also has the option of seeing other regulated health practitioners such as a public health nurse, a psychologist (eating disorders) or a naturopath. Alternatively, they have the option of seeing an unregulated practitioner such as a community college-trained nutrition counsellor.

The Nutritional Consultants Organization of Canada (NCOC) wrote that they were "very concerned about . . . granting the BCDNA any reserved acts of any kind. To do so would unnecessarily deprive the public of the services of many capable nutritional practitioners." NCOC represents 408 practicing Registered Nutritional Consultants, 40 of whom are in British Columbia. The letter also commented:

Administering a therapeutic diet is not the same as designing the diet. It is not the same as deciding who has the condition that requires following the diet. It is simply carrying out the instructions of the

doctor who has diagnosed that a particular person requires a certain diet as part of his/her therapy. Any risk to the patient from following the diet is the responsibility of the doctor who diagnosed the patient and prescribed the diet. The dietitian is simply following the doctor's orders and performing the task delegated to him/her by the doctor.

The NCOC commented that other professions are more qualified to perform therapeutic diet administration than dietitians, among them holistic medical doctors, naturopaths, and registered nutritional consultants. With regard to the specific therapeutic diets, NCOC objected to reservation of these diets to dietitians on several grounds: either there were others qualified to administer (diabetic diets, gestational diabetes diets, dysphagia diets), dietitians are unqualified (allergy diets), doctors are ultimately responsible for the diagnosis, therefore, dietitians have no responsibility for the administration (renal diets, enteral and parenteral nutrition), dietitians are not trained in pharmacology (drug-diet interactions) or that the diet is self-administered for weight loss (ketogenic diet).

The Council carefully considered these submissions and the BCDNA proposal for a reserved act encompassing eight therapeutic diets. The Council accepts, as was commented by one respondent, that when nutrients are prescribed, compounded or administered as therapy for a serious health condition, diet is no longer in the realm of an ordinary food consumption activity. It is a health care therapy. Whether, as the applicant submits, the therapy is analogous to drug therapy or any other physically invasive therapy was carefully considered as discussed in this report. If there is significant risk of harm involved in these therapies, the Council must consider whether they form part of an existing reserved act or whether a new reserved act should be recommended.

The Council recognizes the concern of some respondents that there are other qualified health care professionals who have the expertise to administer therapeutic diets as a reserved act. However if a reserved act is recommended for any of the therapeutic diets, that reserved act may be shared among several qualified health professions.

As a result of questions raised at the public hearing, the Council met on September 28, 1998 with Dr. Laird Birmingham and members of the BCDNA and again met with the BCDNA, Dr. G. Davidson and Dr. John Tibbles on April 12, 1999. The purpose of these

meetings was to clarify the role of dietitians in prescribing, designing, compounding, and dispensing the eight therapeutic diets requested as reserved acts. During the course of the meetings it became clear that the physician diagnoses the disease, disorder, or condition requiring a therapeutic diet and prescribes that diet. The physician then refers the patient to a dietitian who designs and often compounds and dispenses the diet. All of these functions are aspects of the administration of a therapeutic diet.

The therapeutic diet itself, when properly designed, is often the only or the primary treatment for many of the disorders, diseases or conditions encompassed in the reserved acts proposed by the BCDNA. These diets are necessary to prevent further deterioration in a person who is diagnosed with what is usually a chronic condition. With the exception of gestational diabetes, most of the conditions for which the eight therapeutic diets are prescribed are chronic, life-threatening or disabling conditions, if not properly controlled. In some cases, these conditions are not amenable to self-monitoring and require intensive ongoing interventions by a dietitian. Some examples of these conditions are: Crohn's disease, cancer, inborn errors of metabolism such as phenylketonuria, sprue (celiac), and dysphagia i. e. subsequent to a stroke (cardiovascular accident) or numerous other conditions. Additionally, some of these diets are administered by invasive means. They frequently require close daily monitoring and adjustment based upon laboratory values and patient condition.

The Council accepts that when therapeutic diets are a primary therapy for a severely disabling or life-threatening condition, there must be regulation of the practitioners who design, compound and dispense those diets. These diets involve more than simple nutritional assessment and counselling. This supports the Council's recommendation to designate the profession of dietetics under the *HPA*. However further analysis was undertaken to determine if any of the eight therapeutic diets present such a significant risk of harm that they must be classified as reserved acts.

The Council examined the possible reserved acts associated with each of the eight therapeutic diets in turn. The Council considered whether any of their current list of reserved acts applied or could be modified to include some of the eight therapeutic diets. The Council looked most closely at reserved acts 2(d), 5 and 7 in its analysis of the information provided by the applicant.

1. Therapeutic Diets for Food Allergies: The Council agreed with the comments of some respondents who commented that this proposed therapeutic diet reserved act was too broadly stated and could include both food sensitivities as well as allergies which can result in anaphylaxis. The Council considered a reserved act for food allergies where a possible risk is anaphylactic reaction. It was suggested this would limit and define the use of this therapeutic diet to only those diets for allergic conditions where there is a serious, life-threatening risk of harm. It was also suggested that this would coincide with the Council's reserved act #7 "*allergy challenge testing in which a positive result of the test is a significant allergic response; or allergy desensitizing treatment in which there is a risk of significant allergic response*".

Evidence was presented that competent counselling about allergy diets, particularly for children, is important to health and well-being. The applicant submitted several articles documenting cases where incompetent, inaccurate or incomplete diagnosis of allergies and dietary advice to parents of young children led to complications such as failure to thrive syndrome, with serious long-term and potentially life-threatening consequences in a young child. One article referred to the need for prospective, population-based studies to determine the true extent of the problems resulting from inaccurately diagnosing allergies in children. Failure to thrive may result from inaccurate advice either from alternative practitioners or from medical practitioners.

In the case of food allergies, an accurate diagnosis and prescription of a therapeutic diet defines and controls the risk of harm. Dietitian intervention allows the patient and family to identify sources of offending nutrients and eliminate them from the diet. However, the use of self-injectible epinephrine is a last resort when strict avoidance of the offending food fails. Patients are trained to utilize this therapy by their physician or nurse.

The Council has concluded that allergy diets are generally prescribed for otherwise healthy persons who, with appropriate advice, learn to self-monitor and control their diets independently. It is primarily the responsibility of the patient and/or family to follow through with diet counselling and advice. While food allergies can be serious life-threatening conditions in the case of type I allergic reactions, the diagnosis and prescription of a therapeutic diet for the allergy condition defines and controls the risk of harm. Diet counselling is also distinct from allergy challenge testing as it is a function performed using communication skills rather than an act or activity which could have an immediate harmful effect

on the patient. The Council concluded that this diet would not constitute a reserved act.

2. Therapeutic Diets for Drug-Diet Interactions: The applicant submitted evidence that drug-diet interactions can be life-threatening. The Council reviewed the *Reference Guide to Drug and Nutrient Interactions*, published by the BCDNA and the BC Pharmacy Association. Examples include drug-diet combinations for HIV patients where failure to follow the diet can result in malabsorption of HIV drugs and serious, life threatening consequences to the patient. Some other serious drug-diet interactions occur with regard to pharmaceutical agents affecting blood formation and coagulation or with over-the-counter medications, antihistamines and antineoplastic agents. Central nervous system agents can cause serious reactions such as hypertensive crisis and altered electrolyte imbalance; diuretics and electrolyte replacement therapy can be associated with cardiac arrhythmias. This is not an all inclusive listing of drug-diet interactions.

In the Council's view, drug-diet interactions are similar to food allergy reactions. Therapeutic diets play a prominent role in preventing serious consequences. The risk of harm is controlled and defined by the advice given to the patient and avoidance of those foods which would precipitate a significant risk of harm if ingested, similar to food allergy advice. The goal is self-monitoring after initial diet counselling. For similar reasons to those given for diets for food allergies, the Council concluded that this diet should not constitute a reserved act.

3. Ketogenic diets: In materials provided to the Council and in subsequent meetings, the applicant clarified that the diet referred to is the pediatric ketogenic diet utilized for children with seizure disorders, not the weight loss diet that has been periodically fashionable though not recommended by dietitians. When used for pediatric seizure disorders, the ketogenic diet is a prescribed treatment for those children for whom drug therapy may not be effective or desirable. The diet can suppress or significantly reduce seizure activity in approximately 50 per cent of children with resistant forms of epilepsy. These diets are most effective for children under six years of age; therefore, early identification is important for seizure control. Occasionally, this diet is used in adolescents who have intractable seizures, however tube feedings are usually required for these patients. The issue of tube feedings will be discussed in the section of this report dealing with enteral/parenteral diets.

The dietitian customizes the diet combination of protein, carbohydrates and fat and creates a mixture unique to each child. The combination of nutrients is based upon each child's age, developmental needs, size, weight and metabolism. The dietitian monitors the diet by phone communication with the parent. The parent tests urine ketones daily and the dietitian adjusts the diet accordingly. Although the dietitian is very closely involved with the family, it is primarily the responsibility of the parent to administer the diet as adjusted by the dietitian.

The ketogenic diet requires a high degree of compliance for success and patients generally must remain on the diet for two years followed by up to eighteen months of weaning off the diet. One fifth of children with "*intractable seizure disorder*" use the ketogenic diet monitored by the BC Children's Health Centre (BCHC) team. There are currently 80 - 90 children on this diet in BC. According to information provided by the applicant, sixty percent of the children who are admitted to the Ketogenic Diet Epilepsy Program at BCHC are successful and become seizure-free. The diet has become widely utilized throughout North America. Administration of such a diet clearly requires special expertise and could result in harm if the diet was not properly administered, including malnutrition and growth failure, or brain damage should seizures reoccur. The prescribed diet has a direct drug-like effect on the disorder. Although these children may have health care needs that require a team approach, only the dietitian is able to provide the intensive monitoring and adjustments to the unique food combinations required in the ketogenic diet.

While the risk to the patient who does not follow the diet is high, in the Council's view the risk of incompetent dietitian practice causing harm is likely low. Ketogenic diets are managed by highly trained dietitians who practise independently but within the context of a team approach. These patients are medically monitored on a frequent basis and team support is high. It would be very unlikely that a patient would seek this type of diet therapy from an untrained or unqualified person. In the context of a highly specialized health care team approach, the creation of a reserved act does not seem necessary, since the environment in which these patients are treated and monitored could be seen as a form of regulated environment. Additionally, while the diets are complex, the dietitian's interventions are essentially performed using communication skills rather than activities or procedures which could have an immediate harmful effect on the patient.

4. Therapeutic Diets for Inborn Errors of Metabolism: Taber's Cyclopedic Medical Dictionary defines inborn errors of metabolism (page 1204) as:

. . . a group of inherited metabolic diseases caused by the absence of (sic) deficiency of specific enzymes essential to the metabolism of basic substances such as amino acids, carbohydrates, vitamins, or essential trace elements. Examples include phenylketonuria and hereditary fructose intolerance.

According to information provided by the applicant there are hundreds of metabolic disorders and 910 patients in BC have some variety of inborn error of metabolism. Of these, 188 have phenylketonuria (PKU), a phenylalanine deficiency. PKU is the most prevalent inborn error of metabolism for which diet is the primary therapy.

Diets for inborn errors of metabolism, such as PKU, often involve special formulae for newborn infants and others who are at risk of serious, irreversible harm, such as brain damage, if the diet is not followed properly. The purpose of the diet therapy for inborn errors of metabolism is to reduce or eliminate the offending nutrient while ensuring the patient receives proper nutrition essential for health and development.

In BC there are approximately six babies with PKU born each year. During the first six years of life, there is at least weekly consultation with a dietitian who adjusts the child's diet based upon the results of laboratory or blood data provided by the parents who monitor the blood work at home. Because phenylalanine, in some amount, is necessary for life, the dietitian adds it back into the patient's diet, monitoring laboratory data daily, to determine the patient's ability to tolerate and digest phenylalanine. The tolerance can vary considerably as the patient grows and develops. During the growth process of early childhood through adolescence this design is particularly critical since miscalculation can rapidly result in damage to a growing child. The applicant submits that current experience indicates this is now a "*diet for life*" due to the increased survival rate since screening and diet treatment was instituted in the 1970s. Design, compounding and dispensing of the diet by a dietitian is the only known treatment.

In the Council's view, this diet therapy is similar to ketogenic diet therapy in that both require a team approach with close medical monitoring. For similar reasons, the Council concludes that while the risk to the patient who does not follow the diet is high, the risk of incompetent practice causing harm is low since the patient is closely monitored by a physician and other team support is available.

5. Therapeutic Diets for Enteral Nutrition/Parenteral Nutrition: The applicant submitted several selected articles to describe parenteral and enteral nutrition and to substantiate the risk of harm involved in these therapeutic diets which are generally described below:

The term "specialized nutrition support" refers to the administration of enteral and parenteral nutrition to patients. . . . Enteral nutrition is defined as the administration of nutrients via the gastrointestinal tract either orally or by tube, catheter, or stoma distal to the oral cavity. Parenteral nutrition is defined as the administration of nutrients intravenously either by means of a large central vein (usually the superior vena cava), or a peripheral vein (usually in the hand or forearm).¹

According to the applicant, designing, compounding and dispensing enteral or parenteral nutrition requires special training and is usually accomplished by the dietitian as a member of a multidisciplinary health team. Although a multidisciplinary approach is utilized, the dietitian is often solely responsible for the nutritional maintenance of the patient, whether the patients are receiving assistance from the dietitian in an institution or at home.

¹"Position of the American Dietetic Association: The role of registered dietitians in enteral and parenteral nutrition support", *ADA Reports*, March 1997, vol. 97, no. 3, at 302.

The Council examined whether, as the applicant submits, the role of the dietitian can be seen as analogous to that of the pharmacist who compounds and dispenses drugs by prescription.

The Council recognized the risk of harm associated with prescription drugs in reserved act #5:

Prescribing, compounding, dispensing or administering by any means a drug listed in Schedule I or II of the Pharmacists, Pharmacy Operations and Drug Scheduling Act.

For the purposes of this reserved act, the following definitions shall apply:

"prescribing": the ordering of a drug.

"compounding": mixing ingredients, at least one of which is a drug.

"dispensing": preparing or filling a prescription for drugs.

While pharmacists may play a significant role in parenteral and enteral nutrition, dietitians with specialty certification are frequently responsible for management of these patients. Their training is described below:

Certification in nutrition support has been available to registered dietitians (certified nutrition support dietitian) since 1988, for the purpose of setting a standard for basic nutrition support competency . . . Registered dietitians certified in nutrition support are not necessarily advanced-level practitioners, but possessors of the skills necessary for safe and effective delivery of nutrition support.²

² *Ibid.*

The applicant has submitted that designing, compounding and dispensing parenteral and enteral nutrition carries a significant risk of harm. The choice of ingredients, the compounding of the solution, the port-of-entry to the body (either through vein or directly into the stomach or intestine), as well as the method of instilling the solution all present significant risks of harm. The risks include infection, disruption of the intestine, and serious metabolic disorders. In support of this submission the applicant has provided several selected articles which are included as Appendix D to this report. The articles address the importance of design, monitoring and adjustment of parenteral and enteral nutrition to prevent various gastrointestinal, mechanical and metabolic complications. The applicant also submits the position paper of the American Dietetic Association (ADA) which describes the current role of registered dietitians in nutrition support:

Position Statement

It is the position of The American Dietetic Association that a registered dietitian (RD) with competency in nutrition support is qualified to assume responsibility for the assessment, planning, implementing, and monitoring of enteral, parenteral, and specialized oral therapies in patient care.

Role of Dietitians

- *Identifies patients at nutritional risk*
- *Performs periodic assessment of patients receiving nutrition support*
- *Acts as the advocate for all aspects of nutrition care*
- *Participates in the design, implementation, and monitoring of enteral and parenteral nutrition regimens*
- *Provides for nutritionally complete transitional feeding*
- *Documents nutrition care plans*
- *Provides education to patients, families, and health care professionals*
- *Translates the nutrition care plan into understandable language*

- *Participates in the design, implementation, and monitoring of home enteral and parenteral nutrition regimens . . .*³

a) Parenteral Nutrition: The risks involved in this type of nutritional supplementation are similar to the risks involved in the Council's reserved act #2(d) "*administering a substance by injection or inhalation*". The Council has determined that there are serious risks involved in the act of administering substances which do not qualify as drugs under Reserved Act 5, and that these activities should be restricted as discussed in the Council's *Working Paper*:

*2(d) administration of a substance by injection or inhalation . . .
The substances of concern include intravenous fluids, oxygen and gases
which, if improperly administered, can cause extremely serious or life
threatening complications . . .*

³ *Ibid.*

Parenteral nutrition is administered to the patient by means of an intravenous pump directly into the blood stream therefore it fits within Reserved Act 2(d): *administration of a substance by injection* and carries with it all of the risks of intravenous administration of any kind.

In addition to the risks inherent in intravenous administration of a substance, the applicant submits there are risks involved in the design, compounding and dispensing of parenteral nutrition. Design of the parenteral mixture involves the dietitian closely monitoring laboratory values and adjusting the solution based on specialized knowledge and expertise acquired in both undergraduate and graduate preparation. The risk of harm from design and administration of parenteral nutrition includes starvation, malnutrition, and serious metabolic disorders.

b) Enteral Nutrition: The applicant has submitted the following risks of harm associated with enteral feeding:

*Mechanical complications are problems associated with the feeding tube--tube obstruction and pulmonary complications caused by improper tube placement and/or formula aspiration . . . Gastrointestinal symptoms are the most common complications associated with tube feedings. Diarrhea is the most frequently encountered complication, but patients can also develop abdominal distention, delayed gastric emptying, nausea, vomiting, cramping and constipation . . . Metabolic complications are frequently ascribed to parenteral therapy but occur with enteral therapy as well. Because central venous lines are not used and because of the buffering effects of the gastrointestinal tract, enteral complications of this type are generally less severe than parenteral complications. In most cases, these complications can be easily prevented with proper monitoring and management.*⁴

The applicant submits that the design of an enteral nutrition program involves knowledge of chemistry, anatomy and physiology, position of the feeding tube, the patient's particular nutritional status as well as the types of enteral feedings available. Gastrointestinal, mechanical or metabolic complications can occur as a result of the design and administration of enteral feedings.

⁴Carol L. Kohn, MS, RN, and Joyce K. Keithley, DNSc, RB_, "Enteral Nutrition. Potential Complications and Patient Monitoring", *Nursing Clinics of North America*, vol. 24, no. 2, June 1989, at 339, 343, 347.

During 1996, the Council requested responses from all the health professions to its *Reserved Acts Discussion Paper*. In its June 1997 response, the BC Nurses Union pointed out the risk of harm in routes of administration, other than those which the Council had mentioned in Reserved Act 2(d):

. . . [I]n (d) we would like to expand the definition to include "administering a substance by injection, irrigation, inhalation or via catheters or other instruments". This would address the fact that there are other potentially harmful substances that can be administered. An example is irrigating a wound with hydrogen peroxide which could disturb a clot and lead to haemorrhage.

. . .

In (e) we would like the definition of instrument clarified. We assume it would include tubes, lines and cannulas.

The Council in its *Working Paper* considered the risk of harm associated with administration by instillation, however concluded at that time that the risks were limited to the use of instruments inserted into various openings in the body listed in Reserved Act 2(e) and did not include administration of a substance by routes other than injection or inhalation:

The BC Nurses' Union submits that other forms of administration such as "irrigation, instillation, . . . or via catheters or other instruments" should be included within this reserved act [2(d)]. In the Council's view, however, the risks associated with such procedures would fall within other reserved acts such as (e), below.

2(e) putting an instrument, hand or finger(s),

- i. beyond the external ear canal,*
- ii. beyond the point in the nasal passages, where they normally narrow,*
- iii. beyond the pharynx,*
- iv. beyond the opening of the urethra,*

v. *beyond the labia majora,*

vi. *beyond the anal verge, or*

vii. *into an artificial opening into the body.*

Through this application for designation the Council has now been presented with evidence of an independent risk associated with the administration of a substance by enteral or parenteral nutrition instillation through a feeding tube into an artificial opening into the body. The risks have been shown to include not only risks from placement of the tube itself, which is included in Reserved Act 2(e)(vii), not granted to dietitians, but also risks involved in the administration of a substance by this route. Administration of enteral nutrition would fall within Reserved Act 2(d) expanded to include administration of a substance by instillation.

The Council concludes that designing, compounding or dispensing either enteral or parenteral nutrition carries a significant risk of harm and can cause serious mechanical and metabolic complications, infection, or disruption of the intestine. The patient's total nutrition and metabolic maintenance is dependent upon proper design and adjustment of that design based upon the patient's individual laboratory values. For this reason, designing, compounding and dispensing enteral and parenteral nutrition should only be performed by health professionals with special training and expertise. Dietitians are such a profession. The Council also concludes that instillation of parenteral or enteral nutrition carries a significant risk of harm.

The applicant has provided basic competency documentation for entry level practice in parenteral and enteral nutrition. The applicant has also provided information indicating that there is a certification program which sets a standard for achieving advanced competency in nutritional support. The Council relies on the College to monitor its members and to establish the basic requirements for its members who provide nutritional support services which involve reserved acts.

The Council has modified Reserved Act 2(d) as follows: "*instillation through enteral or parenteral means; by injection; or by inhalation*" and to include enteral

and parenteral nutrition as substances of concern, in addition to intravenous fluids and gases.

Further the Council has modified Reserved Act 5 by adding subclause 5(b):

designing, compounding or dispensing therapeutic diets where nutrition is administered through enteral or parenteral means.

For the purposes of this reserved act, the following definitions shall apply:

"designing": the selection of appropriate ingredients for parenteral or enteral nutrition.

"compounding": mixing ingredients, for parenteral or enteral nutrition.

"dispensing": filling a prescription for parenteral or enteral nutrition.

RECOMMENDATION 3:

The Council recommends that the following be reserved acts for registrants of the College:

5(b) designing, compounding or dispensing therapeutic diets where nutrition is administered through enteral or parenteral means.

For the purposes of this reserved act, the following definitions shall apply:

"designing": the selection of appropriate ingredients for parenteral or enteral nutrition.

"compounding": mixing ingredients, for parenteral or enteral nutrition.

"dispensing": filling a prescription for parenteral or enteral

nutrition.

2(d) administration of a substance by instillation through enteral or parenteral means.

6. Therapeutic Diets for Chronic Renal Failure and End Stage Renal Disease:
The applicant submitted several articles about renal disease and diet therapy as discussed below:

Papper defines renal failure as "that stage of renal function in which the kidney is no longer able to maintain the integrity of the internal environment of the organism". For purposes of this article, end stage renal disease (ESRD) is defined as irreversible kidney disease causing chronic abnormalities in the internal environment and necessitating treatment with dialysis or kidney transplantation for survival . . . The reader should keep in mind that the pathophysiological changes discussed in this article arise when overall renal function is less than 20-25% of normal (75-80% of renal function is lost), at which point kidneys have lost their ability to regulate the internal environment. These problems may often be managed conservatively (diet and fluid control and medications) until [kidney function] decreases to 10-15% of normal. Maintenance dialysis must then be implemented or renal transplantation performed to sustain life .⁵

These diets are prescribed for patients with renal disease, on dialysis due to kidney failure, and pre and post transplant patients. Certain foods and nutrients are prohibited to a greater or lesser degree and blood chemistry is closely monitored by laboratory testing. The purpose of the diet is to maintain the patient who is often in an extremely debilitated state, to promote health and prevent deterioration. Failure to properly administer this diet can result in death or continued severe disability. If the diet is not monitored properly, the patient can have increased kidney failure, heart and lung complications or damage to other organs. Although there are a team of practitioners involved in treatment of kidney patients, diet is one of the primary treatments to prevent deterioration and the diet is designed and dispensed entirely by the dietitian.

⁵Larry E. Lancaster, R.N., M.S.N., Ed.D., "Renal Failure: Pathophysiology, Assessment and Intervention", *Nephrology Nurse*, March/April 1983, at 38 and 40.

*Strict dietary restrictions are imposed on patients suffering from renal failure who require hemodialysis, which is appropriate. For some patients, however, protein malnutrition can develop. Protein malnutrition has been associated with increased complications, prolonged hospital stay, or frequent rehospitalization and death. There is a significant beneficial impact on outcome when malnutrition is eliminated from disease and trauma. The patient's ability to recover and respond to therapy depends on an ability to synthesize proteins necessary to regain homeostasis. It is quite possible for a patient to die more of complications of progressive malnutrition than the disease which precluded the ability eat.*⁶

The dietitian monitors laboratory values, other patient specific data such as physical status and patient preferences, and then formulates a meal plan based upon the data. This plan and subsequent laboratory values are monitored and provide the basis for dietary adjustments. While the dietitian's role is monitoring, counselling and teaching, it is primarily the patient's responsibility to follow through with the diet.

⁶M.V. Kaminski, Jr., E.G. Lowrie, S.G. Rosenblatt, and T. Haase, "Malnutrition is Lethal, Diagnosable, and Treatable in ESRD Patients", *Transplantation Proceedings*, vol. 23, no. 2, April 1991, at 1810.

The Council concludes that while the risk of harm to the ESRD patient who does not follow the renal diet is serious, the risk of incompetent dietitian practice causing harm is low. The patient's physical status and laboratory values are closely monitored by a team including a medical practitioner and nurses. Additionally, the dietitian's functions are performed using communication skills rather than activities or procedures which could have an immediate effect on the patient. The Council concludes that these diets should not constitute a reserved act.

7. Dysphagia: The applicant submitted information which indicates that dysphagia diets have potential for serious, life threatening consequences if not properly administered. Dysphagia occurs across a spectrum of swallowing difficulty. A stroke patient, for example, who can relearn the mechanics of swallowing is normally assisted by a team including registered nurses and occupational and/or speech therapists in an institutional environment. A dietitian monitors the nourishment of the patient and ensures that food is being prepared in a manner that can be properly ingested. The administration and design of the diet, while a key element, are not as critically dependent on the dietitian because the patient and other members of the health care team are involved in planning and adjusting the diet.

8. Diabetes Mellitus/Gestational Diabetes: The applicant is requesting a reserved act for the full range of diabetic diets. The Council has considered the suggestion that therapeutic diet administration for diabetic diets be narrowed to include only those diabetic diets which are controlled by drugs or medication and diets for gestational or juvenile diabetes. This would limit the reserved act to those diets which have the potential for the most significant risk of harm that is, those conditions where deviation from the diet could cause irreversible brain or cellular damage or serious life-threatening emergencies. Where gestational diabetes is concerned, if proper advice is not given there could be serious adverse effects on the health of the fetus and the mother. Juvenile diabetics who experience rapid growth and development, depend on strict diabetic control for successful treatment. The Council has learned that the self-monitoring process, while supported by the team in the early stages, is the only means by which diabetes can be controlled.

The Council accepts that all diabetics, especially women with gestational diabetes and juvenile diabetics, should have the benefit of rigorous education. The basic goal of self-monitoring and administration is similar to that goal in allergy diets. The importance of strict compliance with this diet can only be accomplished through

an appropriate educational program. Juvenile diabetics are referred to the juvenile diabetes program in their community or closest centre. They are taught how to manage their diet and lifestyle. Self-monitoring and self-administration is the goal with support of the team. The Council concludes that diets for diabetes do not constitute a reserved act, for reasons similar to those for therapeutic diets for seizure control and inborn errors of metabolism.

Conclusion: During the course of its investigation the Council was impressed by the depth of knowledge possessed by dietitians who teach and monitor therapeutic diets for the patients who depend upon them. The Council does not wish to minimize the risks involved, nor the professional expertise required to safely manage diabetic and ketogenic diets or those for inborn errors of metabolism, chronic and end stage renal disease, type I food allergies, dysphagia or drug-diet interactions. The professional expertise involved in management of these therapeutic diets was one of the principal reasons for the Council's decision to recommend designation under the *HPA*. The Council was also impressed by the referral system in place and the health care team which supports the family and patients involved. In the Council's view, while health can be seriously compromised by failure to follow these diets, the controls in place for referral to the dietitian, education, support and monitoring the progress of these patients provides sufficient safeguards to minimize the risks to the public. In the Council's view, the regulatory body has a role to play in educating the public about the important role that dietitians play in these diet therapies and the education and training which make dietitians the experts in dietary management of these conditions.

In the case of parenteral and enteral nutrition, because of the invasive nature of both the route of administration and the design of the substances involved, which involve acts or procedures which could have a direct or immediate harmful effect on the patient, the Council has recommended granting those reserved acts to qualified dietitians.

D. RESERVED TITLE

The applicant requested the use of either "Registered Dietitian", "R.D." or "Dietitian and Nutritionist" which would continue the use of the titles currently protected under the *Society Act* for members of the applicant association.

The Council considers that a reserved title for dietitians and nutritionists is in the public interest and will assure the public and other health professionals that anyone using the title is a registrant of the College and is therefore qualified and is subject to disciplinary processes for incompetent, impaired, or unethical practice. A reserved title will enhance consumer recognition. The inclusion of the term "registered" was suggested but the practice of the Council has been to avoid use of the term "registered" and to reserve the descriptive term, in this case "dietitian", for exclusive use of members of the college. The use of the term "registered" is unnecessary in this case. Additionally, the Council does not recommend reserving initials such as "R.D.". The Council understands that those initials are widely used by dietitians throughout North America and they would not be prohibited from continuing to use them.

The Council has not recommended the reservation of the term "nutritionist" for exclusive use by members of a college. The term "nutritionist" may continue to be used by dietitians and others who are not qualified to be members of the college. Reservation of the term "nutritionist" would remove this title from the public domain. It appears that there are a number of nutritional consultants and counsellors practicing in the province. The reservation of this title would prevent them from using the term "nutritionist". The public should be entitled to choose from among a number of other types of nutrition practitioners where there is not a significant risk of harm.

RECOMMENDATION 4:

The Council recommends the title "dietitian" be reserved for the exclusive use of registrants of the College of Dietitians.

The Council further recommends that any other titles reserved under the *Society Act* which conflict with the above recommendation regarding reserved titles for dietitians should be reviewed by the appropriate ministers as they may be misleading to the public. It is the Council's view that the current situation where other titles with respect to health professions can be reserved under s.9(1) of the *Society Act* is not in the public interest as the Council noted in its *Report on the Designation of Occupational Therapy*, September 1996, and its *Report on the Designation of Counselling*, February 1997. Unlike the Council's review of an application for designation under the *HPA*, the Registrar under the *Society Act* does not conduct a detailed public interest analysis of the society, its membership or

the services it provides with a view to regulation of the members of the applicant society. The Council believes that the title protection system under the *Society Act* could be confusing or misleading to members of the public who may conclude on the basis of the exclusive use of title conferred under the *Society Act*, that a member of a registered society or association is subject to regulation which does not, in fact, exist. In addition, there is no restriction on a health care worker using a title which includes the words *registered, licensed or certified* even though he or she has not been granted a title under either the *Society Act* or the *HPA*. This situation can be misleading to the public. In the Council's view, such unregulated use of these terms is not in the public interest as it may imply government sanction.

In its 1991 Report: *Closer to Home*, the Royal Commission on Health Care and Costs recommended that:

7.
 - a. *the Society Act be amended so that the Health Professions Council must approve an occupational title or abbreviation before the Registrar grants protection of it;*
 - b. *all health profession titles previously granted protection under the Society Act that have not been approved by the Health Professions Council be revoked two years after the passing of the revised Health Professions Act; and*
 - c. *the Health Professions Act be amended to prohibit the use of words like "registered", "licensed" or "certified" by any health care worker unless that use has been approved by the Health Professions Council.*

The Council adopts and supports these conclusions and recommends their implementation.

E. NAME OF THE COLLEGE

The Council recommends the use of the practitioner title, i.e., "dietitian", rather than the title of the profession, i.e., "dietetics", in naming the College.

RECOMMENDATION 5:

The Council recommends that the college established for the health profession be named the "College of Dietitians."

SUMMARY OF RESPONSES TO THE
BC DIETITIANS' AND NUTRITIONISTS' ASSOCIATION
APPLICATION

1a) Submission by the applicant, the British Columbia Dietitians' and Nutritionists' Association (BCDNA)

November, 1995

Scope of practice

In its application, the British Columbia Dietitians and Nutritionists Association (BCDNA) proposes the following scope of practice:

The practice of dietetics and nutrition is the translation and application of the scientific knowledge of foods and human nutrition towards the attainment, maintenance, and promotion of the health of the public, and may include but is not limited to:

- (i) Establishing and reviewing nutrition guidelines, standards and policies and goals for healthy and ill people throughout their lives;*
- (ii) Assessing nutritional needs of individuals and developing, implementing and evaluating nutrition care plans, therapeutic diets and other nutrition interventions based on the assessments;*
- (iii) Managing and monitoring food service systems to provide nutrition care;*
- (iv) Assessing the overall nutritional needs of a community, and planning, coordinating, implementing, and evaluating the nutrition component of prevention and health promotion programs;*
- (v) Collecting, interpreting, evaluating and disseminating nutrition information for the public and health professionals;*
- (vi) Planning, conducting and evaluating educational programs on nutrition for the public and health professionals;*
- (vii) Promoting healthy eating, healthy growth and development related to nutritional health, and access to safe, nutritious and culturally acceptable food;*

(viii) *Consulting to individuals, families, groups and other health professionals on the principles of food and nutrition, and the practical application of those principles;*

(ix) *Conducting basic and applied research in food, nutrition, and food service.*

The dietitian/nutritionist is an autonomous health professional, exercising specialized skills and judgment related to services within the scope of practice. There should not be any requirement for supervision, nor limits and conditions on the performance of services within the scope of practice outlined.

Further, the BCDNA proposes the following exclusive scope of practice for dietitians and nutritionists:

The dietitian/nutritionist is the only health professional whose primary responsibility is the provision of services to promote nutritional health. No other health professional is uniquely qualified to:

i) *Assess nutritional status to determine the need for therapeutic diet modification;*

ii) *Develop therapeutic diets and nutritional care plans;*

iii) *Translate therapeutic diets and nutritional care plans into food service and production standards;*

iv) *Counsel patients with respect to therapeutic diets.*

Such tasks or services should be exclusively performed by, or under the supervision of, the dietitian/nutritionist. This exclusive scope of practice would not preclude a physician licensed under the Medical Practitioner Act from performing services as a physician.

1b) **BCDNA Response to Pacific Society of Nutrition Management (PSNM)**

2 page letter from Darlene Ravensdale, Chair, BCDNA Government Relations Committee, September 26, 1996¹

1c) **BCDNA Response to BC Naturopathic Association (BCNA), BC Home Economics Association (BCHEA), Public Health Association of BC (PHABC), College of Denturists of BC (CDBC), College of Physicians and Surgeons of BC (CPSBC) and Registered Nurses Association of BC (RNABC)**

3 page letter from Darlene Ravensdale, Chair, BCDNA Government Relations Committee, September 27, 1996²

PROFESSIONAL ASSOCIATIONS/SOCIETIES

2. **Pacific Society of Nutrition Management (PSNM)**

5 page letter and one page request to BCDNA for consideration as joint applicant, Susan Malo, NM (CSNM) President, PSNM, June 28, 1996

The PSNM makes the general comment that it is in public interest to designate the practice of dietetics under the *HPA*. It explains that this is due to substantial risk of harm to the ill, very young and aged populations who are at greater risk to foodborne illnesses caused by improper food handling and inadequate or damaging diets that may cause medical complications.

Scope of practice

The PSNM supports the proposed scope of practice and does not believe there should be limits placed on the services of DNs.

With respect to the issue of exclusive scope of practice, the PSNM has the following concerns about overlap with nutritional managers (NMs):

Nutrition managers were created for the purpose of providing a much needed link between nutrition service staff and administration in health care facilities. Nutrition Managers work as food service supervisors, diet technicians, food service managers and/or directors of the nutrition and/or food service departments in acute, extended and long term care facilities.

¹For ease of reference, the BCDNA response to the PSNM follows after the PSNM submission, at page 5.

²For ease of reference, the BCDNA response follows after the respective submission.

Nutrition Managers monitor the flow of food through the kitchen, from procurement to service, ensuring food safety and sanitation standards are met by implementing quality assurance programs and risk management programs such as HACCP and WHIMIS. We monitor tray delivery systems, as well as supervise the staff.

- i. *Counsel patients with respect to therapeutic diets:* The PSNM states that NMs are qualified to counsel patients and do not require direct supervision. It states that other health professions whose primary responsibility is not within the dietetic profession require direct supervision. It further states that it is appropriate that counselling of therapeutic diets be restricted to Dietitians and NMs.

Reserved titles

The PSNM states that the titles "dietitian and nutritionist" and "RD" distinguish themselves from others performing similar services, such as its titles Nutrition Manager, NM(CSNM) or CNM.

With respect to the establishment of college, the PSNM states that it should encompass the full scope of professionals exclusively trained in the field of dietetics. It states that public protection is better served by registering both dietitians and NMs under the same college, then the proposed exclusive scope is appropriate and should be restricted to dietitians and NMs.

Finally, the PSNM states that BC Dietary Technologists Association has voted to merge with PSNM and it anticipates its application for designation be submitted to the Council by the end of 1996.³

Response to the BCDNA June 1997 proposal regarding eight therapeutic diets as reserved acts (#34 in white scope binder)

(1 page letter from Judith Gray, President, January 8, 1998)

The PSNM states that it is entirely appropriate that provision of the proposed reserved acts be restricted to DNs and NMs.

BCDNA comment to the PSNM submission (#1b in white scope binder)

³The PSNM submitted its application for designation under the HPA in October, 1997.

The BCDNA generally comments that it is "*most anxious that our application for College designation be considered separately*". The BCDNA and the PSNM have engaged in preliminary discussions on the merits of a joint college, but the BCDNA has not made a recommendation to its members about this possibility. The BCDNA would welcome an opportunity to meet with the Council and the PSNM to discuss its different perspectives on scopes of practice and future potential of a joint college. The BCDNA represents 800, or almost all dietitians. The PSNM has 160 of a potential 300 members. The BCDNA has had standardized, accredited and internationally recognized education for over 50 years; whereas the PSNM has only recently begun assuring practice standards, through newly established national competency standards and continuing education requirements.

The BCDNA makes the following specific comments on the submission by the PSNM:

- ii. *Assess nutritional status to determine the need for therapeutic diet modification:* "determine" means "*to fix conclusively and authoritatively*" which accurately refers to dietitians practice re: therapeutic diets. The BCDNA does not wish to change the wording of this clause in its original submission. At times nurses and NMs may recommend or even initiate basic standard dietary changes. Dietitians integrate the parameters of physical conditions, medical diagnosis, lab values, patient dietary habits and patient resources to determine an individual's requirement for therapeutic diet modification.
- iii. *Develop therapeutic diets and nutritional care plans:* Dietitians interpret medical and scientific health and nutrition research for diet application, evaluate and translate research into dietary guidelines for healthy persons and treatment of individuals with disease of chronic conditions. NMs follow standards, developed by dietitians and nutritionists (DNs) to write menus and apply a prescribed therapeutic diet in care of patients. The BCDNA does not wish to change the wording of this clause.
- iv. *Translate therapeutic diets and nutritional care plans into food and production standards:* The BCDNA agrees this is an area of overlapping practice and will provide an exclusion clause for NMs.
- v. *Counsel patients with respect to therapeutic diets:* After further consideration, the BCDNA agrees that nurses, NMs and others do basic diet counselling, but it is based on principles and standards that DN's have evolved. DN's train other health professionals in nutrition and diet counselling. The BCDNA would like the phrase "*or delegated by the dietitian*" to read "*under the supervision of or delegated by a dietitian*".

The BCDNA still requests its originally proposed exclusive scope of practice, with the one exception noted in (iii) and (iv), above.

3. Public Health Association of BC (PHABC)

1 page letter from Ann Geddes, President, PHABC, June 29, 1996

Scope of practice

The PHABC supports the following aspects of the proposed scope of practice statement:

- (i) Establishing and reviewing nutrition guidelines, standards and policies and goals for healthy and ill people throughout their lives;
- (iv) Assessing the overall nutritional needs of a community, and planning, coordinating, implementing, and evaluating the nutrition component of prevention and health promotion programs;
- (v) Collecting, interpreting, evaluating and disseminating nutrition information for the public and health professionals;
- (vi) Planning, conducting and evaluating educational programs on nutrition for the public and health professionals;
- (vii) Promoting healthy eating, healthy growth and development related to nutritional health, and access to safe, nutritious and culturally acceptable food;
- (viii) Consulting to individuals, families, groups and other health professionals on the principles of food and nutrition, and the practical application of those principles.

With respect to limitations to scope of practice, the PHABC states that it should be linked with educational preparation. The public needs to know that the therapeutic diet or nutritional information it receives is provided by a dietetic/nutrition professional who has been properly qualified.

Further, the PHABC supports the exclusive scope of practice. It states that infants have suffered harm to their growth by incorrect diet or feeding advice regarding iron intake or fluid intake, and the same is true for adults who have had inadequate nutrient intake resulting from advice from a non-dietitian or non-nutritionist using the title. The PHABC further states that this information has come from experience in public health practice and not from literature. It states that parents comment that the dietitian at the health food store or at a health group or weight loss club gave them the advice. The PHABC believes that the public's attempt to take positive health action is thwarted by unprepared or inadequately prepared individuals assuming the role and using the label of a legitimate professional group.

Reserved titles

The PHABC states that anyone can use the name "nutritionist" so public safety is not adequately assured with the initials "RD".

BCDNA comment on the PHABC submission (#1c in white scope binder)

The BCDNA states that "RD" is the standard for dietitian/nutritionist initials which have been used in the U.S. and now in Ontario and Quebec by the colleges of dietitians. To be consistent with the

rest of Canada, the US and other countries, these are the initials that must be adopted. The Dietitians of Canada is working with the provinces and the USA/Mexico to abide by the provisions of the NAFTA and AIT agreements to standardize credentialling.

4. BC Home Economics Association (BCHEA)

2 page letter from Pat Facer, President, BCHEA, June 27, 1996

Scope of practice

The BCHEA states that home economists have overlapping practice, especially in the following areas:

- establishing and reviewing nutrition guidelines, standards and policies and goals for healthy and ill people through their lives;
- managing and monitoring food service systems;
- assessing the overall nutritional needs of a community, and planning, coordinating implementing, and evaluating the nutrition component of prevention and health promotion programs;
- collecting interpreting, evaluating and disseminating nutrition information for the public and health professionals;
- planning conducting and evaluating educational programs on nutrition for the public and health professionals;
- promoting healthy eating, growth and development and access to safe, nutritious and culturally acceptable food;
- conducting basic and applied research in food, nutrition, and food service.

The BCHEA does not object to items (i) to (iv) dealing with exclusive scope of practice.

BCDNA comment to the BCHEA submission (#1c in white scope binder)

The BCDNA states that the practice areas which the BCHEA has noted as overlapping have not been requested by BCDNA as exclusive areas of practice. The BCDNA supports BCHEA members working in these areas. Home economists share a common academic base with DNs.

5. BC Naturopathic Association (BCNA)

2 page letter from D. Eugene Pontius, President, BCNA, June 20, 1996

The BCNA supports designation of DNs under the *HPA*. As regards exclusive scope of practice, the BCNA finds it inappropriate and unnecessarily restrictive. First, it ignores the scope of naturopathic physicians (NPs) who are primary care providers and able to diagnose. The BCNA also states that nutritional counselling is at the core of naturopathic medicine. The BCNA explains that there is a significant difference between nutrition in the sense of food and diet planning/modification and that of nutrition as a therapeutic tool in the treatment of disease. NPs practice therapeutic nutrition to treat disease.

With respect to the statement that the dietitian is the only health professional whose primary responsibility is the provision of services to promote nutritional health, the BCNA states it is simply untrue. It asserts that any exclusion clause in the dietetics submission should explicitly state that other recognized health professionals, trained in nutrition, will be able to continue to use their skills in a professional environment. Finally, the BCNA states that there should be clarification of the educational preparation for DNs.

Response to the BCDNA June 1997 proposal regarding eight therapeutic diets as reserved acts (#32 in white scope binder)

(2 page letter from Dr. Eugene Pontius, January 6, 1998)

The BCNA's primary concern is that the BCDNA's proposed reserved acts infringe on the scope of practice of naturopathic physicians. Further, the BCNA is shocked that the naturopathic physicians scope of practice review will be heard after the dietetics hearing.

BCDNA comment on the BCNA submission (#1c in white scope binder)

The BCDNA states that the BCNA is misinformed about education and standards of DNs. Dietitians and nutritionists receive identical training and it is the choice of the practitioner which title is used. The BCDNA acknowledges overlapping practice with others, including DNs, however, it states that "*ours is the only profession whose primary responsibility is the provision of services to promote nutritional health*", and justifies the exclusive clause. The BCDNA agrees, as BCNA points out, that "*there is a significant difference between nutrition in the context of food and diet planning and nutrition as a therapeutic tool in the treatment of disease*". The education and training has provided DNs with the most comprehensive expertise and professional knowledge to utilize nutrition as a therapeutic tool and consequently request an exclusive scope in therapeutic nutrition (but not in food services).

REGULATORY BODIES

6. Registered Nurses Association of BC (RNABC)

2 page letter from Pat Cutshall, Executive Director, RNABC, July 10, 1996

The RNABC does not support the proposed exclusive scope of practice, because it does not provide for an exemption for registered nurses (RNs) who provide nutritional and diet counselling to clients in a variety of circumstances. The RNABC explains that the concept of therapeutic diet is used to differentiate the practice of dietitians/nutritionists when describing the proposed restricted

activities, but the submission does not define therapeutic diet. Further, the RNABC states that RNs provide services which involve "therapeutic" use of diet and nutrition, such as RNs who are diabetic educators, lactation consultants as well as RNs working in cardiac care, home care and community health nursing. Therefore, the RNABC requests an exemption from the proposed exclusive scope of practice.

BCDNA comment on the RNABC submission (#1c in white scope binder)

The BCDNA asserts that it is well recognized that registered nurses (RNs) and DNs have overlapping scopes of practice. The BCDNA states that RNs do not have sufficient education on therapeutic diet and consequently, its use in their practice is limited to provision of current written diet guidelines which have been prepared by dietitians. The BCDNA also states that it is also recognized that RNs and other health care professionals, as part of the health care team or in areas where the number of health care providers is limited, may be delegated by dietitians to assist the nutrition care process by providing written diet information. Referral to a dietitian should be made for more detailed counselling where services are available.

7. College of Physicians and Surgeons of BC (CPSBC)

2 page letter from T.F. Handley, M.B., Ch.B., Registrar, CPSBC, July 4, 1996

The CPSBC states it is probably in the public interest for professional dietitians to be designated and regulated. This would enable the public to identify those dietitians whose standards of competence and conduct meet the standards required for registration, i.e. the professions's stamp of approval.

Scope of practice

The CPSBC states that dietitians are not highly trained in recognition of medical disorders. For example, they are not able, based on their training, to interpret the need for an exclusionary diet for allergies to specific metals or foods. Similarly, the CPSBC states that although the dietitian has an expert role in providing nutritional information and ongoing assessment, there are numerous aspects of enteral and parenteral feeding, such as the placement of catheters and lines and the complications thereof, which are outside his or her realm of expertise. The CPSBC does not support the suggestion of independent practice without any limitations or conditions requiring supervision.

With respect to the issue of exclusive scope of practice, the CPSBC states that dietitians are not able to assess nutritional status, as they do not take a full medical history, nor do they do a physical examination. The CPSBC states that they are also not qualified to interpret ancillary tests. The CPSBC further states that it is doubtful, from a practical point of view, whether nutritional assessment and dietary advice outside the setting of accredited institutions could be realistically restricted to registered dietitians.

Reserved titles

The CPSBC states that the title "registered dietitian" is most appropriate. With respect to the proposed title "nutritionist", the CPSBC feels it implies that dietitians are qualified to adequately

assess nutritional status. The CPSBC states it has been informed that they are not qualified to do so, but they are qualified to assess nutritional intake which is different from a clinical assessment of nutritional status.

BCDNA comment on the CPSBC submission (#1c in white scope binder)

The BCDNA explains that dietitians do not diagnose medical conditions, nor do they provide medical therapeutic nutrition intervention except on confirmation of diagnosis and referral from a physician. The BCDNA further states that DNs have a thorough knowledge of medical disorders, and "diet therapy" is an extensive part of the required university course work and of the one year internship. In response to the CPSBC's question on "nutritional assessment", the BCDNA responds that its members are well trained in this area. The BCDNA explains that dietitians do not provide nutritional intervention based on their assessment findings without confirmation from and collaboration with a physician. Finally, the BCDNA states that dietitians and nutritionists have the same training, and that the titles "dietitian" and "nutritionist" are used interchangeably.

8. College of Denturists of BC (CDBC)

2 page letter from John Mayr, R.D., F.D.A.K., Registrar, June 24, 1996

Reserved titles

The CDBC states that the terms "dietitian" and "nutritionist" adequately protect the public and should be protected. It states that "RD" could refer to a registered denturist, although this abbreviation is not protected in the Denturist Regulation. The CDBC states that the protection of abbreviated designations is not required and could be confusing to the public.

BCDNA comment on the CDBC submission (#1c in white scope binder)

The BCDNA states that denturists are also concerned about its request for designation of the initials "RD". The BCDNA understands that although these initials may be a logical abbreviation of Registered Denturist, they are not widely used by denturists nor are they currently designated for denturists.

9. College of Dental Surgeons of BC (CDSBC)

1 page letter from G.R. Thordarson, D.M.K., Registrar/CEO, May 22, 1996

The CDSBC states, in general, that it is important that the practice of dietetics be regulated to provide some control concerning the variety of unscientific advice provided to the public in the area of diet and nutrition.

With respect to the issue of exclusive scope, the CDSBC states that it must not preclude a dentist from analyzing and providing diet advice with regard to the prevention and treatment of dental disease.

OTHER ORGANIZATIONS/INDIVIDUALS

10. BC Nutrition Council

1 page letter from Margaret Beddis, Chairperson, June 27, 1996

The BC Nutrition Council is in full agreement with the submission by the BCDNA.

11. Heart and Stroke Foundation of BC and Yukon (Heart and Stroke Foundation)

1 page letter from Richard Rees, Executive Director, May 9, 1996

Scope of practice

The only concern of the Heart and Stroke Foundation pertains to #1: "*establishing and reviewing nutrition guidelines, standards and policies and goals...*" It unreservedly accepts the leading role of dietitians in developing such standards but believes their adoption involves other key stakeholders. For example, the model for nutrition standards is the Canada Food Guide. The Heart and Stroke Foundation does not like to see the BCDNA empowered through the *HPA* to have responsibility for provincial and community standards without the involvement of government agencies, institutions and health agencies.

As regards the issue of exclusive scope, the Heart and Stroke Foundation believes the proposal to be appropriate, through its understanding of the relationship of diet to health.

EDUCATIONAL PROGRAMS/UNIVERSITIES

12. Vancouver Community College (VCC)

1 page letter from John Cruickshank, President, June 18, 1996

Scope of practice

VCC states it has no problems with the proposed scope of practice.

OTHER PROVINCES

13. Northwest Territories Health and Social Services

1 page letter from David Ramsden, Deputy Minister, June 28, 1996

The territory does not have legislation for the practice of dietetics.

14. Government of Newfoundland and Labrador

2 page letter from Kathy Babstock, Policy, Planning and Research Analyst, May 17, 1996

The practice of dietitians is governed by the *Dietitians Act* which contains no scope of practice statement. It contains the titles "Registered Dietitian" and "R.Dt."

15. Office des professions du Quebec

3 page letter and copy of the Quebec Professional Code from Robert Diamant, President, June 18, 1996

The Office des professions states that dietitians' scope of practice in Quebec is to "*prepare food diets according to the principles of nutrition and see that they are applied*" in section 37(c) of the *Code des professions*.

The Office des professions further states that the following reserved titles are found in the *Code des professions*: "dietitian", "nutritionist" or any abbreviation which may lead to the belief that he is (one) or the initials "P.Dt", "Dt.P." or "R.D."

Response to the BCDNA June 1997 proposal regarding eight therapeutic diets as reserved acts (#30 in white scope binder)

(2 page letter from Robert Diamant, President, December 15, 1997)

The Office des professions makes no comment about the dietitians' application for designation.

16. Alberta Health

(a) 2 page letter from Janet Fulton, Deputy Minister, May 8, 1996

(b) 1 page letter from Donald M. Ford, July 3, 1996

Scope of practice

Alberta Health states that dietitians' scope of practice definition in Alberta is as follows:

practice of dietetics means the translation and application of the scientific knowledge of foods and human nutrition towards the attainment, maintenance and promotion of the health of individuals, groups and the community and includes the following:

(i) *administering food service systems;*

(ii) *assessing nutritional needs of individuals and developing and implementing nutritional care plans based on the assessments;*

(iii) *establishing and reviewing the principles of nutrition and guidelines for healthy and ill people throughout their lives;*

(iv) *assessing the overall nutritional needs of a community in order to establish priorities and influence policies which provide the nutritional component of preventative programs, and implementing and evaluating those programs;*

(v) *interpreting and evaluating, for consumer protection, information on nutrition that is available to the public;*

(vi) consulting with individuals, families and groups on the principles of food and nutrition and the practical application of those principles;

(vii) planning, conducting and evaluating educational programs on nutrition for registered dietitians and other professionals and supporting occupations;

(viii) conducting basic and applied research in food, nutrition and food service systems.

Reserved titles

Alberta Health has no concerns regarding what BCDNA has proposed concerning reserved titles and initials.

Currently, Alberta's dietitians have the following reserved titles: "Registered Dietitian" or the initials "RD" or any title, name, description, letter or symbol, in such a way as to represent expressly or by implication that he is a registered dietitian.

17. Yukon Health and Social Services

1 page letter from Bruce McLennan, Acting Deputy Minister, April 23, 1996

Yukon Health and Social Services states that there are three nutritionists in the territory. It consulted with the nutritionists at Whitehorse General Hospital and they agree with the proposed exclusive scope of practice, the scope of practice statement, and reserved titles.

18. Prince Edward Island, Department of Health and Social Services

1 page letter with enclosed statute from Rob Thomson, April 1, 1996

Prince Edward Island states that in 1994, a new *Dietitians Act* was enacted.

Scope of practice

The scope of practice of dietitians in PEI is as follows:

dietetics means the professional practice of applying scientific knowledge of foods and nutrition to human health and, in particular,

(i) assessing the nutritional status and requirements of individuals or groups of individuals,

(ii) designing general standards and determining care plans appropriate to meet nutritional requirements,

(iii) designing, evaluating and communicating to the public, information on nutrition matters for the purposes of health education and consumer protection,

(iv) *directing nutritional therapy,*

(v) *ensuring the nutritional quality and safety of food service in a health-care institution or program.*

Reserved titles

The following are the reserved titles for PEI dietitians: "dietitian", "RD", "P.Dt.", "dietetiste professionnelle" or other similar designation implying that the person is a registered dietitian.

ADDITIONAL SUBMISSIONS

19. Ministry of Education, Skills and Training (MOEST)

1 page letter from Moe Sihota, Minister, November 1, 1996

The MOEST states there are better qualified bodies to make a comment on the BCDNA application for designation under the *HPA*.

20. Jenny Craig, Personal Weight Management

1 page letter from Doris Barnhart, Corporate Dietitian, June 18, 1996

Jenny Craig declines to make a comment.

21. Board of Registration for Social Workers of the Province of BC

1 page letter from Ben Van Den Assem, Registrar, September 10, 1996

Scope of practice

The Board has no concerns or objections to the scope of practice proposed by the BCDNA.

22. Ontario Ministry of Health, Professional Relations Branch

5 page letter from Alan R. Burrows, Director, July 12, 1996

The Ministry states that dietitians are regulated under the *Regulated Health Professions Act*, 1991 (RHPA) and the *Dietetics Act*, 1991 which were proclaimed in December 1993.

Scope of practice

The Ministry recounts that the independent Health Professions Legislation Review (HPLR) concluded that because of the size of the profession and services provided, there was a public interest in ensuring an accountable complaints and discipline process was in place for the profession of dietetics.

The Ministry states that the proposed scope of practice is appropriate. Dietitians in Ontario have the following scope statement:

...the assessment of nutrition and nutritional conditions and the treatment and prevention of nutritional related disorders by nutritional means."

With respect to the proposed exclusive scope of practice, the Ministry states that the BCDNA proposed an exclusive scope for the following tasks:

- 1) Assess nutritional status to determine the need for therapeutic diet modification;
- 2) Develop therapeutic diets and nutritional care plans;
- 3) Translate therapeutic diets and nutritional care plans into food services and production standards; and
- 4) Counsel patients with respect to therapeutic diets.

In Ontario, dietitians do not have an exclusive scope of practice, and as such, the above-mentioned tasks are in the public domain. The Ministry states that if a person needs to have a nutritional assessment, a therapeutic diet or nutrition counselling, a physician may refer the person to a registered dietitian. However, this person also has the option of seeing other regulated health practitioners, such as a public health nurse, a psychologist (eating disorders) or a naturopath. Alternatively, the person has the option of seeing an unregulated practitioner such as a community college-trained nutrition counsellor.

The Ministry states that the BCDNA has requested that dietitians and nutritionists be regulated in BC. The Ministry explains that nutrition consultants are not regulated in Ontario because this profession is not one in which all those entering practice must first obtain a diploma or degree. The HPLR also felt that the number of practitioners in the field, the lack of support by nutritional consultants for regulation, and the risk of harm to individual patients was insufficient to support a regulatory college. With respect to "counselling", this was not made a controlled act due to definitional and enforcement problems. Virtually all professions, regulated and otherwise, "counsel" to some degree.

Early in the review process, food service supervisors also asked to be regulated. The HPLR believed that the practice of this profession did not pose a substantial risk of harm to the public on the basis that risk is effectively monitored by supervisors in publicly-regulated institutions, often by supervisors who are themselves regulated health professionals accountable for the activities they supervise.

One of the public protection features of the *RHPA* is that it is an offense if unregulated practitioners, or regulated practitioners who exceed their scope of practice, cause serious physical harm to their patients.

Reserved titles

The Ministry states that it is unclear if education and training of DNs in BC is equivalent or whether the professional association has asked to reserve both "dietitian" and "nutritionist". The

Ontario Dietetic Association recognized that job titles include the term dietitian and/or nutritionist; however, it only requested the protection of the title "registered dietitian" or "RD". The Ministry suggests the title "nutritionist" be included if education and training was equivalent in BC.

23. New Brunswick Department of Health and Community Services

2 page letter from Janet Cameron, Consultant, July 9, 1996

New Brunswick states that dietitians have been regulated since 1988.

Scope of practice

The scope of practice in New Brunswick is as follows:

dietitian means a professional who specializes in relating the art and science of food and nutrition to health and individual lifestyles for the purpose of enhancing the quality of life;

"Practice of dietetics" means the translation and application of the scientific knowledge of foods and human nutrition towards the attainment, maintenance and promotion of the health of individuals, groups and the community and includes the following:

(a) administering food service systems though this function is not exclusive to dietitians;

(b) assessing nutritional needs of individuals and developing and implementing nutritional care plans based on the assessments;

(c) establishing and reviewing the principles of nutrition and guidelines for healthy and ill people throughout their lives;

(d) assessing the overall nutritional needs of a community in order to establish priorities and to influence policies which provide the nutritional component of preventative programs, and implementing and evaluating those programs;

(e) interpreting and evaluating, for consumer protection, information on nutrition that is available to the public;

(f) consulting with individuals, families and groups on the principles of food and nutrition and the practical application of those principles;

(g) planning, conducting and evaluating educational programs on nutrition;

(h) conducting basic and applied research in food, nutrition and food service systems though this function is not exclusive to dietitians.

New Brunswick states that the scope proposed in BC is appropriate, although certain functions should not be exclusive, such as (c) and (h) above, if the remainder of the scope is limited to dietitians.

New Brunswick further states that DNs exercise a very special field of expertise that no other health professional or individual is qualified to do. However, there may be insufficient numbers of DNs to provide the required service. New Brunswick suggests that it is appropriate to include the following in the scope statement, "*such tasks and services should be exclusively performed by, or under the supervision of the dietitian/nutritionist*".

Finally, New Brunswick notes that physicians are not precluded from performing tasks and services outlined on page 3. There may be other regulated health professions in the same position.

Reserved titles

New Brunswick states that the title "nutritionist" by itself is not protected. Since the Act was passed, the Dietitians Association has directed members to use the title "Dietitian, R.D.". The Act protects: "Dietitian" and "Dietitian-Nutritionist" and the abbreviations R.D.(P.Dt.) or RDN.

Response to the BCDNA June 1997 proposal regarding eight therapeutic diets as reserved acts (#41 in white scope binder)

(2 page letter from Marilyn Born, February 6, 1998)

New Brunswick Health and Community Services agrees that the proposed reserved acts carry a sufficient risk of harm if inappropriately administered. It also states that the eight proposed reserved acts were accurately and objectively presented. New Brunswick Health and Community Services believes that the importance of balanced nutrition in an institutional setting and the need for a nutritionist's services are often overlooked by the primary care provider.

24. Dial-A-Dietitian Nutrition Information Society of BC (Dial-A-Dietitian)

9 page letter from Kathleen Quinn, R.D., Executive Director, June 30, 1996

Dial-A-Dietitian states that it supports designation of the profession of dietetics under the *HPA*.

Scope of practice

Dial-A-Dietitian finds the proposed scope of practice appropriate. As to the issue of limitation to scope, Dial-A-Dietitian states that standard diets and nutrition guidelines to be widely used for a specific medical conditions should be developed by dietitians practicing in that area and should be reviewed by physicians or multidisciplinary committees with expertise in the same area. Dial-A-Dietitian further states that DNs should not diagnose medical conditions and should refer

clients in need of diagnosis to a physician. Finally, Dial-A-Dietitian states that professional dietitians and referring physicians should make every effort to consult each other in order to coordinate nutrition management.

With respect to the proposed exclusive scope of practice, Dial-A-Dietitian states that there is sufficient risk of harm to support these restrictions. Dial-A-Dietitian cites examples such as diets for patients with acute and chronic renal failure, diabetes during pregnancy, therapeutic diets for children with severe allergies, diabetes, renal disease, cancer, HIV, inborn errors of metabolism such as phenylketonuria, cystic fibrosis, or multiple nutrition related disorders, Crohn's disease, colitis.

Dial-A-Dietitian cites several examples from the Dial-a-Dietitian Hotline where a caller had serious problems resulting from inadequate nutritional advice from MDs and NDs among others, citing supportive journal articles.

Reserved titles

Dial-A-Dietitian proposes the following reserved titles for DNs: "Dietitian and Nutritionist, RD" or "Dietitian, RD".

Response to the BCDNA June 1997 proposal regarding eight therapeutic diets as reserved acts (#35 in white scope binder)

(6 page letter from Kathleen Quinn, Executive Director, January 9, 1998)

Dial-A-Dietitian states that the BCDNA's proposed reserved acts are appropriate. It also states that the proposed list of reserved acts should be expanded to include the following:

- *pancreatic disease and liver disease,*
- *a person with **any** of the above conditions **requiring nutrition counselling for any additional condition**,*
- *all children, youth and pregnant women requiring **any** nutrition counselling, especially in the area of clinical/therapeutic diets,*
- *all persons in facilities under the jurisdiction of the BC Ministry of Health and the BC Ministry of Children, Youth and Families requiring any nutrition counselling.*

Dial-A-Dietitian elaborates on some of the BCDNA's proposed reserved acts. It also states that professional DNs are qualified nutrition professionals that doctors, nurses and pharmacists turn to when nutrition counselling of clients is needed. DNs are the only nutrition professionals trusted with nutrition counselling in hospitals, continuing care facilities and health units. Dial-A-Dietitian further explains DNs' education, standards of practice and their well-developed code of ethics.

25. BC Society of Occupational Therapists (BCSOT)

1 page letter from Heather Burgess, President, July 3, 1996

The BCSOT supports designation of DNs under the *HPA*.

Scope of practice

The BCSOT finds the proposed scope statement appropriate with no limits. As regards the proposed exclusive scope of practice, the BCSOT finds it reasonable.

Reserved titles

The BCSOT finds the proposed titles satisfactory.

26. Canadian Society of Nutrition Management (CSNM)

1 page letter from Janet Milner, Executive Director, July 2, 1996

The CSNM makes a general support for the Pacific Society of Nutrition Management (PSNM) request to be included in this college for DNs, if designated. The CSNM is the national organization of which PSNM is the local chapter.

27. Traditional Chinese Medicine Association of BC (TCMABC)

2 page letter from James Knights, President, June 18, 1996

Scope of practice

The TCMABC states that it has no particular concerns to raise about the proposed scope of practice except that the performance of DNs should be based on a Western-scientific understanding of diet and nutrition.

With respect to the proposed exclusive scope of practice, the TCMABC states that only traditional Chinese medicine (TCM) practitioners are uniquely qualified to determine the need for therapeutic diet modification, development of therapeutic diets, and to counsel patients with respect to therapeutic diets as a result of the application of the theory, practice, and clinical experience of TCM. In short, the TCMABC states that its practitioners should not be precluded from performing such services by the exclusive scope of practice for DNs.

THE FOLLOWING RESPONSES WERE MADE TO THE BCDNA JUNE 1997 PROPOSAL REGARDING EIGHT THERAPEUTIC DIETS AS RESERVED ACTS

28. College of Pharmacists of British Columbia (CPBC)

1 page letter from Linda J. Lytle, Registrar, November 27, 1997

The CPBC's only concern is with regard to "*the administration of specific therapeutic diets for drug: diet interactions*". It states that pharmacists routinely provide patients with warnings and advice about these matters in the course of providing information to individuals about their medications. The CPBC states that as long as pharmacists are able to continue providing this service there would be no objection to the BCDNA's proposal.

29. Gaia Garden Herbal Dispensary (Gaia Garden)

1 page letter from Chanchal Cabrera, December 9, 1997

Gaia Garden's concern is with the proposed restriction on food allergies and diabetes. Gaia Garden states that the two conditions are amenable to self-treatment. To consider restricting the activity is ridiculous and impossible. Gaia Garden believes that thousands of patients would suffer if the practice of natural medicine was banned or "owned" by the BCDNA because the provincial health care system cannot supply sufficient dietitians for the demand and need. Gaia Garden also states that many patients may not wish to consult with a dietitian in a hospital setting and may seek alternative approaches.

30. Office des professions du Québec

2 page letter from Robert Diamant, President, December 15, 1997⁴

31. Citizens for Choice in Health Care

(a) 1 page letter from Croft Woodruff, President, January 5, 1998

Mr. Woodruff indicates he wishes to make a presentation before the scheduled hearing on the application for designation by the BCDNA under the *HPA*.

(b) 7 page submission from Croft Woodruff, February 8, 1998 (**#40 in white scope binder**)

⁴ See submission #15, at page 13.

Citizens for Choice in Health Care states that nutrition is an evolving science and as such, it is very dangerous to allow one nutrition profession to become the sole arbiter of what is right or wrong in nutritional information or practice. It adds that broadening the scope of exclusivity of the BCDNA opens the door to potential abuse. It also states that the BCDNA did not prove that DNs are qualified to intrude in the areas of disease management.

- (c) 9 page submission from Croft Woodruff, President, February 12, 1996⁵ (**#44 in white scope binder**)

32. British Columbia Naturopathic Association (BCNA)

2 page letter from Dr. Eugene Pontius, January 6, 1998⁶

33. Nutritional Consultants Organization of Canada, BC Chapter (NCOC)

6 page letter from Jean Pearce, January 2, 1998

The NCOC has serious objections about granting any reserved acts to the BCDNA. It states that the BCDNA is seeking a monopoly of services. The NCOC also states that its practitioners, the registered nutritional consultants (RNCs), are the ones that compete most directly with the services of dietitians. It also states that the BCDNA's hidden agenda is to obtain monopoly practice of dietetics.

In particular, the NCOC disagrees with the following BCDNA's statements and finds them self-serving and untrue:

- (a) that BCDNA members are the "experts" in nutrition;
- (b) that BCDNA members are uniquely qualified to integrate and apply the principles of food, nutrition and health to promote the nutritional well-being of the public;
- (c) that BCDNA members are the only health professionals "*whose primary responsibility is the provision of services to promote nutritional health*"; and
- (d) that BCDNA members "*have the unique expertise to provide guidance on the safe management of diet for allergies.*"

With respect to (d), the NCOC states that a number of health care professions are more qualified than dietitians, such as physicians and surgeons, naturopaths, and RNCs.

With respect to the issue of risk of harm to the public, the NCOC states that the BCDNA did not provide sufficient evidence of potential harm to warrant the need for exclusive rights to practise. The NCOC further states that administering a therapeutic diet is different from designing the diet.

⁵This is identical to submission #40, above, with additional 10 anecdotal paragraphs.

⁶See submission #5, at page 9.

Any risk to the patient from following the diet is the responsibility of the doctor who diagnosed the patient and prescribed the diet.

In particular, the NCOC has the following comments for each proposed reserved act:

1. With respect to food allergies, the NCOC claims that the BCDNA's own statements bring into question the competence of its members to administer therapeutic diets for food allergies.
2. As regards drug-diet interactions, the NCOC claims that dietitians have no formal training in pharmacology and must therefore follow the lead of the experts in the field, the pharmacists.
3. As to ketogenic diets, the NCOC states that the BCDNA did not provide evidence for its claim that ketogenic diets can cause death.
4. With respect to inborn errors of metabolism, the NCOC states that dietitians are not the only experts in administering therapeutic diets for inborn errors of metabolism.
5. As regards the issue of enteral and parenteral nutrition, the NCOC states that dietitians have neither the expertise nor the authority to insert feeding tubes into intestines or catheters into veins, or to diagnose which patients require such invasive forms of feeding. The dietitians are simply following physicians' instructions.
6. As regards renal disease, the NCOC states that it is the physicians who diagnose the disease and therefore put these patients at risk.
7. Regarding dysphagia, the NCOC states that restricting this act to dietitians would jeopardize the health and lives of many of these unfortunate people by preventing others from helping them.
8. Finally, with regard to diabetes mellitus/gestational diabetes, the NCOC states that dietitians are not the only health care professionals trained in administering therapeutic diets for diabetics.

Reserved titles

The NCOC also disagrees with the BCDNA that dietetics and nutrition are one and the same. Therefore, the NCOC objects to grant any title to the BCDNA that includes the words "nutrition" or "nutritionist". The NCOC suggests the following reserved titles: "registered dietitian" or "dietitian, RD".

6 page submission from Patricia Raymond, Executive Director, Nutritional Consultants Organization of Canada, January 6, 1998⁷ (**#37 in white scope binder**)

⁷This is identical to submission # 33, above.

34. **The Pacific Society of Nutrition Management (PSNM)**
1 page letter from Judith Gray, President, January 8, 1998⁸
35. **Dial-A-Dietitian Nutrition Information Society of BC (Dial-A-Dietitian)**
6 page letter from Kathleen Quinn, Executive Director, January 9, 1998⁹
36. **Citizens Voice for Health Rights**
9 page submission from Debbie Anderson, Co-ordinator, January 9, 1998

Citizens Voice for Health Rights believes that giving special rights to the DNs, to the exclusion of other practitioners, is contrary to fundamental right of every person to make objective informed choices. Citizens Voice for Health Rights finds the statement, that foods and nutrients have pharmacological effects, meaningless because all foods have pharmacological effects. Citizens Voice for Health Rights wonders whether "pharmacological" means "harmful". Also, Citizens Voice for Health Rights wonders when and where DNs have to act autonomously when all they do is administer therapeutic diet in an institutional setting following a physician's instructions.

With respect to each proposed reserved act, Citizens Voice for Health Rights makes the following comments:

1. Allergy - food or nutrient: Citizens Voice for Health Rights disagrees that DNs are the only ones qualified to deal with diets for persons with allergies.
2. Drug-diet interactions: Citizens Voice for Health Rights states that therapeutic diet involving drug-nutrient reaction are discussed with pharmacists who have the pharmacological training.
3. Ketogenic diets: Citizens Voice for Health Rights states that it is the individual's choice to follow a ketogenic diet. The individual therefore bears the responsibility, not the DNs.

⁸ See submission #2, at page 3.

⁹ See submission #24, at page 19.

4. Inborn errors of metabolism: Citizens Voice for Health Rights states that it is the physician who diagnoses inborn errors of metabolism. In many instances, it is the parent who administers the diet once the child is discharged from the hospital. Citizens Voice for Health Rights states that it is counter-productive to state that only DNs can supervise such diets.
5. Enteral and parenteral nutrition: Citizens Voice for Health Rights states that DNs neither have the training nor the authority to insert feeding tubes. It is the doctor who writes the prescription for the diet and who may put the patient at risk for harm, not the dietitian.
6. Renal disease: Citizens Voice for Health Rights states that here too, the physician diagnoses the disease and writes the dietary instructions. Thus, it is the doctor who is responsible for any harm caused the patient.
7. Dysphagia: Citizens Voice for Health Rights states that this is an area where team effort is vital.
8. Diabetes Mellitus/gestational diabetes: Citizens Voice for Health Rights again states that the dietitian follows the doctor's instructions to work with the patient in adjusting to the diet.

Citizens Voice for Health Rights concludes that BCDNA did not provide scientific data or any logical rationale for the inclusion of the eight therapeutic diets to be reserved acts. It suggests to the Council to look at Ontario where dietitians were not granted any reserved act.

37. **Nutritional Consultants Organization of Canada (NCOC)**
6 page submission from Patricia Raymond, Executive Director, January 6, 1998¹⁰
38. **Ministry of Health - Ontario**
1 page letter from Alan Burrows, Director, January 13, 1998¹¹
39. **Health Professions Regulatory Advisory Council (HPRAC)**
1 page letter from Gary Lentz, Acting Executive Co-ordinator, January 20, 1998

The HPRAC repeats the information provided by the Ontario Minister of Health, submission #22, at page 16.

¹⁰This is identical to submission # 33, at page 23.

¹¹This is identical to submission # 22, at page 16.

40. **Citizens for Choice in Health Care**
7 page submission from Croft Woodruff, February 8, 1998¹²
41. **New Brunswick Health and Community Services**
2 page letter from Marilyn Born, February 6, 1998¹³
42. **The College of Dental Hygienists of British Columbia (CDHBC)**
3 page letter from Nancy Harwood, Registrar, February 11, 1998

The CDHBC states that the proposed eight reserved acts must first be examined whether or not they pose a significant risk of harm to the public. It then states that the following reserved acts pose a significant risk of harm:

- diets related to food allergies;
- drug/diet interactions;
- inborn errors of metabolism;
- dysphagia; and
- diabetes

The CDHBC feels it is not qualified to determine whether or not the following proposed reserved acts pose significant harm:

- ketogenic diets;
- enteral/parenteral nutrition; and
- renal disease.

The CDHBC states that DNs are well qualified to perform the proposed reserved acts.

Reserved titles

The CDHBC states that the existing titles "dietitian" and "nutritionist" should be reserved.

43. **Dial-A-Dietitian Nutrition Information Society of BC (Dial-A-Dietitian)**
3 page letter from Kathleen Quinn, Executive Director, February 11, 1998¹⁴

¹² See submission #31, at page 22.

¹³ See submission #23, at page 18.

¹⁴ This submission is the statement of the Dial-A-Dietitian Nutrition Information Society of BC for the BCDNA hearing on February 12, 1998.

44. Citizens for Choice in Health Care

9 page submission from Croft Woodruff, President, February 12, 1996¹⁵

45. Anne Kraskin Registered Nutrition Consultant

1 page letter, February 22, 1998

Ms. Kraskin strongly objects to the BCDNA's application for certain reserved acts. She states that no one body should have exclusivity over practising nutritional counselling and therapy. She urges the Council to dismiss the BCDNA application.

¹⁵This is identical to submission #40 (with additional 10 anecdotal paragraphs), which is appended to submission #31, at page 22.

**JUNE 1997 SUBMISSION BY
THE BC DIETITIANS' AND NUTRITIONISTS' ASSOCIATION**

(For a copy of the submission, please contact the Council's office, at 604-775-3582.)

**LIST OF PARTICIPANTS AT PUBLIC HEARING
February 12, 1998**

**Participants at the public hearing with respect to
the designation of dietitians and nutritionists**

Dr. Thomas F. Handley and Dr. C.L. Birmingham
College of Physicians and Surgeons of BC

Glenn Cassie
Executive Director, British Columbia Naturopathic Association

Croft Woodruff
President, Citizens for Choice in Health Care

Jean Pearce
Nutritional Consultants Organization of Canada

Kathleen Quinn
Executive Director, Dial-A-Dietitian Nutrition Information Society of BC

Sandy Simpson
Citizens Voice for Health Rights

Judith Gray
President, The Pacific Society of Nutrition Management

ARTICLES REGARDING PARENTERAL AND ENTERAL NUTRITION

1. Axel G. Feller, MD, Daniel Rudman, MD, Peter R. Erve, PhD, Robert C. Johnson, PhD, Jane Boswell, RD, Daniel L. Jackson, RN, and Dale E. Mattson, PhD, "Subnormal concentrations of serum selenium and plasma carnitine in chronically tube-fed patients," *American Journal of Clinical Nutrition* 1987;45:476-83.
2. Carol L. Kohn, MS, RN, and Joyce K. Keithley, DNSc.,RN, "Enteral Nutrition, Potential Complications and Patient Monitoring," *Nursing Clinics of North America*, vol.24, no.2, June 1989:339-353.
3. Anita L. Gallagher, MS, RD; Regina M. Onda, PhD, RD, "Using quality assurance procedures to improve compliance with standards of nutrition care for patients receiving isotonic tube feeding," *Journal of the American Dietetic Association*, vol.93, no.6, June 1993:678-679.
4. John E. Morley, MD, Andrew J. Silver, MD, Maria Fiatarone, MD, and Arshag D. Mooradian, MD, "Geriatric Grand Rounds: Nutrition and the Elderly," *Journal of the American Geriatric Society*, vol.34, no.11, November 1986:823-832.
5. Scott M. Solomon, MD and Donald F. Kirby, MD,FACP, "The Refeeding Syndrome: A Review," *Journal of Parenteral and Enteral Nutrition*, vol.14, no.1, 1990:90-97.
6. Elizabeth E. Gleghorn, MD, Lawrence D. Eisenberg, MD, Shirley Hack, RD, Patricia Parton, MD, and Russell J. Merritt MD, PhD, "Observations of vitamin A toxicity in three patients with renal failure receiving parenteral alimentation" *American Journal of Clinical Nutrition* 1986; 44: 107-112.
7. G. Alves, MD, J. Thiebot, PhD, A. Tracqui, PhD, T. Delangre, MD, C. Guedon, MD, and E. Lerebours, MD, "Neurologic disorders due to brain manganese deposition in a jaundiced patient receiving long-term parenteral nutrition," *Journal of Parenteral and Enteral Nutrition*, vol.21, no.1:41-45.
8. Charles Mueller, MS, RD, and Eva P. Shronts, MMSc, RD (contributing authors), "Position of the American Dietetic Association: The role of registered dietitians in enteral and parenteral nutrition support," *Journal of the American Dietetic Association*, vol. 97, no. 3, March 1997:302-304.
9. M.V. Kaminski, Jr., E.G. Lowrie, S.G. Rosenblatt, and T. Haase, "Malnutrition is Lethal, Diagnosable, and Treatable in ESRD Patients," *Transplantation Proceedings*, vol. 23, April 1991: 1810-1815.

(For a copy of the articles listed in this appendix, please contact the Council's office, at 604-775-3582.)