



PRACTICE ADVICE

COMMUNICATING CLINICAL INFORMATION OR A DIAGNOSIS: DO YOU KNOW THE DIFFERENCE?

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The purpose of this article is to provide clarity about the clinical information that CASLPO members **can** communicate to patients and substitute decision makers (SDM) when providing health care services contrasted with information that is involved when communicating a diagnosis.

A diagnosis is the identification of an underlying disease or disorder that causes the speech, language, audiology and swallowing symptoms or disorders.

According to the [Regulated Health Professions Act](#) (RHPA), communicating a diagnosis is a controlled act that speech-language pathologists (SLPs) and audiologists are not allowed to perform. Communicating a diagnosis is described as:

"Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis." (RHPA 27 (2) 1.)

CONTROLLED ACT: KEY COMPONENTS	IMPACT ON MEMBERS
1. Members are prohibited from <i>Communicating to the individual or their personal representative a diagnosis</i>	Members have the knowledge, skills and judgement to assess the patient and make an SLP/AUD diagnosis within their scope and area of practice. However, members, by law, cannot communicate the diagnosis (underlying cause) to the patient or their personal representative (SDM).
2. The diagnosis you are communicating <i>"identifies a disease or disorder as the cause of symptoms"</i>	Members cannot communicate the disease or disorder that causes the speech, language, audiology and swallowing symptoms or disorders. For example, members cannot tell patients that they have the following: stroke, autism, otosclerosis, cerebral palsy, ALS, Meniere's Disease, Parkinson's disease, genetic syndromes etc. Members can communicate their clinical findings, including speech language pathology and audiology symptoms and dysfunctions if they are not the cause of symptoms.
3. <i>"It is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis."</i>	If another authorized health professional has communicated the diagnosis, members can refer to the provided diagnosis in discussions with the patient and/or SDM. Patients often ask SLP and audiologists for more information about the disease or disorder. Providing this information, when the disease or disorder has already been communicated by the diagnosing professional, does not, in the College's opinion, fall within the controlled act of communicating a diagnosis, so this is permitted.

WHAT INFORMATION CAN BE SHARED WITH PATIENTS AND/OR SDMS?

PRINCIPLES

Speech language pathologists and audiologists have a professional obligation to communicate their assessment results and clinical findings to their patients and/or SDMs ([Code of Ethics Principle 1](#)). However, in communicating assessment results and clinical findings, members must not communicate the underlying cause (diagnosis).

CONSENT

SLPs and audiologists must provide patients/SDMs with sufficient information to obtain informed consent for assessment and treatment. Informed consent for treatment requires an SLP or audiologist to communicate the nature of the proposed service, the risks and benefits of the proposed plan and alternatives before commencing treatment. ([SAT Professional Standards, Consent Guide](#) and [Health Care Consent Act](#)). The nature of the proposed service is based on the assessment results which are shared with the patient and/or SDM.

COMMUNICATING ASSESSMENT RESULTS

When communicating assessment results, members may use terms which describe [symptoms](#) and [dysfunctions](#) within their scope of practice. They may also use qualifiers such as mild, moderate, severe or profound.

Some of these terms may include the word "disorder". Members must make sure the word disorder is being used to describe [symptoms](#); for example, "swallowing disorder" or "vestibular disorder". Here the word "disorder" describes symptoms but does not identify the cause of the symptoms.

Examples of terms that describe symptoms include, but are not limited to:

- Speech, motor speech, articulation delay and disorder
- Language delay and disorder
- Sensorineural, conductive or mixed hearing loss
- Fluid in the ear
- Aphasias, dysarthrias, apraxias, including childhood apraxia of speech
- Cognitive communication disorder
- Stuttering, hoarseness, hypo/hyper-nasality
- Tinnitus, vestibular disorders
- Auditory processing disorder
- Dysphagia or swallowing disorder
- Velopharyngeal insufficiency
- Auditory Neuropathy Spectrum Disorder

When using these terms, members should follow a patient-centred approach and discuss the symptoms and dysfunctions that contribute to the disorder. Members should explain that the disorder or dysfunction is not the underlying cause, that the cause could be multifactorial or unknown. When the patient or SDM want more information regarding the underlying cause (diagnosis), they should consult a physician or other professional who is authorized to communicate the diagnosis.

WHAT INFORMATION **CANNOT** BE SHARED WITH PATIENTS AND/OR SDMS?

When sharing clinical information and assessment results with patients and/or SDMs, members should avoid using the words “diagnose”, “diagnosing” or “diagnosis”. These words could lead the patient or SDM to rely on your information as the underlying cause, which is prohibited.

When members are the first health professional to identify a potential underlying cause (the diagnosis has NOT been communicated by an authorized health professional), members must not communicate terms that include an underlying cause or are outside the member’s scope of practice.

Examples include, but are not limited to:

- Vocal nodules/polyps etc.
- Gastro esophageal reflux disease
- Noise induced hearing loss
- Meniere’s disease
- Autism spectrum disorder
- Attention-deficit/hyperactivity disorder
- Acoustic neuroma
- Benign Paroxysmal Positional Vertigo (BPPV)
- Depression or Anxiety disorder
- Aspiration pneumonia
- Concussion or Traumatic Brain Injury (TBI)
- Zenker’s diverticulum
- Esophageal dysmotility

INTERPROFESSIONAL COLLABORATION

Members are encouraged to work collaboratively with other professionals to improve patient health outcomes through communication, enhanced decision making and mitigation of risk. You can discuss your clinical findings, including possible underlying causes with other professionals. This does not constitute communicating a diagnosis to a patient or SDM. The conversations you have with fellow professionals are different from the conversations you have with patients and SDMs. Use your professional judgement regarding patient risk of harm and urgency of referral.

REFERRALS

SLPs and audiologists during their assessment, may be alerted to signs or symptoms which are indicative of a disease or disorder. Often SLPs and Audiologists are uniquely qualified to assess signs or symptoms and to provide data that is essential for a health professional with authority to communicate a diagnosis to arrive at a definitive diagnosis. In this case, it is the member’s responsibility to make the patient aware of the significance of the signs or symptoms and to suggest a referral to an appropriate diagnosing professional for a definitive diagnosis.

There are many programs in all areas of healthcare that include a diagnostic label. Because you are recommending to the patient or SDM that a referral be made to such a program, you are not

communicating a diagnosis. This communication should occur in a manner that will not result in the patient or SDM relying upon the information as a diagnosis.

When members are communicating assessment information, they must ask themselves the following:

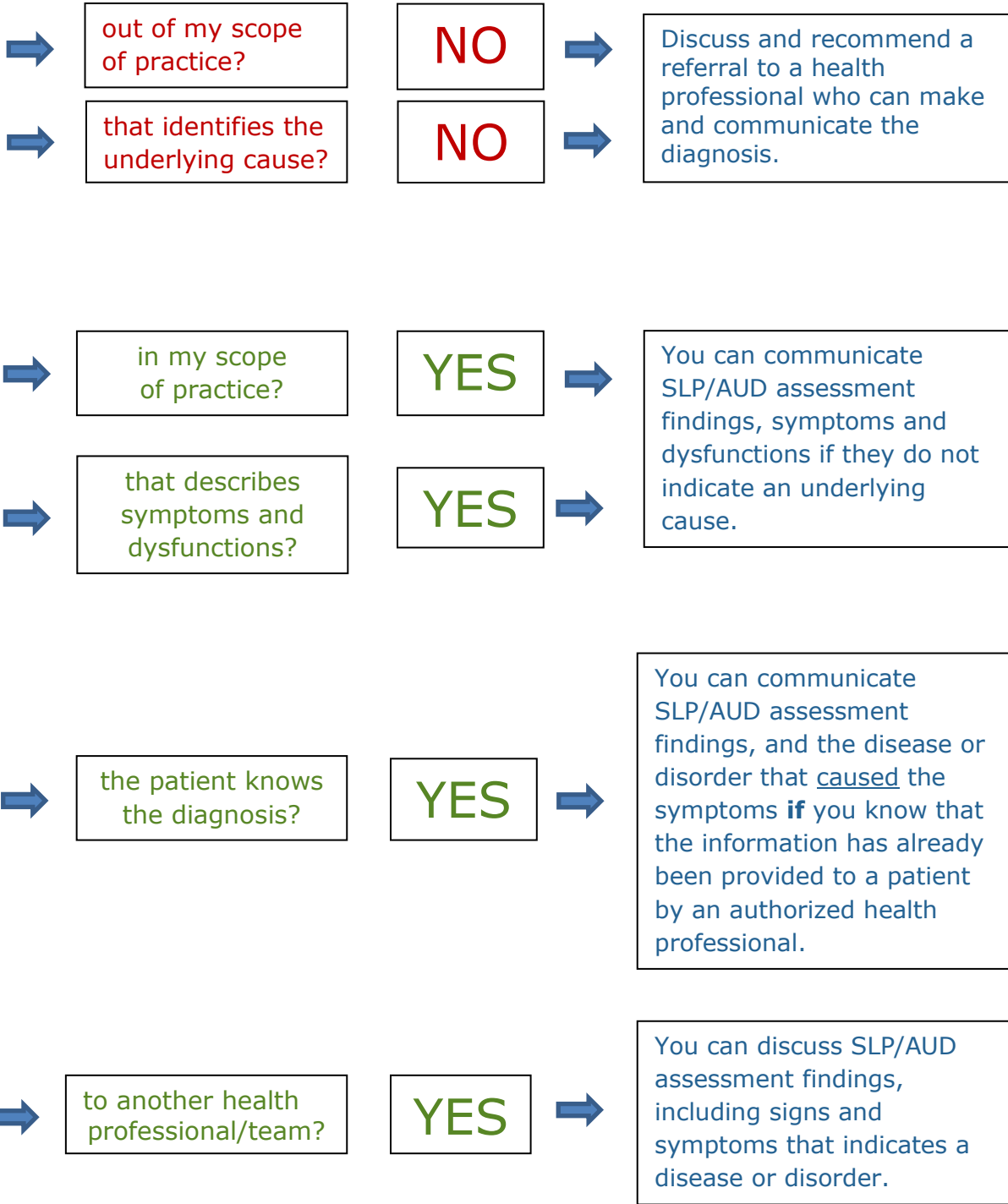
1. Does the patient and/or SDM already know the causal diagnosis?
2. Is the clinical information I want to communicate:
 - a. in my scope of practice?
 - b. describing symptoms and dysfunctions?
 - c. identifying the underlying cause of the symptoms (diagnosis)?

EXAMPLES OF LANGUAGE TO USE WITH PATIENTS AND SDMS

These examples refer to situations where diagnostic information has NOT been provided by an authorized health professional.

- The results of the aphasia assessment indicate that you have the symptoms of non-fluent aphasia, let me explain what this means . . .
- The audiogram and other tests show you have a moderate conductive hearing loss in both ears, the next steps are . . .
- The assessment results and my classroom observations suggest that your child has a language disorder. This means . . .
- I have assessed your son and observed him both in the classroom and during school recess with his friends. The results show that he presents with moderate to mild stuttering. We can explore treatment options which might include. . .
- As you know, your wife coughs when drinking liquids. The results of the video fluoroscopic swallowing study show that she has a swallowing disorder. The liquids entered her throat too quickly and the muscles that protect her airway are slow, so traces of liquid went into her airway and lungs. My recommendations are . . .
- From the background information you gave as well as my assessment, you have symptoms consistent with a balance disorder, also known as a vestibular disorder.
- Based on the assessment results, I am concerned about some of the atypical communication social and non-verbal behaviours and I would encourage you to have them investigated by a physician or a psychologist. They will be able to look at broader developmental skills that are beyond speech and language. There could be several reasons for these behaviours, so I recommend that you discuss this with your child's physician.
- The results of the hearing assessment combined with your background information show a sensorineural hearing loss. There are many causes for this type of hearing loss. If you want to know more about the underlying cause, you need to consult a physician.

Can I communicate clinical information



FREQUENTLY ASKED QUESTIONS

SLP SERVICES TO CHILDREN

1 Q: What if the team member that you communicate with documents your information in the patient record that includes a possible diagnosis?

1 A: Educate the team on who can and cannot communicate a diagnosis. There are other professionals who may not have access to the controlled act. Ensure your team members document your clinical findings without including a diagnosis.

2 Q: I am an SLP working in a school board. I have assessed a grade one student and the results indicate a severe language disorder. His language disorder is a barrier to him accessing the curriculum and I want to initiate a referral to Special Equipment funding, so he can use a dedicated iPad in the classroom. I have discussed my assessment results and recommendations with the student's parents and told them they will receive a copy of the report. I am worried that the report is communicating a diagnosis because I have written "severe language disorder", but if I don't, he might not get the special equipment funding.

2 A: Because the term "severe language disorder" is a specific label for a description of symptoms, and does not suggest a cause, you can inform the parents of your assessment results, which indicate a severe language disorder. You can include the term in your recommendation of funding for an iPad and software to help him in the classroom. However, if the parent asks you what caused the language disorder you can say the cause is often unknown. Nevertheless, if they wish to pursue this question, they should consult a pediatrician, child psychologist or developmental assessment team.

3 Q: I see many children who show clear signs of being on the autism spectrum, before the diagnosis has been made by a pediatrician or psychologist. I document my assessment findings in the patient record but am cautious about what I communicate to the parents. However, given the patient/SDM may request a copy of the record, should I document that my findings may suggest a potential diagnosis of autism?

3 A: It is prudent to avoid documenting diagnostic terms such as 'autism'. Even though the patient record is not a typical vehicle of communication between a health professional and a patient, you are correct to consider that the patient has the right of access. At the same time the patient record must be accurate, complete, accessible and retained ([Records Regulation](#)). You should document the signs and symptoms you have observed, such as social skills, play behaviour, non-verbal communication etc. but avoid the diagnostic term, 'autism'. You should also document your recommended referrals.

Speech language pathologists and audiologists are uniquely qualified to provide clinical information that contributes to a diagnosis outside of our scope of practice made by health professionals who can make and communicate the diagnosis.

4 Q: I am an SLP working in a preschool setting. When I assess a child who shows the typical signs of autism I make a referral to the local Autism Assessment Team. Also, the Hanen Program has an excellent program called 'More than Words for Parents of Children for Autism'. How do I make a referral for either program without communicating a diagnosis to the parents?

4 A: After discussing the signs and symptoms you have observed, you can explain to the parents that although you recommend a referral to the Autism Team or Hanen Program, it does not necessarily mean that their child has autism. It does mean, however, that s/he will get a thorough developmental assessment or participate in the most suitable program. Explain that you are trained to examine one area of development, which is communication. The communication patterns you have observed are not typical and combined with other social and play behaviours warrant further investigation to ensure the best plan of care. The pediatrician/psychologist and team will examine all areas of development then the pediatrician/psychologist can make and communicate a diagnosis and discuss a plan of care.

5 Q: I recently assessed a young boy who shows 'red flags for autism'. In the discussion following the assessment, the parents asked me if their child has autism. How do I respond?

5 A: You cannot make or communicate a diagnosis of autism as it is out of your scope of practice. However, you can discuss clinical information. In doing so, use your professional judgement in how you frame the information and the terms you may or may not use based on the perception of the parents.

Key points for your discussion:

- Discuss observed communication issues within your scope of practice
- Make it very clear that you are NOT making a diagnosis of autism
- Refer the child to an authorized health professional who can make and communicate an autism diagnosis
- Document the conversation in detail in the patient record

Example:

Some of the atypical communication, social and play behaviours I am seeing, such as XXX, are behaviours that may be associated with developmental issues such as autism. However, as an SLP, I am only looking at one area of your child's development.

It is not within my scope of practice to make an autism diagnosis. I strongly recommend that you see your family doctor to get a full developmental assessment that will look at all areas of your child's development. For example, a developmental pediatrician, psychiatrist, or a psychologist are the professionals that can look at all areas of development and can make and communicate a diagnosis.

Don't say "I think your child has autism".

6: The College has said that we can communicate apraxia as long as we don't provide information on the cause of the apraxia. Can we use the term Childhood Apraxia of Speech (CAS) when talking to parents?

6: Yes, you can. You must make sure that the child's parents understand the motor speech symptoms and proposed plan of care. Ensure they are not under the assumption that you are providing a diagnosis identifying a disease or disorder as the cause of the symptoms.

SLP SERVICES TO ADULTS

7 Q: I work in an adult outpatient rehab clinic. The other day I saw a patient for an initial assessment and my observations and clinical findings suggest signs and symptoms of Parkinson's disease. I know I cannot communicate Parkinson's disease to the patient, but can I discuss my concerns about a potential progressive neurological disease with her family physician?

7 A: Yes, you can. Consistent with a patient centred approach, discuss your concerns with the patient first regarding her speech, voice or swallowing without using diagnostic terms such as Parkinson's disease. Recommend that you would like to communicate directly with her physician regarding your findings, and if required, obtain consent to do so. You can call or write to the physician outlining your assessment results, the signs and symptoms you have observed and recommend a neurological consultation. Finally, recommend that the patient make an appointment to see their physician for further investigations and discussions.

8 Q: Can we quote objective findings from the patient chart in our reports that outline a diagnosis; e.g.; CT results which describe an infarct or chest X-ray that shows pneumonia?

8: Yes you can when the findings have been documented by a physician and shared with the patient. When writing reports, you are always using your clinical judgement to determine relevance of what needs to be included.

9 Q: When an outpatient presents with symptoms of esophageal dysphagia and gastroesophageal reflux, how can we communicate this to the individual and give them lifestyle or diet strategies that may help to alleviate their symptoms while they wait for an appointment to see their physician?

9 A: You can discuss their symptoms, your clinical findings and offer suggestions for lifestyle modifications and diet suggestions to see if these make a difference, until they see their physician. If the patient asks about the cause and diagnosis, encourage them to discuss it with their physician. The physician can confirm an underlying cause of the symptoms they are experiencing.

10 Q: I often ask my patients: "Do you know what has happened to you?" as part of the interview. If they reply with: "Yes, I have had a stroke", would this be sufficient evidence of the diagnosis already being known?

10 A: Yes, you can assume this is sufficient evidence, and refer to the stroke when explaining the communication issues the patient is experiencing.

11 Q: What can I say when reporting on imaging of the esophagus during a VFSS? If the radiologist is not available immediately to comment on the esophageal phase or a structural abnormality, can I document what I've seen, with the intent of seeking consultation after the VFSS?

11 A: Yes, you can document what you are observing such as a protrusion, reduced esophageal clearing, or prominence specifying the area. You cannot use terms that indicate a diagnosis such as esophageal motility, achalasia, web, or any additional anatomical structural abnormalities or esophageal abnormalities. The authorized physician can make and communicate these diagnoses (cricopharyngeal bar, cervical osteophytes, Zenker's diverticulum, Barrett's esophagus, etc.).

12 Q: I am an SLP who works in a hospital outpatient voice clinic. The format of the team is interprofessional and the ENT physician has delegated the controlled act of communicating to patients and SDMs the voice diagnosis of vocal nodules. We do not communicate any other voice disease or disorder which provides information about the underlying cause. Is this okay with the College?

12 A: Yes, as long as you have the competencies necessary to distinguish between vocal nodules and other voice pathologies and follow the requirements in the [Position Statement on the Acceptance of Delegation of a Controlled Act](#).

AUDIOLOGY SERVICES

13 Q: During the hearing assessment of a child with reported speech delay, I conducted tympanometry and the results were suggestive of middle ear fluid. During inspection of the ear (otoscopy) I saw that the ear drum was inflamed, and audiometry indicated an air-bone gap. What can I communicate to the child's parents?

13 A: You can report your findings, that the hearing test results indicate a conductive hearing loss and that otoscopy and tympanometry suggest fluid in the middle ear. You cannot tell the parents that the child has an ear infection (i.e., otitis media) because this would be identifying the disease or disorder that causes the audiology symptoms, the conductive hearing loss and middle ear fluid being the symptoms. You would share your recommendations for follow-up, for example, encouraging the parents to consult with a family physician or an ENT for the diagnosis and treatment. Finally, you would document the assessment findings and information you provided to the parents, being cautious about the language you use so that the information in your report is not interpreted as a diagnosis.

14 Q: I am confused! I am an audiologist working at a children's hospital. Can we communicate Auditory Processing Disorder (APD)? Research shows that APD is not a diagnostic term rather it is a disorder with either an unknown cause or it is linked to various other causes, for example autism, ADHD, or traumatic brain injury. APD is a term that describes symptoms or dysfunctions, so can I tell the parents that their child has APD?

14 A: Yes, you can use the term Auditory Processing Disorder, and discuss the symptoms and dysfunctions with the parents and how it affects their child and the child's learning. If the parents have been informed by a professional with access to the Controlled Act, you can discuss the underlying cause, for example, a traumatic brain injury.

15 Q: In my audiology practice, I often see patients who present with a case history and hearing assessment results typical of noise induced hearing loss (NIHL). Is it acceptable for me to say to the patient, or to write in the patient file, that the type of hearing loss is "consistent with NIHL"? Also, am I providing a diagnosis if I refer the patient to the WSIB NIHL program of care and provide them with the funding application?

15 A: Audiologists can make the diagnosis of NIHL. However, they can't communicate NIHL because it is a diagnosis identifying the disease or disorder that causes symptoms such as sensorineural hearing loss or difficulty hearing in noise. Therefore, you must be cautious about using NIHL in your direct communication with the patient and in your documentation. You can use terminology

such as “consistent with”, “may be consistent with” or “may suggest” NIHL, if it is clear to the patient, and in your documentation, that you are not communicating a diagnosis.

A referral to the WSIB’s program for NIHL, does not mean that you are communicating a diagnosis. However, if you suspect that your patient is interpreting your referral to the NIHL program as a diagnosis, you should take steps to clarify the information with the patient and document appropriately.

16 Q: I had a patient with all the typical signs for acoustic neuroma. I went through his hearing test results and told him that he should be referred to an ENT for further investigation (I did not mention my diagnostic findings). He agreed to the referral and to me writing a report to his family physician outlining my findings. The patient came back into the office today very distressed, he had looked up his symptoms on the internet. He wanted to know if he had an acoustic neuroma. What can I say?

16 A: You can acknowledge that the symptoms may appear consistent with what was found on the internet related to acoustic neuroma, but that the symptoms may have another cause. Underscore the peril of relying on the internet and the value of consulting a physician. It would not be appropriate to confirm the diagnosis of acoustic neuroma. Advise your patient to discuss his symptoms with the ENT, who will be able to identify many other factors that go into an accurate diagnosis. If his appointment is not immediate, encourage him to visit his family physician.

17 Q: I am an audiologist who does testing for the Infant Hearing Program (IHP). We are trained to follow specific protocols to determine if an infant has Auditory Neuropathy Spectrum Disorder (ANSD). If assessment results indicate ANSD I feel compelled to communicate this information immediately to the parents/family. If I do not communicate my findings right away it could delay important intervention needed by the infant and the family. In addition, if I do not specifically indicate “ANSD” in my report I fear that the other healthcare providers, including physicians, involved with follow-up care may not act upon my findings. How can I ensure that I meet my professional obligations while also being compliant with the legislation on communicating a diagnosis?

17 A: It is understandable that in some circumstances it may be crucial for timely intervention that the patient and family immediately receive information about assessment results.

ANSD is a term used to describe a “component” of, or type of, hearing loss, much like the terms sensorineural or conductive. The term ANSD does not refer to an underlying disease or disorder that causes symptoms but rather refers to specific assessment findings associated with a cluster of symptoms that lead to serious auditory challenges. Therefore, use of the term ANSD in your communication with patients or in a patient report would not be outside the legislation.

However, it is important to carefully consider how the parent/family will rely on the information you provide. If you tell the parents that your results indicate possible ANSD, you must ensure that the parents are not relying on this information as a diagnosis. If the parents ask you what caused the ANSD, or if ANSD is a diagnosis, then you must tell them that identifying the cause of ANSD is outside your scope of practice and encourage them to consult with the ENT physician. In your documentation and reporting you should use the term ANSD judiciously and be clear that your use of this term is not a diagnosis.

FURTHER QUESTIONS

If you have questions about what you can and cannot communicate to patients and families, contact our Practice Advice team:

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