

COLLEGE OF CHIROPRACTORS OF ONTARIO



**PUBLIC INFORMATION PACKAGE FOR
COUNCIL MEETING
TUESDAY, APRIL 30, 2019 – 8:30 A.M.**

RHPA

Duties and Objects of Colleges

Duty of College

2.1 It is the duty of the College to work in consultation with the Minister to ensure, as a matter of public interest, that the people of Ontario have access to adequate numbers of qualified, skilled and competent regulated health professionals. 2008, c. 18, s. 1.

Objects of College

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

1. To regulate the practice of the profession and to govern the members in accordance with the health profession Act, this Code and the *Regulated Health Professions Act, 1991* and the regulations and by-laws.
2. To develop, establish and maintain standards of qualification for persons to be issued certificates of registration.
3. To develop, establish and maintain programs and standards of practice to assure the quality of the practice of the profession.
4. To develop, establish and maintain standards of knowledge and skill and programs to promote continuing evaluation, competence and improvement among the members.
- 4.1 To develop, in collaboration and consultation with other Colleges, standards of knowledge, skill and judgment relating to the performance of controlled acts common among health professions to enhance interprofessional collaboration, while respecting the unique character of individual health professions and their members.
5. To develop, establish and maintain standards of professional ethics for the members.
6. To develop, establish and maintain programs to assist individuals to exercise their rights under this Code and the *Regulated Health Professions Act, 1991*.
7. To administer the health profession Act, this Code and the *Regulated Health Professions Act, 1991* as it relates to the profession and to perform the other duties and exercise the other powers that are imposed or conferred on the College.
8. To promote and enhance relations between the College and its members, other health profession colleges, key stakeholders, and the public.
9. To promote inter-professional collaboration with other health profession colleges.
10. To develop, establish, and maintain standards and programs to promote the ability of members to respond to changes in practice environments, advances in technology and other emerging issues.
11. Any other objects relating to human health care that the Council considers desirable. 1991, c. 18, Sched. 2, s. 3 (1); 2007, c. 10, Sched. M, s. 18; 2009, c. 26, s. 24 (11).

Duty

(2) In carrying out its objects, the College has a duty to serve and protect the public interest. 1991, c. 18, Sched. 2, s. 3 (2).



COLLEGE OF CHIROPRACTORS OF ONTARIO MISSION, VISION, VALUES AND STRATEGIC OBJECTIVES

MISSION

The College of Chiropractors of Ontario regulates the profession in the public interest to assure ethical and competent chiropractic care.

VISION

Committed to Regulatory Excellence in the Public Interest in a Diverse Environment.

VALUES

- Integrity
- Respect
- Collaborative
- Innovative
- Transparent
- Responsive

STRATEGIC OBJECTIVES

1. Build public trust and confidence and promote understanding of the role of CCO amongst all stakeholders.
2. Ensure the practice of members is safe, ethical, and patient-centered.
3. Ensure standards and core competencies promote excellence of care while responding to emerging developments.
4. Optimize the use of technology to facilitate regulatory functions and communications.
5. Continue to meet CCO's statutory mandate and resource priorities in a fiscally responsible manner.

Developed at the strategic planning session: September 2017

CCO CODE OF CONDUCT FOR CURRENT AND FORMER ELECTED AND PUBLIC MEMBERS OF COUNCIL AND NON-COUNCIL COMMITTEE MEMBERS



Executive Committee

Approved by Council: September 28, 2012

Amended: February 23, 2016, April 19, 2016, September 15, 2016

Re-Affirmed by Council: November 29, 2018

Current and former elected and public members of Council and non-Council committee members must, at all times, maintain high standards of integrity, honesty and loyalty when discharging their College duties. They must act in the best interest of the College. They shall:

1. be familiar and comply with the provisions of the *Regulated Health Professions Act, 1991 (RHPA)*, its regulations and the *Health Professions Procedural Code*, the *Chiropractic Act 1991*, its regulations, and the by-laws and policies of the College;
2. diligently take part in committee work and actively serve on committees as elected and appointed by the Council;
3. regularly attend meetings on time and participate constructively in discussions;
4. offer opinions and express views on matters before the College, Council and committee, when appropriate;
5. participate in all deliberations and communications in a respectful, courteous and professional manner, recognizing the diverse background, skills and experience of members on Council and committees;
6. uphold the decisions made by Council and committees, regardless of the level of prior individual disagreement;
7. place the interests of the College, Council and committee above self-interests;
8. avoid and, where that is not possible, declare any appearance of or actual conflicts of interests¹;
9. refrain from including or referencing Council or committee positions held at the College in any personal or business promotional materials, advertisements and business cards;²

¹ There is a general assumption of real or perceived conflict unless confirmation of no conflict by the Executive Committee and/or Council, which will be addressed promptly.

² This section does not preclude the use of professional biographies for professional involvement.

10. preserve confidentiality of all information before Council or committee unless disclosure has been authorized by Council or otherwise exempted under s. 36(1) of the *RHPA*;
11. refrain from communicating to members, including other Council or committee members, on statutory committees regarding registration, complaints, reports, investigations, disciplinary or fitness to practise proceedings which could be perceived as an attempt to influence a statutory committee or a breach of confidentiality, unless he or she is a member of the panel or, where there is no panel, of the statutory committee dealing with the matter;
12. refrain from communicating to members and stakeholder³ on behalf of CCO, including on social media, unless authorized by Council⁴;
13. respect the boundaries of staff whose role is not to report to or work for individual Council or committee members; and
14. be respectful of others and not engage in behaviour that might reasonably be perceived as verbal, physical or sexual abuse or harassment.

Potential Breaches of the Code of Conduct

15. An elected or appointed member of Council or non-Council committee member who becomes aware of any potential breach of this code of conduct should immediately advise the President and Registrar, or if the potential breach involves the President, advise the Vice President and Registrar; and
16. Potential breaches will be addressed first through informal discussion with the Council member(s) or non-Council committee member(s), and subsequently by written communication expressing concerns and potential consequences.

I, _____, Council member or non-Council committee member of the College of Chiropractors of Ontario undertake to comply with the CCO Code of Conduct for Current and Former Elected and Public Members of Council and Non-Council Committee Members, both during and following my term on CCO Council or a committee

Signature: _____ Witness: _____

Date: _____

³ Stakeholders include professional associations, societies, and other organizations related to the regulation, education and practice of chiropractic.

⁴ This does not preclude Council members from communicating about CCO, provided they are not communicating on behalf of CCO.

**Rules of Order of the Council of the
College of Chiropractors of Ontario
Approved by Council: September 20, 2014**

1. In this Schedule, "member" means a council member.
2. Each agenda topic will be introduced briefly by the person or committee representative raising it. Members may ask questions of clarification, then the person introducing the matter shall make a motion and another member must second the motion before it can be debated.
3. When any member wishes to speak, he or she shall so indicate by raising his or her hand and shall address the chair and confine himself or herself to the matter under discussion.
4. Staff persons and consultants with expertise in a matter may be permitted by the chair to answer specific questions about the matter.
5. Observers at a council meeting are not allowed to speak to a matter that is under debate.
6. A member may not speak again on the debate of a matter until every council member who wishes to speak to it has been given an opportunity to do so. The only exception is that the person introducing the matter or a staff person may answer questions about the matter. Members will not speak to a matter more than twice without the permission of the chair.
7. A member may not speak longer than five minutes upon any motion except with the permission of Council.
8. When a motion is under debate, no other motion can be made except to amend it, to postpone it, to put the motion to a vote, to adjourn the debate of the council meeting or to refer the motion to a committee.
9. A motion to amend the motion then under debate shall be disposed of first. Only one motion to amend the motion under debate can be made at a time.
10. When a motion is on the floor, a member shall make every effort to be present and to remain in the room.
11. When it appears to the chair that the debate in a matter has concluded, when Council has passed a motion to vote on the motion or when the time allocated to the debate of the matter has concluded, the chair shall put the motion to a vote and no further debate is permitted.

12. A member is not entitled to vote upon any motion in which he or she has a conflict of interest, and the vote of any member so interested will be disallowed.
13. Any motion decided by the Council shall not be re-introduced during the same session except by a two-thirds vote of the Council then present.
14. Whenever the chair is of the opinion that a motion offered to the Council is contrary to these rules or the by-laws, he or she shall rule the motion out of order and give his or her reasons for doing so.
15. The chair shall preserve order, etiquette and decorum, and shall decide questions of order, which include addressing any distractions that interfere with the business of the meeting, subject to an appeal to the Council without debate.
16. The above rules may be relaxed by the chair if it appears that greater informality is beneficial in the particular circumstances unless the Council requires strict adherence.
17. Members are not permitted to discuss a matter with observers while it is being debated.
18. Members are to be respectful, courteous and professional while others are speaking.
19. In all cases not provided for in these rules or by other rules of Council, the current edition of Robert's Rules of Order shall be followed so far as they may be applicable.

List of Commonly Used Acronyms at CCO

as at September 2017

Acronym	Full Name
ADR	Alternative Dispute Resolution
AFC	Alliance For Chiropractic (formerly CAC)
BCCC	British Columbia College of Chiropractors
BDC	Board of Directors of Chiropractic
CAC	Chiropractic Awareness Council
CCA	Canadian Chiropractic Association
CCEB	Canadian Chiropractic Examining Board
CCEC	Council on Chiropractic Education (Canada)
SCERP	Specified Continuing Education or Remediation Program
CCGI	Canadian Chiropractic Guideline Initiative
CCO	College of Chiropractors of Ontario
CCPA	Canadian Chiropractic Protective Association
CCRF	Canadian Chiropractic Research Foundation
<i>Chiropractic Act</i>	<i>Chiropractic Act, 1991</i>
CMCC	Canadian Memorial Chiropractic College
CNO	College of Nurses of Ontario
<i>Code</i>	<i>Health Professions Procedural Code, Schedule 2 to the RHPA</i>
CONO	College of Naturopaths of Ontario
CPGs	Clinical Practice Guidelines
CPSO	College of Physicians and Surgeons of Ontario
CRC	Chiropractic Review Committee
DAC	Designated Assessment Centre
FCC	Federation of Canadian Chiropractic
FCCOS(C)	Fellow of the College of Chiropractic Orthopaedic Specialists (Canada)
FCCR(C)	Fellow of the Chiropractic College of Radiologists (Canada)
FCCPOR(C)	Fellow of the Canadian Chiropractic College of Physical and Occupational Rehabilitation (Canada)
FCCS(C)	Fellow of the College of Chiropractic Sciences (Canada)
FRCCSS(C)	Fellow of the Royal College of Chiropractic Sports Sciences (Canada)
FCLB	Federation of Chiropractic Licensing Boards
FHRCO	Federation of Health Regulatory Colleges of Ontario
<i>HARP</i>	<i>Healing Arts Radiation Protection Act</i>
<i>HIA</i>	<i>Health Insurance Act</i>
HPARB	Health Professions Appeal and Review Board
HPRAC	Health Professions Regulatory Advisory Council
ICRC	Inquiries, Complaints & Reports Committee
LSUP	Law Society of Upper Canada
MESPO	Model for the Evaluation of Scopes of Practice in Ontario
MOHLTC	Ministry of Health and Long-Term Care
MTCU	Ministry of Training, Colleges and Universities
NBCE	National Board of Chiropractic Examiners
OCA	Ontario Chiropractic Association
ODP	Office Development Project
OFC	Office of the Fairness Commissioner
OHIP	Ontario Health Insurance Plan
<i>PHIPA</i>	<i>Personal Health Information Protection Act</i>
<i>PPA</i>	<i>Protecting Patients Act, 2017</i>
<i>PIPEDA</i>	<i>Personal Information and Protection of Electronic Documents Act</i>
<i>RHPA</i>	<i>Regulated Health Professions Act, 1991</i>
UQTR	Université du Québec à Trois-Rivières
WHO	World Health Organization
WSIB	Workplace Safety and Insurance Board

COLLEGE OF CHIROPRACTORS OF ONTARIO

Council Meeting

Tuesday, April 30, 2019 (8:30 a.m. – 4:30 p.m.)¹

AGENDA (Public)²

SECTIONS OF THE CODE FOR IN-CAMERA SESSIONS IF DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level ³
		CALL TO ORDER AND WELCOME TO NEW COUNCIL MEMBERS		Starmer	High
		Appoint Parliamentarian		Council	High
<u>Vol. 1</u>		1. Consent Agenda	Approve	Council	High
9		1.1 Discipline Committee Report			
11		1.1.1 CCO v Dr. Shaun Lambrou (received April 2, 2019)			
24		1.1.2 FHRCO Conducting a Discipline Hearing Program (Basic – May 3, 2019)			
27		1.2 Fitness to Practise Committee Report			
27		1.3 Inquiries, Complaints and Reports Committee Report (ICRC)			
28		1.4 Registration Committee Report			

¹ Subject to Council's direction.

² If you would like the complete background documentation relating to any item on the agenda, please speak to Ms Willson (subject to confidentiality provisions).

³ Subject to Council's direction. Consider addressing all agreed upon high priority items first whether they are old or new business items.

SECTIONS OF THE CODE FOR IN-CAMERA SESSIONS IF DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level ³
		2. Adoption of Agenda	Adopt	Council	<u>High</u>
		2.1 Conflict of Interest	Review/ Declare any real or perceived conflicts of interest	Council	<u>High</u>
		3. Adoption of Minutes ⁴	Approve	Council	<u>High</u>
		4. Committee Reports and Recommendations	Report/ Approve Recom- mendations	Committee Chairs/ Council	<u>High</u>
	59	4.1 Executive Committee Report	Report	Starmer	<u>High</u>
		<i>CCO Elections</i>	Verbal Report/ Review/ Consider any changes to ensure fair election process ⁵	Willson/ Council	<u>High</u>

⁴ Only members present at the meeting should approve the minutes.

⁵ Currently the Election Review Committee is responsible for responding in a timely way to issues or concerns arising during the elections, and to reviewing all campaign material by candidates for general consistency with CCO’s advertising provisions.

SECTIONS OF THE CODE FOR IN-CAMERA SESSIONS IF DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level ³
Ss. 7 (2)(a) (b)(c) (d)(e)	<u>Vol. 2</u>	Go in Camera	Ratify decisions made in-camera		
	219	4.1.16 Memo dated April 30, 2019 to Ms Willson from Mr. Friedman re: Technology Upgrade Update	Verbal Report	Friedman	Medium
		By-laws	Approve Process for circulation and approval	Council	Medium
	236	4.1.17 Memorandum dated April 30, 2019 to Ms Willson from Mr. Friedman re: Distribution of By-law Amendments			
	244	4.1.18 Proposed By-law Amendments			
		Standards of Practice, Policies, Guidelines			
	308	4.1.23 Policy P-010: Professional Misconduct Relating to Orthopractic	Revoke	Council	Medium
		Chiropractic/Health Related Stakeholders <i>Federation of Canadian Chiropractic (FCC)</i>	Verbal Report re: April 2019 meetings FYI	Starmer/ Willson	High
	309	4.1.24 CCO Report to FCC			
	315	4.1.25 Invitation to Fall 2019 Meeting – CCPA/Regulators	Verbal Report	Willson	Medium

SECTIONS OF THE CODE FOR IN-CAMERA SESSIONS IF DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level ³
		<i>Canadian Memorial Chiropractic College (CMCC)</i>			
	317	4.1.26 News Release dated March 27, 2019 re: International Position Statement	Review for regulatory implications	Council	Medium
		<i>Canadian Chiropractic Association (CCA)</i>			
	336	4.1.29 President’s Message dated April 18, 2019	Discuss CCO future direction/ collaboration	Council	Medium
	342	4.2 Advertising Committee Report	Report	Amlinger	High
	370	4.3 Patient Relations Committee Report	Report	Bourdeau	High
	372	4.3.1 Tent Cards of Partnership of Care (mock up)	Provide Feedback		
	376	4.4 Quality Assurance Committee Report	Report	Amlinger on behalf of Anderson-Peacock	High
	398	4.4.4 Information re: RFP for Web Scanning Technology	FYI		
		5. New Business			
	403	5.1 Scope of Practice for Chiropractic	Introduce Item	Budgell	Medium
	409	5.3 Decision of the Social Justice Tribunal Ontario re: Aron Airall	FYI		
	<u>Vol. 3</u>	6. Background Information for Committee Reports ⁶	Primarily FYI		

⁶ A Council member may request pulling information from the background information section and adding to the main agenda if relevant to an agenda item and public interest protection.

SECTIONS OF THE CODE FOR IN-CAMERA SESSIONS IF DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level ³
		6.1 Executive Committee Report (background)			
		<i>Elections</i>			
	414	6.1.1 By-law 6: Election of Council Members			
	422	6.1.2 Information distributed to members electronically including voting guide, notice of election and nomination guide, election information guideline			
	438	6.1.3 Ontario Chiropractic Association (OCA) info re: elections			
	450	6.1.4 Alliance for Chiropractic (AFC) info re: elections			
		<i>Ministry of Health and Long-Term Care (MOHLTC)</i>	Review Information for health regulatory context		
	592	6.1.9 Bulletin and information dated January 2019 re: Hallway Medicine			
	627	6.1.10 Bulletins dated February 26, 2019 re: “Super Agency”			
	640	6.1.11 Overview of Bill 74 – <i>The People’s Health Care Act, 2019</i> , Steinecke			
	643	6.1.12 Miscellaneous news reports			
		<i>Communications/Strategic Planning</i>			
	932	6.1.28 Media stories re: chiropractic, regulators, members			
	1010	6.1.32 Chiropractic Winter 2019			
		<i>Chiropractic/Health Related Stakeholders</i>			
		<i>Ontario Chiropractic Association (OCA)</i>			
	1051	6.1.33 Miscellaneous bulletins/communications			
		<i>Federation of Canadian Chiropractic (FCC)</i>			

SECTIONS OF THE CODE FOR IN-CAMERA SESSIONS IF DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level ³
	1158	6.1.37 Information dated March 6, 2019 from Alberta College and Association of Chiropractors re: Advertising etc. <i>Canadian Chiropractic Protective Association (CCPA)</i>	Consider best practices?	Advertising Committee	Low
	1167	6.1.38 Communique dated January 2019 <i>Canadian Chiropractic Examining Board (CCEB)</i>			
	1171	6.1.39 CCEB Annual Report 2017/2018			
	1191	6.1.40 Correspondence dated April 9, 2019, Upcoming BOG Vacancies			
	1198	6.1.41 Canadian Chiropractic Guidelines Initiative – Stakeholder Report and Invoice <i>Council on Licensure, Enforcement & Regulation</i>			
	1210	6.1.42 Information re: International Conference hosted by Canada in Vancouver June 2019 ⁷	Approve	Council	Low
	1218	6.1.43 Internal Policy: I-010: Procedures for Attending Educational Sessions/Professional Development Programs			
		6.2 Advertising Committee Report (background)			
	1222	6.2.1 Advertising Committee Terms of Reference (current) 6.2.2 P-004: Advertising Committee Protocol			
	1223	6.2.3 S-016: Advertising (current)			
	1228	6.2.4 G-16: Advertising (current)			
	1236	6.2.5 Memo dated April 30, 2019 to Chair, Quality Assurance Committee			

⁷ Dr. Starmer and Ms Willson would like to attend (subject to approval).

SECTIONS OF THE CODE FOR IN-CAMERA SESSIONS IF DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level ³
	1237	6.3 Patient Relations Committee Report (background) 6.3.1 Partnership of Care (10 languages)			
	1279 1285	6.4 Quality Assurance Committee Report (background) 6.4.2 S-001: Scope of Practice (current) 6.4.3 G-008: Business Practices (current)			
		7. For Your Information ⁸			
		<i>Chiropractic in other Canadian Jurisdictions</i>			
		<i>British Columbia</i>			
	1292	7.1 Correspondence dated March 23, 2019, CBC News “ <i>Chiropractic Treatment for Children to Face ‘Rigorous’ Review in BC</i> ”			
	1312	7.2 Correspondence dated March 5, 2019, “ <i>Nurse Says There is Practically Zero Evidence for Chiropractic – Especially in Infants</i> ”			
		<i>Manitoba</i>			
	1314	7.3 CBC Article dated April 11, 2019, “ <i>Lawsuit Alleges Manitoba Physicians College Broke Agreement to ‘Refrain from Criticism’ of Chiropractors</i> ”			
		<i>Quebec</i>			
	1320	7.4 La Presse Article dated April 12, 2019, “ <i>A Professor at UQTR Multiplies the Anti-Vaccine Remarks</i> ” <i>Various Chiropractic Publications and Articles from Canada and the U.S.A.</i>			

⁸ A Council member may request pulling information from the FYI section and adding to the main agenda if relevant to an agenda item and public interest protection. Committee Chairs to review from perspective of inclusion on committee agenda for future recommendations to Council.

SECTIONS OF THE CODE FOR IN-CAMERA SESSIONS IF DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level ³
	1324	7.5 Research Article from the BMC Complementary and Alternative Medicine, “ <i>Manual Therapy for the Pediatric Populations: A Systematic Review</i> ”			
	1364	7.6 Correspondence dated March 11, 2019, “ <i>Vitalism and Chiropractic</i> ”			
	1365	7.7 Article published February 21, 2019, Chiropractic and Manual Therapies, “ <i>Chiropractic, One Big Unhappy Family: Better Together or Apart?</i> ” <i>Australia</i>			
	1371	7.8 Interim Policy dated March 14, 2019, Chiropractic Board of Australia, “ <i>Chiropractic Board Announces Interim Policy on Spinal Manipulation</i> ” <i>Japan</i>			
	1375	7.9 Article dated March 21, 2019, Chronicle of Chiropractic, “ <i>President of Tokyo College of Chiropractic Issues Statement on Australian Ban of Infants</i> ” <i>Health Care Related Articles</i>			
	1378	7.10 Toronto Star Article dated February 27, 2019, “ <i>Health-Care Overhaul Called ‘Biggest in 50 Years’</i> ” <i>Other Regulators</i> <i>College of Massage Therapists</i>			
	1380	7.11 CBC Article dated March 21, 2019, “ <i>Massage Therapist Mark Donlevy Faces 14th Sexual Assault Charge</i> ” <i>College of Pharmacists</i>			
	1382	7.12 Toronto Star article dated February 25, 2019 “ <i>Getting away with pharmacy fraud is no problem in Ontario</i> ”			

SECTIONS OF THE CODE FOR IN-CAMERA SESSIONS IF DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level ³
		<i>College of Physicians and Surgeons of Ontario</i>			
	1393	7.13 Canadian Press Article dated March 13, 2019, “Regulator Won’t Pursue Complaints about Doctor’s Advocacy Work”			
	1395	7.14 Extract from Dialogue 2018 re: <i>Striving for Balance</i> Striving for Balance – Right Touch Regulation			
	1402	7.15 <i>CPSO v Peirovy</i> re: Standard of Review			
		<i>Law Society of Upper Canada</i>			
	1439	7.16 Various Information LSO Elections			
		Miscellaneous			
	1443	7.17 Staffing change dated February 28, 2019 re: Health Professions Appeal and Review Board			
	1444	7.18 Move Notice dated March 8, 2019 re: Health Workforce Regulatory Oversight Branch			
	1447	7.19 C.D. Howe Institute (April 2019), “Regulating Alternative Medicines: Disorder in the Borderlands”			
	1471	7.20 Legislative Update: March 2019			
	1478	7.21 Grey Areas – February/March 2019			
	1484	7.22 Council Member Terms			
		DATE AND TIME OF MEETINGS ⁹			

⁹ Please mark your Calendar and Advise Rose Bustria ASAP if you are unable to attend any meetings.

SECTIONS OF THE CODE FOR IN-CAMERA SESSIONS IF DIRECTED BY COUNCIL	Page No.	ITEM	Action Required	Action By	Priority Level ³
		ADJOURNMENT			

Council Meeting Dates to November 2019

All Council meetings are at CCO and are scheduled from **8:30 a.m. – 4:30 p.m.** unless otherwise noted. Schedule meeting dates to June 2020?

Year	Date	Time	Event	Location
2019	Tuesday, June 18	3:00 p.m.	Site Visit	59 Hayden
	Tuesday, June 18	6 p.m. – 9:30 p.m.	Annual General Meeting	Four Seasons Hotel Vinci Room
	Wednesday, June 19	8:30 a.m. – 4:30 p.m.	Council Meeting	CCO
	Friday, September 13	1:00 p.m. – 4:30 p.m.	Strategic Planning/Topic Specific Focused Meeting (in camera items)	Kingbridge Conference Centre and Institute, 12750 Jane Street, King City Ontario L7B 1A3 www.kingbridgecentre.com
	Saturday, September 14	8:30 a.m. – 4:30 p.m.	Council Meeting	Kingbridge
	Sunday, September 15	8:30 a.m. – 12 noon	Strategic Planning/Topic Specific Meeting (as required)	Kingbridge
	Thursday, November 28	8:30 a.m. – 4:30 p.m.	Council Meeting	CCO (new premises!)
	Friday, November 29	Evening	Holiday Party	TBD

**College of Chiropractors of Ontario
Discipline Committee Report to Council
Tuesday, April 30, 2019**

9

Core Members: Mr. Doug Cressman, *Chair*
Ms Karoline Bourdeau
Dr. Brian Budgell
Dr. David Starmer
Dr. Daniela Arciero, *non-Council member*
Dr. Angela Barrow, *non-Council member*
Dr. Liz Gabison, *non-Council member*
Dr. Colin Goudreau, *non-Council member*
Dr. Colleen Pattrick, *non-Council member*
Dr. Matt Tribe, *non-Council member*

Staff Support: Ms Jo-Ann Willson, *Registrar and General Counsel*

Though not unheard of, it is unusual for chiropractors to appear before a Discipline Panel more than once. Most of course never have the experience which is obviously a good thing. In any given year, less than one fifth of one percent of members of CCO find themselves to be the subject of a discipline hearing. Although the goal might be zero, that is probably unrealistic to attain. The lack of second appearances, however, may be due to the effectiveness of the penalty order. In ordering a penalty, or agreeing to a penalty order presented by the parties, a Panel will consider the following:

- Is this penalty fair, as in, is it in the range of past penalties for similar misconduct?
- Is there a deterrence factor built into the penalty, specific to the individual member, and more generally to other members of the profession?
- Is there an educational or rehabilitative component built in to support the member?
- Does the penalty meet the bar of protecting the public into the future?

Penalties often include an oral reprimand, a suspension, a requirement to take refresher courses such as the Record Keeping course offered by the College, an agreement to be assessed by a Quality Assurance assessor in the near future, and a financial penalty. In the most serious of cases, a penalty order can even include revoking the privilege to practice in Ontario.

One hearing has been held since the last Council meeting.

- Dr. Shaun Lambrou – March 6, 2019
Panel: Ms Karoline Bourdeau, Chair, Dr. Brian Budgell, Mr. Doug Cressman,
Dr. Colin Goudreau and Dr. Colleen Patrick

A hearing has been scheduled on the following:

- Dr. Niousha Golhassani – April 29, 2019
Panel: Dr. Matt Tribe, Chair, Ms Karoline Bourdeau, Dr. Brian Budgell,
Mr. Doug Cressman and Dr. Colleen Patrick

The Federation of Health Regulatory Colleges of Ontario (FHRCO) is holding its next Discipline Orientation on May 3, 2019 (Basic). Just a reminder that according to our bylaws, every member of Council is a member of the Discipline Committee and as such may be called upon to serve on an upcoming panel. Therefore, if any Council members are interested in the above training in order to enhance the skills which would better enable them to serve, please contact Ms Rose Bustria.

I would like to thank all members of Council and all Non-Council Professional members appointed to the Discipline Committee for your willingness to serve, your professionalism, your engagement and your support personally to me as Chair over this past year. I'd also like to recognize the good work done by counsel for the College, various defense counsel and those who have served as independent legal counsel for our Panels. Your contributions are important in keeping hearings running fairly, effectively, and focused on the public interest.

Respectfully submitted,
Doug Cressman, Chair

INTRODUCTION

A hearing into allegations of professional misconduct against Dr. Shaun Lambrou took place before a panel of the Discipline Committee (the "Panel") of the College of Chiropractors of Ontario (the "College" or "CCO") on March 6, 2019. The College has a mandate to regulate the practice of the chiropractic profession and to govern its members and, in so doing, serve and protect the public interest.

The Panel found that the Member engaged in professional misconduct by breaching subsections 51(1)(c) of the Health Professions Procedural Code of the Chiropractic Act, 1991, S.O. 1991, c. 21, as amended, and paragraphs 1(2) and 1(33), of Ontario Regulation 852/93. Below we explain that decision.

THE ALLEGATIONS

The allegations against Dr. Shaun Lambrou (the "Member"), were stated in a Notice of Hearing, dated October 12, 2018 which was filed as Exhibit 1. The original allegations were:

- (a) you have committed an act of professional misconduct as provided by subsection 51(1)(b.1) of the *Health Professions Procedural Code of the Chiropractic Act, 1991*, S.O. 1991, c. 21, as amended, in that in December 2017 you sexually abused a patient known as Patient A;
- (b) you have committed an act of professional misconduct as provided by subsection 51 (1)(c) of the *Health Professions Procedural Code of the Chiropractic Act*,

1991, S.O. 1991, c. 21, as amended, and paragraph 1(2) of Ontario Regulation 852/93, in that in December 2017, you contravened a standard of practice of the profession or failed to maintain the standard of practice expected of members of the profession with respect to your treatment of and/or conduct towards a patient known as Patient A;

- (c) you have committed an act of professional misconduct as provided by subsection 51 (1)(c) of the *Health Professions Procedural Code* of the *Chiropractic Act*, 1991, S.O. 1991, c. 21 (1) as amended, and paragraph 1(5) of Ontario Regulation 852/93, in that in December 2017, you abused a patient known as Patient A verbally and/or physically and/or psychologically and/or emotionally; and
- (d) you have committed an act of professional misconduct as provided by subsection 51 (1)(c) of the *Health Professions Procedural Code* of the *Chiropractic Act*, 1991, S.O. 1991, c. 21, as amended, and paragraph 1(33) of Ontario Regulation 852/93, in that in December 2017, you engaged in conduct or performed an act, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional with respect to your treatment of and/or conduct towards a patient known as Patient A.

The CCO, however, as part of a Resolution Agreement, withdrew allegations (a), (c) and the claims of disgraceful and dishonourable conduct in (d).

THE EVIDENCE

An Agreed Statement of Facts (Exhibit 2) was filed. This provided that:

1. Dr. Shaun Lambrou ("Member") became a member of the College of Chiropractors of Ontario ("CCO") in 2010. The Member has not been the subject of a previous Discipline Committee hearing.
2. During the relevant time, the Member was a practitioner at Massage Matters ("Clinic") in Toronto, Ontario.

Patient A

3. In December 2017, Patient A was experiencing neck pain caused by stress. She had been receiving chiropractic treatment and massage for the pain. However, her usual chiropractor moved and she found massage alone was no longer effective. Patient A decided to obtain treatment from a new chiropractor.
4. On December 14, 2017, Patient A attended at the Clinic and completed patient intake forms. The Member greeted her in the reception area of the Clinic and took her into a treatment room. He asked Patient A questions, assessed her and diagnosed her as having mechanical neck strain caused by stress and posture. The Member proposed treating her with adjustments, soft tissue work and possibly acupuncture in the future. Patient A agreed to the proposal.
5. The Member provided Patient A with a treatment on December 14, 2017. She was wearing street clothes, including a shirt and sweater. According to Patient A, the Member asked her to remove her sweater and she did so. The Member put cream on his hands and did soft tissue

work on the back of her neck and clavicle area. During the soft tissue work, the Member leaned his body against Patient A's back. Had he testified, the Member would have said that he needed to position himself in that manner so he could generate the appropriate amount of force required to do the soft tissue work.

6. The pressure from the Member's body against her back made Patient A uncomfortable, but, she did not say anything. Following the soft tissue work, Patient A lay down prone on the treatment table and the Member did soft tissue work on her back, putting his hands under her shirt from the bottom to do so. This also made her feel uncomfortable, but she didn't say anything. The Member then had Patient A lie supine on the treatment table and he adjusted her neck and back.

7. Following the treatment, the Member escorted Patient A to the reception area. He encouraged her to book three more appointments, and she booked two: one on December 20, 2017 and one on December 23, 2017.

8. On December 20, 2017, Patient A returned to the Clinic for a second treatment. She was no longer having neck pain and reported that her tension was much lesser but not completely gone. Similar to the first treatment, the Member asked her to remove her sweater, and began to do soft tissue work on her neck and clavicle area. Similar to the first treatment, he leaned his body against her back during the soft tissue work.

9. Had Patient A testified, she would have said that when the Member leaned his body against her, she believed she felt his penis against her back. Had he testified, the Member

would have denied his penis ever touched Patient A, and that what she felt was the side of his leg and his hip.

10. Following the soft tissue work, the Member asked Patient A to lie supine on the treatment table. She did so and he did soft tissue work on her neck. During the soft tissue work on her neck, Patient A sat up and asked him to stop. She told the Member that she had just finished reporting a situation that involved years of sexual harassment from a fellow employee at her workplace. She told him that when he massaged her and leaned against her, she had felt his private parts rubbing up against her and that it was not Ok. The Member told her that he was sorry.

11. Had the Member testified, he would have said he was shocked and surprised by Patient A's comments and that he apologized because there had been a misunderstanding.

12. Patient A then ended the treatment early and left the room. She went to the reception area. She paid for the treatment and cancelled the next appointment. The same day Patient A made a complaint to the CCO.

13. In addition to documenting the assessment and treatment of Patient A on December 20, 2017, the Member also documented "Clinical Note Addendum: Patient left treatment early, was not feeling well."

14. Patient A was very upset by what she perceived happened to her on December 20, 2017. On December 28, 2017, Patient A saw a psychologist for treatment for her distress. The

psychologist made a mandatory report of sexual abuse of a patient to the CCO on December 29, 2017.

CCO Standards and Guidelines

15. CCO Standard of Practice S-001 Chiropractic Scope of Practice requires a member to provide relevant, safe, supportive patient-centered quality care and to document legible and accurate notes capturing any unique aspects of treatment.

16. CCO Standard of Practice S-002 Record Keeping requires a member to maintain accurate and complete patient records that contain comprehensive information about the initial examination and all assessments, the diagnosis or clinical impression, and a plan of care for the patient. The record must contain a copy of the patient's consent to any course of care, and reasonable information about advice and treatment given to the patient. The record should accurately recreate the doctor/patient interaction and should include reasonable information about a procedure that was commenced but not completed, including the reasons for non-completion.

17. CCO Standard of Practice S-013 Consent, requires a member to obtain consent to care or a plan of care that is fully informed, voluntarily given, related to the patient's conditions and circumstances and documented in the patient health record.

18. CCO Guideline G-001 Communication with Patient, requires a member to ensure that a patient, at all times, understands what is being done and why. The member has an

obligation to respect a patient's dignity and personal space and demonstrate particular awareness when touching a sensitive area of the body.

Admissions

19. The Member admits that he failed to adequately explain to Patient A the nature of the treatment he was proposing to provide to her and the reason for it. He, therefore, did not obtain informed consent for the treatment. The Member admits he did not adequately communicate with the patient throughout the treatment so that she understood what he was doing and did not take steps to ascertain her comfort with his treatment. He failed to document why the treatment on December 20, 2017 was not completed. He admits his documentation in the addendum on December 20, 2017 was misleading, inaccurate and incomplete.

20. The Member admits that, based on the facts set out above, he committed acts of professional misconduct as set out in the Notice of Hearing dated August 17, 2018

("Notice of Hearing") because he:

- (a) contravened a standard of practice of the profession or failed to maintain the standard of practice expected of members of the profession, as described in Allegation 2; and
- (b) engaged in conduct or performed acts that, having regard to all the circumstances would reasonably be regarded by members as unprofessional as described in Allegation 4.

Other

The Member also acknowledged that he had received legal advice from his counsel, Valerie Wise, prior to signing the Resolution Agreement and that he had signed the Agreed Statement of Facts freely and voluntarily.

DECISION

After a brief recess to consider our decision the Panel accepted the submission from the parties and found Dr. Lambrou to have committed professional misconduct as alleged in the outstanding allegations in the Notice of Hearing.

SUBMISSIONS ON PENALTY AND COSTS

The parties presented the Panel with a joint submission on penalty and costs which was filed on consent as Exhibit 3. This submission asked the Panel to make the following orders:

1. Requiring the Member to appear before the Panel to be reprimanded.
2. Directing the Registrar and General Counsel ("Registrar") to suspend the Member's certificate of registration for a period of four months ("Suspension") beginning on April 15, 2019.

3. Directing the Registrar to impose the following terms, conditions and limitations ("Conditions") on the Member's certificate of registration:

- (a) by July 15, 2019, the Member must:
 - (i) review, and undertake in writing to comply with, all CCO regulations, standards of practice, policies and guidelines, including, but, not limited to CCO Standard of Practice S-001 Chiropractic Scope of Practice; CCO Standard of Practice S002: Record Keeping; CCO Standard of Practice S-013 Consent, and CCO Guideline G-001: Communication with Patients; and
 - (ii) provide evidence that he has successfully completed, at his own expense, the Legislation and Ethics Examination and the Record Keeping Workshop;
- (b) requiring the Member to be peer assessed at his own expense within six months of returning to practice after the lifting of the suspension.

4. Directing the Registrar to suspend one month of the Suspension if the Member completes the Conditions set out in Paragraph 3(a), by July 15, 2019.

5. Requiring that the results of the proceeding be recorded in the public portion of the Register and published in the Annual Report or other publications at the discretion of the College of Chiropractors of Ontario.

The CCO and the Member also requested the Panel order the Member to pay \$10,500.00 by December 31, 2019 to the CCO to partially pay for its costs of the investigation and the costs and

expenses of the hearing and of legal counsel, with the Member to provide post-dated cheques for the costs at the completion of the Discipline Committee hearing.

Dr. Lambrou again acknowledged that he had received advice from his counsel, Valerie Wise, prior to entering into this Resolution Agreement and affirmed that he had signed the Joint Submission on Penalty and on Costs freely and voluntarily. Dr. Lambrou also stated that he would not appeal or seek judicial review of the decision of the Discipline Committee regarding the allegations set out in the Notice of Hearing so long as the Panel accepted the Joint Submission on Penalty.

ORDERS

After retiring to consider the penalty the Panel accepted the recommendations from the parties and made the following orders:

1. Requiring the Member to appear before the Panel to be reprimanded.
2. Directing the Registrar and General Counsel ("Registrar") to suspend the Member's certificate of registration for a period of four months ("Suspension") beginning on April 15, 2019.
3. Directing the Registrar to impose the following terms, conditions and limitations ("Conditions") on the Member's certificate of registration:
 - (a) by July 15, 2019, the Member must:

- (i) review, and undertake in writing to comply with, all CCO regulations, standards of practice, policies and guidelines, including, but not limited to, CCO Standard of Practice S-001 Chiropractic Scope of Practice, CCO Standard of Practice S002: Record Keeping, CCO Standard of Practice S-013 Consent, and CCO Guideline G-001: Communication with Patients and
 - (ii) provide evidence that he has successfully completed, at his own expense, the Legislation and Ethics Examination and the Record Keeping Workshop;
- (b) requiring the Member to be peer assessed at his own expense within six months of returning to practice after the lifting of the suspension;
4. Directing the Registrar to suspend one month of the Suspension if the Member completes the Conditions set out in Paragraph 3(a), by July 15, 2019.
5. Requiring that the results of the proceeding be recorded in the public portion of the Register and published in the Annual Report or other publications at the discretion of the College of Chiropractors of Ontario.
6. Requiring the Member to pay \$10,500.00 by December 31, 2019 to the CCO to partially pay for its costs of the investigation and the costs and expenses of the hearing and of legal counsel, with the Member to provide post-dated cheques for the costs at the completion of the Discipline Committee hearing.

The Panel concluded that the proposed penalty was both fair and reasonable, as it falls within the range of penalties appropriate based on the admissions and findings in this matter. We acknowledge that it was negotiated by counsel for both parties and we are satisfied that the review of CCO guidelines, regulations, standards of practice and policies as well as taking the record keeping workshop and legislation and ethics exam will be effective remediation tools. The Panel believes that by making this order, the public interest is served through a strong message of deterrence and a clear assurance of the College's commitment to the public protection.

REPRIMAND ADMINISTERED

7. As Dr. Lambrou had undertaken not to appeal or seek judicial review if we accepted the Joint Submission, at the conclusion of the hearing, the Panel administered the oral reprimand required by its penalty order.

I, Karoline Bourdeau, sign this decision and reasons as chair of this Discipline Panel and on behalf of the members of the Discipline Panel listed below:

April 2, 2019

Karoline Bourdeau

KAROLINE BOURDEAU, J.D., Chair

Panel Members: Mr. Doug Cressman
Dr. Colleen Patrick
Dr Colin Goudreau
Dr. Brian Budgell



CONDUCTING A DISCIPLINE HEARING

Federation of Health Regulatory Colleges of Ontario

Friday, May 3, 2019

Osgoode Professional Development Centre
26th Floor, Classroom B
1 Dundas St W
Toronto ON M5G 1Z3

Faculty

Brian Gover/Luisa Ritacca
Stockwoods LLP &
Richard Steinecke
Steinecke Maciura LeBlanc

Program Objectives

This program is designed to provide professional regulators with a comprehensive orientation to the discipline process. At the conclusion of the session, participants will have an understanding of:

- Relevant principles of administrative law
- Roles of various participants in the hearings process
- Activities that occur prior to a hearing
- Procedures associated with the hearings process
- Responsibilities of panel members

Discipline Orientation Committee (being confirmed April 25, 2019)

- **Tina Langlois**, College of Medical Radiation Technologists of Ontario (Chair)
- **Eyal Birenberg**, College of Optometrists of Ontario
- **Aoife Coghlan**, College of Occupational Therapists of Ontario
- **Genevieve Plummer**, Ontario College of Pharmacists
- **Ravi Prathivathi**, College of Nurses of Ontario

Discipline Orientation Workshop Basic Session

8:30 a.m. – 9:00 a.m.

Registration and LIGHT CONTINENTAL BREAKFAST

9:00 a.m. – 9:30 a.m.

Introduction and Legal Framework

Topics include: applicable legislation, jurisdiction, the public interest, confidentiality, disclosure, allegations, penalties and costs

9:30 a.m. – 10:00 a.m.

Video of a Discipline Hearing

10:00 a.m. – 10:30 a.m.

Principles of Administrative Law

Topics include: nature of a hearing, natural justice, transparency, burden of proof and accountability

10:30 a.m. – 10:45 a.m. BREAK

10:45 a.m. – 11:00 a.m.

Fitness to Practice (FTP)

Topics include: how the FTP process differs from discipline, definition of incapacity

11:00 a.m. – 11:30 a.m.

Pre-Hearing Procedures

Role play will focus on the Pre-Hearing Conference and the goal of narrowing the issues, coming to an agreed statement of fact, and developing joint submissions on penalty

11:30 a.m. – 12:15 p.m.

Roles of Various Participants in the Hearing Process

Discussion will focus on the roles of panel members, prosecution and defence counsel, independent legal counsel, intervenors, media, experts, witnesses, court reporters, and staff

12:15 p.m. – 1:00 p.m. LUNCH (provided)

1:00 p.m. – 2:30 p.m.

The Discipline Hearing

Through role play, attendees will experience an abbreviated contested hearing

2:30 p.m. – 2:45 p.m. BREAK

2:45 p.m. – 3:00 p.m.

The Discipline Hearing (continued)

3:00 p.m. – 4:00 p.m.

Responsibilities of Panel Members

Discussion will focus on panel member conduct prior to, during, and after the hearing by using real case examples of situations where panel member conduct is questioned

4:00 p.m. – 4:15 p.m.

Concluding Remarks and Evaluation

All registrations will be confirmed via fax or email within five (5) business days of receipt of the form. If you do not receive a confirmation, please contact the Federation office by phone (416-493-4076), fax (1-866-814-6456), or email (info@regulatedhealthprofessions.on.ca)

See Registration Form for rates and payment information.

Conducting a Discipline Hearing Registration Form

DISCIPLINE ORIENTATION WORKSHOP — BASIC SESSION

Friday, May 3, 2019

Osgoode Professional Development Centre, 26th Floor, Classroom B, 1 Dundas St W, Toronto ON M5G 1Z3

Contact information: (for name badge) Dr. Mr. Ms Mrs. Other (Please specify _____)

Registrant's Name: _____

Organization: _____

Address: _____

Phone #: _____ Fax #: _____

Registrant's Email : _____

Name of person completing form (if different from Registrant): _____

Email/Phone # of person completing form: _____ / _____

Send registration information to: Registrant Person completing form Both

Registrant Information:

Dietary Restrictions: _____

Accommodation Needs: _____

Please advise if you wish to be contacted regarding your specific needs.

Questions for the Registrant to help with planning for this Session:

Have you attended a Federation Discipline Hearing Program previously? Yes No

Have you participated in discipline hearings? Yes (1) Yes (between 2-5) Yes (6 or more) No

Are you willing to participate in a scripted role play? Yes No

RATE SCHEDULE (INCLUDES HST)	Early Bird (to April 15)	Regular (After April 15)	Total
Federation Member*	\$550.00	\$600.00	
Non-Member	\$650.00	\$750.00	

*Member rates apply to all Council, Committee Members, and Staff of Federation Members

Submit completed forms to the Federation Office via:

email: info@regulatedhealthprofessions.on.ca, or

Fax: 1-866-814-6456, or

Mail: Federation of Health Regulatory Colleges of Ontario
Suite 301 - 396 Osborne St, PO Box 244
Beaverton ON L0K 1A0

Make cheques payable to:

Federation of Health Regulatory Colleges of Ontario

Payment Method:

Cheque VISA MasterCard AMEX

If by credit card:

Card #: _____ Exp: _____

Cardholder's Name: _____

Signature: _____

(If completing form electronically, cardholders not able to include e-Signature will be contacted for verification)

Policies: Cancellations received in writing not less than ten (10) business days prior to the event will receive a full refund. Cancellations received less than ten (10) business days will not be refunded, but substitutions are permitted. Registration in the FHRCO Discipline Orientation Program is restricted to individuals who serve on or support a Discipline Committee at a regulatory College and employees of related agencies at the invitation of a FHRCO member or administration.

Confirmation: All registrations will be confirmed via fax or email within five (5) business days of receipt of the form. If you do not receive a confirmation, please contact the Federation office by phone (416-493-4076), fax (1-866-814-6456), or email (info@regulatedhealthprofessions.on.ca)

**College of Chiropractors of Ontario
Fitness to Practise Committee Report to Council
April 30, 2019**

26

Members: Dr. Kristina Peterson, *Chair*
Ms Georgia Allan
Dr. Brian Budgell

Staff Support: Jo-Ann Willson, *Registrar and General Counsel*
Joel Friedman, *Director, Policy & Research*

Committee Mandate

- To hear and determine allegations of mental or physical incapacity referred to the committee by the Inquiries, Complaints and Reports Committee.
- To review applications for reinstatement following an incapacity finding.

I. Introduction and Recommendations

The Committee has not held any meetings since the last council meeting.

There are no recommendations to council.

No referrals were received since the last council meeting.

I would like to thank the Fitness to Practise Committee members for their time; Ms. Georgia Allan, Dr. Brian Budgell and our staff support Ms. Jo-Ann Willson and Mr. Joel Friedman.

Respectfully submitted,

Dr. Kristina Peterson, Chair
Fitness to Practise Committee

**College of Chiropractors of Ontario
Inquiries, Complaints and Reports Committee Report to Council
April 30, 2019**

Members: Dr. Gauri Shankar, *Chair*
Dr. Steve Gillis, *non-Council Member*
Ms Tamara Gottlieb, *Public Member*
Dr. Brian Schut, *Council Member*

Staff Support: Ms Christine McKeown, *Investigations, Complaints & Reports Officer*
Ms Tina Perryman, *Manager, Inquiries, Complaints & Reports*

Since the last Council meeting, the Inquiries, Complaints and Reports Committee (ICRC) met on three occasions, and reviewed 25 complaints, four reports and five inquiries. ICRC made decisions on 16 complaints and six reports. Nine section 75(c) investigator appointments were requested by the ICRC.

I would like to thank, Ms Andrea Szametz for her precise minutes, and the experience and expertise of both Ms Christine McKeown and Ms Tina Perryman.

Respectfully submitted,

Dr. Gauri Shankar, Chair
Inquiries, Complaints & Reports Committee

**College of Chiropractors of Ontario
Registration Committee Report to Council
Tuesday, April 30, 2019**

Members: Dr. Cliff Hardick, *Chair*
Ms Karoline Bourdeau
Dr. Dennis Mizel
Mr. Doug Cressman

Staff Support: Mr. Joel Friedman, *Director, Policy and Research*
Ms Madeline Cheng, *Registration Coordinator*
Ms Jo-Ann Willson, *Registrar and General Counsel*
Ms Andrea Szametz, *Recording Secretary*

I. Report

Since the last meeting of Council, the Registration Committee met once via teleconference on March 13, 2019. The Committee has no recommendations at this time.

Current Member Status

Chart 1: Membership Statistics as at April 15, 2019

Status	Total
Active	4559
Inactive – Resident	226
Retired	135
All categories	4920

Chart 2: Change in Registration statistics for February 1, 2019 – April 15, 2019

Description	Total
New registrants	15
Female	6
Male	9

Chart 3: Colleges of Graduation for New Registrants

CMCC	5
Life CC	2
NUHS	1
Palmer	2
NYCC	3
Logan	2

Respectfully submitted,

Dr. Cliff Hardick,
Chair, Registration Committee

Generated Internally

**College of Chiropractors of Ontario
Executive Committee Report to Council
April 30, 2019**

Members: Dr. David Starmer, *President*
Dr. Liz Anderson-Peacock, *Vice-President*
Mr. Doug Cressman, *Treasurer*
Ms Georgia Allan
Ms Karoline Bourdeau
Dr. Kristina Peterson
Dr. Gauri Shankar

Staff Support: Mr. Joel Friedman, *Director, Policy and Research*
Ms Jo-Ann Willson, *Registrar and General Counsel*

I Introduction

- I am pleased to present the Executive Committee (“Committee”) report to Council. Since the Council meeting on February 27, 2019, the Committee has met for one meeting on March 12, 2019. The draft, confidential minutes are included in the council information package and are subject to approval by the Committee at the meeting on May 21, 2019. I would like to thank departing Committee members, Drs. Shankar and Anderson-Peacock for their work on the Committee and contributions to Council over the past many years.

- Ms Willson and I have discussed various amendments to the council information packages and structuring of the agenda, and we would appreciate any feedback about the changes to date or any future directions. One of the challenges is to include relevant background information and an environmental scan of health regulation in Ontario, the rest of Canada, and internationally, while not including too much information. Council should remain focused on matters directly relevant to public protection and CCO's statutory mandate. With this package, the revised format is to have all the reports and recommendations together, and any background information in a separate section primarily as FYI for Council members to refer to as required. One possible future direction is to not circulate any FYI information, but to have a council member portal for any information which traditionally has been included in that section. Only reports and recommendations requiring action would then be distributed.
- As the new committees are composed on May 1, 2019, all committee chairs are asked to please diarize all Council meeting dates, and note that committee reports need to be filed no later than 15 business days before a Council meeting to ensure the information package can be distributed promptly to Council members. Meeting dates within the 15 day window of a Council meeting will have recommendations deferred to the subsequent Council meeting date. This will facilitate council information packages being distributed promptly to Council members and posted on the website for stakeholders including the public and members. I anticipate the Council meeting dates will be selected immediately following the May 1, 2019 council elections.
- By the time of the Council meeting, many Council members will have had an opportunity to participate in the training being offered on April 26, 2019. Originally, this day was set aside for training the new Council members, but an opportunity arose to have Ms Lori Lukinuk attend and provide some training on Rules of Order. When the information was distributed, many Council members indicated they would like to attend both sessions, and accordingly, the day was opened to all Council members who wanted to attend.

- Ms Lukinuk initially indicated that she could make herself available to help facilitate the Council meeting on April 30, 2019, but Ms Willson and I thought it best to have an opportunity to present the various options about the nature of her participation as well as her experience so an informed decision could be made. The Ontario College of Teachers recommended Ms Lukinuk to Ms Willson.
- There will be other training opportunities which the new Executive will consider and recommend to Council with more notice, keeping in mind both priorities and budget. Other topics previously discussed topics include: Regulatory Boot Camp, Effective Chairing, Discipline and/or Fitness to Practice training.

II High Priority Items

A. Elections

- In Ms Willson's view, there are insufficient grounds upon which Council should recall the recent CCO elections (see April 17, 2019 memo from Ms Willson enclosed in Council information package). There are however a number of matters that should be considered and addressed for future elections, and this will be included on the agenda for the May 21, 2019 Committee meeting. In the interim, it would be appropriate to communicate with members about the concerns that have been raised as they relate to the elections in general, which is separate and apart from any matters which may be addressed through other CCO processes.

Recommendation 1

That Council approve a high level communication to stakeholders including members addressing the various expression of concerns about the recent elections, what parameters will be around future elections (including respectful, professional discourse), and that CCO is encouraged by the high level of engagement of the membership as demonstrated by the rate of voter turn-out.

B. Communications/Strategic Planning

- Consistent with CCO's review of important influencers and decisions makers concerning CCO, Ms Willson has provided information to the MOHLTC concerning all of CCO's recent communications involving recent media attention, including the Professional Advisory on Vaccination, the Request for Proposal for website scanning technology, and the numerous communications with reporters. Responses have been reviewed by CCO's communications consultants, Mr. Boyd Neil and Mr. Chris Winsor.
- As Council members know, there was an effort to approve a revised S: 001: Scope of Practice and a revised Advisory via e-mail, but the majority of feedback reflected a need to have further discussion at Council. I am hopeful that at the April 30, 2019 meeting, Council will be in a position to approve a revised standard and advisory, and that the information can be shared both with MOHLTC and our stakeholders including members. The discussion concerning these matters must remain focused on CCO's public interest mandate.
- Included in the council information package is a variety of feedback concerning CCO's communications. I think it is important that we communicate thoroughly and clearly about CCO's position about important health related matters. Also included is a request from Ms Willson to Ms Henry about whether or not MOHLTC has a position on health regulatory colleges actively advising health professions to promote vaccination/immunization or other public health positions of the Ministry when those matters are not in scope. As of the time of writing this report, there has not been a response to this question, but it would help inform CCO's review of existing standards and guidelines.

IV Medium Priority Items

A. By-laws

- The Committee has at various times considered by-law amendments for recommendation to Council. Some, but not all by-law amendments require a 60 day circulation for feedback before being approved. There are some by-law amendments which are consistent with best practices at other colleges, and are reflected in the chart prepared by Mr. Friedman which is included in the council information package; others which are more controversial and with respect to which there hasn't been a consensus (like composition of Council and the advisability of an academic position); others which are to be considered by the new Executive (such as the composition of the ICRC); and others that are brand new for Council's consideration, such as the appointment of an external Registrar to address any conduct matters involving Council or Committee members.

- Council has options relating to approval and circulation of by-law amendments such as:
 - Approve noncontroversial minor by-law amendments (bylaws 1: Definitions and Interpretations, 3: Executive of Documents, 5: Financial Year and Auditing, 6: Election of Council, 7: Elections within Council, 8: Council Meetings, 10: Indemnification, 11: Committee Composition (identify quorum), 12: Appointment of Non-Council members, 13: Fees and 14: Professional Corporations.
 - Circulate by-law amendments requiring circulation pursuant to the *RHPA*, namely By-law 16: Professional Liability Insurance;
 - Agree on other by-law amendments not requiring circulation (Bylaw 11: Committee Composition to change ICRC to two public members) and new proposed By-law 18: Concerns about Council or Committee Members;
 - Hold back all by-law amendments until there is a consensus on the direction of all of them, including any changes to the Eligibility for Council by-law;
 - Choose to circulate all by-law amendments, including those not requiring circulation as part of an overall by-law review; or
 - Compose a By-law Review Committee at the May 1, 2019 meeting to review all by-laws and make recommendations to Council (this would have budgetary considerations).

- The suggestion that Council approve a new by-law which authorizes Council to retain an External Registrar in any conduct matter involving Council or Committee members was not previously reviewed by the Committee, and arises out of recent discussions between Ms Willson and Mr. Steinecke who have reviewed various alternatives to having the Registrar involved in any conduct matters with respect to Council members. Apparently one other health regulatory college, namely, the Royal College of Dental Surgeons, appoints an outside Registrar in any circumstance involving the conduct of a Council member. Although this is not a common practice, it may be a best practice, given that it reduces the potential appearance of bias or any conflict of interest. I am hopeful there is sufficient support for the recommendation so that it may be approved at the April 30, 2019 meeting. This by-law does not require circulation.

Recommendation 6

That Council approve the draft by-law relating to retaining an External Registrar in any conduct matter involving Council or Committee members.

- The background information concerning various by-law amendments is included in the Council information package. It is up to Council to determine the process for approving by-law amendments. Information about the by-laws has been included in every information package. The simplest would be for Council to approve anything noncontroversial, come up with an action plan for circulation of other by-laws, and factor in circulation of by-laws requiring circulation so Council has a comprehensive package before it for approval at the earliest opportunity.

B. Standards of Practice, Policies, Guidelines

- Consistent with the approval of amendments to various standards approved by Council on February 27, 2019, Mr. Friedman has prepared a draft communication to stakeholders including members. However, there are further amendments being recommended to S-001: Scope of Practice at the April 30, 2019 meeting, and accordingly, the communication will be revised to reflect any further changes. Given the importance of the issue, I suggest we not wait until approval of the minutes on June 19, 2019 before distributing the communication:

Recommendation 7

That Council approve the circulation of the draft communication relating to amendments to the Standards of Practice approved by Council on February 27, 2019 including any further changes to S-001: Scope of Practice approved by Council April 30, 2019.

Recommendation 8

That Council approve P-010: Use of Professional Titles, Designations and Credentials.

Recommendation 9

That Council revoke P-010: Professional Misconduct Relating to Orthopractic.

V Chiropractic/Health Related Stakeholders

- Included in the Council information package is a variety of information and documentation relating to chiropractic and other health related stakeholders. Council members will note that:
 - CCO continues to work with other stakeholders, namely, OCA and CMCC in furthering the initiative to enhance the chiropractic scope of practice to include advanced diagnostics and laboratory tests;
 - Ms Willson and I attended the recent Federation of Canadian Chiropractic (FCC) meetings in Montreal, April 12, 2019. There were many interesting topics being discussed nationally.
 - Consistent with Council's previous direction, Ms Willson, along with Dr. Gregg Dunn, Canadian Chiropractic Protective Association, co presented to the Regulatory Council of the FCC on a plan to host a national meeting for regulators and CCPA. A copy of the invitation is included in the Council information package. Ms Willson and Dr. Dunn expressed the view that the meeting would be open to all regulators, whether they are members of FCC or not, and that the other advocacy bodies such as the CCA would not be involved in the planning for or participation at the meeting. CCPA has offered to help support the smaller provinces who may not be able to attend for financial reasons. Ms Willson has offered CCO's new space as the location for the workshop. The intention would be to try to harmonize standards on topics such as advertising, social media, continuing education, and to move towards consistency in the patient experience coast to coast. Plans are still in development but early interest has been high and suitable dates are being considered.
 - CMCC has signed a document called the International Position Statement on Chiropractic Education (released March 27, 2019).
 - Based on Council's feedback, I declined the invitation from Ms Dantas at CCA to participate in a panel discussion at the Presidents' meeting on April 27, 2019. There may be other opportunities for CCO and CCA to dialogue about matters in which our jurisdictions overlap.

- In June 2019, Canada is hosting the international Council on Licensure, Enforcement and Regulation Conference in Vancouver, British Columbia. Ms Willson and I would like to attend. It is the first time Canada is hosting the international conference, and there are many relevant and interesting topics on the agenda which is included in the Council information package.
- The Federation of Health Regulatory Colleges of Ontario is hosting its Annual General Meeting on Thursday, April 25, 2019. Ms Willson has been nominated to serve on the Executive for another term. Other staff members are participating in various other working groups (Quality Assurance, Registration, and Corporate Services).

VI Conclusion

- In addition to the matters noted above, the Committee is dealing with a variety of other issues reflected in the draft minutes. I encourage all Council members to diarize the various meeting dates reflected in the agenda and encourage all committee chairs to set meeting dates as soon as possible after the new committees are composed on May 1, 2019.
- I appreciate everyone's ongoing involvement and commitment to CCO. I thank each of you for your commitment and support over what has been a challenging but rewarding year. I believe we can work together to face new challenges and opportunities including the upcoming AGM in June 2019, move to new premises in the summer 2019 and Strategic Planning Session and Council meeting in September 2019. Thank you for time, enthusiasm and dedication to CCO's important role in regulating chiropractic in the public interest.

Respectfully submitted by,

Dr. David Starmer
President

**MEMORANDUM
COLLEGE OF CHIROPRACTORS OF ONTARIO**

To: Candidates in Districts 2, 3 and 4
C: Council
 CCO Noncouncil Committee Members
 Chiropractic Stakeholders ¹

From: Jo-Ann Willson, Registrar and General Counsel

Date: March 28, 2019

Subject: Unofficial Results of Election to CCO Council – Districts 2, 3 and 4

Unofficial Results

The *unofficial* results of CCO's electronic elections are as follows:

District 2 – Unofficial Election Results

Name of Candidate	Numbers
Dr. Paul Groulx (elected)	185
Dr. Peter Wise	154
Votes cast	339
Eligible voters	460
Percentage voted	73.7 %

District 3 – Unofficial Election Results

Name of Candidate	Numbers
Dr. Elizabeth Anderson-Peacock	184
Dr. Steven Lester (elected)	203
Votes cast	387
Eligible voters	573
Percentage voted	67.5 %

¹ Ontario Chiropractic Association (OCA), Canadian Chiropractic Association (CCA), Canadian Chiropractic Examining Board (CCEB), Canadian Chiropractic Protective Association (CCPA), Federation of Canadian Chiropractic (FCC), Canadian Memorial Chiropractic College (CMCC), Alliance for Chiropractic (AFC) and World Federation of Chiropractic (WFC).

100

District 4 – Unofficial Election Results

Name of Candidate	Numbers
Dr. Gerard Arbour	279
Dr. Janet D'Arcy (elected)	551
Votes cast	830
Eligible voters	1685
Percentage voted	49.3 %

Request for a Recount

Please note that the deadline to make a written request for a recount, with a \$150.00 deposit, must be received at CCO by April 16, 2019 at 4 p.m. (please refer to notice of election and nomination guide). The first regular meeting of Council is scheduled for Tuesday, April 30, 2019, followed by internal elections and orientation meeting on Wednesday, May 1, 2019.

The spring 2019 elections had the highest rate of return for any Council elections which demonstrates members' interest and involvement in the self-regulation of the chiropractic profession in Ontario. CCO's reliance on technology and movement to electronic voting has permitted the earlier than anticipated release of the unofficial results. Thank you to all candidates for putting your name forward to serve on CCO Council and to continue CCO's important work in regulating the profession in the public interest.

*For Anne
Wilson*

- 6.9 A member is eligible for election to Council in an electoral district, if on the closing date of nominations and anytime up to and including the date of the election:
- (a) the member has his/her primary practice of chiropractic located in the electoral district in which he/she is nominated or, if the member is not engaged in the practice of chiropractic, has his/her primary residence located in the electoral district in which he/she is nominated;
 - (b) the member is not in default of payments of any fees prescribed by by-law or any fine or order for costs to CCO imposed by a CCO committee or court of law;
 - (c) the member is not in default in completing and returning any form required by CCO;
 - (d) the member is not the subject of any disciplinary or incapacity proceeding
 - (e) a finding of professional misconduct, incompetence or incapacity has not been made against the member in the preceding three years;
 - (f) the member is not an employee, officer or director of any professional chiropractic association such that a real or apparent conflict of interest may arise, including but not limited to being an employee, officer or director of the OCA, CCA, CCPA, AFC, CCEB, CSCE or the CCEC of the FCC;
 - (g) the member is not an officer, director, or administrator of any chiropractic educational institution, including but not limited to, CMCC and UQTR, such that a real or apparent conflict of interest may arise;
 - (h) the member has not been disqualified from the Council or a committee of the Council in the previous three years;
 - (i) the member is not a member of the Council or of a committee of the College of any other health profession; and
 - (j) the member has not been a member of the staff of CCO at any time within the preceding three years.
- 6.10 The registrar shall supervise the nomination of candidates.

- 6.11 No later than 60 days before the date of an election, the registrar shall notify every member eligible to vote of the date, time and place of the election and of the nomination procedure.
- 6.12 The nomination of a candidate for election as a member of Council, and undertaking to the CCO Registrar shall be in writing and shall be given to the registrar at least 45 days before the date of the election (i.e., the nomination date).
- 6.13 The nomination shall be signed by the candidate and by at least 10 members who support the nomination and who are eligible to vote in the electoral district in which the election is to be held.
- 6.14 The candidate shall provide to the registrar by the nomination date or such later date as the registrar permits, biographical information in a manner acceptable to the registrar for the purpose of distribution to eligible members in accordance with the by-laws.
- 6.15 The candidate may withdraw his or her nomination for election to Council no later than 30 days before the date of the election.
- 6.16 If the number of candidates nominated for an electoral district is less than or equal to the number of members to be elected, the registrar shall declare the candidates to be elected by acclamation.
- 6.17 The registrar shall supervise and administer the election of candidates and, for the purpose of carrying out that duty, the registrar may, subject to the by-laws,
- (a) appoint returning officers and scrutineers;
 - (b) establish a deadline for the receiving of electronic ballots;
 - (c) provide for the notification of all candidates and members of the results of the election;
 - (d) if there has been a non-compliance with a nomination or election requirement, determine whether the non-compliance should be waived in circumstances where the fairness of the election will not be affected; and
 - (e) provide for the destruction of electronic ballots following an election.

RCDSO Code of Conduct

In June 2000, Council passed a Code of Conduct for Council members. This Code of Conduct emphasizes that Council members must exercise care, diligence, skill, civility, and prudence when carrying out the business of the College. In the event of a breach, the Code of Conduct provides for sanctions, including removal from Council.

This Code of Conduct aims to provide instruction and guidance to Council members regarding confidentiality, communication between Councillors and communication with local dental societies, conflicts of interest and general decorum.

Conflict of Interest by-law

In April 2002, Council enacted a Conflict of Interest by-law. This by-law defined related persons and related corporations and sets out what type of action or inaction may result in a situation of conflict of interest or a situation where there may be the appearance of a conflict of interest.

This by-law also provides guidance and protocols for Council members to follow if they are unsure as to whether they may be acting in conflict. All Council members should be aware that there are possible conflict of interest scenarios that are not specifically addressed in the by-law. There is an ever-evolving body of law that must be considered when assessing potential conflicts of interests.

Election and Selection of Councillors

While legislation provides for the number of elected dentists, the by-laws set out the College's electoral districts, eligibility of members (dentists) to vote, nominations and electoral procedures, eligibility of candidates to stand for election, and the selection of two academic representatives.

The by-laws also detail the process for disqualifying an elected or selected member from sitting on Council, including procedural and other safeguards. The same provisions apply to the members of Council who are selected from the universities, with slight modification.

Campaign Guidelines for Council Elections

These guidelines, passed by Council, are for dentists seeking election or re-election to the Council of the Royal College of Dental Surgeons of Ontario and are intended to apply to written campaign materials, oral presentations/speeches and general decorum of candidates:

- Be respectful, polite, dignified and professional in everything you do.
- It is more effective and credible to announce your qualifications than to try to denounce another candidate's qualifications.
- Only rely on and promote information that is both factual and provable.
- It is not appropriate to mount a personal or professional attack on any candidate.
- Focus on your ideas and the positives that you have to offer.
- Ensure that the words you use are inclusive and would not offend any specific group.
- Remember the mandate of the College and the Council, and don't make promises that could be viewed as contrary to those mandates.
- Avoid empty rhetoric.
- Be mindful of the College's Code of Ethics, Code of Conduct, Professional Misconduct Regulations and common law.
- Remember that you are a professional and a member of an important and well-regarded profession, and so are your opponents.

College staff cannot support any particular candidate or incumbent and, while they may be a resource for certain information where appropriate, they must not be asked to assist in a campaign.

Transparent Decision-Making

The RHPA requires that all Council meetings are open to members of the public, and discussions, committee recommendations and council decisions are transparent. The only exceptions are discussions that take place in camera.

Council members are expected to make informed decisions by preparing before all Council meetings and listening attentively to the presentation of committee reports by each Committee's chair. A well-informed, non-biased decision should be the outcome.



COLLEGE OF CHIROPRACTORS OF ONTARIO

MEMORANDUM

To: Ms Jo-Ann Willson, Registrar and General Counsel

From: Mr. Joel Friedman, Director, Policy and Research

Date: April 30, 2019

Re: Technology Upgrade Update

Database, Website and Online Portal for Members and Applicants

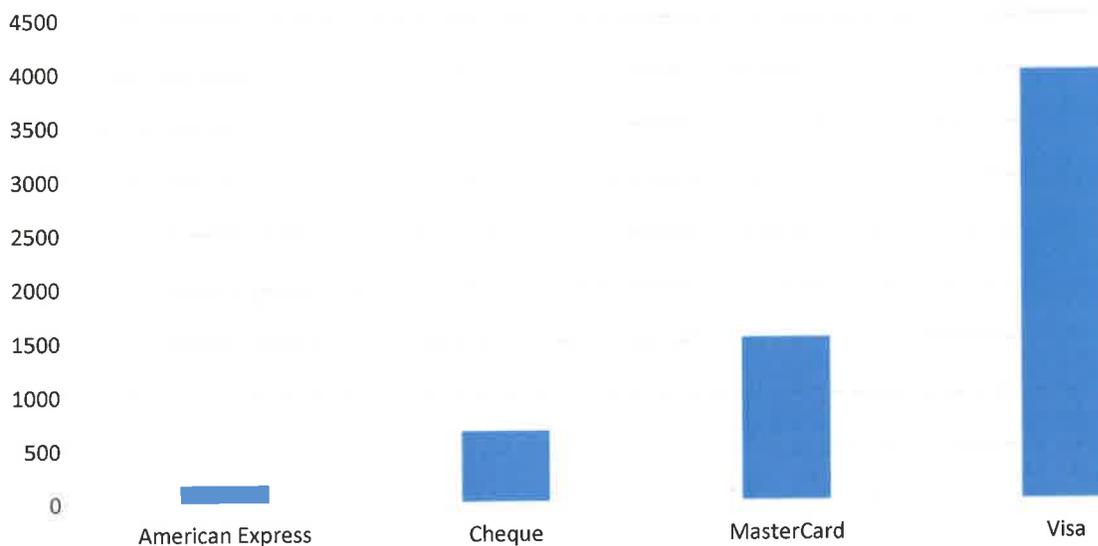
2019 Member Renewal, Incorporation Renewal and Continuing Education Reporting

CCO has completed its second year of online renewal. As of March 5, 2019, 4,952 members and 889 professional corporations have renewed.

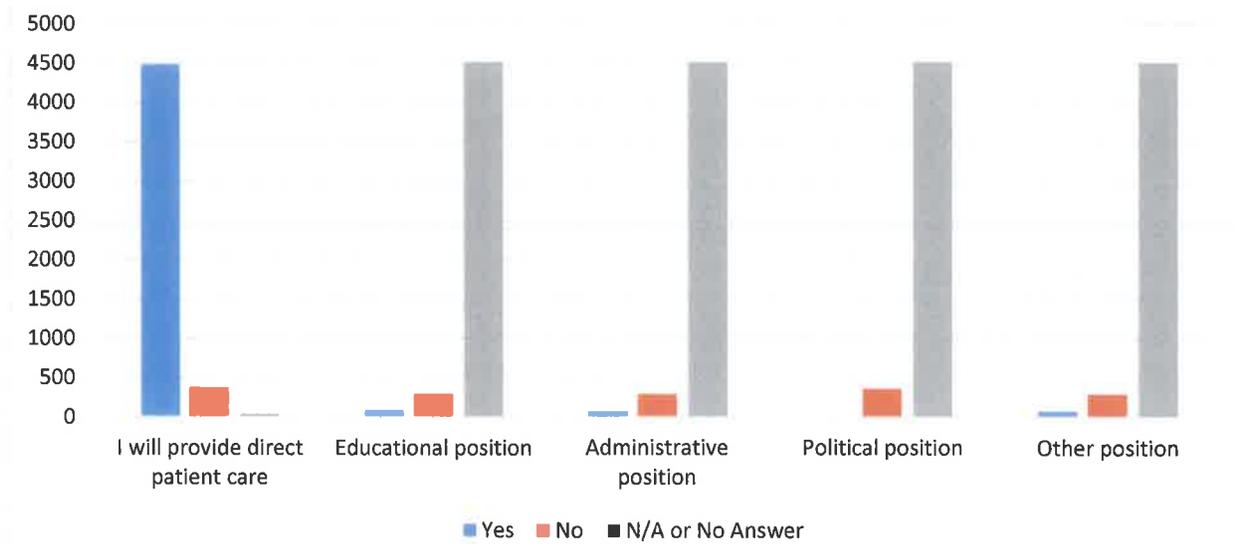
1275 Members paid a half renewal fee. 43 member renewed using paper renewal.

Statistics from 2019 Renewal as of March 5, 2019

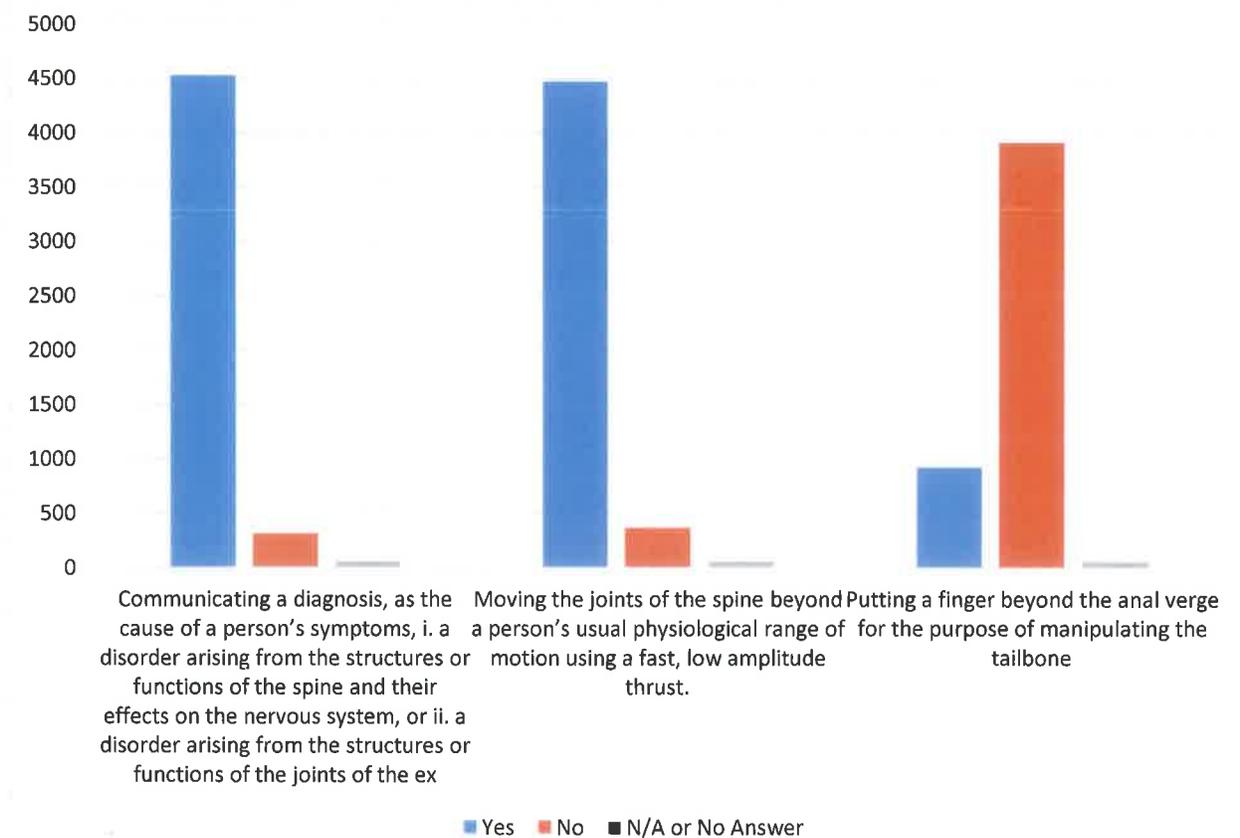
Method of Payment (all payments from October 31, 2018 – March 5, 2019)



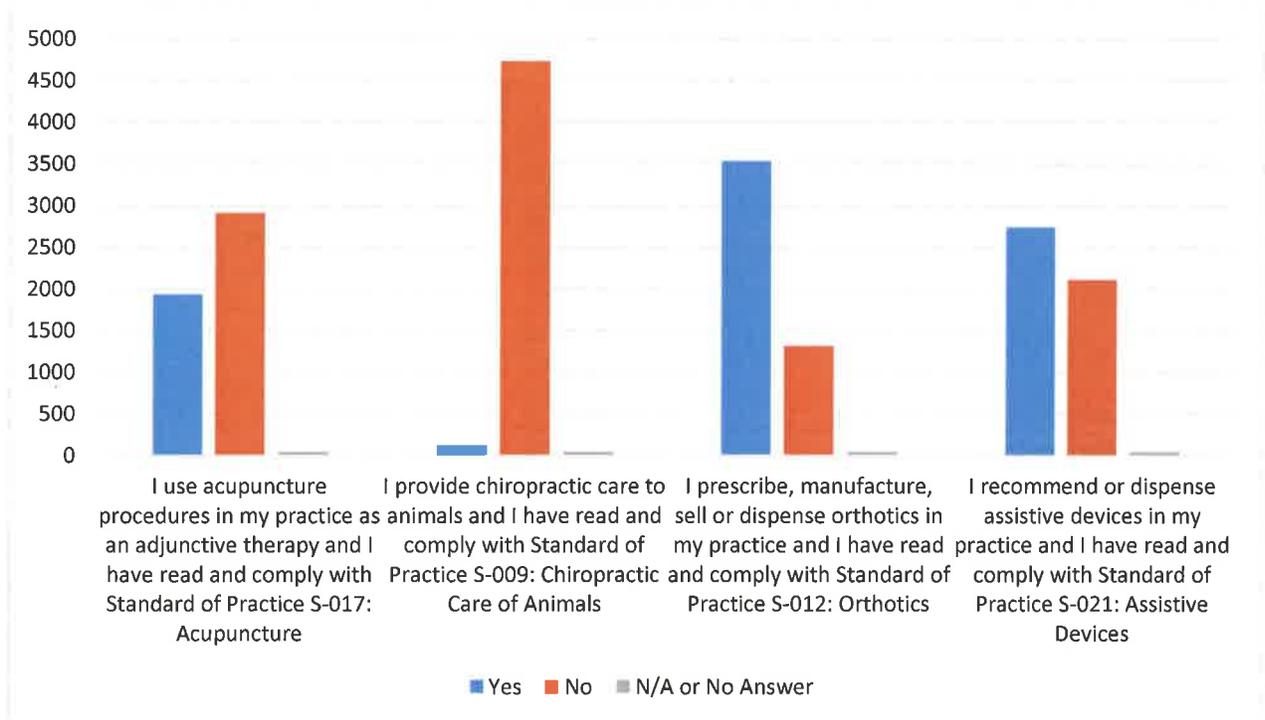
Practice Information



Controlled Acts



Adjunctive Therapies



Information for the Health Profession Database

Type of Practice	% of Members' Practices
Comprehensive Primary and Continuing Care/ General Service Provision	55.17%
Other Area of Direction Service/Consultation	20.10%
Acute/Critical/Emergency Care	16.70%
Public Health	3.60%
Chronic Disease Management and Prevention	2.30%
Consultation	0.88%
Education and Research	0.57%
Palliative Care	0.19%
Administration	0.19%
Quality Management	0.15%
Sales	0.07%
Primary Maternity Care	0.05%
Infectious Disease Prevention and Control	0.03%
Geriatric Care	0.02%
Mental Health and Addiction	0.02%

Employment	% of Members' Practices
Self-Employed	71.80%
Permanent	21.34%
Casual	5.56%
Temporary	1.28%

Full Time/Part Time Status	% of Members' Practices
Full Time	76.26%
Part Time	19.93%
Casual	3.81%

Practice Setting	% of Members' Practices
Independent Health Facility	29.23%
Other Group Practice Office	27.24%
Solo Practice Office	23.45%
Health Related Business/Industry	15.14%
Rehabilitation Facility	11.76%
Other	3.75%
Association/Government/Regulatory Organization/Non-Government Organization	1.49%
Community Health Centre	1.35%
Client's Environment	0.88%
Family Health Teams	0.86%
Post-Secondary Education Institution	0.68%
Hospital	0.42%
Spa	0.24%
Mental Health and Addiction Facility	0.07%
Laboratory Facility	0.03%
Nurse Practitioner Led Clinics	0.03%
Residential/Long Term Care Facility	0.03%
Assisted Living/Supportive Housing	0.03%
Group Health Centre	0.03%
Blood Transfusion Centre	0.02%
Centralized Diagnostic Laboratory Facility	0.02%
Children Treatment Centres	0.02%
Correctional Facility	0.02%

Primary Role	% of Members
Service Provider	47.82%
Owner/Operator	45.49%
Manager	6.15%
Consultant	2.82%
Administrator	1.30%
Instructor/Educator	0.10%
Researcher	0.27%
Quality Management Specialist	0.22%

Geographical Distribution	% of Members
District 1	4.89%
District 2	9.55%
District 3	11.87%
District 4	35.00%
District 5	27.44%
District 6	11.25%

Client Age Range	% of Members' Practices
All Ages	89.03%
Adults	10.70%
Seniors	0.15%
Pediatrics	0.14%

Goals for 2019

CCO and Thentia continue to work on the objectives related to technology upgrades not yet launched, which include:

- Applicant portal for membership and professional incorporation
- Registering for the legislation and ethics examination online
- Registering for the Record Keeping Workshop online

Council and Committee Meetings

CCO is receiving an online boardroom called “SmartGovern” as part of the statement of work with Thentia; however, will be focusing on developing this for mid-2019.

CCO Communication with Membership and Applicants

CCO continues to send out mass emails through Constant Contact about upcoming events, policy updates and distributions for feedback.

Online Elections to Council

CCO conducted elections using BigPulse in 2019. Election information is included in the Executive Committee package.

Glossary of Terms (Renewal)

Member

Member of CCO.

Business Address

A member registered in the General class of registration is required to have a business address, including address, telephone number, and email address on the public register. Up to 3 business addresses can be displayed on the public register.

Mailing Address

This is the address which will be used for all communication from CCO, which must include an address, telephone number and confidential email address.

Residential Address

This is the residential address of the member which will not be on the public register.

Certificate Number

CCO Registration Number.

Class of Registration

Eligibility to practise chiropractic in Ontario.

Electoral District

The district in which the member is eligible to vote in CCO elections.

General

The member is eligible to practise chiropractic, perform controlled acts, and/or bill third-party payors in Ontario.

Inactive

The member may not practise chiropractic, perform controlled acts, and/or bill third-party payors in Ontario.

Retired

The member may not practise chiropractic, perform controlled acts, and/or bill third-party payors in Ontario.

Health Profession Corporation

All chiropractic professional corporations where the member is a shareholder or director. Only members may own shares or be a director of a chiropractic professional corporation. This is a distinct type of corporation defined in legislation.

Radiographic Information

Information related to a member's use of x-ray facilities in accordance with the *Healing Arts Radiation Protection Act, 1990*.

Professional Conduct and Self-Reporting

- A finding of regulatory proceeding of professional misconduct, incompetence or incapacity from a regulatory body,
- A finding of guilt related to an offence made by a court, and/or
- A finding of professional negligence or malpractice made by a court.

Level of Education Outside of Chiropractic Profession

- **“Diploma”** - Diploma or equivalent conferred by a community college, university or comparable institution.
- **“Baccalaureate”** - An undergraduate degree conferred by a university or comparable institution.
- **“Master”** - A graduate level university degree.
- **“Professional Doctorate”** - A first professional degree conferred by a university or comparable institution.
- **“Doctorate”** - A post-graduate level university degree.
- **“Entry to Practice Post Diploma Certificate/Courses”** – A university level certificate or collection of university level courses obtained after completion of (at minimum) an undergraduate degree. This certificate/these courses is/are a mandatory entry to practice requirement into the profession. Continuing education certificates and courses are not included within this definition.
- **“None of the Above”** - The individual has completed a level of education in the profession that is not listed above.

Field of Study for Highest Education Outside of Chiropractic Profession

- **“General Rehabilitation Science”** - Comprises of any program that includes a systematic study of the physical and psychosocial dimensions of human function throughout the lifespan of individuals with impairments, disabilities and/or handicaps.
- **“Medical Laboratory Science”** - Comprises of any program that prepares individuals to conduct and supervise complex medical tests, clinical trials and research experiments; manage clinical laboratories; and consult with physicians and clinical researchers on diagnoses, disease causation and spread, and research outcomes.

- **“Mathematics, Computer Information Sciences”** - Comprises of any general program that focuses on the analysis of quantities, magnitudes, forms and their relationships, using symbolic logic and language or any general program that focuses on computing, computer science and information science and systems as part of a broad and/or interdisciplinary program.
- **“Health Administration/Management”** - Comprises of any program that prepares individuals to develop, plan, and manage health care operations and services within health care facilities and across health care systems.
- **“Public Administration”** - Comprises of instructional programs that prepare individuals to analyze, manage and deliver public programs and services.
- **“Public Health”** - Comprises of any program that generally prepares individuals to plan, manage and evaluate public health care services and to function as public health officers.
- **“Kinesiology and Exercise Science”** - Comprises of any scientific program that focuses on the anatomy, physiology, biochemistry and biophysics of human movement, and applications to exercise and therapeutic rehabilitation.
- **“Gerontology”** - Comprises of any program that focuses on the human aging process and aged human populations, using the knowledge and methodologies of the social sciences, psychology and the biological and health sciences.
- **“Psychology”** - Comprises of any instructional programs that focus on the scientific study of the behaviour of individuals, independently or collectively, and the physical and environmental bases of mental, emotional and neurological activity.
- **“Health Professions and Related Clinical Sciences”** - Comprises of any instructional programs that prepare individuals to practise as licensed professionals and assistants in the health care professions and focus on the study of related clinical sciences.
- **“Biological and Biomedical Sciences”** - Comprises of any instructional programs that focus on the biological sciences and the non-clinical biomedical sciences, and that prepare individuals for research and professional careers as biologists and biomedical scientists.
- **“Physical Sciences”** - Comprises of any instructional programs that focus on the scientific study of inanimate objects, processes of matter and energy, and associated phenomena.
- **“Social Sciences, Arts and Humanities”** - Comprises of any instructional programs that focus on the systematic study of social systems, social institutions, and social behaviour or independent or individualized studies in the liberal arts subjects, the humanities disciplines, literature, history and the general curriculum.
- **“Education”** - Comprises of any instructional programs that focus on the theory and practice of learning and teaching, and related research, administrative and support services.
- **“Law”** - Comprises of any instructional programs that prepare individuals for the legal profession, for related support professions and professional legal research, and focus on the study of legal issues in non-professional programs.

- **“Business, Management, Marketing and Related”** - Comprises of any instructional programs that prepare individuals to perform managerial, technical support, and applied research functions related to the operation of commercial and non-profit enterprises and the buying and selling of goods and services.
- **“Engineering”** - Comprises of any instructional programs that prepare individuals to apply mathematical and scientific principles to the solution of practical problems.
- **“Other Field of Study”** - Any program not mentioned above.

Employment Category

- **“Permanent”** - Status with employer is permanent with an indeterminate duration (no specified end date) of employment and guaranteed or fixed practice hours per week.
- **“Temporary”** - Status with employer is temporary with fixed duration of employment, based on a defined start and end date, and guaranteed or fixed practice hours per week.
- **“Casual”** - Status with employer is on an as-needed basis, with employment that is not characterized by a guaranteed or fixed number of hours per week. There is no arrangement between employer and employee that the employee will be called to work on a regular basis.
- **“Self-Employed”** - A person who operates his or her own economic enterprise in the profession. The individual may be the owner of a business or professional practice, or an individual in a business relationship in which he or she agrees to perform specific work for a payer in return for payment.

Full time/Part Time Status

- **“Full-Time”** - Official status with employer is full-time or equivalent, or usual hours of practice are equal to or greater than 30 hours per week.
- **“Part-Time”** - Official status with employer is part-time, or usual hours of practice are less than 30 hours per week.
- **“Casual”** - Status with employer is on an as needed basis, with employment that is not characterized by a guaranteed or fixed number of hours per week. There is no arrangement between employer and employee that the employee will be called to work on a regular basis.

Practice Setting

- **“Hospital”** - A health care facility that offers a range of in-patient and out-patient health care services (e.g. medical, surgical, psychiatry etc.) available to the target population. Includes specialty and complex continuing care hospitals not otherwise classified.

- **“Rehabilitation Facility”** - A health care facility that has as its primary focus the post-acute, inpatient and outpatient rehabilitation of individuals.
- **“Mental Health and Addiction Facility”** - A health care facility that has as its primary focus the acute or post-acute, inpatient and/or outpatient care of individuals with mental health issues and illness and/or addictions.
- **“Residential/Long-Term Care Facility”** - A long-term care facility designed for people who require the availability of 24-hour nursing care and supervision within a secure setting. In general, long-term care facilities offer high levels of personal care and support. These facilities include nursing homes, municipal homes and charitable homes.
- **“Assisted Living Residence/Supportive Housing”** - A retirement home or supportive housing that provides varying degrees of care to assist individuals/couples to live independently. Services include home making, meal preparation, low to daily personal care and availability of a personal support worker or staff on a 24-hour basis. These facilities include group homes, retirement homes, community care homes, lodges, supportive housing and congregate living setting.
- **“Community Health Centre (CHC)”** - A CHC employs physicians and other interdisciplinary providers, such as nurse practitioners, nurses, mental health counsellors, chiropractors, community workers and dietitians to serve high-risk communities and populations who may have trouble accessing health services because of language, culture, physical disabilities, socioeconomic status or geographic isolation. CHCs emphasize health promotion, disease prevention and chronic disease management based on local population health needs. The organization must be recognized as a CHC and there are 54 CHCs throughout Ontario (May 2008).
http://www.health.gov.on.ca/english/public/contact/chc/chc_mn.html
- **“Family Health Teams (FHTs)” **** - A Family Health Team is a group that includes physicians and other interdisciplinary providers, such as nurse practitioners, nurses, pharmacists, mental health workers, and dietitians. The FHT provides comprehensive primary health care (PHC) services. The FHT provides services on a 24/7 basis through a combination of regular office hours, after-hours services, and access to a registered nurse through the Telephone Health Advisory Service (THAS). The FHT emphasizes health promotion, disease prevention and chronic disease management based on local population health needs. The FHT must enrol patients. The group must be recognized as a FHT and there are 150 FHTs in Ontario (2008).
http://www.health.gov.on.ca/transformation/fht/fht_mn.html
- **“Group Health Centre (Sault St. Marie)”** - An interdisciplinary practice in Sault Ste. Marie that includes physicians, nurse practitioners, dietitians, pharmacists, physiotherapists, and many other providers. The group provides comprehensive primary health care (PHC) services. The services are provided on a 24/7 basis through a combination of regular office hours, after-hours services,

and access to a registered nurse through the Telephone Health Advisory Service (THAS). The group emphasizes health promotion, disease prevention and chronic disease management based on local population health needs. The group must enroll patients.

- **“Nurse Practitioner Led Clinic”** - This clinic is led by a nurse practitioner and provides primary health care in collaboration with family physicians, and other interdisciplinary health care providers. The focus of the clinic is on comprehensive primary health care services in areas where access to family health care is limited.
- **“Other Group Practice Office”** - A community based group (not already noted) professional practice or clinic that is composed of two or more health professionals working together to deliver health services. Clients typically come to the professionals' location to receive services. Other administrative support staff may also be involved; however, the health professionals are the focus of service provision.
- **“Solo Practice Office”** - A community-based professional practice/business composed of a single practitioner who delivers health services. Clients typically come to the professional's location to receive services. Administrative support staff may also be involved; however, the health professional is the focus of service provision. **Client's Environment** - The professional travels to one or more sites that may be the client's home, school and/or workplace environment to provide services (e.g. Homecare or CCAC contracts).
- **“Client's Environment”** – The professional travels to one or more sites that may be the client's home, school and/or workplace environment to provide services (e.g. Homecare or CCAC contracts).
- **“Post-Secondary Educational Institution”** - A post-secondary institution, either a university or equivalent institution or a college or equivalent institution, with a primary focus on the delivery of education.
- **“Preschool/School System/Board of Education”** - A preschool or elementary or secondary school (or equivalent institution), or the associated school board (or equivalent entity) that has responsibility for the governance and management of education funding issued by provincial governments.
- **“Children Treatment Centres (CTC)”** - This centre is a community-based organization that serves children with physical disabilities and multiple special needs. The centre provides physiotherapy, occupational therapy and speech therapy along with other additional services. There are 19 CTCs in Ontario. http://www.health.gov.on.ca/english/public/program/ltc/21_other.html
- **“Association/Government/ Regulatory Organization/Non-Government Organization (e.g. Diabetes Association)”** - An organization or government that deals with regulation, advocacy, policy development, program development, research and/or the protection of the public, at a national, provincial/territorial, regional or municipal level.

- **“Board of Health or Public Health Laboratory or Public Health Unit”** - A public health laboratory or official health unit that administers health promotion and disease prevention programs to inform the public about healthy life-styles, communicable disease control including education in STDs/AIDS, immunization, food premises inspection, healthy growth and development including parenting education, health education for all age groups and selected screening services.
- **“Community Care Access Centre (CCACs)”** - A local organization that assists its clients to access government-funded home care services and long-term care homes. The organization helps people to navigate the array of community support and health agencies in their communities.
- **“Community Pharmacy”** - A retail setting where drugs and related products are distributed primarily through direct face-to-face client contact (e.g. Shoppers Drug Mart).
- **“Other Community-Based Pharmacist Practice”** - Pharmacist practice, not otherwise classified, that delivers onsite or offsite community-based, direct-client-care, pharmacy services.
- **“Cancer Centre”** - A facility that specializes in services related to the treatment, prevention and research of cancer.
- **“Independent Health Facility”** - Refers to a stand-alone facility or clinic offering specialized or broadly based imaging services.
- **“Mobile Imaging Unit”** - Refers to a facility that is transported to various sites and offers specialized or broadly based imaging services.
- **“Centralized Diagnostic Laboratory Facility”** - A laboratory (public or community) that serves as the centralized focus of specialized or broadly based human health related diagnostic laboratory services, as part of a distributed system that includes collection, transportation, testing and results reporting. Excludes any public health or blood transfusion service laboratory.
- **“Freestanding Diagnostic Laboratory”** - A stand-alone laboratory providing specialized or broadly based human health related diagnostic laboratory services including collection, testing and results reporting. Excludes any public health or blood transfusion service laboratory.
- **“Specimen Collection Centre”** - A site providing human health related testing and/or specimen procurement (e.g. specimen collection station, patient service centre, or any laboratory focused on specimen procurement only). Excludes any public health or blood transfusion service procurement sites.
- **“Blood Transfusion Centre”** - Refers to a facility that collects, screens, tests, processes, stores and/or supplies blood, blood products, or its alternatives for the purposes of transfusion (e.g. Canadian Blood Services).
- **“Dental Laboratory”** – An independent dental laboratory that specializes in the design, construction, repair or alteration of a dental prosthetic, restorative or orthodontic device.
- **“Dental Practice Laboratory”** – A dental laboratory within an established dental practice that specializes in the design, construction, repair or alteration of a dental prosthetic, restorative or orthodontic device.

- **“Other Laboratory Facility”** - Other laboratory not otherwise listed.
- **“TeleHealth Ontario and Telephone Health Advisory Services”** - A program that provides free, confidential 24/7 service that provides Ontario residents with easy access to health information.
- **“Spa”** - A facility that focuses on providing services related to health, fitness, beauty and relaxation.
- **“Health Related Business/Industry”** - A business or industry whose focus of activities is not in the direct delivery of health care services, but rather the health of workers, health-related product development or the selling of health-related products (e.g. medical device companies, pharmaceutical companies).
- **“Other Place of Work”** - Place of work is none of the above.
- **“Diabetes Education Centre (DEC)”** – A DEC, usually staffed by nurses and dietitians, provides education and support to people with diabetes, their families, friends and community agencies.
- **“Correctional Facility”** – A stand-alone organization/facility that has as its primary focus the treatment and rehabilitation of persons detained or on probation due to a criminal act.
- **“Remote Nursing Station”** – A remote and or rural stand-alone centre that has nurses as the on-site managers and practitioners.

Primary Role

- **“Manager”** - Major role is in the management of a particular team/group that delivers services.
- **“Owner/Operator” *** - An Individual who is the owner of a practice site and who may or may not manage or supervise the operation at that site.
- **“Service Provider”** - Major role is in the delivery of professional services specific to the profession.
- **“Consultant”** - Major role is the provision of expert guidance and consultation, without direct patientcare, to a third-party.
- **“Administrator”** – A person whose primary role is involved in administration, planning and organizing.
- **“Instructor/Educator”** - Major role is as an educator for a particular target group.
- **“Researcher”** - Major role is in knowledge development and dissemination of research.
- **“Quality Management Specialist”** - Major role is the assurance and control of the quality of procedures and/or equipment.
- **“Sales Person”** – Major role is in the sales of health related services and products.

Area of Practice Activity

Areas of Service Provision - Services provided for a client(s) primarily within the areas of:

- **“General Service Provision” *** - Services provided primarily to clients across a range of service and/or consultation areas specific to the profession (e.g. general rehabilitation, laboratory work etc.).

- **“Critical Care” *** - Services provided primarily to clients dealing with serious life-threatening and/or medically complex conditions who require constant care, observation and specialized monitoring and therapies.
- **“Acute Care” *** - Services provided primarily to clients who have an acute medical condition or injury that is generally of a short duration. This includes surgical and peri-operative care.
- **“Continuing Care” *** – Services provided primarily to clients with continuing health conditions for extended periods of time (e.g. long-term care or home care).
- **“Comprehensive Primary Care” *** – Services provided primarily to a range of clients, possibly at first contact, to identify, prevent, diagnose and/or treat health conditions (e.g. oral care, foot care, etc.).
- **“Chronic Disease Prevention and Management” *** – Services are provided primarily to address chronic diseases early in the disease cycle to prevent disease progression and reduce potential health complications. Diseases can include diabetes, hypertension, congestive heart failure, asthma, chronic lung disease, renal failure, liver disease and rheumatoid and osteoarthritis.
- **“Public Health”** - Services are provided primarily with the purpose of improving the health of populations through the functions of health promotion, health protection, health surveillance and population health assessment.
- **“Mental Health and Addiction”** - Services provided primarily to clients with a variety of mental health and addiction conditions.
- **“Primary Maternity Care” **** - Services provided primarily to assess and monitor women during pregnancy, labour, and the post-partum period and of their newborn babies, the provision of care during normal pregnancy, labour, and post-partum period, and to conduct spontaneous normal vaginal deliveries.
- **“Cancer Care”** - Services provided primarily to clients with a variety of cancer and cancer related illnesses.
- **“Geriatric Care”** - Services provided primarily to care for elderly persons and to treat diseases associated with aging through short-term, intermediate or long-term treatment/interventions.
- **“Palliative Care”** - Services provided primarily to clients with the aim of relieving suffering and improving the quality of life for persons who are living with or dying from advanced illness or who are bereaved.
- **“Other Area of Service/Consultation”** - Other area of service/consultation not otherwise listed.
- **“Areas of Consultation”** - Expert consultation is provided on the profession related to medical and/or legal matters.
- **“Areas of Administration”** - Focus of activities is management or administration.
- **“Areas of Quality Management”** - Focus of activities is on the assurance of the operational integrity, based on compliance with staffing, technical and organizational requirements.
- **“Areas of Post-Secondary Education”** - Focus of activities is directed at providing post-secondary teaching to individuals registered in formal education programs.

- **“Areas of Research”** - Focus of activities is in knowledge development and dissemination of research including clinical and non-clinical.
- **“Areas of Sales”** - Focus of activities is in the sales and/or service of health related apparatuses or equipment.
- **“Other Areas”** - Other area of activity not otherwise listed.
- **“Emergency”** – Care provided to patients who have immediate medical problems, frequently before complete clinical or diagnostic information is available, in a comprehensive emergency department or an urgent care centre.
- **“Infectious Disease Prevention and Control”** – Services are provided to primarily prevent and control health-care associated infections and other epidemiological significant organisms. This includes providing services to reduce the risk, spread and incidence of infections in populations. This includes pandemic planning.

Client Age Range

- **“Paediatrics”** - Paediatric clients that are between the ages of 0 to 17 years.
- **“Adults”** - Adult clients that are between the ages of 18 and 64 years inclusive.
- **“Seniors”** - Adult clients that are 65 years of age and older.
- **All Ages** - Clients across all age ranges.

Description of Practice

- **“Practice”** – Has met basic requirements of the profession and is able to practise in the profession in Ontario.
- **“Academic Practice”** - Appointed as a faculty member in an approved university/college program in the profession and able to practise the profession.
- **“Non-Practising”** – Member of the College who may be using knowledge in the profession in research, teaching etc. but cannot perform any of the controlled acts.
- **“Educational”** – Practising under supervision and working towards meeting basic requirements of profession while
 - Enrolled in an education program
 - Waiting to write professional exam or,
 - Obtaining clinical experience.

Number of Practice Weeks in the Past 12 Months

Number of practice weeks in the past 12 months across all practice settings excluding vacation, on-call time and sick and leave time greater than one week. Note that at least 1 practice day in a week constitutes a week of practice.

Average Number of Weekly Practice Hours in the Past 12 Months

Average number of practice hours per week across all practice sites. Hours indicated are inclusive of all practice hours (eg. travel time to various settings, preparation and service provision, time spent working during on-call hours). Hours should exclude any volunteer, extra-curricular time outside of the profession or any on-call hours where the individual was not working.

Proportion of Average Weekly Practice Hours on Direct Professional Services

Proportion of the average practice hours spent per week on direct health professional services across all practice sites (eg. conducting tests, patient care, health promotion, dispensing/building/repairing health apparatuses). This excludes clinical education hours (providing professional services while teaching).

Proportion of Average Weekly Practice Hours on Teaching

Proportion of the average practice hours spent per week across all practice sites on teaching to prepare students for a health profession (eg. post-secondary) excluding clinical education (providing professional services while teaching).

Proportion of Average Weekly Practice Hours on Clinical Education

Proportion of the average practice hours spent per week on clinical education only (eg. providing direct professional services while teaching) across all practice sites.

Proportion of Average Weekly Practice Hours on Research

Proportion of the average practice hours spent per week across all practice sites conducting research in profession.

Proportion of Average Weekly Practice Hours on Administration

Proportion of the average practice hours spent per week across all practice sites on administration in profession.

Proportion of Average Weekly Practice Hours on All Other Activities

Proportion of the average practice hours spent per week across all practice sites on all other activities in profession excluding direct professional services, teaching, research and administration.

**COLLEGE OF CHIROPRACTORS OF ONTARIO****MEMORANDUM**

To: Ms Jo-Ann Willson, Registrar and General Counsel
From: Mr. Joel Friedman, Director, Policy and Research
Date: April 30, 2019
Re: Distribution of By-law Amendments

Provisions of the Health Professions Procedural Code

Section 94 of the Health Professions Procedural Code, Schedule 2 under the *Regulated Health Professions Act, 1991 (The Code)* specifies the content and process on making by-laws relating to the administrative and internal affairs of the College.

Historically, CCO has distributed all new by-laws and proposed by-law amendments for the purposes of transparency and involving feedback from members and stakeholders.

Subsection 94(2) specifies that certain specific by-laws are required to be circulated to every member at least 60 days before the by-laws are approved by Council, as follows:

“A by-law shall not be made under clause (1) (l.2), (l.3), (s), (t), (v), (w) or (y) unless the proposed by-law is circulated to every member at least 60 days before it is approved by the Council.”

In accordance with subsection 94(2), the following by-laws are required to be circulated to members in this manner:

94(1)(l.2): specifying information as information to be kept in the register for the purposes of paragraph 20 of subsection 23 (2), designating information kept in the register as public for the purposes of subsection 23 (5), and designating information kept in the register as public for the purposes of subsection 23 (5) that may be withheld from the public for the purposes of subsection 23 (6);

94(1)(l.3): requiring members to give the College their home addresses and such other information as may be specified in the by-law about themselves and the places they practise the profession, the services they provide there, their participation in continuing education programs and the names, business addresses, telephone numbers and facsimile numbers of their associates, partners, employers and employees and prescribing the form and manner in which the information shall be given;

- 94(1)(s): requiring members to pay annual fees, fees upon application for a certificate and upon registration and fees for examinations, appeals from examinations, election recounts and continuing education programs and for anything the Registrar or a committee of the College is required or authorized to do and requiring members to pay penalties for the late payment of any fee;
- 94(t): specifying the amount of any fee or penalty required under clause (s);
 - (t.1) prescribing the form and manner in which a health profession corporation shall notify the Registrar of a change in the shareholders of the corporation and the time period for doing so;
 - (t.2) requiring the payment of fees upon application for a certificate of authorization and for the issue or renewal of a certificate of authorization and specifying the amount of such fees;
- 94(v): requiring members to pay specified amounts to pay for the program required under section 85.7, including amounts that are different for different members or classes of members and including amounts,
 - (i) that are specified in the by-law,
 - (ii) that are calculated according to a method set out in the by-law, or
 - (iii) that are determined by a person specified in the by-law;
- 94(w): requiring members to participate in an arrangement set up by the College in which members pay a person such amounts as may be determined by the person for the members or for classes of members and the person pays amounts to the College to pay for the program required under section 85.7;
- 94(y): requiring members to have professional liability insurance that satisfies the requirements specified in the by-laws or to belong to a specified association that provides protection against professional liability and requiring members to give proof of the insurance or membership to the Registrar in the manner set out in the by-laws;

CCO Proposed By-law Amendments

With the exception of proposed amendments to By-law 16: Professional Liability Insurance, the proposed by-law amendments recommended to Council from the Executive Committee are not required to be distributed to members for feedback for 60 days prior to approval.

By-laws

94 (1) The Council may make by-laws relating to the administrative and internal affairs of the College and, without limiting the generality of the foregoing, the Council may make by-laws,

- (a) adopting a seal for the College;
- (b) providing for the execution of documents by the College;
- (c) respecting banking and finance;
- (d) fixing the financial year of the College and providing for the audit of the accounts and transactions of the College;
- (d.1) respecting the election of Council members, including the requirements for members to be able to vote, electoral districts and election recounts;
- (d.2) respecting the qualification and terms of office of Council members who are elected;
- (d.3) prescribing conditions disqualifying elected members from sitting on the Council and governing the removal of disqualified Council members;
- (e) providing procedures for the election of the President and Vice-President of the College, the selection of the chairs of the committees, the filling of a vacancy in those offices, and setting out the duties and powers of the President, Vice-President and the chairs;
- (f) respecting the calling, holding and conducting of the Council meetings and respecting the duties of the Council's members;
- (g) respecting the calling, holding and conducting of meetings of the members;
- (g.1) providing that a meeting of the Council or of members or a meeting of a committee or of a panel that is held for any purpose other than for the conducting of a hearing may be held in any manner that allows all the persons participating to communicate with each other simultaneously and instantaneously;

(g.2) prescribing what constitutes a conflict of interest for members of the Council or a committee and regulating or prohibiting the carrying out of the duties of those members in cases in which there is a conflict of interest;

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(h) providing for the remuneration of the members of the Council and committees other than persons appointed by the Lieutenant Governor in Council and for the payment of the expenses of the Council and committees in the conduct of their business;

(h.1) respecting the filling of vacancies on the Council or on committees;

Note: On a day to be named by proclamation of the Lieutenant Governor, clause 94 (1) (h.1) of Schedule 2 to the Act is repealed and the following substituted: (See: 2017, c. 11, Sched. 5, s. 30 (1))

(h.1) subject to the regulations made under clauses 43 (1) (p) to (s) of the *Regulated Health Professions Act, 1991*,

(i) respecting the filling of vacancies on the Council or on committees,

(ii) providing for the composition of committees,

(iii) respecting the qualification, selection, appointment and terms of office of members of committees required by subsection 10 (1) who are not members of the Council,

(iv) prescribing conditions that disqualify committee members from sitting on committees required under subsection 10 (1) and governing the removal of disqualified committee members;

(h.2) providing for the composition of committees;

Note: On a day to be named by proclamation of the Lieutenant Governor, clause 94 (1) (h.2) of Schedule 2 to the Act is repealed. (See: 2017, c. 11, Sched. 5, s. 30 (1))

(h.3) respecting the qualification, selection, appointment and terms of office of members of committees required by subsection 10 (1) who are not members of the Council;

Note: On a day to be named by proclamation of the Lieutenant Governor, clause 94 (1) (h.3) of Schedule 2 to the Act is repealed. (See: 2017, c. 11, Sched. 5, s. 30 (1))

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(h.4) prescribing conditions disqualifying committee members from sitting on committees required under subsection 10 (1) and governing the removal of disqualified committee members;

Note: On a day to be named by proclamation of the Lieutenant Governor, clause 94 (1) (h.4) of Schedule 2 to the Act is repealed. (See: 2017, c. 11, Sched. 5, s. 30 (1))

- (i) providing for the appointment, powers and duties of committees other than the committees required by subsection 10 (1);
- (j) delegating to the Executive Committee powers and duties of the Council, other than the power to make, amend or revoke regulations and by-laws;
- (k) providing for a code of ethics for the members;
- (l) providing for the appointment of inspectors for the purposes of regulations made under clause 95 (1) (h);
 - (l.1) respecting the maintenance of the register kept by the Registrar and providing for the issuing of certificates when information contained in the register is made available to the public under section 23;
 - (l.2) specifying information as information to be kept in the register for the purposes of paragraph 20 of subsection 23 (2), designating information kept in the register as public for the purposes of subsection 23 (5), and designating information kept in the register as public for the purposes of subsection 23 (5) that may be withheld from the public for the purposes of subsection 23 (6);
 - (l.3) requiring members to give the College their home addresses and such other information as may be specified in the by-law about themselves and the places they practise the profession, the services they provide there, their participation in continuing education programs and the names, business addresses, telephone numbers and facsimile numbers of their associates, partners,

employers and employees and prescribing the form and manner in which the information shall be given;

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- (l.4) respecting the duties and office of the Registrar;
- (m) providing procedures for the making, amending and revoking of by-laws;
- (n) prescribing forms and providing for their use;
- (o) respecting the management of the property of the College;
- (p) authorizing the College to make arrangements for the indemnity of members against professional liability and providing levies to be paid by members;
- (q) respecting membership of the College in a national organization of bodies with similar functions, the payment of annual assessments and representation at meetings;
- (r) authorizing the making of grants to advance scientific knowledge or the education of persons wishing to practise the profession, to maintain or improve the standards of practice of the profession or to provide public information about, and encourage interest in, the past and present role of the profession in society;
- (s) requiring members to pay annual fees, fees upon application for a certificate and upon registration and fees for examinations, appeals from examinations, election recounts and continuing education programs and for anything the Registrar or a committee of the College is required or authorized to do and requiring members to pay penalties for the late payment of any fee;
- (t) specifying the amount of any fee or penalty required under clause (s);
 - (t.1) prescribing the form and manner in which a health profession corporation shall notify the Registrar of a change in the shareholders of the corporation and the time period for doing so;
 - (t.2) requiring the payment of fees upon application for a certificate of authorization and for the issue or renewal of a certificate of authorization and specifying the amount of such fees;

- (u) requiring persons to pay fees, set by the Registrar or by by-law, for anything the Registrar is required or authorized to do;
- (v) requiring members to pay specified amounts to pay for the program required under section 85.7, including amounts that are different for different members or classes of members and including amounts,
 - (i) that are specified in the by-law,
 - (ii) that are calculated according to a method set out in the by-law, or
 - (iii) that are determined by a person specified in the by-law;
- (w) requiring members to participate in an arrangement set up by the College in which members pay a person such amounts as may be determined by the person for the members or for classes of members and the person pays amounts to the College to pay for the program required under section 85.7;
- (x) authorizing the Patient Relations Committee to require therapists and counsellors who are providing therapy or counselling that is funded through the program required under section 85.7 and persons who are receiving such therapy or counselling, to provide a written statement, signed in each case by the therapist or counsellor and by the person, containing details of the therapist's or counsellor's training and experience, and confirming that therapy or counselling is being provided and that the funds received are being devoted only to that purpose;
- (y) requiring members to have professional liability insurance that satisfies the requirements specified in the by-laws or to belong to a specified association that provides protection against professional liability and requiring members to give proof of the insurance or membership to the Registrar in the manner set out in the by-laws;
- (z) respecting the designation of life or honorary members of the College and prescribing their rights and privileges;
- (z.1) exempting any member or class of member from a by-law made under this section;

(z.2) specifying or setting out anything that is required to be specified or set out under this subsection. 1991, c. 18, Sched. 2, s. 94 (1); 1998, c. 18, Sched. G, s. 22 (1-4); 2000, c. 42, Sched., s. 40; 2007, c. 10, Sched. M, s. 73 (1, 2); 2017, c. 11, Sched. 5, s. 30 (2).

243**Circulation of certain by-laws**

(2) A by-law shall not be made under clause (1) (l.2), (l.3), (s), (t), (v), (w) or (y) unless the proposed by-law is circulated to every member at least 60 days before it is approved by the Council. 1998, c. 18, Sched. G, s. 22 (5).

Exception

(2.1) Despite subsection (2), the Council may, with the approval of the Minister, exempt a by-law from the requirement that it be circulated or abridge the 60-day period referred to in subsection (2) to such lesser period as the Minister may determine. 1998, c. 18, Sched. G, s. 22 (5).

Copies of by-laws, etc.

(3) A copy of the by-laws and standards of practice made by the Council, and any documents that are referred to in the by-laws and regulations made by the Council shall be given to the Minister and to each member and shall be made available to the public during normal business hours in the office of the College. 2007, c. 10, Sched. M, s. 73 (3).

Public copies

(3.1) Any person is entitled to a copy of any by-law, standard of practice or other document mentioned in subsection (3) on the payment of a reasonable fee, if required, to the Registrar. 2007, c. 10, Sched. M, s. 73 (3).

Unanimous by-laws, etc.

(4) A by-law or resolution signed by all the members of the Council is as valid and effective as if passed at a meeting of the Council called, constituted and held for the purpose. 1991, c. 18, Sched. 2, s. 94 (4).

Application

(5) Subsections (3) and (4) apply to by-laws made under this section or under a health profession Act. 1998, c. 18, Sched. G, s. 22 (6).

STANDARD OF PRACTICE S-001

Chiropractic Scope of Practice

Quality Assurance Committee
Approved by Council: February 8, 2011
Amended: April 24, 2018, February 27, 2019

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

INTENT

To provide guidance to members and the public about CCO's expectations concerning members as providers of chiropractic services to patients and as responders to general health-related questions from patients and the public.

CCO recognizes that:

- One of the underlying principles of the *Regulated Health Professions Act, 1991 (RHPA)* is to permit the public to exercise freedom of choice of health professional within a range of safe options;
- Chiropractors (members) are primary health professional who provide care within the chiropractic scope of practice and see patients with a variety of conditions, who may also have co-morbidities.
- Members are required to practise within the chiropractic scope of practice set out in the *Chiropractic Act, 1991*, in providing patient-centred care;
- Members use a variety of diagnostic and therapeutic procedures in providing chiropractic care to patients; and
- Members are primary contact portal of entry health professionals who are frequently asked general health-related questions by patients.

Definitions

For the purpose of this standard:

"controlled act" means any diagnostic or therapeutic procedure listed in section 27(2) of the *RHPA* that is authorized only to certain regulated health professionals in providing patient care

"public domain" means any diagnostic or therapeutic procedure other than those listed in section 27(2) of the *RHPA* that any regulated health professional may utilize in the course of providing patient care

DESCRIPTION OF STANDARD

Practising Within the Chiropractic Scope of Practice

All activities and services performed by members must relate to the chiropractic scope of practice and authorized acts as set out in the *Chiropractic Act, 1991*, as follows:

Chiropractic Scope of Practice

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

- (a) dysfunctions or disorders arising from the structures or functions of the spine and the effects of those dysfunctions or disorders on the nervous system; and
- (b) dysfunctions or disorders arising from the structures or functions of the joints.

Authorized Acts

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

1. Communicating a diagnosis identifying, as the cause of a person's symptoms,
2. **2**
 - i. A disorder arising from the structures or functions of the spine and their effects on the nervous system, or
 - ii. A disorder arising from the structures or functions of the joints of the extremities.
2. Moving the joints of the spine beyond a person's usual physiological range of motion using a fast, low amplitude thrust.
3. Putting a finger beyond the anal verge for the purpose of manipulating the tailbone.

Expectations of a Chiropractic Visit and Use of Diagnostic and Therapeutic Procedures

CCO regulates the full range of chiropractic approaches and a member must always practise within the chiropractic scope of practice. CCO recognizes that patients present with a variety of co-morbidities and conditions. As such, a member is required to perform the following, which is to be clearly and legibly reflected in the patient health record:

- a consultation related to the patient's presenting condition and/or goals;
- an assessment of chiropractic conditions related to the spine, nervous system and joints; and
- a diagnosis or clinical impression related to the chiropractic scope of practice, consistent with Standard of Practice S-008: Communicating a Diagnosis;
- recommendations for care, including possible referral to an appropriate health care provider if necessary; and
- obtaining of informed consent, consistent with Standard of Practice S-013: Consent

On each patient visit (as outlined and defined in G-013: Chiropractic Assessments), the member must allow sufficient time to:

- provide relevant, safe, supportive and patient-centred quality care within the chiropractic scope of practice, and related to the patient's condition and goals;
- conduct outcome measures, assessment and reassessment of progress related to the patient's presenting condition and goals, as required (as outlined and defined in G-013: Chiropractic Assessments); and
- document legible and accurate, individualized and personalized notes capturing the unique aspects of that particular patient encounter (as outlined and defined in G-013: Chiropractic Assessments)

A member must take reasonable steps to ensure that when providing chiropractic care, any proposed diagnostic or therapeutic procedures to be used for the benefit of a patient, relate to the chiropractic scope of practice.

For a diagnostic or therapeutic procedure to be acceptable for clinical purposes, it must be taught in the core curriculum, post-graduate curriculum or continuing education division of an accredited educational institution.

In order to perform a diagnostic or therapeutic procedure, a member shall:

- achieve, maintain and be able to demonstrate clinical competency (e.g., examination, certification, or proof of training) in the diagnostic or therapeutic procedure; or
- be fulfilling the requirements to achieve clinical competency and have informed the patient that they are fulfilling the requirements to achieve clinical competency.

A member must obtain the patient's consent to the use of the diagnostic or therapeutic procedure, consistent with Standard of Practice S-013: Consent, that is:

- fully informed;
- voluntarily given;
- related to the patient's condition and circumstances;
- not obtained through fraud or misrepresentation; and
- evidenced in a written form signed by the patient or otherwise documented in the patient health record.

If a proposed diagnostic or therapeutic procedure does not relate to the chiropractic scope of practice, a member should not use the diagnostic or therapeutic procedures in their professional capacity.

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In providing patient care, a member may use adjunctive diagnostic and therapeutic procedures that are in the public domain. This includes, but is not limited to, providing nutritional counselling, prescribing orthotics, giving advice on lifestyle and exercise, providing therapeutic modalities, and other therapies.

A member is reminded that CCO has specifically prohibited the use of some diagnostic and therapeutic procedures including, but not limited to, dark field microscopy, hyperbaric oxygen therapy, pelvic and prostate examinations, and vega testing.

Responding to General Health-Related Questions

A member is restricted from treating or advising outside the chiropractic scope of practice by section 30 of the *RHPA* as follows:

Treatment, etc., where risk of harm

30 (1) No person, other than a member treating or advising within the scope of practice of his or her profession, shall treat or advise a person with respect to his or her health in circumstances in which it is reasonably foreseeable that serious bodily harm may result from the treatment or advice or from an omission from them. (specific, limited exemptions are referenced in section 30 of the *RHPA*)

Offences

- 40 (1) Every person who contravenes subsection ... 30 (1) is guilty of an offence and on conviction is liable,
- (a) for a first offence, to a fine of not more than \$25,000, or to imprisonment for a term of not more than one year, or both; and
 - (b) for a second or subsequent offence, to a fine of not more than \$50,000, or to imprisonment for a term of not more than one year, or both.

In responding to general health-related questions by patients or the public that relate to controlled acts outside the chiropractic scope of practice (including but not limited to prescribing a drug as defined in the *Drug and Pharmacies Regulation Act, 1990*, performing surgery and administering vaccinations), a member must:

- advise the patient or member of the public that the performance of the act is outside the chiropractic scope of practice and the patient requires the care or would be more appropriately treated by a health professional who has the act within their scope of practice;
- respond in a professional, accurate and balanced manner in the context of providing primary health care to the patient consistent with the chiropractic scope of practice;
- encourage the patient to be an active participant in their own health care which allows the patient to make fully informed decisions concerning their health care; and
- record this communication in the patient health record.

Implications of Failure to Comply

A member is reminded that he/she may be the subject of an inquiry, complaint or report concerning the provision of chiropractic services or discussions related to general health-related questions from patients. The Inquiries, Complaints and Reports Committee (ICRC), composed of elected (chiropractor), appointed (public) and non-council (chiropractor) committee members will review any inquiry, complaint or report to determine the member's compliance with all relevant standards of practice including Standard of Practice S-001: Scope of Practice. In exercising its discretion, the ICRC may consider if:

- the diagnostic or therapeutic procedure related to the chiropractic scope of practice for the benefit of the patient;
- the member achieved, maintained and can demonstrate clinical competency in the diagnostic or therapeutic procedure; and
- the discussions with the patient relating to general health-related questions were consistent with this standard of practice.

LEGISLATIVE CONTEXT

In addition to the legislative provisions outlined above, members are reminded that the following are acts of professional misconduct under Ontario Regulation 852/93 (Professional Misconduct):

2. Contravening a standard of practice of the profession or failing to maintain the standard of practice expected of members of the profession.
12. Failing to reveal the nature of a remedy or treatment used by the member following a patient's request to do so.
- 6 13. Failing to advise a patient to consult with another health professional when the member knows or ought to know that,
 - the patient's condition is beyond the scope of practice and competence for the member;
 - the patient requires the care of another health professional;
 - or
 - the patient would be appropriately treated by another health professional.
14. Providing a diagnostic or therapeutic service that is not necessary.

STANDARD OF PRACTICE S-004

Quality Assurance Committee
Approved by Council: November 16, 1996
Amended: November 30, 2002,
September 28, 2012, February 27, 2019

Reporting of Designated Diseases

288

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

INTENT

Members of CCO are primary contact health care practitioners who act as portals of entry for patients into the health care system. As such, patients may present to members with suspected signs and symptoms of reportable diseases of which the diagnosis and treatment are outside of the chiropractic scope of practice.

The intent of this standard of practice is to advise members of the requirement to report suspected specified diseases in accordance with the *Health Protection and Promotion Act, 1990 (HPPA)* when they form the opinion that a patient has or may have a disease of public health significance.

OBJECTIVES

This standard of practice is consistent with the purpose of the *HPPA*, section 2, which provides:

The purpose of this Act is to provide for the organization and delivery of public health programs and services, the prevention of the spread of disease, and the promotion and protection of the health of the people of Ontario.

Definition of Reportable Diseases

A member must report diseases that are listed in Ontario Regulation 559/91 under the *HPPA*, as outlined in Appendix A of this standard of practice.

DESCRIPTION OF STANDARD

- The *HPPA* requires members to notify the local medical officer of health as soon as possible of any reportable diseases defined in the regulations.
- A member is required to maintain confidentiality of all information concerning a person in respect of whom a report is being made with the exception of complying with the *Regulated Health Professions Act, 1991 (RHPA)*.
- A member is protected from liability for making a report in good faith.

- It is an offence punishable by fine for a member to fail to comply with his/her obligation to report reportable diseases.

LEGISLATIVE CONTEXT

The governing legislation is the *HPPA*. Specific relevant provisions are outlined below.

Duty to Report Disease

The duty to report suspected diseases of public health concern to the medical officer of health is outlined in section 25 of the *HPPA*, which provides:

- (1) A physician or a practitioner as defined in subsection (2) who, while providing professional services to a person who is not a patient in or an out-patient of a hospital, forms the opinion that the person has or may have a disease of public health significance shall, as soon as possible after forming the opinion, report thereon to the medical officer of health of the health unit in which the professional services are provided.
- (2) In subsection (1), "practitioner" means,
 - (a) a member of the College of Chiropractors of Ontario,
 - (b) a member of the Royal College of Dental Surgeons of Ontario,
 - (c) a member of the College of Nurses of Ontario,
 - (d) a member of the Ontario College of Pharmacists,
 - (e) a member of the College of Optometrists of Ontario,
 - (f) a member of the College of Naturopaths of Ontario,
 - (g) a prescribed person.

- 2 Members of all Ontario regulated health professions under the *RHPA* are required to report diseases of public health concern to the medical officer of health, as described in the *HPPA*. Public health units in Ontario can be found at the following link: <http://www.health.gov.on.ca/en/common/system/services/phu/locations.aspx>.

Members may see patients with signs and symptoms of a specified disease and are required to perform a consultation and examination/assessment consistent with CCO standards of practice, policies and guidelines. A member has a duty to report a suspected specified disease to the medical officer of health as soon as possible when they form an opinion that the person has or may have a suspected disease in the course of providing professional services to that patient.

A member must document in the patient health record their opinion that a patient has or may have a specified disease and the reporting of the suspected specified disease to a local medical officer of health.

According to the Regulation 569: Report, under the HPPA, a Reportable Disease Report must contain the following information about the person:

- name and address in full,
- date of birth in full,
- sex, and
- date of onset of symptoms.

A member is also required to provide any additional information regarding the reportable disease that the medical officer of health considers necessary and any additional information required in accordance the Regulation 569 <https://www.ontario.ca/laws/regulation/900569>.

The duty to report reportable diseases, includes providing identifying information and as such does not require the patient to first provide consent to disclose their personal health information.

Confidentiality

The duty to report diseases includes the duty to report identifying information (e.g., the patient's name), notwithstanding the duty of confidentiality owed to the patient. Section 39, subsection 1 of the *HPPA* provides, in part:

No person shall disclose to any other person the name of or any other information that will or is likely to identify a person in respect of whom an application, order, certificate or report is made in respect of a communicable disease, a reportable disease, a virulent disease or a reportable event following the administration of an immunizing agent.

Subsection 1 does not apply,

- (0.a) where the disclosure is authorized under this Act or the *Personal Health Information Protection Act, 2004*;
- (a) in respect of an application by a medical officer of health to the Ontario Court of Justice that is heard in public at the request of the person who is the subject of the application;
- (b) where the disclosure is made with the consent of the person in respect of whom the application, order, certificate or report is made;
- (c) where the disclosure is made for the purposes of public health administration;

- (d) in connection with the administration of or a proceeding under this Act, the *Regulated Health Professions Act, 1991*, a health profession Act as defined in subsection 1 (1) of that Act, the *Public Hospitals Act*, the *Health Insurance Act*, the *Canada Health Act* or the *Criminal Code (Canada)*, or regulations made thereunder; or
- (e) to prevent the reporting of information under section 72 of the *Child and Family Services Act* in respect of a child who is or may be in need of protection.

Protection from Liability for Reports

A member is afforded protection for liability arising from reporting diseases in good faith. Subsection 95 (4) of the *HPPA* provides:

“No action or other proceeding shall be instituted against a person for making a report in good faith in respect of a communicable disease or a reportable disease in accordance with Part IV.”

Offence - Failing to Report

It is an offence to fail to report diseases in accordance with *HPPA*. Subsection 100 (2) of the *HPPA* provides:

“Any person who contravenes a requirement of Part IV to make a report in respect of a reportable disease, a communicable disease or a reportable event following the administration of an immunizing agent is guilty of an offence.”

The penalty for failing to report is outlined in subsection 101 of the *HPPA*:

“Every person who is guilty of an offence under this Act is liable on conviction to a fine of not more than \$5,000 for every day or part of a day on which the offence occurs or continues.”

Please Note: If copies of the Act or Regulations are required, they may be obtained from the Ontario Government Bookstore, located at:

Publications Ontario
ServiceOntario Centre, College Park Building
777 Bay Street, Market Level
Toronto, ON M6G 2C8
Telephone: (416) 326-5300 or 1-800-668-9938
Fax: (416) 326-5317
www.publications.serviceontario.ca/ecom/

APPENDIX A (AS OF MAY 1, 2018)

Ontario Regulation 135/18: Designation of Diseases (the most updated version of this regulation is available at <https://www.ontario.ca/laws/regulation/180135>).

1. For the purposes of the Act, a disease set out in Column 1 of the Table is designated as a disease of public health significance and,
- (a) a communicable disease, if it is identified as such in Column 2 of the Table; and
- (b) a virulent disease, if it is identified as such in Column 3 of the Table.

TABLE
DESIGNATED DISEASES

Item	Diseases of public health significance	Whether the disease is a communicable disease	Whether the disease is a virulent disease
1	Acquired Immunodeficiency Syndrome (AIDS)	Yes	No
2	Acute Flaccid Paralysis	No	No
3	Amebiasis	Yes	No
4	Anthrax	Yes	No
5	Blastomycosis	Yes	No
6	Botulism	Yes	No
7	Brucellosis	Yes	No
8	Campylobacter enteritis	Yes	No
9	Carbapenemase-producing Enterobacteriaceae (CPE) infection or colonization	Yes	No
10	Chancroid	Yes	No
11	Chickenpox (Varicella)	Yes	No
12	Chlamydia trachomatis infections	Yes	No
13	Cholera	Yes	Yes
14	Clostridium difficile infection (CDI) outbreaks in public hospitals	Yes	No
15	Creutzfeldt-Jakob Disease, all types	Yes	No
16	Cryptosporidiosis	Yes	No
17	Cyclosporiasis	Yes	No
18	Diphtheria	Yes	Yes
19	Echinococcus multilocularis infection	Yes	No
20	Encephalitis, primary, viral	Yes	No

S-004: Reporting of Designated Diseases
Version Date: February 27, 2019

21	Encephalitis, post-infectious, vaccine-related, subacute sclerosing panencephalitis, unspecified	No	No
22	Food poisoning, all causes	Yes	No
23	Gastroenteritis, outbreaks in institutions and public hospitals	Yes	No
24	Giardiasis, except asymptomatic cases	Yes	No
25	Gonorrhoea	Yes	Yes
26	Group A Streptococcal disease, invasive	Yes	No
27	Group B Streptococcal disease, neonatal	No	No
28	Haemophilus influenzae disease, all types, invasive	Yes	No
29	Hantavirus pulmonary syndrome	Yes	No
30	Hemorrhagic fevers, including: Ebola virus disease, Marburg virus disease, Lassa fever, and other viral causes	Yes	Yes
31	Hepatitis A, viral	Yes	No
32	Hepatitis B, viral	Yes	No
33	Hepatitis C, viral	Yes	No
34	Influenza	Yes	No
35	Legionellosis	Yes	No
36	Leprosy	Yes	Yes
37	Listeriosis	Yes	No
38	Lyme Disease	No	No
39	Measles	Yes	No
40	Meningitis, acute, including: bacterial, viral and other	Yes	No
41	Meningococcal disease, invasive	Yes	No
42	Mumps	Yes	No
43	Ophthalmia neonatorum	No	No
44	Paralytic Shellfish Poisoning	Yes	No
45	Paratyphoid Fever	Yes	No
46	Pertussis (Whooping Cough)	Yes	No
47	Plague	Yes	Yes
48	Pneumococcal disease, invasive	Yes	No
49	Poliomyelitis, acute	Yes	No
50	Psittacosis/Ornithosis	Yes	No
51	Q Fever	Yes	No
52	Rabies	Yes	No
53	Respiratory infection outbreaks in institutions and public hospitals	Yes	No
54	Rubella	Yes	No
55	Rubella, congenital syndrome	Yes	No

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56	Salmonellosis	Yes	No
57	Severe Acute Respiratory Syndrome (SARS)	Yes	No
58	Shigellosis	Yes	No
59	Smallpox	Yes	Yes
60	Syphilis	Yes	Yes
61	Tetanus	Yes	No
62	Trichinosis	Yes	No
63	Tuberculosis	Yes	Yes
64	Tularemia	Yes	No
65	Typhoid Fever	Yes	No
66	Verotoxin-producing E. coli infection, including Haemolytic Uraemic Syndrome (HUS)	Yes	No
67	West Nile Virus Illness	No	No
68	Yersiniosis	Yes	No

Quality Assurance Committee
Approved by Council: June 22, 2007
Amended: September 11, 2007, December 11, 2008, December 3, 2009,
September 15, 2016, February 27, 2019

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

INTENT

Chiropractors have been using acupuncture treatments for many years as an adjunctive therapy for their patients. The use of acupuncture, as an adjunctive therapy, requires a high degree of skill and is not without risk. This standard of practice outlines the elements necessary to maintain a high level of skill in the application of acupuncture as an adjunctive therapy in the chiropractic practice.

Note: This standard of practice applies to members of CCO when they are providing acupuncture under their chiropractic certificate of registration, and not to members of CCO who may be also members of the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario, providing acupuncture services as a traditional Chinese medicine practitioner or acupuncturist.

OBJECTIVES

- To assist members who intend to provide acupuncture services as an adjunctive therapy to their patients.
- To remind members of their duties, obligations and scope of practice when providing acupuncture services as an adjunctive therapy to their patients.

DESCRIPTION OF STANDARD

Scope of Practice

Members are authorized under Regulation 107/96 of the *Regulated Health Professions Act, 1991 (RHPA)* to perform acupuncture, a procedure performed on tissue below the dermis, in accordance with this standard of practice and within the chiropractic scope of practice. Regulation 107/96 creates a specific exemption for specific regulated health professionals, including chiropractors, to perform the controlled act of a procedure performed on tissue below the dermis, in accordance with the standard of practice and within the scope of practice of the profession.

Therefore, a member may **only** perform the controlled act of performing acupuncture, a procedure below the dermis, as an adjunctive treatment, within the chiropractic scope of practice, and in accordance with this standard of practice.

The chiropractic scope of practice, as defined in the *Chiropractic Act 1991*, is as follows:

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

- (a) dysfunctions or disorders arising from the structures or functions of the spine and the effects of those dysfunctions or disorders on the nervous system; and
- (b) dysfunctions or disorders arising from the structures or functions of the joints.

See Standard of Practice S-001: Chiropractic Scope of Practice for further information.

For the purposes of this standard of practice, the performance of dry needling is considered as performing the controlled act of acupuncture, a procedure performed below the dermis, and has the professional responsibilities outlined in Regulation 107/96 and this standard of practice.

Titles

Members who use acupuncture as an adjunctive therapy are reminded that they are restricted from using certain titles and representations to the public as outlined in section 8 of the Traditional Chinese Medicine Act, 2006:

- 8(1) "No person other than a member (of the College of Traditional Chinese Medicine Practitioners and Acupuncturists) shall use the titles "traditional Chinese medicine practitioner" or "acupuncturist", a variation or abbreviation or an equivalent in another language."
- 2 8(2) "No person other than a member shall hold himself or herself out as a person who is qualified to practise in Ontario as a traditional Chinese medicine practitioner or acupuncturist or in a specialty of traditional Chinese medicine."

Therefore, members may not make any misrepresentations to the public that they are a traditional Chinese Medicine Practitioner or acupuncturist. Members must clearly communicate to the public, including advertising, signs websites and social media and billing and business practices, that they are a chiropractor who performs acupuncture as an adjunctive treatment, and not an acupuncturist or a member of the College of Traditional Chinese Medicine Practitioners or Acupuncturists.

A member shall consider whether their overall representation of their use of acupuncture as an adjunctive treatment is misleading to a reasonable member of the public. In addition the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario has the jurisdiction to address any inappropriate representation of someone who is not a member of their college holding themselves out as a person who is qualified to practise in Ontario as a traditional Chinese medicine practitioner or acupuncturist or in a specialty of traditional Chinese medicine.

For example, CCO considers the use of the titles "acupuncture provider" and "acupuncture clinic" to be a variation of the title "acupuncturist", contrary to the Traditional Chinese Medicine Act, 2006, if the member is also not a member of the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario. It would be more accurate for a member to list acupuncture as an adjunctive therapy that is provided, in the context of providing chiropractic care.

Assessment and Care Related to Acupuncture

A member shall ensure that they are providing acupuncture within the chiropractic scope of practice and in accordance with CCO standards of practice.

In providing acupuncture, a member must perform a chiropractic consultation and examination, communicate a diagnosis or clinical impression within the chiropractic scope of practice, obtain informed consent and deliver a plan of care, which may involve acupuncture as an adjunctive treatment, consistent with the chiropractic scope of practice.

Consideration of Public Safety

A member is reminded that the use of any acupuncture procedure or protocol may have significant benefits for a patient, but also carries some risks. As such, a member must be:

- skilled at prevention of infection and familiar with clean needle techniques;
- aware of any and all contraindications to the use of acupuncture;
- trained in the appropriate responses to accidents and untoward reactions; and
- aware of precautions necessary to prevent injury.

A member is required to obtain patient consent prior to treatment by acupuncture that is:

- fully informed;
- voluntarily given;

- related to the patient's condition and circumstances;
- not obtained through fraud or misrepresentation; and
- evidenced in a written form signed by the patient or otherwise documented in the patient health record.

Members are reminded that this standard should be read in conjunction with Standard of Practice S-013: Consent. Members should refer to the World Health Organization's (WHO) *Guidelines on Basic Training and Safety in Acupuncture, 1999* (WHO Guidelines) for a more in-depth discussion of prevention of infection, contraindications, accidents and untoward reactions, and injury to organs.

Educational Requirements in Establishing Degree of Skill

To practise acupuncture as an adjunctive therapy in the context of their chiropractic practice, a member must have completed specific acupuncture training as taught in the core curriculum, post-graduate curriculum or continuing education division of one or more colleges accredited by the Council on Chiropractic Education Inc., or in an accredited Canadian or American college/university, or in an accredited school of acupuncture.¹

CCO adopts the WHO Guidelines that a combined (clinical and academic) minimum of 200 hours of formal training² is required for a member who intends to use acupuncture as an adjunctive procedure in his/her primary practice.

Members are required to achieve, maintain and be able to demonstrate clinical competency in any diagnostic or therapeutic procedure that they use in practice. As such, members who are authorized to perform acupuncture are required to participate in ongoing continuing education activities in the performance of acupuncture as an adjunctive therapy within the chiropractic scope of practice.

Billing Practices for Acupuncture as an Adjunctive Treatment

4

The financial record and invoice for acupuncture must reflect the clinical delivery of acupuncture as an adjunctive treatment. Therefore, the records must reflect that the member performed acupuncture under their certificate of registration as a chiropractor, within the chiropractic scope of practice, and in accordance with this standard of practice as an adjunctive procedure.

Grandparenting Clause

Members who have actively practised acupuncture as an adjunctive therapy in their chiropractic practice for a minimum of five consecutive years immediately before the enactment of this standard of practice will be deemed to have met the qualifications to practise acupuncture as an adjunctive therapy, as outlined above.

Actively practising acupuncture as an adjunctive therapy means performing 150 acupuncture treatments per year for each of the last five years within a chiropractic practice prior to the date of the enactment of this standard of practice.

Professional Liability Protection

A member shall provide evidence, satisfactory to the Registrar, of carrying professional liability insurance in the applicable minimum amount per occurrence and minimum aggregate amount per year, including coverage for claims after the member ceases to hold a certificate or membership in a protective association that provides equivalent protection unless the applicant is, or will be when registered, an employee of a member, a health facility or other body that has equivalent professional liability insurance coverage or membership in a protective association that provides equivalent protection.

LEGISLATIVE CONTEXT

Health Professions Procedural Code (The Code), Schedule 2 of the *Regulated Health Professions Act, 1991*

The QA program is defined in section 1(1) of the Code as “a program to assure the quality of the practice of the profession and to promote continuing evaluation, competence and improvement among members.”

Objects and Duties of CCO - Section 3 of the Code

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Section 3(1): The College has the following objects:

3. To develop, establish and maintain standards of practice to assure the quality of the practice of the profession
4. To develop, establish and maintain standards of knowledge, skill and programs to promote continuing competence among the members

Regulation 107/96 of the RHPA: Controlled Acts

Section 8(2)

Subject to subsection (4), a person who is a member of a College listed in Column 1 of the Table is exempt from subsection 27(1) of the Act for the purpose of performing acupuncture, a procedure on tissue below the dermis, in accordance with the standard of practice and within the scope of practice of the health profession listed in Column 2..

	Column 1	Column 2
1.	College of Chiropractors of Ontario	Chiropractic
2.	College of Chiropractors of Ontario	Chiropractic
3.	College of Massage Therapists of Ontario	Massage Therapy
4.	College of Nurses of Ontario	Nursing
5.	College of Occupational Therapists of Ontario	Occupational Therapy
6.	College of Physiotherapists of Ontario	Physiotherapy
7.	Royal College of Dental Surgeons of Ontario	Dentistry

Titles

Members who use acupuncture as an adjunctive therapy are reminded that they are restricted from using certain titles as outlined in section 8(1) of the *Traditional Chinese Medicine Act, 2006*:

Section 8(1)

No person other than a member (of the College of Traditional Chinese Medicine Practitioners and Acupuncturists) shall use the titles "traditional Chinese medicine practitioner" or "acupuncturist", a variation or abbreviation or an equivalent in another language.

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Chiropractic Act, 1991

Scope of Practice

A member who uses acupuncture as an adjunctive therapy is reminded that the scope of practice of chiropractic is defined in section 3 of the *Chiropractic Act, 1991*:

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

- (a) dysfunctions or disorders arising from the structures or functions of the spine and the effects of those dysfunctions or disorders on the nervous system; and
- (b) dysfunctions or disorders arising from the structures or functions of the joints.

Conclusion

Identifying and complying with safeguards will ensure safer administration of this form of treatment. Therefore, risks to the public will be minimized and the benefits of safe, effective therapeutic treatment will be maintained. This standard should be read in conjunction with Standards of Practice S-003: Professional Portfolio, S-011: Members of More Than One Health Profession and S-013: Consent.

¹Examination, certification or other proof of clinical proficiency is required.

²The course should comprise at least 200 hours of formal training, and should include the following components:

1. Introduction to traditional Chinese acupuncture
2. Acupuncture points:
 - location of the 361 classical points on the 14 meridians and the 48 extraordinary points; and
 - alphanumeric codes and names, classifications of points, direction and depth of insertion of needles, actions and indications of the commonly used points selected for basic training.
3. Applications of acupuncture in modern Western medicine:
 - principle clinical conditions in which acupuncture has been shown to be beneficial;
 - selection of patients and evaluation of progress/benefit; and
 - planning of treatment, selection of points and methods of needle manipulation, and the use of medication or other forms of therapy concurrently with acupuncture.
4. Guidelines on safety in acupuncture
5. Treatment techniques:
 - general principles; and
 - specific clinical conditions.

Federation of Healthy Regulatory Colleges of Ontario Resources

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The College of Chiropractors of Ontario is a member of the Federation of Health Regulatory Colleges of Ontario (FHRCO). FHRCO is a federation of all health regulatory colleges in Ontario, which develops a forum for inter-professional collaboration, develops training programs, and creates resources for colleges, regulated health professionals and members of the public.

Please visit [FHRCO's website](#) for a variety of resources related to care from your regulated health professional.

Please see the following two links for videos produced by FHRCO on the prevention of sexual abuse:

<https://www.youtube.com/watch?v=WEylaKLWo8I&feature=youtu.be>

https://www.youtube.com/watch?v=BIHoDtLEb_0&feature=youtu.be

**POLICY
P-010**

Executive Committee
Approved by Council: January 20, 1995
Re-affirmed: June 18, 2014

**Professional Misconduct
Relating to Orthopractic**

308

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

INTENT

To delineate the terms, titles or designations relating to orthopractic, the use of which is prohibited by CCO.

DESCRIPTION OF POLICY

Use of the following terms, titles or designations by members are contrary to the policies of CCO for the purposes of subsections 16 and 17 of the Professional Misconduct Regulation under the *Chiropractic Act, 1991*:

- orthopractice;
- orthopractic;
- orthopractor;
- Orthopractic Manipulation Society International (OMSI); and
- any similar term, title or designation.

From: Jo-Ann Willson
Sent: Tuesday, April 09, 2019 2:35 PM
To: John Sutherland
Cc: Rose Bustria
Subject: FCC Report from Ontario
Attachments: 19April9CCORep.docx; Professional-Advisory-Vaccination-March142019.pdf; RFPWebsiteandSocialMediaComplianceScanningSoftwareMarch272019.pdf; 19April4MacPhailL.pdf; Ryan Armstrong.pdf

Attached is Ontario's Report to the FCC Regulatory Council. Please circulate to members. Thank you.

Jo-Ann Willson, B.Sc., M.S.W., LL.B.
Registrar & General Counsel

College of Chiropractors of Ontario
130 Bloor St. West, Suite 902
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THE FEDERATION
FEDERATION OF CANADIAN CHIROPRACTIC
LA FÉDÉRATION
FÉDÉRATION CHIROPRACTIQUE CANADIENNE

FCC Regulatory Council Member Reporting Form – April 2019

Please respond to the following questions as best you can. This form is intended to capture basic information and to generate discussion among regulatory jurisdictions for the benefit of all members. The questions are based upon previous oral reports and recommendations from the Regulatory Council Co-Chairs. To allow for maximum member interaction during the Regulatory Council meeting, the reports will not be read but please be prepared with any questions you may have regarding any of the reports.

This form is a regular Word document which will allow you the maximum flexibility in providing as much or as little information as you determine. Please complete by **April 5, 2019** and send as an email attachment to amacdonald@pathfinder-group.com for distribution to the Regulatory Council.

Administrative Matters

A1 What is your province/territory?

Ontario

A2 What is the size of your Council/Board?

15 currently (could be up to 16, nine elected and 7 appointed members)

A3 What is the number of annual scheduled meetings of your Executive?

5

A4 What is the number of annual scheduled meetings of your Council/Board?

5

A5 How many individuals are normally elected/appointed to your board annually?

3

Membership Matters

M1 Number of members as at December 31, 2018:

4963

M2 Number of new members added since December 31, 2018:

17

M3 Longer term trend in membership: flat, increasing, decreasing?

Increasing

Licensing Matters

L1 What challenges are you experiencing regarding the licensure or re-licensure of practitioners?

No significant challenges in licensure or re-licensure.

Discipline Matters

D1 What are your major disciplinary issues?

- Allegations of sexual abuse
- Billing and Business practices
- Patient Harm

Trends in Your Jurisdiction

T1 Complaints – what is the number of new complaints received for the year ended December 31, 2018?

94

Health Care Chiropractic Critics filing multitude of complaints (much higher than patient or other professionals' complaints).

T2 Length for complaints resolution: are they flat, increasing, decreasing?

Flat

T3 Internal political issues: are they flat, increasing, decreasing?

Increasing

T4 External political issues: are they flat, increasing, decreasing?

Increasing

T5 What new or changed opportunities do you anticipate in your jurisdiction?

Government is considering changes to Regulated Health Professions Act. Major stakeholders such as the College of Nurses have proposed wide changes with a movement towards smaller boards and competency based selection criteria for both elected and public members.

Increased use in technology for renewal, continuing education reporting, initial registration, elections to Council and monitoring of websites and social media compliance.

T6 What new or changed risks do you anticipate in your jurisdiction?

Increased media coverage. Diversity within the profession and different pressures on CCO as regulator.

T7 What issues are you dealing with related to continuing competency?

For the first time in 2018, members reported on their continuing education activities and self-assessment compliance online. CCO will continue to explore methods to creating efficiencies and using technology for reporting of Quality Assurance initiatives.

Legislative Matters

L1 What legislative changes or updates do you have to report for the year ended December 31, 2018?

Effective May 1, 2018, there were significant amendments made to the law relating to patients as reflected in the *Protecting Patients Act, 2017*, which amends the *RHPA* as follows:

- there is a new definition of patient for the purposes of the prohibition of sexual abuse provisions;
- complainants with sexual abuse allegations have immediate access to funding for therapy or counselling (and do not need to wait for a finding of professional misconduct to access funding) (section 85.7 of the Health Professions Procedural Code, schedule 2 of the *RHPA*);
- the mandatory reporting requirements have been expanded (sections 85.6.3 and 85.6.4 of the Health Professions Procedural Code, schedule 2 of the *RHPA*);
- the information colleges must maintain on the public register has been expanded;
- the types of criminal offences that require the mandatory revocation of a member's certificate of registration have been expanded.

L2 What regulatory changes or updates do you have to report for the year ended December 31, 2018?

CCO approved several new and amended standards of practice, policies and guidelines, as of December 31, 2018. Several of the significant updates include:

- Amendments to Standard of Practice S-014: Prohibition of a Sexual Relationship with a Patient to ensure consistency with amendments to the *RHPA*.
- Amendments to Standard of Practice S-019: Conflict of Interest in Commercial Ventures to increase the requirement of disclosure to patients of any exchange of benefit related to chiropractic services or products.
- Amendments to Guideline G-001: Communication with Patients to restrict certain inappropriate behaviour related to boundary crossings and grooming behaviours
- New Guideline G-013: Chiropractic Assessments to describe policies and procedures related to different types of chiropractic assessments
- New Guideline: G-014: Delegation, Assignment and Referral of Care to describe policies and procedures of assigning care to an assistant and referring care to another health care provider
- Amendments to By-law 6: Election of Council Members to require a “cooling off” period for members who are employees, officers and directors of any professional chiropractic association such that a real or apparent conflict of interest may arise, before being eligible for election to CCO Council.
- Amendments to By-law 17: Public Register to increase the information available on the public register, consistent with amendment to the *RHPA*.
- Various bulletin and communiques to members about advertising, websites and use of social media.

Mobility Matters

M1 What challenges are you experiencing regarding mobility in Canada?

No significant challenges.

M2 What challenges are you experiencing regarding international mobility?

No significant challenges.

Special Projects or Activities

S1 What special projects or activities do you have to report for the year ended December 31, 2018? This would include such things as communication, advertising, joint projects with others, etc.

- Completion of first round of Peer and Practice Assessment 2.0

- Launch of online elections to Council
- Launch of online Continuing Education reporting
- Use of educational videos and other communication content from the Federation of Health Regulatory Colleges of Ontario (FHRCO)
- Various bulletins and communiques about advertising, websites and use of social media

S2 What special events is your jurisdiction planning or considering that may be open or available to other jurisdictions?

- Future road shows
- Annual General Meeting

Recognition and Awards

R1 What recognition/awards have your jurisdiction or members of your council/board received since December 31, 2017?

N/A

Other Matters

O1 What other matters would you like to report or see reported using this format?

Other significant initiative for 2019 is movement to new premises – building out the space and moving all operations.

CCO is exploring methods of using technology to assess members' websites and social media sites for compliance with advertising standards of practice and guidelines.

Form completed by:

Dr. David Starmer
Ms Jo-Ann Willson

Date:

From: Jo-Ann Willson
Sent: Wednesday, April 17, 2019 11:44 AM
To: Chris Prior; Lauren Cormier, DC; Darrell Wade; denise@saskchiro.ca; plariviere@ordredeschiropraticiens.qc.ca; jsutherland@chirofed.ca; ssteger@albertachiro.com; jfhenry@ordredeschiropraticiens.qc.ca; drmegmcdonald@gmail.com; drcjlevere.nbca@rogers.com; drjanisd@gmail.com; Doug.shatford@cshlaw.ca; registrar@mbchiro.org; deputyregistrar@chirobc.com; registrar@chirobc.com; rgwatkin@hotmail.com; drstarmer@gmail.com; drlarichard@hotmail.com; dgryfe@sympatico.ca; fleblanc@nbchiropractic.ca; khenbid@sasktel.net; drhalowski@haloclinic.ca; Greg Dunn (gdunn@ccpaonline.ca)
Cc: david.hayes@dr.com; John Sutherland
Subject: Fall 2019 Meeting - CCPA/Regulators - Possible Dates

Dear Colleagues:

Thank you to all regulators who attended the Federation of Canadian Chiropractic (FCC) Regulatory Council meeting on Friday, April 12, 2019. Dr. Dunn and I would like to follow up by scheduling a Fall 2019 meeting between CCPA and *all regulators* to discuss common strategies and best practices in an effort to harmonize standards of practice relating to topics such as advertising, social media and continuing education, while recognizing that the scopes of chiropractic practice differ somewhat across the country. We would also like to look at making the office visit, both for new and subsequent office visits, standardized, consistent and recognizable from office to office and province to province. It is important that regulators learn from one another, and that we hear how some regulators have dealt effectively with current challenges.

The underlying principle is that there is a public interest in ensuring high quality, ethical, competent and consistent care delivered by chiropractors coast to coast. We would very much appreciate one or two other regulators taking the lead at the workshop, particularly if they have already engaged in processes that they think other regulators should follow. The expectation is that the Registrar, President and a public member from each province would be invited to attend. CCPA has generously offered to provide financial assistance to those regulators who may have financial constraints on their ability to attend. A formula for that will be worked out once we have confirmed that all regulators will attend. CCO is prepared to host the meeting at its new office space at 59 Hayden, 8th Floor, Toronto. We are open to any and all suggestions about how chiropractic regulators can demonstrate national leadership through a public interest lens.

The possible dates for the workshop are as follows:

- Saturday, October 19, 2019
- Saturday, October 26, 2019
- Saturday, November 2, 2019

At this early planning stage, it would be helpful to know which dates are workable for you and that you are committed to attending and participating. Once we have the date, we will be in communication with everyone further about the details. I trust I have included all Canadian regulators on this e-mail, but if not, please feel free to forward the communication. Thank you.

Jo-Ann Willson, B.Sc., M.S.W., LL.B.
Registrar & General Counsel

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College of Chiropractors of Ontario
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Subject: FW: For Immediate Release: CMCC signs International Position Statement on Chiropractic Education
Attachments: ICEC Position Statement Background and Q and A stakeholdersMarch27.pdf

From: Jo-Ann Willson
Sent: Wednesday, March 27, 2019 3:29 PM
To: Rose Bustria <RBustria@cco.on.ca>
Subject: FW: For Immediate Release: CMCC signs International Position Statement on Chiropractic Education

Council.

Jo-Ann Willson, B.Sc., M.S.W., LL.B.

From: Joel Friedman
Sent: Wednesday, March 27, 2019 3:28 PM
To: Jo-Ann Willson <jpwillson@cco.on.ca>
Subject: FW: For Immediate Release: CMCC signs International Position Statement on Chiropractic Education

Joel D. Friedman, BSc, LL.B
Director, Policy and Research
College of Chiropractors of Ontario
130 Bloor Street West, Suite 902
Toronto, ON M5S 1N5
Tel: (416) 922-6355 ext. 104
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From: communications [<mailto:communications@cmcc.ca>]
Sent: Wednesday, March 27, 2019 2:45 PM
To: communications <communications@cmcc.ca>
Subject: For Immediate Release: CMCC signs International Position Statement on Chiropractic Education



FOR IMMEDIATE RELEASE

[The Canadian Memorial Chiropractic College becomes a signatory to the International Clinical and Professional Chiropractic Education Position Statement](#)

Toronto, ON, Canada, March 27, 2019 : The Canadian Memorial Chiropractic College (CMCC) Board of Governors today announced that CMCC has become a signatory to the [International Chiropractic Clinical and Professional Chiropractic Education Position Statement](#), joining 12 institutions around the world.

The statement, originally formulated as a collaborative effort among several European chiropractic institutions and one in South Africa was formally released at the 2015 scientific meeting of the World Federation of Chiropractic in Athens, and updated in 2017. The statement was developed as a way to provide a cohesive view of how, in the interest of the welfare of the patient, chiropractic education should be of the highest quality and founded on the principles of evidence-based care, with curricula that is responsive to changing patient, societal and community needs and expectations within a modern health care system.

Dr. Rahim Karim, Chair of the CMCC Board of Governors noted, "The Board of Governors has dedicated considerable thought and deliberation to this issue over the past several years, and the final decision to move forward into joining this collaborative effort was unanimously approved at our October 2018 meeting. We feel it is time to make our educational position clear regarding the alignment of our curriculum, research efforts and model of care with our continued emphasis upon evidence-based and patient-centred care."

Reflecting on this important milestone in the history of CMCC, President Dr. David Wickes commented, "CMCC is committed to continually evolve its programs and realize our vision to create leaders in spinal health. We have undertaken extraordinary efforts over the past few years to emphasize the rapid translation of research into our curriculum and patient care practices, and to forge partnerships with other innovative institutions. Declaring our support for the Position Statement will better enable us to attract the best students and faculty, and to strengthen and build trust with the public, partners and communities we serve."

About CMCC

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The Canadian Memorial Chiropractic College is recognised for creating leaders in spinal health. With graduates practicing in 37 countries and faculty who are leaders in their fields, CMCC delivers world class chiropractic education, research, and patient care. The campus features modern teaching and laboratory space, including new simulation and biomechanics laboratories, and is extended across Toronto through its network of community based interprofessional clinics that serve diverse patient populations. CMCC offers a four-year undergraduate program leading to a Doctor of Chiropractic Degree. This degree program is offered under the written consent of Ontario's Minister of Training, Colleges and Universities for the period from 24/3/11 to 24/3/21. For more information, visit www.cmcc.ca or follow us on [Twitter](#) and [Facebook](#) and [LinkedIn](#).

Additional Resources

Attached: [Backgrounder and Questions and Answers](#)

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**Backgrounder and Questions Re:
About the International Chiropractic Education Collaboration's
Position Statement on Clinical and Professional Chiropractic Education**

The Canadian Memorial Chiropractic College has officially endorsed the International Chiropractic Education Collaboration's (ICEC) Position Statement on Clinical and Professional Chiropractic Education, joining many other institutions around the world with a similar approach to evidence-based, patient-centred contemporary chiropractic education. On October 19, 2018, the CMCC Board of Governors concluded an almost three-year study and deliberation of the Position Statement, considered the results of a faculty survey demonstrating overwhelming support of the Position Statement, and voted unanimously to become a signatory to the Statement. CMCC opted to wait until the March 2019 World Federation of Chiropractic (WFC)/European Chiropractors' Union (ECU) Berlin conference to formally sign the document in the presence of representatives from many of the other signatory institutions. A formal announcement was made on March 27, 2019.

Primary Reason for Signing:

The major impetus to sign this Position Statement is to make clear to prospective students what to expect from CMCC's educational program. As an educational institution, CMCC has an obligation to accurately portray and promote its educational programs to prospective students and interested future faculty members. Additionally, student protective standards for the Ontario Ministry of Training, Colleges and Universities and the Council on Chiropractic Education (Canada; CCEC) mandate that CMCC's student recruitment materials and practices properly depict the nature of education provided at CMCC. Although all accredited Doctor of Chiropractic programs provide a core educational experience that is in compliance with their respective country's CCE accreditation standards, within the chiropractic profession and its educational institutions there are considerable variations in practice philosophy and educational delivery methods. Whereas some programs identify themselves as providing a vitalistic or metaphysical philosophy deeply rooted in historical constructs from the early years of the emerging chiropractic profession, CMCC has for several decades promoted itself as being an evidence-based program, with a model of care focusing on chiropractic as a primary contact health care profession with expert knowledge in spinal and musculoskeletal health, emphasizing differential diagnosis, patient centred care and research.

Alignment of the Position Statement with CMCC's Strategic Plan

CMCC has been steadily moving forward on evidence-informed, scientific practices over the past several decades guided and supported by our Board of Governors, by our faculty and by

our strategic planning process, as well as our national and international collaborative partners in research and education. The CMCC Strategic Plan framework, developed in consultation with the Board of Governors, staff, faculty, administration, students and stakeholders, establishes a roadmap to guide CMCC through its next phase of growth and development for the period of 2017 to 2021. It identifies six strategic themes/areas of excellence which shape the future of the institution.

- I. Excellence in teaching and learning
- II. Excellence in support and service for students and employees
- III. Excellence in clinical care
- IV. Excellence in collaboration and communication
- V. Excellence in institutional leadership and management
- VI. Excellence in research, scholarship and innovation

By signing the International Chiropractic Education Collaboration Position Statement, CMCC speaks directly to the majority of the themes. The goal with such a bold move as this is to set the record straight on the direction and focus of the institution, continue to evolve the curriculum, to protect the reputation of CMCC, preserve its academic and scientific integrity and improve existing and foster new collaborative and integrative efforts to improve healthcare for the benefit of the patient.

Emphasis of the Position Statement:

The Position Statement reinforces the educational concepts of evidence-based and patient-centred care and stresses the avoidance of certain clinical practices that are not sufficiently supported by scientific rationale or best practices, or which subject the patient to unnecessary procedures. The primary purpose of the Position Statement is to clarify CMCC's educational practices and not address wider professional or regulatory matters. The Position Statement commits to a modern, continually evolving curriculum founded on the principles of evidence-based care and acknowledging the biopsychosocial model of care underpinned by peer-reviewed research. The Position Statement emphasizes the value of providing a DC degree program education that is rich in evidence-based practice concepts and principles, embraces innovative teaching methods, and promotes widely accepted preventative and public health measures (including vaccination).

Subluxation and Vitalism:

A portion of the Position Statement addresses the concept of vertebral subluxation within the curriculum, stating *"The teaching of vertebral subluxation complex as a vitalistic construct that claims that it is the cause of disease is unsupported by evidence. Its inclusion in a modern chiropractic curriculum in anything other than an historical context is therefore inappropriate and unnecessary. [Specifically, the form of vitalism as distinct from holism that proclaims 'If the specific vertebral subluxation is correctly adjusted, interference is released, pressure is eliminated, carrying capacity restored to normal, tissue cell is re-established, and life and health begin to regrow back to normal. All this is directed, controlled, and performed by INNATE*

INTELLIGENCE' (Ref: BJP Fame and Fortune Vol. XXXIII)]". CMCC acknowledges that the terms referring to "subluxation" and "vitalism" can often be confusing and lack agreed-upon definitions within the chiropractic and other healthcare professions. The Position Statement attempts to place the two terms into a specific context.

It is important to distinguish between the concept of **subluxation** as being primarily a biomechanical dysfunction that may produce secondary local and remote signs and symptoms, and that of the vitalistic concept of subluxation originally described by D.D. Palmer as being a direct cause of neurologic dysfunction resulting in organ system dysfunction and which if not removed will result in a deterioration of health even up to clinical disease and death. A large number of chiropractors in Canada still use the term "subluxation" in the biomechanical sense (i.e., joint or segmental dysfunction), and there is nothing in the Position Statement that specifically discourages that use. It is only the more extreme, vitalistic, context of subluxation that the Position Statement takes exception to because there is presently a lack of supporting evidence to justify its inclusion in the curriculum.

The concept of **vitalism** (or "neo-vitalism") also widely varies among users of the term, and this debate has gone on for centuries among philosophers and biologists. Few practitioners would deny the very simplest use of the term to describe the human body's inherent ability to regulate and heal itself. It is when the use of the term expands to include metaphysical connotations of a life force connected to all organisms and which becomes blocked by vertebral subluxation, that most scientists, and the Position Statement, reject the concept.

The astute clinician is ready to dismiss dogmatic beliefs when confronted with new knowledge developed through the scientific method. This is why CMCC engrains in its students a passion for seeking and applying the best available evidence, an understanding of the hierarchies of evidence (including their limitations), the development of a habit of lifelong learning, and a willingness to challenge practices that are poorly supported by scientific evidence or sound biologic or physiologic principles. As an educational institution, CMCC is willing to challenge dogma and practices that are founded primarily on beliefs and which have become invalidated by emerging science.

Research at CMCC:

The CMCC Institutional Strategic Plan is replete with references to research, including performing research in the core elements of chiropractic. These core elements include basic science studies in neurophysiology, mechanotransduction, mechanisms of pain and inflammation, spinal manipulation, biomechanics, and clinical outcomes. One stream of research includes studies in the areas of cellular and molecular biology, immunology, biomechanics, ergonomics, mechanobiology, morphology, and neurophysiology. One of the three research departments is the Life Sciences department that is currently studying autonomic nervous system interactions, and which has just hired a post-doctoral fellow to add strength to this department. CMCC spends a larger proportion of its operating budget on research than any other chiropractic institution in North America, demonstrating its commitment to the continuous development of new knowledge.

MSK vs. NMSK:

In some professional settings, there has been debate over the use of the terms “musculoskeletal” (MSK) vs. “neuro-musculoskeletal” (NMSK) as to whether the former term is too limiting or de-emphasizes the importance of the nervous system. The Canadian Chiropractic Association primarily uses the MSK version in order to provide a consistent message to the public. CMCC similarly most often refers to MSK rather than NMSK, however that should not be interpreted as ignoring the importance of the nervous system. At CMCC, students learn to appreciate the body as a complex, dynamic interconnected web of structures and functions, with continuous interactions between the nervous system and the musculoskeletal system. From a scientific literature perspective, searching the healthcare literature databases using the NMSK term yields only about 1% of the number of publications yielded when using the MSK term, illustrating that the NMSK term is not as widely used.

It should be noted that CMCC does not focus solely on a biomechanical, mechanistic model of care. One need only look at CMCC’s research efforts described above, as well as our core education curriculum that includes extensive training and assessment in the neurosciences, including neuroanatomy, neurophysiology, differential diagnosis, and case management, to appreciate the importance placed on the nervous system by CMCC.

Distinguishing Between Chiropractic Educational Institutions:

It is widely understood within the chiropractic community that there is a considerable variation between the different chiropractic educational programs, however this variation may not be clear to the public and to prospective students. All DC degree programs provide for the development of competencies mandated in the accrediting standards and qualifying students to sit for licensing/registration examinations, but these programs have considerable latitude to implement curricula matching their unique missions and visions. In 2005 and 2013, reports issued by the Institute for Alternative Futures as part of studies commissioned by the National Chiropractic Mutual Insurance Company Foundation, classified the USA schools into those emphasizing a “focused scope” (i.e., emphasizing a subluxation-based practice), “middle scope” (a blend of therapeutic approaches), and “broad scope” (leaning towards primary care and management of MSK and non-MSK disorders with broad range of treatments that might include prescription drugs). Although CMCC was not included in those studies, it would likely fit into the middle scope category and considerably distanced from the focused scope schools embracing neo-vitalism. Most schools in North America promote their programs as being “evidence-based”, so it may be difficult for prospective students to select the program providing the best fit for the student. Through the Position Statement, CMCC is better able to clarify what potential students will and will not receive from their CMCC education. Endorsing the Position Statement will also help CMCC attract the most appropriate and best qualified faculty and researchers, as well as better clarify our educational and practice model to potential institutional partners, other healthcare professions, and the public.

ICEC Position Statement Timeline at CMCC:

In October 2018, the Board unanimously voted to have CMCC sign the Position Statement. This followed several years of discussions. At the June 2015 annual Board Retreat, the Position Statement was introduced for preliminary discussion. Discussion continued over the next two years as support appeared to grow internationally for the Position Statement and CMCC was invited to become a signatory. At the June 2017 Board Retreat, the Board was supportive of becoming a signatory to the Position Statement but wanted greater faculty input. A faculty poll in 2018 indicated overwhelming support for the Position Statement, and at the October 2018 Board meeting the Board voted unanimously to sign the Position Statement. This was done formally on March 22, 2019 at the WFC/ECU Conference in Berlin in a gathering of representatives of many of the other signatory institutions.

Questions and Answers regarding International Education Position Statement

OF PARTICULAR INTEREST TO CURRENT STUDENTS:

Q. *How will this affect the curriculum and my education at CMCC?*

A. This will have no impact on the curriculum or clinical experience at CMCC. Everything mentioned in the Position Statement conforms to what is currently taught and practised at CMCC. The primary intended audience of the Position Statement includes prospective students and other persons who may not be familiar with our curriculum or model of care.

Q. *Do CMCC's faculty members support the Position Statement?*

A. The faculty was polled in October 2018 prior to the Board of Governors taking a vote on the issue. There was overwhelming support (98%) by the faculty of the content of the Position Statement.

Q. *Will this affect my ability to get external clinical placements?*

A. There will probably be little impact on placements. All of our formal clinic training sites currently affiliated with CMCC provide a clinical experience in conformance with CMCC's model of care and the Position Statement. There may be some field practitioners who may opt not to apply to be a preceptorship/observation site because their practice model is not in conformance. We attempt to recruit clinics to participate as external training sites that are aligned with our model of care and which do not engage in practices that are discouraged by the Position Statement.

OF PARTICULAR INTEREST TO FACULTY MEMBERS:

Q. *How did the faculty survey on signing the Position Statement affect the decision to become a signatory?*

A. The results of the faculty poll in October 2018 were compiled and shared with the Board of Governors. The Board was impressed to see that there was overwhelming faculty support for the Statement. It is highly unlikely that the Board would have voted to become a signatory if the faculty had not so strongly supported the issue.

Q. *How many faculty members responded to the survey?*

A. The survey was distributed to all full- and part-time faculty members with CMCC email addresses. There were 78 respondents.

OF PARTICULAR INTEREST TO CMCC STAFF MEMBERS:

Q. *Will this affect CMCC's ability to recruit students and employees?*

A. We currently have almost four times as many applicants as we have seats available for new students. The impact of the statement on the applicant pool will not be known until next year, however one of the primary purposes for signing the Position Statement is to ensure that students who apply and are admitted to CMCC are a "best fit" for our educational program. This means that we expect some students who desire to receive an education more philosophically aligned with a vitalistic model of care will opt to apply at a different program. Similarly, our clear statement of educational and clinical orientation may encourage more students to apply to CMCC rather than other programs.

Q. *How might this affect CMCC Membership and Fundraising?*

A. That's an area that the Board of Governors discussed at length and concluded that although there might be some loss of membership or donor pledges in the immediate future, it was still in the best interests of the institution to become a signatory to the Position Statement. All fundraising centers around matching the vision and values of the potential donor to that of the institution. Just as with students and employees, we want a "best fit" between donors and CMCC. Just as we have heard from some alumni that they are disappointed that CMCC has become focused on spine and musculoskeletal care rather than vitalistic care, we've also heard from other alumni that they are excited that CMCC has taken a firm position and will be proud to support the institution.

OF PARTICULAR INTEREST TO BOARD OF GOVERNORS MEMBERS AND CMCC ALUMNI:

Q. *I'm a long standing ____ (CMCC Member, Governor's Club Member, Donor) and I'm upset that CMCC has abandoned its chiropractic roots by signing this Statement. Why should I bother continuing to support CMCC?*

A. We are grateful for the support of our alumni and friends. Please remember, there is nothing in the Position Statement that differs from CMCC's educational philosophy that has been in place for several decades. The primary purpose of the Position Statement is to clarify what CMCC teaches, and what it does not teach, so that prospective students' expectations are met. CMCC continues to do research in the foundational chiropractic sciences, including the neurologic ramifications of the chiropractic adjustment. At present, there is an insufficient body of evidence supporting the chiropractic treatment (spinal adjusting) of many patients with non-musculoskeletal diseases or disorders. We recognize that many patients have experienced remarkable changes in these disorders while under the care of a chiropractor, but until there is sufficient scientific evidence and biologic plausibility of improvement directly attributable to the adjustment, we do not feel that this should be part of the core chiropractic curriculum. Donations to CMCC substantially help us grow our research program, provide our students with the latest technology to assist their learning, and continue to raise the stature of our institution as a valued member of Canadian academia and the scientific community – something that benefits all alumni.

Q. *Is CMCC abandoning the "neuro" part of NMSK (neuromusculoskeletal)?*

A. No, it is not. CMCC recognizes that tissues and organ systems interact and communicate with each other, and that pain, inflammation and irritation can have impact upon both the central nervous system as well as peripheral tissues. We have conducted considerable research on these effects and will continue to do so. We just added another full-time researcher for our Life Sciences laboratory, under the guidance of Dr. Budgell, which explores the effects of the adjustment on the nervous and immune systems. The CMCC Institutional Strategic Plan includes many research strategies, including performing research in the core elements of chiropractic. CMCC spends a greater portion of its budget on research than any other institution in North America. Our research, along with our core education curriculum that includes extensive training and assessment in the neurosciences, including neuroanatomy, neurophysiology, differential diagnosis, and case management, should reassure alumni that CMCC is paying attention to the nervous system.

Q. *Is CMCC denying the existence of the vertebral subluxation?*

A. The term "subluxation" is often very confusing to different audiences. It is important to distinguish between the concept of **subluxation** as being primarily a biomechanical dysfunction that may produce secondary local and remote signs and symptoms, and that of the vitalistic

concept of subluxation as being a direct cause of neurologic dysfunction resulting in organ system dysfunction and which if not removed will result in a deterioration of health. Many chiropractors still use the term “subluxation” in the biomechanical sense (i.e., joint or segmental dysfunction), and there is nothing in the Position Statement that specifically discourages that use. CMCC does not support the use of the term “subluxation” in its vitalistic context as promoted by BJ Palmer or Stephenson.

OF INTEREST TO ALL:

Q. *How many schools (programs) have signed the Position Statement*

A. As of March 2019, signatories of the agreement are: AECC (England), WIOC (Wales), IFEC-Paris and IFEC-Toulouse (France), SDU-Odense (Denmark), UZ-Zurich (Switzerland), UJ-Johannesburg (South Africa), Durbin University of Technology (South Africa), Macquarie University (Australia), Murdoch University (Australia), the International Medical University (Malaysia), the Madrid College of Chiropractic at the Real Centro Universitario Escorial-María Cristina (Spain), the University of Bridgeport School of Chiropractic (USA) and CMCC (Canada).

Q. *What is CMCC’s position on vaccination?*

A. By signing the Position Statement, CMCC has publicly emphasized its support for contemporary public health practices that include immunization. The Statement specifically states that CMCC supports the World Health Organization’s “*WHO’s vision and mission in immunization and vaccines - 2015-2030*”. Although some individual practitioners within the different health professions may take personal exception to this, it is important that as an educational institution we provide our students with an evidence-based curriculum that incorporates public health best practices, including the overall value of vaccination. The chiropractic profession has frequently drawn criticism from scientists and healthcare providers because of the public anti-vaccination stances voiced by some practitioners, and CMCC wants to make clear that it does not condone such positions.

Q. *Why is there inclusion of business practices (“practice styles”) in an educational statement?*

A. It is only those business practices that have repeatedly been questioned by the chiropractic community or other healthcare professionals that are mentioned in the Position Statement. These include those practices that potentially expose patients to unnecessary x-rays, may jeopardize patient privacy, or which encourage patient dependency or unnecessary visits. CMCC’s curriculum includes training in imaging guidelines, radiation safety, business, jurisprudence, ethics, entrepreneurship and professionalism. The practices mentioned in the Position Statement do not conform to what is taught at CMCC or what CMCC feels is in the best interests of patients.

Q. *Is CMCC fully supportive of the concept of interprofessional education, or would it be better to train chiropractic students solely within a chiropractic setting?*

A. CMCC is absolutely supportive of providing chiropractic students with opportunities to learn from and learn with other healthcare professionals. We strive to develop collaborative relationships with other care providers, researchers, and institutions. Examples of these include the UOIT-CMCC Centre for Disability Prevention and Rehabilitation, our inclusion within the Department of Family and Community Medicine and St. Michael’s Academic Family Health Team, our clinic within St. John’s Rehab, our involvement in the South Riverdale Community Health Centre and the Sherbourne Health Centre, and our agreements with several other academic institutions. The 2017-2021 CMCC Strategic Plan lists as one of its strategies, “Expand inter-professional and inter-

organizational research collaborations.” The trend in chiropractic practice is towards interdisciplinary settings, and a key part of preparing our students for this type of practice is to include multiple opportunities to learn in an interprofessional, multidisciplinary setting.

Q. *Will the Position Statement change in the future?*

A. The Position Statement was modified slightly in 2017 and will probably change in the future. Changes in the document are reached through a consensus process and thus agreed to by all signatories. As of March 2019, discussion amongst the members of the International Chiropractic Education Collaboration included possible minor wordsmithing in the paragraph on teaching about vertebral subluxation and adding a recommendation about teaching spinal radiography in accordance with established radiographic guidelines. If any changes are adopted by the Collaboration, then a new Position Statement will be released.

ITEM 4.2

Submitted April 16, 2019

**College of Chiropractors of Ontario
Advertising Committee Report to Council
Tuesday, April 30, 2019**

Members: Dr. Peter Amlinger, *Chair*
Dr. Brian Budgell
Ms Tamara Gottlieb
Dr. Janine Taylor, *non-Council member*

Staff Support: Mr. Joel Friedman, *Director, Policy & Research*

Meetings

The Advertising Committee has met once in person on April 9, 2019

Recommendations***Recommendation 1***

The Advertising Committee recommends to Council an amendment to By-law 11: Committee Composition to re-format the Quality Assurance into two committees: A General Quality Assurance Committee (Quality Assurance Committee) and a Quality Assurance Advertising Committee (Advertising Committee), to be circulated for feedback to members and stakeholders.

The Advertising Committee is of the opinion that the public interest would be served and that opportunities for compliance would be improved if there was a less formal method to communicate with members regarding advertisements that are brought to the attention of CCO, which may be non-compliant with Standard of Practice S-016: Advertising.

Following the review of legal advice from Richard Steinecke, the Advertising Committee is of the opinion that the Advertising Committee becoming a sub-committee of the Quality Assurance would provide the Advertising Committee with additional powers under the *Regulated Health Professions Act, 1991* to refer a matter to the Inquiries, Complaints and Reports Committee, in the event of continued non-compliance with the direction of the Advertising Committee.

Recommendation 2

The Advertising Committee recommends to Council amendments to the Advertising Committee Terms of Reference.

The Advertising Committee is recommending amendments to its terms of reference to:

- Create consistency with the template for terms of reference for CCO Committees;

- Increase the number of members of the Advertising Committee to reflect the possible increased workload of the Committee and create the opportunity for the Advertising Committee to split into two separate panels of the purpose of reviewing advertisements;
- Increase the number of meetings to reflect the possible increased workload of the Advertising Committee.

The Advertising Committee foresees that these changes will also require an increase in the budget of the Committee for future years.

Recommendation 3

The Advertising Committee recommends to Council amendments to Policy P-004: Advertising Committee Protocol.

The Advertising Committee is recommending changes to Policy P-004: Advertising Committee Protocol as follows:

- Define advertising consistently with Standard of Practice S-016: Advertising;
- Encourage members to identify specific sections of websites or social media sites for review;
- Continue the method of review of advertisements containing 500 words or less by email or other electronic mechanisms, and review advertisements more than 500 words or that include video content in meetings. Following the review of several websites, the Committee is of the opinion that review of extensive advertising material, such as a full website review is more appropriately done in a meeting setting rather than by email.
- Create a protocol for the review of advertisements that are brought to CCO's attention, separate from the Inquiries, Complaints and Reports process.

Recommendation 4

The Advertising Committee recommends to Council amendments to Standard of Practice S-016: Advertising.

The Advertising Committee is recommending several amendments to Standard of Practice S-016: Advertising, as follows:

- Rewording the intent and definition of the standard to create more clarity;
- Clarifying that a member is responsible for any advertising produced on their behalf by other health care practitioners or other third-parties;
- Requiring members to clearly communicate that they are members of CCO and have a link to the CCO website on any advertising;
- Requiring members to disclose any benefit exchanged for an endorsement;
- Expanding rules for testimonials to include self-testimonials, include disclaimers and to not include any information, testimonial or narrative on treating family members;
- Including references to relevant sections of the Canadian Code of Advertising Standards and the Competition Act;
- Clarifying that a guaranteed success of care may not be express or implied;

- Requiring that an advertisement for complimentary or discounted services may not include any obligations for follow-up;
- Emphasizing that communications to patients or prospective patients may not pressure a patient to bring family member or guest to a subsequent treatment or appointment.

Recommendation 5

The Advertising Committee recommends to Council amendments to Guideline G-016: Advertising.

Amendments to Guideline G-016: Advertising create consistency with proposed amendments to the standard of practice, while providing further explanations and examples.

Committee Work

The Committee continues to review and provide feedback on proposed advertisements submitted by members for review, which include websites and electronic media.

The Committee will work with any WebCrawler technology, as directed by Council, and is of the opinion that Council communicate with other regulators in Ontario to inquire if they have any feedback or advice related to their activities in this area.

The Committee has drafted a memorandum to the Chair of the Quality Assurance Committee to develop standards on health care claims and levels of acceptable evidence.

Acknowledgements

I would also like to thank my fellow committee members Drs Brian Budgell and Janine Taylor and new member Ms Tamara Gottlieb, for agreeing to serve on the committee. I also wish to thank former committee member Ms Karoline Bourdeau for serving on this committee. Their commitment to the work of this committee and to regulating the profession in the public interest is most appreciated.

Respectfully submitted,

Dr. Peter Amlinger,
Chair, Advertising Committee

**College of Chiropractors of Ontario
Patient Relations Committee Report to Council
April 30, 2019**

370

Members: Ms Karoline Bourdeau, *Chair*
Ms Georgia Allan
Dr. Dennis Mizel
Dr. Keith Thomson, *non-Council member* (for January 9, 2019 meeting)
Dr. Janit Porter, *non-Council member*

Staff Support: Mr. Joel Friedman, *Director, Policy and Research*
Ms Jo-Ann Willson, *Registrar and General Counsel*

I. Introduction and Recommendations

The Patient Relations Committee met once on March 27, 2019 since the last meeting of Council. The following recommendations are reflected in the minutes of that meeting.

Recommendation 1

That a letter be sent to Dr Wickes requesting information about how the scope of practice is being taught and in particular, whether students are being taught the full scope of practice, which differs somewhat from province to province.

Recommendation 2

That, in consideration of CCO by-law amendments, the question of the composition of Council reflect the diversity of the profession.

II. Ongoing Business

Federation of Health Regulatory Colleges of Ontario (FHRCO) videos are now posted to the CCO website and we urge that this be brought to member's attention as these videos would count towards CE hours.

Partnership of Care is now on the CCO web site in 10 different languages.

Tent cards for the Partnership of Care are being prepared for distribution shortly. The Patient Relations Committee has received and reviewed mock-ups of the tent cards, included in the Council package, and would be interested in any feedback from Council on selecting a mock-up for a final version.

Patient questionnaires are now being finalized and a suggestion is that Peer Assessors be a great test group for randomly selecting patients as respondents. We suggest that it perhaps be distributed in the form of a post card or a web page with a code. We believe this would be in keeping with the objects of the College.

Throughout this past year we continued to monitor funding requests. We also suggested that as funding nears the allowable amount a letter be sent to the recipient informing them of the termination of funding.

III. Acknowledgements

Many thanks are extended to the members of this committee Ms Georgia Alan, Dr. Janit Porter, Dr. Dennis Mizel, and past member Dr. Reginald Gates.

Many thanks also for staff support Ms Jo-Ann Willson, Mr. Joel Friedman, Ms Jacqui Shaw, and Ms Andrea Szametz .

Sincerely,
Ms Karoline Bourdeau
Chair, Patient Relations

ITEM 4.4

**College of Chiropractors of Ontario
Quality Assurance Committee Report to Council
April 30, 2019**

376

Members:

Dr. Elizabeth Anderson-Peacock, Chair
Dr. Peter Amlinger (delivering report)
Ms Karoline Bourdeau
Mr. Rob MacKay
Dr. Joel Weisberg, non-council member

Staff:

Mr. Joel Friedman, Director, Policy & Research
Dr. J. Bruce Walton, Director of Professional Practice
Ms. Jo-Ann Willson, Registrar and General Council
Ms. Jacqui Shaw, Student-at-law
Ms. Andrea Szametz, Recording Secretary

Chair's Report

I. Introduction and Recommendations

Since the last meeting of Council, the Quality Assurance (QA) Committee has met once on March 7, 2019.

We have the following recommendation to council.

Recommendation 1

That Council approve amendments to Standard of Practice S-001: Chiropractic Scope of Practice.

Recommendation 2

That the QA Committee recommends amendments to Guideline G-008: Business Practices with distribution to stakeholders for feedback due to substantial changes in the document.

II. QA Initiatives

A. Review of Regulations, Standards of Practice, Policies and Guidelines

Standard of Practice S-004: Reporting of Diseases

Ms Shaw provided a verbal report on recent conversations she has had with several medical officers of health and nurses. A consistent message from them was that chiropractors need to report early when observing a patient with signs and symptoms and a condition that requires reporting to public health officials. There are stiff penalties if there is a failure to report and it is important to report early for public health measures.

The Committee was in agreement for a future newsletter article that includes what Ms Shaw has found to date and to include the important message that public health officials want practitioners to report without delay. It was also noted that reporting by telephone was quite cumbersome and direct online reporting was somewhat simpler. A newsletter summary can assist members how to best navigate through this process.

B. Record Keeping Workshop (RKW)

None have occurred since the last council meeting. The next scheduled RKW will follow the June 11, 2019 Legislation and Ethics Examination and will take place at the Old Mill Inn and Conference Centre, Toronto.

C. Peer and Practice Assessment

As mentioned in the last QA report to Council, further discussion occurred from ongoing concerns that have arisen, unsolicited, from professional members in the field as well as unsolicited Peer Assessor comments in viewing practices where Chiropractors do not adjust. As the adjustment is a controlled act, the committee considers ongoing competency significant in protecting the public interest and to ensure ongoing appropriate use in the profession. And, since the scope of practice involves “primarily by adjustment”, the committee has added to the work plan how it can best assess the performance of the adjustment. The committee will be looking into any and all possible methods of assessing this skill and competency. It is anticipated that a part of this will build on the mandatory CE requirement that every member participate in a minimum of five hours of CE in every CE cycle, that consists of structured activity on diagnostic or therapeutic procedures related to any of the controlled acts within the chiropractic scope of practice. These mandatory five hours should be relevant to the member's clinical practice, but may not include adjunctive therapies, such as acupuncture, exercise or nutritional counseling.

The committee received feedback that the review of 10 files in the PPA 1.0 is most often not needed when viewing practice patterns. Problems are usually systemic and can be seen quickly. Staff are developing content for PPA 1.0, including changing it to 5 files for review and determining any additional requirements to ensure all PPA materials are up to date with current versions of standards of practice, policies and guidelines.

Staff continues to handle the internal processing of all Peer and Practice Assessment (PPA 1.0) and (PPA 2.0) materials, which includes: PPA 1.0 and PPA 2.0 assignments conducted and submitted. We can report that the processing of the 2018 cycle has been completed and selections will soon be made for the 2019 cycle. Disposition materials are updated for PPA 1.0 and PPA 2.0.

The Committee agreed that the peer assessment materials need to be updated, including editing redundancies and incorporating some of the ideas that have been generated at the meeting. The peer assessors have indicated that it would be valuable to have new materials to address the assessment review such as:

- Did the member reach their short- and long-term goals?
- Is the member doing what's best for their practice?
- What is the demeanour of the member as they interact with the assessor?
- Is there an understanding by the member on how to communicate appropriately in various scenarios?
- How is the member protecting the public from boundary issues?
- How would they diffuse a negative situation with a patient?
- The committee recognizes any additional opportunities for members to self-reflect is positive.

Part of the ongoing QA work plan will be to look for effective and efficient ways to incorporate valuable evaluation tools into the PPA program.

Additional thanks go to Ms Funto Odukoya for assisting Dr. Walton in updating and revising materials.

The committee wishes to thank all the staff involved with ensuring the smooth tracking and handling of the internal PPA process at CCO.

The Committee received and reviewed the PPA 1.0 and 2.0 Peer and Practice Assessment materials completed since the previous meeting and had no questions or concerns.

Ms Shaw provided background on her review of CE and self- and peer-assessment requirements among Ontario's 17 health regulators. It was helpful to have her verbal report on the patterns emerging from numerous regulators that have varying self-assessment and CE cycles, the different terms they use, and differences in how they message what is or is not acceptable with some regulators. File reviews are being done by some colleges. CCO seems to be doing well when viewed in tandem with what other regulators are doing.

Discussion ensued about additional considerations from uploading more CE background materials, enhancing awareness around core competencies and spinal adjustment, providing more learning sources for members, holding members more accountable to review their progress throughout the current CE cycle as a few ideas. We also considered providing auto generated acknowledgement to the member upon completion of uploading their CE requirements online.

It was suggested that CCO consider acquiring a webinar about bullying, communications, and customer service to assist members in understanding that when they do something, it is important to be reflective on how they perceived.

We are considering if there is value on consider on how a self-assessment is done and if it should include a “360” approach with feedback received from others.

The Committee agreed that it would be appropriate to develop new material for the self-assessment program to be launched on July 1, 2020. The QA Committee and staff will be working towards this goal.

D. Other QA Initiatives

The committee prepared a draft request for proposal on social media scanning software that was recommended to executive. The Committee was of the opinion that it was helpful to not put the “cart before the horse” as first identifying and cataloguing what in fact the challenges are before committing to options on how to manage any. It would be helpful to know with any scanning software, what we need to scan and why, before deciding what direction to take, how to communicate that expectation and lastly how to measure any follow-up of changes required. We also discussed how the Peer Assessors could help in this area and any if other options and/or solutions could be used to facilitate CCO achieving its goals in this area.

E. Communication with Members and Stakeholders

The Committee responded to inquiries from members and other stakeholders.

III. Acknowledgements

Many thanks go to each member of the Committee who fully support the mandate of QA in the public interest. I wish to personally thank the valuable contributions of the public members Ms Karoline Bourdeau and Mr. Rob MacKay, and the professional members Dr. Peter Amlinger and Dr. Joel Weisberg for preparation and work on QA. You each provide thoughtful and reflective public interest insight that has helped this committee run smoothly.

Our sincere thanks to the talent of our recording secretary Ms Andrea Szametz, and the CCO resource personnel Ms. Jacque Shaw, Mr. Joel Friedman, Dr. Bruce Walton and Ms. Jo-Ann Willson. You each contribute to the success of the QA committee with your preparation of materials, dedication, precision and timeliness. Always with the public interest in mind. Thank you so much as your support is noticed.

As this is my last QA report to Council as Chair and I wish to thank all those who have provided insightful feedback and support in helping us accomplish our mandate. It has been an absolute pleasure to serve with you. My wish is that future Committees can remain just as open to generating new ideas in an inclusive and respectful way so each individual can contribute their best and the Committee can contribute to facilitating the “right touch” in regulating the profession in the public interest.

Respectfully submitted,

Dr. Elizabeth (Liz) Anderson-Peacock
Quality Assurance Committee

COLLEGE OF CHIROPRACTORS OF ONTARIO**REQUEST FOR PROPOSAL FOR
WEBSITE AND SOCIAL MEDIA COMPLIANCE SCANNING SOFTWARE
VERSION DATE: MARCH 27, 2019****Company Background**

The College of Chiropractors of Ontario (CCO) is the governing body established by the provincial government under the *Regulated Health Professions Act, 1991 (RHPA)* and the *Chiropractic Act, 1991* to regulate chiropractors in Ontario in the public interest. Currently, there are approximately 4,900 members of CCO. CCO is responsible for:

- developing standards of admission to the profession through its registration processes,
- maintaining a public register with member information,
- investigating and disposing of complaints,
- prosecuting members, when necessary, through its Discipline and Fitness to Practise processes,
- developing regulations, standards of practice, policies and guidelines to govern the profession in the public interest,
- ensuring quality chiropractic care through its Quality Assurance program,
- improving doctor/patient relations through its Patient Relations program.

CCO is governed by a 16-member council composed of nine elected chiropractors and up to seven public members appointed by the government.

Project Overview and Requirements

There are approximately 4,900 members of CCO, many of whom have websites and social media accounts associated with their practices. Members are required to ensure that these websites and social media accounts are compliant with CCO standards of practice, policies and guidelines, in particular with respect to advertising and treatment claims.

CCO is seeking a software solution that scans members' websites and social media posts and flags terms and phrases that may be contrary to CCO standards of practice. This solution would be required to scan text and pictures/images for terms and phrases identified by CCO and flag them for further review and action by CCO.

The submission should include a methodology for the identification of target words and phrases and any recommendations for an independent survey to identify the nature and prevalence of problematic postings on websites and social media.

CCO would require the following functionality from this scanning software:

- easily, quickly and regularly scan all website content and public social media posts, including text and pictures/images (preferably including Facebook, Instagram and Twitter), as specified by CCO from an Excel list, other purpose-built database, or random scans,
- enter and change scanning terms and phrases as needed,
- push alerts when terms, images or phrases may be contrary to CCO standards of practice,
- pinpoint specific website URLs or social media posts where the identified terms, images or phrases appear for possible follow up by CCO with website or social media account owners, and
- conduct scans as often as required.

CCO also requires the vendor to train CCO staff or consultants in using the technology and provide ongoing telephone and/or onsite support as needed.

Anticipated Timeline

The request for proposal timeline is as follows:

Request for Proposal:	March 27, 2019
Deadline for Bidders to Submit Proposal:	May 10, 2019
Selection of Bidder:	May 16, 2019

How to Submit a Proposal

Interested applicants should submit the following no later than May 10, 2019:

- A description of your company that includes a general overview, names and credentials of individuals who would be working on this project,
- A description of your background, qualifications and similar projects on which you have worked,
- Any prior experience working with health regulators,
- A description of how you would approach and put into service a software solution for CCO,
- A description of how you would approach this issue and any other approaches you have that may not be part of this Request for Proposal,
- Costs and timelines for the project, including ongoing technology support and product upgrades, or ongoing licensing costs,
- Contact information,
- References.

CCO is not bound to accept the proposal with the lowest bid and reserves the right not to choose any respondent from this process.

Please submit applications to the following address:

Joel Friedman, Director, Policy and Research
College of Chiropractors of Ontario
130 Bloor Street West, Suite 902
Toronto, ON M5S 1N5
jfriedman@cco.on.ca

If you have any questions, please contact CCO at (416) 922-6355 x. 104. Thank you for your interest.

Subject: FW: Agenda item for Council Meeting
Attachments: Defining Scope of Practice in Ontario.pdf; ATT00001.htm

From: Jo-Ann Willson
Sent: Sunday, April 14, 2019 8:10 PM
To: Rose Bustria <RBustria@cco.on.ca>
Cc: David Starmer <drstarmer@gmail.com>; President <President@cco.on.ca>; Liz Anderson-Peacock <drliz@bellnet.ca>
Subject: Fwd: Agenda item for Council Meeting

Council.

Jo-Ann Willson, B.Sc., M.S.W., LL.B.

Begin forwarded message:

From: Brian Budgell <bs.budgell@gmail.com>
Date: April 14, 2019 at 7:24:26 PM EDT
To: David Starmer <drstarmer@gmail.com>, Jo-Ann Willson <jpwillson@cco.on.ca>
Subject: Agenda item for Council Meeting

Dear David and Jo-Ann,

Further to Ms Bustria's call for agenda items, I would like to propose a motion that the Executive Committee undertake to operationalize for members the definition of the scope of practice for chiropractic in the province of Ontario. In support of this motion, I am attaching a brief background document.

Thank you and best wishes,

Brian

--
Brian Budgell
email: bs.budgell@gmail.com
Skype user name: brian.budgell

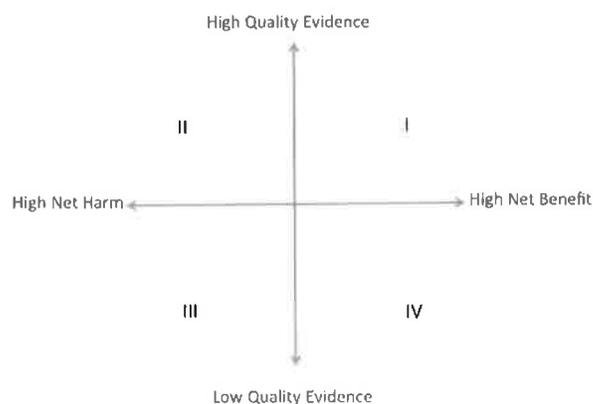


Defining Scope of Practice in Ontario

What is apparently a challenging question for members of the College in Ontario is how to define the scope of practice of chiropractic. This challenge is evident from cases brought to the attention of various committees of the College, and also from direct questions from members of the profession and the public. At the root of this quandary is the province's definition of the scope of chiropractic, which is tied to a hypothetical mechanism of disease. Specifically, the legislation refers to "dysfunctions or disorders arising from the structures or functions of the spine and the effects of those dysfunctions or disorders on the nervous system." There is, of course, no list of particular 'dysfunctions or disorders,' nor a hint of a process by which one would identify the same.

To the extent that our understanding of human disease is evolving rapidly, and so a specific list of disorders within or without the presumptive scope would quickly become out of date, I would like to propose that the Council establish a set of criteria by which the Council itself and members of the College might reasonably be able to judge at any given time whether a particular dysfunction or disorder was indeed 'arising from the structures or functions of the spine and the effects of those dysfunction or disorders on the nervous system' and amenable to chiropractic management.

The Council might wish to engage outside advice on this matter. However, in order not to present the Council with a blank page, I would like to offer a prototypical system for identifying conditions which might reasonably be regarded as 'within scope.' This is illustrated below.



For simplicity, the system might use 2 axes to map the relevant evidence for any particular condition. Positions in the matrix might well evolve over time, but in general one could imagine endorsing management of conditions which fell within quadrant I, while proscribing management of conditions which fell within quadrant II. Conditions which fell within quadrants III and IV might require specific and limited approaches, for example requiring co-management or consultation with experts.

A clear merit of this sort of approach is that it levels the playing field in terms of evidence. Rather than running a popularity contest, or responding in a knee-jerk fashion to changing political winds, decisions on scope would be fair, transparent and defensible.

There will of course be challenges in determining what are appropriate levels of evidence, and in calculating the balance between benefits and harms. However, we are not without guidance here. With regard to levels of evidence, it is generally recognized that clinical decisions are best grounded in clinical evidence, and there is a sense that particular research designs are more or less appropriate for particular applications. For example, it is generally accepted that methodologically sound RCTs and systematic reviews/meta-analyses provide the best basis for broad policies and clinical guidelines on treatment. With regard to risk/benefit ratios, we can take some guidance from the concept of minimal clinically important difference (MCID).

All of this, of course, is work. However, I think it would be regarded as very much in the public's interest, and so very much the College's responsibility.



Social Justice Tribunals Ontario

Providing fair and accessible dispute resolution

Human Rights Tribunal of Ontario
655 Bay Street, 14th Floor
Toronto ON M7A 2A3
Tel: 416 326-1312 or 1-866-598-0322
Fax: 416-326-2199 or 1-866-355-6099
E-mail: hrto.registrar@ontario.ca
Website: sjto.ca/hrto

Tribunaux de justice sociale Ontario

Pour une justice accessible et équitable

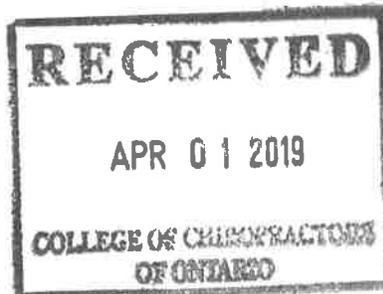
Tribunal des droits de la personne de l'Ontario
655, rue Bay, 14^e étage
Toronto ON M7A 2A3
Tél.: 416-326-1312 ou 1-866-598-0322
Télééc.: 416-326-2199 ou 1-866-355-6099
Courriel: hrto.registrar@ontario.ca
Web: tjso.ca/tdpo

ITEM 5.3

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March 27, 2019

Aron Glenford Airall
330 McCowan Road #302
Scarborough, ON M1J 3N3
Via mail



College of Chiropractors of Ontario
c/o David Starmer
130 Bloor St. W., #902
Toronto, ON M5S 1N5
Via mail

Re: Airall v. College of Chiropractors of Ontario
HRTO File Number: 2018-34796-I

Please find enclosed a Decision of the Tribunal in this matter, dated
March 27, 2019.

Child and Family Services Review Board
Custody Review Board
Human Rights Tribunal of Ontario
Landlord and Tenant Board Ontario
Special Education (*English*) Tribunal Ontario
Special Education (*French*) Tribunal Ontario
Social Benefits Tribunal

Commission de révision des services à l'enfance et à la famille
Commission de révision des placements sous garde
Tribunal des droits de la personne de l'Ontario
Commission de la location immobilière
Tribunal de l'enfance en difficulté de l'Ontario (*anglais*)
Tribunal de l'enfance en difficulté de l'Ontario (*français*)
Tribunal de l'aide sociale



HUMAN RIGHTS TRIBUNAL OF ONTARIO

BETWEEN:

Aron Airall

Applicant

-and-

College of Chiropractors of Ontario

Respondent

DECISION

Adjudicator: Maureen Doyle

Date: March 27, 2019

File Number: 2018-34796-1

Citation: 2019 HRTO 572

Indexed as: Airall v. College of Chiropractors of Ontario

WRITTEN SUBMISSIONS

411

Aron Airall, Applicant

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)
)

Self-represented

INTRODUCTION

[1] This Application alleges discrimination with respect to membership in a vocational institution and employment because of race, colour, ancestry, ethnic origin, creed, age and alleges reprisal contrary to the *Human Rights Code*, R.S.O. 1990, c. H.19, as amended (the "Code").

[2] Much of the Application is difficult to understand and is quite disjointed, and includes quotations from, law, miscellaneous correspondence, various websites and newsletters, among other things. It appears, however, that the applicant alleges that the respondent discriminated against him by denying him membership in a vocational association.

[3] Also included in the Application is an Order of the Superior Court of Justice of Ontario, in a case where the respondent here was the Applicant and where the applicant here was the Respondent. In the Order, the Court ordered this applicant to refrain from:

- i) holding himself out as a person who is qualified to engage in chiropractic practice;
- ii) using the title 'doctor' in the course of providing or offering to provide, in Ontario, health care to individuals;
- iii) performing any controlled act set out in section 4 of the *Chiropractic Act*, and subsection 27(2) of the *Regulated Health Professions Act*; and
- iv) treating or advising a person with respect to his or her health circumstances in which it is reasonably foreseeable that serious physical harm may result from the treatment or advice or from an omission from them.

ANALYSIS AND DECISION

[4] An Application will only be dismissed at a preliminary stage if it is “plain and obvious” on the face of the application that it does not fall within the Tribunal’s jurisdiction. See *Masood v. Bruce Power*, 2008 HRTO 381.

[5] On December 5, 2019, the Tribunal issued a Notice of Intent to Dismiss (NOID) on the basis that the applicant appeared to be challenging the decision or outcome of an adjudicative process. It advised the applicant that the Tribunal has “held on a number of occasions that such decisions are protected by the principle of adjudicative immunity and that ‘services’ within the meaning of the *Code* does not include the outcome or decision resulting from adjudications by other statutory bodies, including the Courts. It cited *Cartier v. Nairn* 2009 HRTO 2208 and *Seberras v. Workplace Safety and Insurance Board*, 2012 HRTO 115. It directed him to provide written submissions responding to the issue identified.

[6] The Tribunal does not have a general power to inquire into all relationships and all difficulties that may occur in those relationships. The Tribunal’s jurisdiction is based on the *Code*, which prohibits discrimination in the social areas of “employment”, “goods, services and facilities”, “accommodation” (housing), “contracts” and “membership in vocational associations”.

[7] The applicant subsequently wrote to the Tribunal, sending various documents, including correspondence from him to several parties, again with quotations of law, Christian scripture, citation from the Church of Scientology, websites, and detailing problems he has had with other people and bodies, including firefighters. He did not address the issue identified by the Tribunal in its December 5, 2019 correspondence to him.

[8] The applicant identifies “membership in a vocational institution” as the social area in which his rights under the *Code* were contravened and he alleges in particular that the respondent College of Chiropractors contravened the *Code* in denying him

BY-LAW 6: ELECTION OF COUNCIL MEMBERS

Approved by Council: February 24, 2001

Amended: February 12, 2002, September 24, 2009, September 17, 2015,

February 23, 2016, February 28, 2017, November 29, 2018

6.1 **Electoral District 1: Northern** comprised of the districts of Kenora, Rainy River, Thunder Bay, Algoma, Cochrane, Manitoulin, Parry Sound, Nipissing, Timiskaming; the district municipality of Muskoka; and the city of Greater Sudbury.

Electoral District 2: Eastern comprised of the counties of Frontenac, Hastings, Lanark, Prince Edward, Renfrew, Lennox and Addington; the united counties of Leeds and Grenville, Prescott and Russell, Stormont, Dundas and Glengarry; and the city of Ottawa.

Electoral District 3: Central East comprised of the counties of Haliburton, Northumberland, Peterborough, and Simcoe, the city of Kawartha Lakes, the regional municipality of Durham and the township of Scugog.

Electoral District 4: Central comprised of the city of Toronto and the regional municipality of York.

Electoral District 5: Central West comprised of the counties of Brant, Dufferin, Wellington, Haldimand and Norfolk, the regional municipalities of Halton, Niagara, Peel and Waterloo, and the city of Hamilton.

Electoral District 6: Western comprised of the counties of Essex, Bruce, Grey, Lambton, Elgin, Middlesex, Huron, Perth and Oxford, and the municipality of Chatham-Kent.

6.2 A member is eligible to vote in the electoral district in which the member, as of January 1st of the election year, has his/her primary practice, or if the member is not engaged in the practice of chiropractic, in which the member has his/her primary residence.

- 6.3 For each electoral district referred to in column 1 of the following table, there shall be elected to Council the number of members set out opposite in column 2.

Column 1	Column 2
Electoral District	Number of Members
1	1
2	1
3	1
4	3
5	2
6	1

- 6.4 The term of office of a member elected to Council is approximately three years, commencing with the first regular meeting of Council immediately following the election. The member shall continue to serve in office until his/her successor takes office in accordance with this by-law.
- 6.5 A member who has served on Council for nine consecutive years is ineligible for election to Council until a full three year term has passed since that member last served on Council.
- 6.6 An election of members to Council shall be held:
- (a) in March, 1995, and in every third year after that for members from electoral districts 2 and 3 and for one member from electoral district 4;
 - (b) in March, 1996, and in every third year after that for members from electoral district 6 and for one member from electoral district 4 and one member from electoral district 5; and
 - (c) in March, 1997, and in every third year after that for members from electoral district 1 and for one member from electoral district 4 and one member from electoral district 5.
- 6.7 The registrar, as directed by Council, shall set the date for the each election of members to Council.
- 6.8 A member is ineligible to vote in a council election if he/she is in default of payment of any fees prescribed by by-law or any fine or order for costs to CCO imposed by a CCO committee or court of law or is in default in completing and returning any form required by CCO.

- 6.9 A member is eligible for election to Council in an electoral district, if on the closing date of nominations and anytime up to and including the date of the election:
- (a) the member has his/her primary practice of chiropractic located in the electoral district in which he/she is nominated or, if the member is not engaged in the practice of chiropractic, has his/her primary residence located in the electoral district in which he/she is nominated;
 - (b) the member is not in default of payments of any fees prescribed by by-law or any fine or order for costs to CCO imposed by a CCO committee or court of law;
 - (c) the member is not in default in completing and returning any form required by CCO;
 - (d) the member is not the subject of any disciplinary or incapacity proceeding
 - (e) a finding of professional misconduct, incompetence or incapacity has not been made against the member in the preceding three years;
 - (f) the member is not an employee, officer or director of any professional chiropractic association such that a real or apparent conflict of interest may arise, including but not limited to being an employee, officer or director of the OCA, CCA, CCPA, AFC, CCEB, CSCE or the CCEC of the FCC;
 - (g) the member is not an officer, director, or administrator of any chiropractic educational institution, including but not limited to, CMCC and UQTR, such that a real or apparent conflict of interest may arise;
 - (h) the member has not been disqualified from the Council or a committee of the Council in the previous three years;
 - (i) the member is not a member of the Council or of a committee of the College of any other health profession; and
 - (j) the member has not been a member of the staff of CCO at any time within the preceding three years.
- 6.10 The registrar shall supervise the nomination of candidates.

- 6.11 No later than 60 days before the date of an election, the registrar shall notify every member eligible to vote of the date, time and place of the election and of the nomination procedure.
- 6.12 The nomination of a candidate for election as a member of Council, and undertaking to the CCO Registrar shall be in writing and shall be given to the registrar at least 45 days before the date of the election (i.e., the nomination date).
- 6.13 The nomination shall be signed by the candidate and by at least 10 members who support the nomination and who are eligible to vote in the electoral district in which the election is to be held.
- 6.14 The candidate shall provide to the registrar by the nomination date or such later date as the registrar permits, biographical information in a manner acceptable to the registrar for the purpose of distribution to eligible members in accordance with the by-laws.
- 6.15 The candidate may withdraw his or her nomination for election to Council no later than 30 days before the date of the election.
- 6.16 If the number of candidates nominated for an electoral district is less than or equal to the number of members to be elected, the registrar shall declare the candidates to be elected by acclamation.
- 6.17 The registrar shall supervise and administer the election of candidates and, for the purpose of carrying out that duty, the registrar may, subject to the by-laws,
 - (a) appoint returning officers and scrutineers;
 - (b) establish a deadline for the receiving of electronic ballots;
 - (c) provide for the notification of all candidates and members of the results of the election;
 - (d) if there has been a non-compliance with a nomination or election requirement, determine whether the non-compliance should be waived in circumstances where the fairness of the election will not be affected; and
 - (e) provide for the destruction of electronic ballots following an election.

- 6.18 No later than 21 days before the date of an election, the registrar shall send electronically, or any other medium as determined by Council, to every member eligible to vote in an electoral district in which an election is to take place, a list of the candidates, the candidates' biographical information if provided, an explanation of the voting procedure, and electronic access to a ballot for voting.
- 6.19 Voting for elections of member to Council shall be by electronic method or any other medium as determined by Council.
- 6.20 The instruction for voting shall contain the following:
- a) a member may cast as many votes on a ballot in an election of members to the Council as there are members to be elected to Council from the electoral district in which the member is eligible to vote.;
 - b) a member shall not cast more than one vote for any one candidate;
 - c) a member shall clearly indicate the voter's choice in one of the appropriate places on the electronic ballot to indicate the voter's choice;
 - d) the electronic vote shall be received by 4 pm on the date indicated in the notice of election and voting guide; and
 - e) the electronic vote will not be counted in the election unless it has been received in accordance with the instructions for voting.
- 6.21 On the date of the election, the registrar or his/her agent shall count the votes for each candidate in each electoral district with a contested election.
- 6.22 The counting of the electronic votes shall be conducted so that no person knows for whom any member voted.
- 6.23 Candidates or their representatives may be present when the electronic votes are counted.
- 6.24 If there is a tie in an election of members to the Council, the registrar shall break the tie by lot.
- 6.25 A candidate may require a recount by giving a written request and deposition the sum or \$150 with the registrar no more than 15 days after the date of an election.
- 6.26 The registrar shall hold the recount no more than 10 days after receiving the request.

- 6.27 If the recount changes the election result, the full amount of the deposit shall be refunded to the candidate. If the recount does not change the election result, CCO will keep the deposit to partially offset recount costs, including staff time.
- 6.28 When there is an interruption of mail service during a nomination or election, the registrar shall extend the holding of nominations and election for such minimum period of time as the registrar considers necessary to compensate for the interruption.
- 6.29 The Council shall disqualify an elected member from sitting on Council if the elected member:
- (a) is subject of any disciplinary or incapacity proceeding;
 - (b) is found to have committed an act of professional misconduct or is found to be incompetent by a panel of the Discipline Committee;
 - (c) is found to be an incapacitated member by a panel of the Fitness to Practice Committee;
 - (d) fails to attend two consecutive meetings of the Council or of a committee or of a subcommittee in which he/she is a member, without reasonable cause in the opinion of Council;
 - (e) fails to attend a hearing or review of a panel for which he/she has been selected, without reasonable cause in the opinion of Council;
 - (f) ceases to either have a primary practice of chiropractic or primary residence in the electoral district in which the member was elected;
 - (g) becomes an employee, officer or director of any professional chiropractic association such that a real or apparent conflict of interest may arise, including but not limited to being an employee, officer or director of the OCA, CCA, CCPA, AFC, CCEB, CSCE or the Accreditation Standards and Policies Committee or the CCEC of The FCC;
 - (h) becomes an officer, director or administrator of any chiropractic educational institution, including but not limited to CMCC and UQTR;
 - (i) becomes a member of the Council or a committee of the College of any other health profession;

- (j) breaches the conflict of interest provision(s) for members of Council and committees, in the opinion of the Council after giving notice to the member of the concern and giving the member an opportunity to respond to the concern;
 - (k) fails to discharge properly or honestly any office to which he/she has been elected or appointed, in the opinion of the Council, after being given notice of the concern and an opportunity to respond;
 - (l) becomes in default of payment of any fees prescribed by by-law or any fine or order for costs imposed by a CCO committee or court of law; or
 - (m) becomes in default of completing and returning any form required by CCO;
- 6.30 A council member shall resign from Council prior to applying for any CCO staff position.
- 6.31 The seat of an elected Council member shall be deemed to be vacant upon the death, resignation or disqualification of the Council member.
- 6.32 If the seat of an elected council member becomes vacant in an electoral district no more than 12 months before the expiry of the member's term of office, the Council may,
- (a) leave a seat vacant;
 - (b) appoint as an elected member the candidate, if any, who had the most votes of all the unsuccessful candidates in the last election of council members for that electoral district; or
 - (c) direct the registrar to hold an election in accordance with this by-law for that electoral district.
- 6.33 If the seat of an elected council member becomes vacant in an electoral district more than 12 months before the expiry of the member's term of office, the registrar shall hold an election in accordance with this by-law for that electoral district.
- 6.34 The term of a member appointed under By-law 6.32(b) or elected in an election under By-law 6.32(c) shall continue until the time the former council member's term would have expired.

- 6.35 Despite By-law 6.32, 6.33, and 6.34, where vacancy would result in the Council not being properly constituted, the Council (in anticipation of the event before it is not properly constituted) or the Executive Committee (after the Council is not properly constituted) may appoint as an elected member for that district an eligible member in that electoral district. The appointed member shall serve until the vacancy can otherwise be filled for that district. When temporarily filling the vacancy in this way, the Council or the Executive Committee shall:
- (a) solicit interest from eligible members where feasible¹ ,
 - (b) take into account the criteria set out in By-law 12.5,
 - (c) require the prospective appointed member to sign an undertaking to not seek or accept a nomination in the next election for the electoral district before the appointment becomes final² .
- 6.36 If, within 90 days from the date of the election, the Council is of the opinion that there is a reasonable ground for doubt or dispute as to the validity of the election of any member of Council, the Council shall hold an inquiry and decide whether the election of the member is valid and, if an election is found to be invalid, the Council shall direct another election to be held.
- 6.37 Despite By-law 6.6 and 6.34, By-law 6.4 applies to the election held in District 1 in 2017 resulting in approximately a three-year term.
- 6.38 The election in District 1 in 2020 shall be for approximately a one-year term commencing with the first regular meeting of Council immediately following the election.

2019 VOTING GUIDE FOR DISTRICTS 2, 3 AND 4

College of Chiropractors of Ontario (CCO)

March 2019

MISSION

The College of Chiropractors of Ontario regulates the profession in the public interest to assure ethical and competent chiropractic care.

VISION

Committed to Regulatory Excellence in the Public Interest in a Diverse Environment.

VALUES

Integrity, Respect, Collaborative, Innovative, Transparent, Responsive

STRATEGIC OBJECTIVES

1. Build public trust and confidence and promote understanding of the role of CCO amongst all stakeholders.
2. Ensure the practice of members is safe, ethical, and patient-centered.
3. Ensure standards and core competencies promote excellence of care while responding to emerging developments.
4. Optimize the use of technology to facilitate regulatory functions and communications.
5. Continue to meet CCO's statutory mandate and resource priorities in a fiscally responsible manner.

Developed at the Strategic Planning Session: September 2017

ELECTION IN DISTRICT 2: EASTERN

As of the close of nominations, two candidates had filed nomination papers and supporting documents:

- Dr. Paul Groulx
- Dr. Peter Wise

ELECTION IN DISTRICT 3: CENTRAL EAST

As of the close of nominations, two candidates had filed nomination papers and supporting documents:

- Dr. Elizabeth Anderson-Peacock
- Dr. Steven Lester

ELECTION IN DISTRICT 4: CENTRAL

As of the close of nominations, two candidates had filed nomination papers and supporting documents:

- Dr. Gerard Arbour
- Dr. Janet D'Arcy

ELECTION TIMETABLE

January 15, 2019: Notice of Election and Nomination Guide sent electronically to members in Districts 2, 3 and 4.

February 8, 2019: Nomination Date: Nomination papers, candidate undertakings and biographical information in a format suitable for distribution to voters must be received by CCO by 4 p.m. CCO provides candidates with a copy of the official voters' list for their district.

February 21, 2019: Deadline for candidates to withdraw from the election by 4 p.m.

March 1, 2019: List of candidates, biographical information, and voting procedures sent electronically to all eligible voters.

March 28, 2019: Votes for Districts 2, 3 and 4 must be received by CCO by 4 p.m.

March 29, 2019: Unofficial election results announced for District 2, 3 and 4.

April 16, 2019: Deadline to make a written request for a recount with a \$150 deposit, which must be received by CCO by 4 p.m.

April 17, 2019: Election results posted on CCO's website at www.cco.on.ca.



College of
Chiropractors
of Ontario

L'Ordre des
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de l'Ontario

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Web site: www.cco.on.ca

VOTER ELIGIBILITY

A member holding a General (Active), Inactive or Retired certificate of registration is **eligible** to vote in the electoral district in which the member, as of January 1st of the election year, has his/her primary practice, or if the member is not engaged in the practice of chiropractic, in which the member has his/her primary residence.

A member is **ineligible** to vote in a Council election if he/she is in default of payment of any fees prescribed by by-law or any fine or order for costs to CCO imposed by a college committee or court of law or is in default in completing and returning any form required by CCO.

COUNTING THE VOTES

Votes for Districts 2, 3 and 4 must be received by CCO on March 28, 2019 by 4 p.m.

In the presence of scrutineers, the Registrar will review the electronic votes in each district.

Voter confidentiality will be maintained throughout the election process, including whether a member did or did not vote.

Make sure your ballots are in on time and make them count!

RESULTS

The Registrar will announce unofficial election results to candidates on March 29, 2019. CCO will post the election results on CCO's website (www.cco.on.ca) on April 16, 2019.

A candidate may request a recount by submitting a written request to the Registrar, accompanied by a \$150 deposit, by 4 p.m. on April 16, 2019. The Registrar will hold a recount within 10 days of receiving the request. If the recount changes the results, the candidate's deposit will be returned in full

VOTING PROCEDURES

- Open the "2019 Elections to CCO Council" e-mail.
- Click the link in the email provided to be brought to the voting page.
- Review the biographical information provided by the candidates.
- Click on the box next to the candidate for whom you are voting.
- Confirm your vote.
- If you do not receive an "Elections to CCO Council" e-mail, please check your spam or junk folder. If after checking these folders you have still not received an e-mail, please e-mail CCO at cco.info@cco.on.ca.
- Vote by 4 p.m. on March 28, 2019.**

RECOUNTS

Thank you for participating in the self-regulation of your profession!

Dr. Paul Groulx – District 2. Eastern.

My name is Paul Groulx, I have been in full-time practice for the last 15 years in **Ottawa, Ontario**.

Prior to my chiropractic career I was a Paramedic in the Greater Toronto Area before completing my undergraduate degree in Nursing at the University of Ottawa. Clinical experience included Critical Care and Oncology.



I love the science of health care as well as the art of **combining** established research, emerging science, clinical experience and our patient's values.

Chiropractors who are elected will reflect their commitment to the public's right to safe, effective and ethical chiropractic care.

I don't need to tell you how much pressure there has been in the media to see Chiropractic and other allied professions reform. Our community of prospective clients is being exposed to this rhetoric on a steady basis and chiropractic utilization rates remain woefully low. Times like these are trying but I also see great opportunity for us as a profession to mature and prosper. For this to happen our professional college must keep, as their number one priority, their pledge to passionately protect the public interest through safe, effective and ethical chiropractic care.

I believe that there are four ways to ensure this. Among others,

1. Preserve the "neuro" in N-MSK. Currently our scope of practice includes diagnosis and treatment of disorders/dysfunctions of the nervous system. The neurological model must be preserved in order to protect the public interest.
2. Our public messaging/marketing must take into consideration what professional research literature demonstrates even if it does not fit our personal narrative. Rethinking how we promote our professional practices will protect the public interest.
3. A commitment to patient-centered care by ensuring our in-office messaging, procedures and clinical care protocols put the patient's priorities over our own. This can be accomplished by **combining** best and emerging research, clinical experience/observations and our patient's personal values.
4. As a father I am grateful that both of my daughters had access to conservative chiropractic care. Chiropractic has played an important role in both of their lives. We must protect the public interest by preserving children's access to chiropractic.

Make sure you exercise your privilege as a member of a self-regulated profession. This may be one of the most important times of your professional life to make your voice heard. VOTE.

Dr. Paul Groulx

Dr. Steven Lester, B.Kin (Hons), M.Sc., DC

**Candidate for CCO
Electoral District 3: Central East**



I would like to formally announce my intention to run as a candidate to become a representative on the CCO Council. I have been a chiropractor since 2009 and have treated the public in district 3 for my entire career. My primary practice is located in Pickering where I believe that I uphold the values of the chiropractic profession and have created a trusting relationship with the patients and my community.

“Chiropractors who are elected will reflect their commitment to the public’s right to safe, effective and ethical chiropractic care.”

If selected to the CCO Council I will contribute to the regulation of chiropractic in the public interest in the following ways:

- 1) As advocate for public health and safety:

In my roles as both health care provider in practice in district 3 since 2009 as well as mentor to emerging professionals through my faculty position at the Canadian Memorial Chiropractic College (CMCC), I pride myself on the ability to keep patient safety in the forefront of my practice and in my teaching. My personal research addresses the safety and effectiveness of Chiropractic adjustment and the ability to match technique skills directly to each patient’s needs, reemphasizing the critical role of adjusting and other manual care in the management of health. As a chiropractor, I strive to provide my patients a safe and effective treatment plan utilizing a multimodal approach to support my patient’s overall health needs.

- 2) As an active participant, directing my passion for this profession in collaboration with CCO Council and committees, to represent Chiropractic creditably and effectively in strengthening working relations with government and other public agencies to accomplish CCO strategic objectives:

In the course of my career, I have repeatedly demonstrated enthusiastic engagement with the needs of the profession, faculty, students and the publics that we serve. I have committed myself to differentiating the roles of specific spinal adjusting procedures and the most effective ways to train our young graduates with the manual skills that they need. My interdisciplinary training and experience through my Masters of Science focusing in Biomechanics provides me with an understanding of other perspectives on our profession. Indeed it, integrated with my day-to-day involvement with patients allows me to remain grounded and focused. These attributes give a balanced outlook for our future and a diversity of knowledge to contribute to the existing expertise within the CCO Council.

It would be an honour and a privilege for me to become a representative on CCO Council, I pledge to work hard to fulfill the CCO’s mandate furthering our profession and ensuring public safety. I kindly ask for your support. If you have any questions, please contact me at dr.stevenlester@gmail.com.

Sincerely,

Steven Lester, B.Kin (Hons), M.Sc., DC



Dr. Janet D'Arcy – District 4

In my opinion, chiropractic in Ontario is at a crossroads. Those with positions on the CCO have a great responsibility to the public and the profession. It is for this reason that I am putting my name forward for CCO council, District 4. I am a graduate of the CMCC class of 1993. I began my teaching career at CMCC in 1994 and currently split my professional time between my private practice of 25 years in the east end of Toronto alongside my position as a primary clinician at the CMCC clinic in Sherbourne Health. I am a fellow of the Royal College of Chiropractic Sports Sciences – a designation that I attained in 2016. Since 2015 I have been a certified Mental Health First Aid Instructor and have trained many CMCC staff, faculty, and students as part of a CMCC initiative to improve mental health literacy. Since 2015 I have served as a supervising clinician on the Toronto to Montreal Friends for Life Bike rally, which is the sustaining fundraiser for the Toronto People With AIDS Foundation. In 2019, in addition to supervising interns while they treat riders and crew as they make their way to Montreal, I will also be participating in the one-day Toronto to Port Hope ride. In addition to running a solo practice and teaching, I have been effective in my contribution on several professional committees at CMCC and these experiences would serve me well as a CCO council member. One particularly challenging role was as a member of the team that was successful in establishing the first collective bargaining agreement for CMCC faculty.

Chiropractors who are elected will reflect their commitment to the public's right to safe, effective and ethical chiropractic care. Self regulation of our profession is a privilege, not a right. This privilege has recently been under the microscope, putting our profession at a crossroads. We can either move forward and accept our responsibility to self regulate, or we can risk losing the autonomy, privilege and respect that comes with self regulation. I possess the leadership, team building and communication skills to help the CCO navigate through these difficult times.

I have contemplated running for council numerous times in the last decade. Until now I have been fulfilled by giving back to the profession by dedicating a significant portion of my career to educating future chiropractors. Recent events have compelled me to look at engaging in a larger role within the CCO to help our profession navigate the challenges we are currently facing. As a chiropractor and educator I have seen the importance of teaching an ethical, evidence informed, collaborative & patient centered approach to care. This is the route to increasing the utilization rate of chiropractic in Ontario. This is our future. Evidence informed care allows room for variability taking into account patient preference and clinician experience. There is no room for unethical practice that takes advantage of vulnerable patients and erodes public trust.

For 25 years I have had the privilege to serve our profession in an educational capacity in addition to maintaining a private practice. I am experienced, enthusiastic, dedicated and motivated to help guide our profession into the future as a member of CCO council. Our profession is at a crossroads. I think that given the chance, I can help the CCO navigate this journey. It would be an honour to serve the CCO, the profession, and the public in this capacity and I ask for your support. Should you have any questions please feel free to contact me janetdarcy@rogers.com.

2019 NOTICE OF ELECTION AND NOMINATION GUIDE FOR DISTRICTS 2, 3, AND 4

College of Chiropractors of Ontario (CCO)

January 2019

NOTICE

Pursuant to By-law 6: Election of Council Members, notice is hereby given that elections to CCO Council will be held in Districts 2, 3 and 4. One member will be elected from each of the following districts:

District 2: Eastern comprised of the counties of Frontenac, Hastings, Lanark, Prince Edward, Renfrew, Lennox and Addington; the united counties of Leeds and Grenville, Prescott and Russell, Stormont, Dundas and Glengarry; and the city of Ottawa.

District 3: Central East comprised of the counties of Haliburton, Northumberland, Peterborough and Simcoe, the city of Kawartha Lakes, the regional municipality of Durham and the township of Scugog.

District 4: Central comprised of the city of Toronto and the regional municipality of York.

ELECTION PROCEDURES

- Upon receiving completed nomination papers and following the closing of nominations, CCO will provide each candidate with a copy of the official voters' list for his/her district. The list shall contain information recorded on the register, including public e-mail addresses.
- Candidates may purchase mailing labels for members in their district for a fee of \$30.
- The elections are carried out by electronic vote and secret ballot. The Registrar supervises all aspects of the election.

ELECTION TIMETABLE

January 15, 2019: Notice of Election and Nomination Guide sent electronically to members in Districts 2, 3 and 4.

February 8, 2019: Nomination Date: Nomination papers, candidate undertakings and biographical information in a format suitable for distribution to voters must be received by CCO by 4 p.m. CCO provides candidates with a copy of the official voters' list for their district.

February 21, 2019: Deadline for candidates to withdraw from the election by 4 p.m.

March 1, 2019: List of candidates, biographical information, and voting procedures sent electronically to all eligible voters.

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March 29, 2019: Unofficial election results announced for District 2, 3 and 4.

April 16, 2019: Deadline to make a written request for a recount with a \$150 deposit, which must be received by CCO by 4 p.m.

April 17, 2019: Election results posted on CCO's website at www.cco.on.ca.



- Candidates are encouraged to forward proposed campaign material (including all e-mail campaign material) to CCO via fax (416-925-9610) or e-mail (jfriedman@cco.on.ca) **PRIOR** to distribution to ensure fairness in the electoral process. This includes all e-mail campaign material and any material distributed before the election is called by the candidate or anyone on his/her behalf. CCO will review all materials for general consistency with the biographical information guideline, the principles of fair, accurate and appropriate election statements and, by analogy, Standard of Practice S-016: Advertising, and will forward a response to the candidate as soon as possible. If you have any questions about any campaign material, contact CCO.
- Elections are conducted in a fair and transparent manner, consistent with democratic principles and failure to comply may jeopardize the election process and results.

ELIGIBILITY TO NOMINATE AND/OR VOTE

- A member holding a General (active), Inactive or Retired certificate of registration **is eligible to vote** in the electoral district in which the member, as of January 1st of the election year, has his/her primary practice, or if the member is not engaged in the practice of chiropractic, in which the member has his/her primary residence.
- A member **is ineligible to vote** in a Council election if he/she is in default of payment of any fees prescribed by by-law or any fine or order for costs to CCO imposed by a CCO committee or court of law or is in default in completing and returning any form required by CCO.

ACRONYMS

AFC	Alliance for Chiropractic
CCA	Canadian Chiropractic Association
CCO	College of Chiropractors of Ontario
CCEB	Canadian Chiropractic Examining Board
CCPA	Canadian Chiropractic Protective Association
FCC	Federation of Canadian Chiropractic
CMCC	Canadian Memorial Chiropractic College
CSCE	Canadian Society of Chiropractic Evaluators
OCA	Ontario Chiropractic Association
RHPA	<i>Regulated Health Professions Act, 1991</i>
UQTR	Université du Québec à Trois-Rivières

ELIGIBILITY TO STAND FOR ELECTION

A member **is eligible for election** to Council in an electoral district, if, on the closing date of nominations and any time up to and including the date of the election:

- the member has his/her primary practice of chiropractic located in the electoral district in which he/she is nominated or, if the member is not engaged in the practice of chiropractic, has his/her primary residence located in the electoral district in which he/she is nominated;
- the member is not in default of payments of any fees prescribed by by-law or any fine or order for costs to CCO imposed by a CCO committee or court of law;
- the member is not in default in completing and returning any form required by CCO;
- the member is not the subject of any disciplinary or incapacity proceeding;
- a finding of professional misconduct, incompetence or incapacity has not been made against the member in the preceding three years;
- the member is not, and has not been in the 12 months before the date of election, an employee, officer or director of any professional chiropractic association such that a real or apparent conflict of interest may arise, including but not limited to being an employee, officer or director of the OCA, CCA, CCPA, AFC, CCEB, CSCE or the Council on Chiropractic Education (Canada) of the FCC;
- the member is not an officer, director, or administrator of any chiropractic educational institution, including but not limited to, CMCC and UQTR, such that a real or apparent conflict of interest may arise;
- the member has not been disqualified from the Council or a committee of the Council in the previous three years;
- the member is not a member of the Council or of a committee of the college of any other health profession; and
- the member has not been a member of the staff of CCO at any time within the preceding three years.



TERM OF OFFICE

The term of office of a member elected to Council is approximately three years, commencing with the first regular meeting of Council immediately following the election (currently scheduled on April 30, 2019). Incumbents continue to serve in office until the first regular Council meeting, unless otherwise disqualified from Council. By-law 6: Election of Council Members outlines the circumstances in which a member may be removed from Council.

Please note: A member who has served on Council for nine consecutive years is ineligible for election to Council until a full three-year term has passed since that member last served on Council. A non-Council member may only serve on CCO committees for nine consecutive years, whether the time is served as a council member or as a non-Council member.

MISSION

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VISION

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VALUES

Integrity, Respect, Collaborative, Innovative, Transparent, Responsive

STRATEGIC OBJECTIVES

1. Build public trust and confidence and promote understanding of the role of CCO amongst all stakeholders.
2. Ensure the practice of members is safe, ethical, and patient-centered.
3. Ensure standards and core competencies promote excellence of care while responding to emerging developments.
4. Optimize the use of technology to facilitate regulatory functions and communications.
5. Continue to meet CCO's statutory mandate and resource priorities in a fiscally responsible manner.

*Developed at the Strategic Planning Session:
September 2017*

ROLE OF CCO AND COUNCIL MEMBERS

CCO is the regulatory body for chiropractors in Ontario, governed by a 16-member Council comprised of six or seven public members appointed by the provincial government and nine registered chiropractors elected by the membership.

CCO's legislative mandate is to govern chiropractic in the public interest. CCO's main responsibilities include:

- developing standards of admission to the profession;
- investigating complaints and disciplining members who have committed acts of professional misconduct or are incompetent; and
- implementing a quality assurance program to ensure continuous quality improvement in the profession at large, including the development of standards of practice to which all members of the profession must conform.

TIME COMMITMENTS

Council membership involves a significant time commitment, which varies according to committee. Members attend Council meetings four or more times per year and may serve on one or more committees. Preparatory readings and work for Council and committee meetings can be extensive. Candidates should also note that, whenever possible, all Council and committee meetings are held during regular business hours, Monday to Friday, from 8:30 a.m. to 5 p.m.

COMPENSATION

Council members are compensated for their time spent on CCO work in accordance with CCO By-law 9: Remuneration and Internal Policy I-012. However, per diems and expenses paid by CCO to Council members are intended to partially offset the cost of a contribution to the self-regulation of the chiropractic profession rather than to pay for services rendered or to compensate for lost income or the opportunity to earn income.



GUIDELINE TO CANDIDATES FOR PROVIDING BIOGRAPHICAL INFORMATION

- Candidates are advised that their biographical information must reflect CCO's role in protecting the public interest.
- The candidate's name must appear on the top of the page.
- The candidate's photograph may be included - head and shoulders only.
- The candidate's biographical information must be typewritten on one 8.5" x 11"-page white bond paper with a minimum of one-inch margins on all four sides, in portrait format (not landscape).
- Candidates must **NOT** imply, in any way, that CCO or any CCO Council or committee member supports their candidacy.
- Candidates **MUST** include the following statement verbatim in their biographical information and, based upon it, describe in the statement how they would contribute to the regulation of chiropractic in the public interest:
"Chiropractors who are elected will reflect their commitment to the public's right to safe, effective and ethical chiropractic care."

CURRENT CCO COUNCIL**ELECTED MEMBERS**

Name	District	Term of Office (April to April)
Dr. Kristina Peterson, <i>Thunder Bay</i>	1	2017-2020
***Dr. Gauri Shankar, <i>Prescott</i>	2	2016-2019
**Dr. Elizabeth Anderson-Peacock, <i>Barrie</i>	3	2016-2019
Dr. Brian Budgell, <i>Toronto</i>	4	2018-2021
Dr. David Starmer, <i>Toronto</i>	4	2017-2020
**Dr. Brian Schut, <i>Toronto</i>	4	2016-2019
Dr. Peter Amlinger, <i>Mississauga</i>	5	2017-2020
Dr. Dennis Mizel, <i>St. Catharines</i>	5	2018-2021
Dr. Clifford Hardick, <i>London</i>	6	2017-2020

**Term of office expires April 2019. Eligible for re-election.

***Term of office expires April 2019. Not eligible for re-election

CCO Committees**Statutory:**

- Executive
- Inquiries, Complaints and Reports
- Discipline
- Fitness to Practise
- Patient Relations
- Quality Assurance
- Registration

Non-Statutory:

- Advertising

PUBLIC MEMBERS

Name	Date Order-in Council Expires
Ms Georgia Allan, <i>Smiths Falls</i>	September 2020
Ms Karoline Bourdeau, <i>Toronto</i>	July 2020
Mr. Douglas Cressman, <i>Kitchener</i>	June 2019
Ms Tamara Gottlieb, <i>Toronto</i>	December 2021
Mr. Rob MacKay, <i>Thunder Bay</i>	November 2021
Ms Sheryn Posen, <i>Toronto</i>	November 2021



**Thank you for participating
in the self-regulation
of your profession!**



ELECTIONS QUESTIONS & ANSWERS**Q. What is the purpose of the election of professional members to the Council?**

- A.** The *RHPA* and the *Chiropractic Act* provide for the election of the majority of the Council from among the membership of the profession. Since chiropractic is a self-regulating profession, it is important that the majority of the Council be members of the profession. While there could be a number of ways for the professional members to be chosen, CCO has chosen an election system to ensure that Council members have the confidence and respect of those whom they regulate.

Q. Is the election of Council members similar to the election of MPPs?

- A.** While the form of election is somewhat similar (i.e., voting for candidates by secret ballot), the purpose is actually quite different. Your MPP represents the interests of those who elected him/her. A Council member does not represent the specific interests of chiropractors, but rather the broader public interest as described in the *RHPA*.

CCO, unlike the legislature, is a corporation. The Council, as the Board of Directors of the corporation, has a fiduciary (trust) duty to fulfill the public interest mandate of the corporation/CCO and not the specific interests of the professional electorate.

Q. Does a Council member represent his/her constituents?

- A.** No, a Council member does not have constituents. A Council member is somewhat like the trustee of an estate: he/she acts in the best interest of the beneficiary, not the persons who selected him/her as Trustee. The beneficiary under the *RHPA*

and the *Chiropractic Act* is the public interest. If a chiropractor from a Council member's district has a problem with CCO, it would be inappropriate for the Council member to intervene on the chiropractor's behalf with the pertinent committee or CCO staff person.

Q. How does this affect a candidate's campaign materials?

- A.** While people sometimes do refer to the election process as a 'campaign', this, too, is a bit of a misnomer. Candidates for election can and should provide information about themselves and their philosophy to the other chiropractors in their district to assist them in making an informed choice.

However, there is not really a role for campaign 'promises' or statements about how a candidate, if elected, will decide specific matters that might arise in the future. In addition, candidates are strongly urged to forward their campaign material to CCO before distribution to ensure the elections are conducted in a fair manner.

Q. Why, then, are Council members elected from districts?

- A.** Perspective. Having Council members elected from various districts ensures that the perspective of all chiropractors, not just those from one region (e.g., the Greater Toronto Area), is reflected on Council. Some issues might have a different impact on the public from rural or northern areas, small towns, medium-sized cities and Toronto. It is important that all perspectives are heard.

This notice explains the election rules established under the *Chiropractic Act, 1991*. To the extent of any inconsistency, the legislation and the by-laws govern. If you have any questions, please contact CCO at (416) 922-6355.



CCO ELECTORAL DISTRICTS

[map not to scale, illustrative of districts only]

District 1: Northern comprised of the districts of Kenora, Rainy River, Thunder Bay, Algoma, Cochrane, Manitoulin, Parry Sound, Nipissing, Timiskaming; the district municipality of Muskoka, and the city of Greater Sudbury.

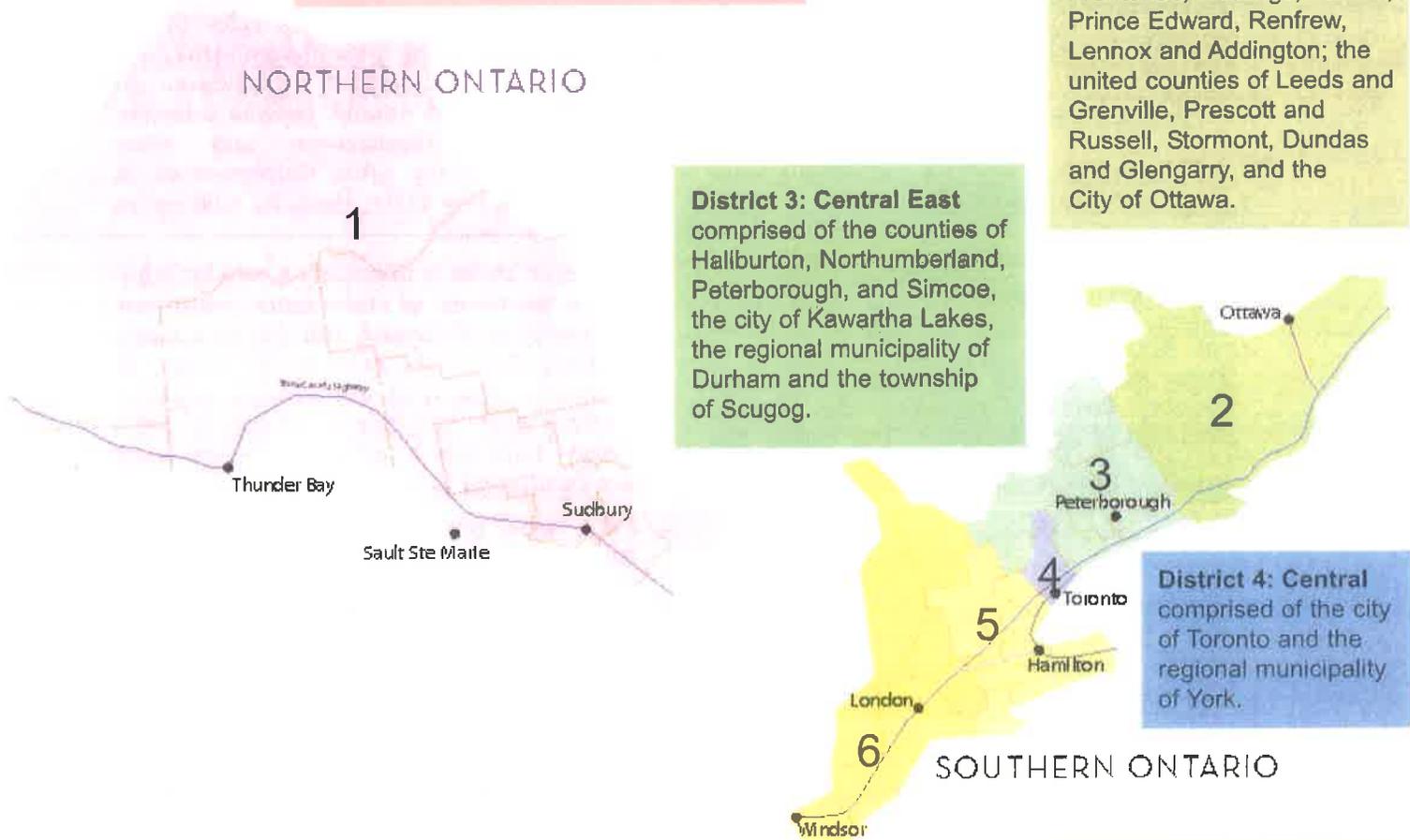
District 2: Eastern comprised of the counties of Frontenac, Hastings, Lanark, Prince Edward, Renfrew, Lennox and Addington; the united counties of Leeds and Grenville, Prescott and Russell, Stormont, Dundas and Glengarry, and the City of Ottawa.

District 3: Central East comprised of the counties of Haliburton, Northumberland, Peterborough, and Simcoe, the city of Kawartha Lakes, the regional municipality of Durham and the township of Scugog.

District 4: Central comprised of the city of Toronto and the regional municipality of York.

District 6: Western comprised of the counties of Essex, Bruce, Grey, Lambton, Elgin, Middlesex, Huron, Perth and Oxford, and the municipality of Chatham-Kent.

District 5: Central West comprised of the counties of Brant, Dufferin, Wellington, Haldimand and Norfolk, the regional municipalities of Halton, Niagara, Peel and Waterloo, and the city of Hamilton.



ELECTION NOMINATION PAPER – ELECTORAL DISTRICTS 2, 3 AND 4

College of Chiropractors of Ontario (CCO)

January 2019

The Election Nomination Paper must be received with the Candidate Undertaking Form at CCO by 4 p.m. on February 8, 2019. Please type or print neatly, using black ink. Forms may be faxed to CCO at 416-925-9610.

We, the undersigned members of CCO, eligible to vote in Electoral District _____,
(Electoral District)

nominate _____ of _____
(Name of Candidate) (City / Town)

as a candidate for the March 2019 election to CCO Council.

Candidate's Registration Number: _____

Business Phone: () _____

Business Address: _____

Confidential E-mail Address : _____

	Nominator's Name¹ (please print)	City / Town	Registration Number	Signature
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

CANDIDATE'S CONSENT: I consent to allow my name to stand for election as a member of CCO for the Electoral District of _____ and agree to serve if elected.

Candidate's Name

Candidate's Signature

Date

¹ Minimum of 10 eligible members who support the nomination and who are eligible to vote in the electoral district is required.

UNDERTAKING TO THE CCO REGISTRAR FROM CANDIDATE

College of Chiropractors of Ontario (CCO)

January 2019

Note to elected members of CCO Council: Initial the box/boxes that apply. Leave blank box/boxes that do not apply and provide an explanation on a separate page.

I, _____, elected member of CCO Council in District _____, undertake to the Registrar as follows:

1. (a) My **primary practice of chiropractic** is located in the electoral district for which I was nominated.
- OR –
- (b) I am not engaged in the practice of chiropractic and my **primary residence** is located in the electoral district for which I was nominated.
2. I am **not**:
- in default of payments of any fees prescribed by by-law or any fine or order for costs to CCO imposed by a CCO committee or court of law.
 - in default in completing and returning any form required by CCO.
 - the subject of a disciplinary or incapacity proceeding.
 - an employee, officer or director of any professional chiropractic association such that a real or apparent conflict of interest may arise, including but not limited to being an employee, officer or director of the AFC, OCA, CCA, CCPA, CCEB, CSCE or the Council on Chiropractic Education (Canada) of the FCC¹.
 - an officer, director, or administrator of any chiropractic educational institution, including but not limited to, CMCC and UQTR, such that a real or apparent conflict of interest may arise.
 - a member of the Council or of a committee of the college of any other health profession.
3. If applicable, I have attached to this undertaking a copy of all letters of resignation from my position as an employee, officer or director of any professional chiropractic association or an officer, director or administrator of any chiropractic educational institution such that a real or apparent conflict of interest may arise.
4. If applicable, I have taken all reasonable and necessary steps to ensure I am not reflected in any documents or on any websites as an employee, officer or director of any professional chiropractic association or an officer, director or administrator of any chiropractic educational institution such that a real or apparent conflict of interest may arise.

¹ The effective date on which the candidate must not be an employee, officer or director of any professional chiropractic association, or an officer, director or administrator of any chiropractic educational institution such that a real or apparent conflict of interest may arise, is the closing date of nominations and any time up to and including the date of the election (i.e., before the election results are known). Copies of relevant letters of resignation must be filed with CCO, along with the candidate's nomination papers. The candidate should take all reasonable and necessary steps to ensure he/she is not reflected in any documents or on any websites as an employee, officer or director of any professional chiropractic association, or an officer, director or administrator of any chiropractic educational institution, such that a real or apparent conflict of interest may arise.

Election Information Guideline

**Campaign Material
of:**

Reviewed by:

Date:

- Campaign material is acceptable
- Campaign material is unacceptable

Comments

- the candidate's election material does not imply, in any way, that CCO or any CCO Council member supports his/her candidacy

The candidate's election material does not include any information or material that is:

- false or misleading
- not readily comprehensible by the persons to whom it is directed
- a comparison to another member's or other health care provider's practice, qualification or expertise
- contrary to any CCO regulations, standards of practice, policies and guidelines, including Policy P-011: Conflict of Interest for Council and Committee Members
- having regard to all the circumstances, would reasonably be regarded as disgraceful, dishonourable or unprofessional

Comments:

Biographical Information Guideline

Campaign Material

of:

Reviewed by:

Date:

- Campaign material is acceptable
- Campaign material is unacceptable

Comments

- the candidate's name appears on the top of the page
- the candidate's photograph (head and shoulders only) is included
- the candidate's biographical information is type-written on one 8.5" x 11" – page white bond paper with a minimum of one-inch margins on all four sides, in portrait form (not landscape)
- the candidate's biography includes the following statement verbatim
"chiropractors who are elected will reflect their commitment to the public's right to safe, effective and ethical chiropractic care"
- the candidate's biography does not imply, in any way, that CCO or any CCO Council member supports his/her candidacy

The candidate's biography does not include any information or material that is:

- false or misleading
- not readily comprehensible by the persons to whom it is directed
- a comparison to another member's or other health care provider's practice, qualification or expertise
- contrary to any CCO regulations, standards of practice, policies and guidelines, including Policy P-011: Conflict of Interest for Council and Committee Members
- having regard to all the circumstances, would reasonably be regarded as disgraceful, dishonourable or unprofessional

Comments:

Rose Bustria

Subject: FW: CCO Election Candidate Profiles, Neck Pain Guideline, WHMIS Advisory

From: Jo-Ann Willson

Sent: Tuesday, March 12, 2019 8:33 PM

To: Rose Bustria <RBustria@cco.on.ca>

Subject: Fwd: CCO Election Candidate Profiles, Neck Pain Guideline, WHMIS Advisory

Council.

Jo-Ann Willson, B.Sc., M.S.W., LL.B.
Registrar & General Counsel

Subject: CCO Election Candidate Profiles, Neck Pain Guideline, WHMIS Advisory

Date: Tue, 12 Mar 2019 20:00:09 +0000

From: OCA <OCA@chiropractic.on.ca>

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Ontario
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Association

CCO Election Update |

CCO Election Candidate Profiles!

We recently asked all six candidates to CCO Council five important questions that will better inform our members, especially those that are eligible to vote in this year's election.

Here are the questions we put to the six candidates:

1. What sets you apart from the other candidates for this CCO Council position?

2. How would you define the state of chiropractic in Ontario in 2019?
3. What should be the CCO's top priority going forward as a regulator?
4. How would you help foster a collaborative approach between the CCO and chiropractic associations, educational institutions and other important chiropractic organizations?
5. Are there final words you would like to share with our members?

For unedited answers to each of the questions from the candidates (in alphabetical order) visit the web links below. Please note that for this election, only chiropractors in the districts listed are eligible to vote. Despite this, we think the profiles are of interest to our entire membership.

District 2: Eastern

[Dr. Paul Groulx](#)

[Dr. Peter Wise](#)

District 3: Central Eastern

[Dr. Elizabeth Anderson-Peacock](#)

[Dr. Steven Lester](#)

District 4: Central

[Dr. Gerard Arbour](#)

[Dr. Janet D'Arcy](#)

We remind you that the OCA is not endorsing any candidate. Please visit the [CCO website](#) for the official [Voting Guide](#), member candidate statements and the election timetable.

CCO Candidates Profiles



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Ontario
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CCO Election Update

Part 1: Virtual Town Hall CCO Election Candidate Q&A

As part of our continued commitment to keep you informed about the College of Chiropractors of Ontario's election, we have posed topical questions to each candidate to get their thoughts on important issues that our profession is facing.

Here's the latest round of questions we asked the six candidates.

1. The CCO [standard of practice](#) mandates that chiropractors responding to questions by patients related to vaccinations shall *"advise the patient that the performance of the act is outside the chiropractic scope of practice and the patient should consult with a health professional who has the act within his/her scope of practice."* What is your position on how chiropractors should engage with the topic of vaccinations, both online and in person with a patient?

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2. Long-term billing practices and “block fees” have been a topic of discussion in our profession for many years. What is your position on these practices and their impact on the profession?
3. There has been substantial media coverage and online discussion around claims made by chiropractors on a variety of topics that are seen to be outside the scope of the profession and not backed by evidence. As a potential CCO Council member, how should CCO tackle this issue in its mandate to protect the public interest?

For unedited answers from all the candidates (in alphabetical order) visit the links below. Please note that for this election, only chiropractors in the districts listed are eligible to vote. Look for our final set of Virtual Town Hall Q&A’s in our next Tuesday bulletin!

District 2: Eastern

[Dr. Paul Groulx](#)

[Dr. Peter Wise](#)

District 3: Central Eastern

[Dr. Elizabeth Anderson-Peacock](#)

[Dr. Steven Lester](#)

District 4: Central

[Dr. Gerard Arbour](#)

[Dr. Janet D’Arcy](#)

We remind you that the OCA is not endorsing any candidate. Please visit the [CCO website](#) for the official [Voting Guide](#), member candidate statements and the election timetable.

March 28, 2019 is the final day to vote!

CCO Candidate Q&As + Profiles

From: Jo-Ann Willson
Sent: Saturday, March 02, 2019 5:46 AM
To: Rose Bustria
Cc: David Starmer; Liz Anderson-Peacock
Subject: FW: CCO Election Begins In Eligible Districts

Exec and Council.

Jo-Ann Willson, B.Sc., M.S.W., LL.B.
Registrar & General Counsel

College of Chiropractors of Ontario
130 Bloor St. West, Suite 902
Toronto, ON M5S 1N5
Tel: (416) 922-6355 ext. 111
Fax: (416) 925-9610
E-mail: jwillson@cco.on.ca
Web Site: www.cco.on.ca

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From: Ontario Chiropractic Association [<mailto:OCA@chiropractic.on.ca>]
Sent: Friday, March 01, 2019 4:31 PM
To: Jo-Ann Willson <jwillson@cco.on.ca>
Subject: CCO Election Begins In Eligible Districts

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Association

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CCO Election Update

The Election Begins

Dear Members,

Today, chiropractors in the **Eastern, Central East and Central** districts received a [list of candidates](#), [biographical information](#), and [voting procedures](#) from the College of Chiropractors of Ontario (CCO). Voting begins today, March 1 through March 28, by 4:00 p.m. to elect three Council members to our regulatory college.

Every election is important, but given recent discussions and media coverage of our profession, we find ourselves at a critical juncture. Every chiropractor has a responsibility to ensure that the CCO is led by strong, effective Council Members that can steer our profession through any issues it may face in the pursuit of their mission: ***“to regulate the profession in the public interest to assure ethical and competent chiropractic care”***.

I'm pleased to share a special message from Dr. Dwight Chapin, our [2018 Chiropractor of the Year](#) and the recent author of a [Globe and Mail article](#) that set the record straight on chiropractic. Based on his gala acceptance speech, this message inspires our members to *“be the change you wish to see in the world”*, starting with voting for the Council Member that best reflects our profession as you want it to be

Dr. Chapin's message reflects our vision for a strong, thriving profession of chiropractors practicing to their [full scope of practice](#). Dr. Chapin delivers a powerful message, ***“The freedom to define our own philosophy of care is precious. The profession is stronger because of this diversity. But only when that pendulum swings with our defined scope. That must be the hard line. This is our common ground. United, let us answer that call.”***



Here are your 2019 CCO Council Member Candidates, in alphabetical order. Look for our candidate profiles to appear in our Tuesday, March 12 bulletin and virtual town hall Q&A's to be published on Tuesday, March 19 and 26.

District 2: Eastern

[Dr. Paul Groulx](#)

[Dr. Peter Wise](#)

District 3: Central Eastern

[Dr. Elizabeth Anderson-Peacock](#)

[Dr. Steven Lester](#)

District 4: Central

[Dr. Gerard Arbour](#)

[Dr. Janet D'Arcy](#)

In anticipation of queries you may have, I include the first of a series of questions and answers.

Question: Will the OCA endorse any specific candidate over another?

Answer: The OCA is not endorsing any candidate. We think a robust roster of candidates,

coupled with well-informed voters, will achieve the best results for the profession in Ontario.

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Question: What exactly is the OCA's role in this election then?

Answer: To mobilize all eligible voters, the OCA will profile every candidate, equitably, in all three districts, and provide helpful questions and answers so members can make informed choices with their votes.

Question: Can I contact specific candidates directly to ask them questions?

Answer: Yes, feel free to reach to any candidate. There is no CCO prohibition on individual chiropractors engaging with council candidates to ask them questions or obtain more information on their views.

To eligible voters, remember that your votes must be received by the CCO by March 28, 4 p.m. If you have any questions, I welcome your email at cbrereton@chiropractic.on.ca or by phone at 416-860-4155.

Sincerely,

Caroline Brereton

Chief Executive Officer, Ontario Chiropractic Association

We're here for you. Call us:

Local: [416-860-0070](tel:416-860-0070) | Toll-free: [1-877-327-2273](tel:1-877-327-2273)

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[unsubscribe](#) from this list

Our mailing address is:

Ontario Chiropractic Association
200-20 Victoria St
Toronto, ON M5C 2N8
Canada

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From: Jo-Ann Willson
Sent: Tuesday, March 05, 2019 4:29 PM
To: Joel Friedman
Subject: FW: Myth Busting re: CCO Election

Jo-Ann Willson, B.Sc., M.S.W., LL.B.
Registrar & General Counsel

College of Chiropractors of Ontario
130 Bloor St. West, Suite 902
Toronto, ON M5S 1N5
Tel: (416) 922-6355 ext. 111
Fax: (416) 925-9610
E-mail: jpwillson@cco.on.ca
Web Site: www.cco.on.ca

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From: OCA [<mailto:OCA@chiropractic.on.ca>]
Sent: Tuesday, March 05, 2019 4:04 PM
To: Jo-Ann Willson <jpwillson@cco.on.ca>
Subject: Myth Busting re: CCO Election

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Association

Myth Busting

Responding to members' questions on information brought to my attention

In follow-up to my message to you on Friday, March 1, regarding the CCO election, I want to clarify some misinformation brought to my attention by members.

Concerns have been raised to me by members that there is a high risk that the scope of

practice in Ontario will be reduced. Certainly it is not the position of the Ontario Chiropractic Association. In fact, in partnership with the CMCC and the CCO, we are strongly advocating with the Ministry of Health and Long-Term Care (MOHLTC) to expand the scope of practice to include 29 diagnostic and lab tests.

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However, misinformation is circulating about the United Kingdom (UK) that the focus on “spinal care experts” has resulted in scope reductions and the inability to treat extremities, for example. This is untrue. According to the president of the British Chiropractic Association, *“Chiropractors in the UK have no limitation on scope of practice, only on advertising which is entirely different. We in fact have a longer and more robust advertising list than physios and osteos due to the work done by the BCA, Royal College of Chiropractors and WFC to extend this. It continues to amaze me how individuals chose to present such false information as fact.”*

Another message I received from members is that the focus we have had on MSK reflects a narrow view of the profession. The advertising campaign highlighting our MSK expertise is a powerful growth strategy, building on established evidence and now acknowledged by key stakeholders. Of course, it is not all that chiropractors do; it was one strategy to advance the value of chiropractors. I invite you to contact me directly on how the OCA fully supports the scope of practice, as defined by regulation in Ontario.

Here are just two examples of what we are working on now to enable full scope of practice in Ontario.

1. OCA is pursuing access to additional diagnostic tools to ensure chiropractors can work to their full scope as I mentioned above.
2. OCA has developed **ASPIRE**, a leading-practice electronic health record and business solution that supports chiropractors’ full scope of practice. **ASPIRE** is designed by chiropractors for chiropractors. Members who use it or have seen a demonstration know that it is designed to support the full scope of practice.

Diversity when respected and consistent with the scope of practice can be a strength. Unethical behaviours, such as claims outside the scope of practice and inappropriate business practices hurt everyone.

We need to work together to have these important dialogues in the right forums. I ask you

to reach out to me if you hear more misinformation, at any time, but particularly during this critical period of CCO elections. We must all work to ensure informed choices are made by members.

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Sincerely,

Caroline Brereton

Chief Executive Officer, Ontario Chiropractic Association



WFC | ECU Congress
Berlin 20-23 March

Global Opportunities in Spine Care

The OCA at EPIC2019!

The OCA, represented by our CEO Caroline Brereton and President Dr. Ken Brough, will be joining a large contingent of Ontario delegates in Berlin for [EPIC2019](#), the World Federation of Chiropractic's (WFC) and the European Chiropractors' Union's (ECU) influential congress.

This year's congress theme is ***EPIC2019: Global Opportunities in Spine Care***.

Evidence-based, Patient-centred, Interprofessional and Collaborative approaches to spine care provides an important framework in which chiropractors can improve function and spinal health and reduce disability for millions of people worldwide.

The WFC has put together an exciting programme of inspiring thought leaders, topical panel discussions, stimulating workshops and the very best in contemporary research presentations from around the world to ensure that there really is something for everyone at EPIC2019.

There is still time to participate in this tremendous opportunity to be part of chiropractic's leading international congress and scientific meeting. [Register now](#) and book your place at this EPIC event!

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Register Now



Buzz-Worthy Practice OpportUnity '19!

We brought incredible chiropractic talent to **Practice OpportUnity '19** through interactive and personally engaging activities. Plus, our booth was buzzing with students wanting to learn more about [Aspire](#) and sign up for our free student membership.

2019 Recap!

The popular **Practice Realities Panel** returned – a dynamic panel discussion with four chiropractic pros about their real life career path challenges and successes. At the **Speed Mentoring** event students got to experience the transformative power of mentorship by connecting with established chiropractors.

From: Jo-Ann Willson
Sent: Monday, March 04, 2019 2:50 PM
To: Rose Bustria
Cc: David Starmer; President; Liz Anderson-Peacock
Subject: FW: College of Chiropractors of Ontario - VOTING is OPEN

Exec and Council.

Jo-Ann Willson, B.Sc., M.S.W., LL.B.
Registrar & General Counsel

College of Chiropractors of Ontario
130 Bloor St. West, Suite 902
Toronto, ON M5S 1N5
Tel: (416) 922-6355 ext. 111
Fax: (416) 925-9610
E-mail: jpwilson@cco.on.ca
Web Site: www.cco.on.ca

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From: allianceforchiropractic.activehosted.com@s4.csa1.acemsb3.com
[mailto:allianceforchiropractic.activehosted.com@s4.csa1.acemsb3.com] **On Behalf Of** Alliance For Chiropractic
Sent: Monday, March 04, 2019 2:45 PM
To: Jo-Ann Willson <jpwilson@cco.on.ca>
Subject: College of Chiropractors of Ontario - VOTING is OPEN



ALLIANCE FOR CHIROPRACTIC
INTEGRITY - ACCOUNTABILITY - LEADERSHIP

Jo-Ann,

The College of Chiropractors of Ontario (CCO) have sent out information for the voting procedures for Districts 2, 3 and 4. At this point, you should have received an email giving you detailed information about the candidates and the voting process. Voting is open until 4:00 PM March 28, 2019.

The Alliance For Chiropractic believes that this is a critical time for chiropractic in Ontario and beyond. In light of recent media publications and declarations from within the profession, the AFC believes that The *Globe and Mail* articles embarrassed **all of us** regardless of where we stand politically/philosophically.

Stories like that damage the public trust – a trust that is hard-won and easily lost. Behavior that jeopardizes the public trust must be reined in.

The singular purpose of the CCO is to protect the public interest and I am asking that you vote for the candidate that will work to:

- **Protect the public interest**

- **Protect your freedom to practice ethically and professionally**
- **Protect professional diversity**

The candidates for each district are:

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District 2: Eastern

Dr. Paul Groulx

Dr. Peter Wise

District 3: Central Eastern

Dr. Steven Lester

Dr. Liz Anderson-Peacock

District 4: Central

Dr. Gerard Arbour

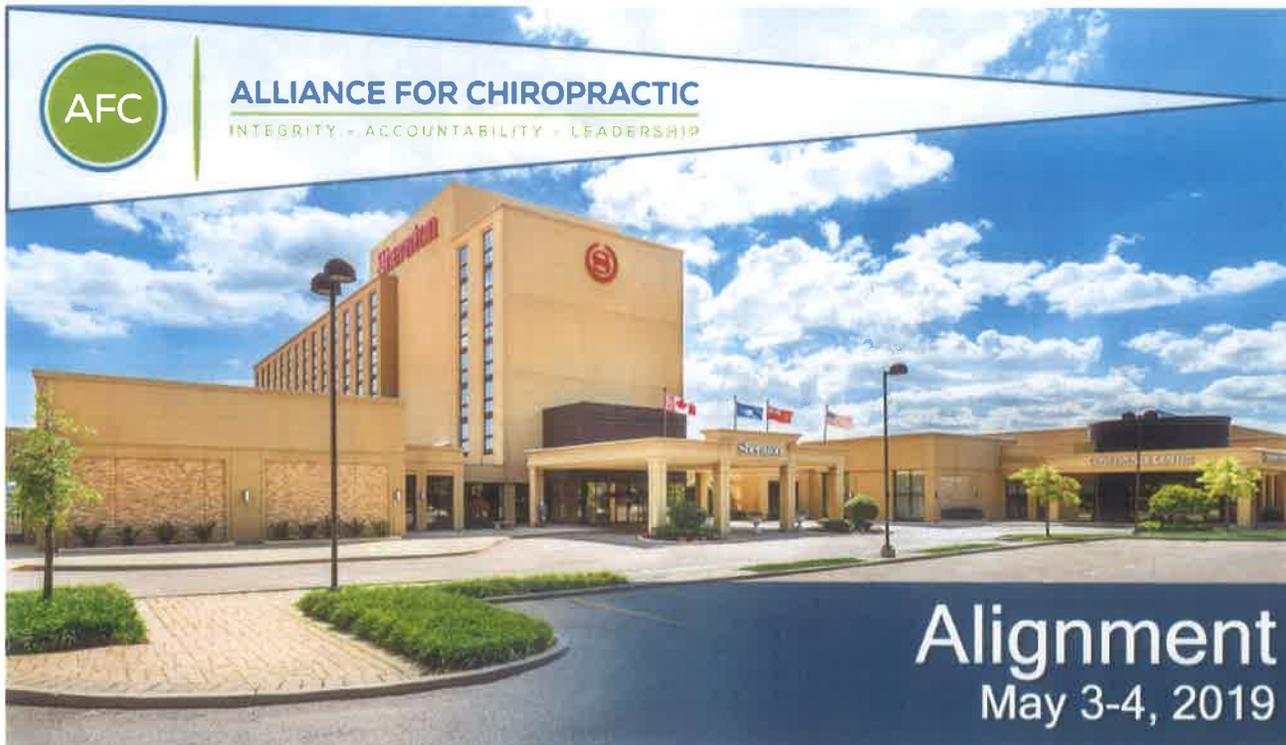
Dr. Janet D'Arcy

Things to consider when placing your vote:

- Does this candidate support the public's right to care regardless of age or health concern?
- Does this candidate support the need to ensure the regulation of chiropractic is applied as written: "The assessment of conditions related to the spine, nervous system and joints and the diagnosis, prevention and treatment, primarily by adjustment of: dysfunctions or disorders arising from the structures or functions of the spine and the effects of those dysfunctions or disorders on the nervous system; and dysfunctions or disorders arising from the structures or functions of the joints."
- Will this candidate support the Ministry with regulatory opportunities to enable us as DCs to practice fully in our scope, do our job more efficiently, completely and safely?
- Does this candidate support my right to practice in a diverse model?

* Please note: in your email, you will have received a link that is specific to you. Use that link only.

Dr. Craig Hazel
Chairman of the Alliance For Chiropractic



Sent to:

452

Alliance For Chiropractic
17A-218 Silvercreek Pwy N, Suite 126
Guelph, ON N1H 8E8

Toll free: 1-877-997-9927
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jwillson@cco.on.ca

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Alliance For Chiropractic, 17A-218 Silvercreek Pwy N, Suite 126, Guelph, Ontario N1H 8E8, Canada

From: Jo-Ann Willson
Sent: Monday, March 04, 2019 3:30 PM
To: Rose Bustria
Cc: David Starmar; President
Subject: FW: AFC Suggests: CCO Candidates

Exec and Council.

Jo-Ann Willson, B.Sc., M.S.W., LL.B.
Registrar & General Counsel

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From: Bruce Walton [mailto:bruce@n8power.ca]
Sent: Monday, March 04, 2019 3:13 PM
To: Jo-Ann Willson <jpwilson@cco.on.ca>; Joel Friedman <JFriedman@cco.on.ca>
Subject: Fwd: AFC Suggests: CCO Candidates

Begin forwarded message:

From: "Alliance For Chiropractic"
<chairman@allianceforchiropractic.com>
Subject: AFC Suggests: CCO Candidates
Date: March 4, 2019 at 2:17:34 PM GMT-5
To: "Dr. Bruce" <bruce@n8power.ca>



ALLIANCE FOR CHIROPRACTIC
INTEGRITY - ACCOUNTABILITY - LEADERSHIP

Dr. Bruce, ✓

As you are well aware, the CCO elections for Districts 2, 3 and 4 are underway. Voting ends March 28 at 4pm.

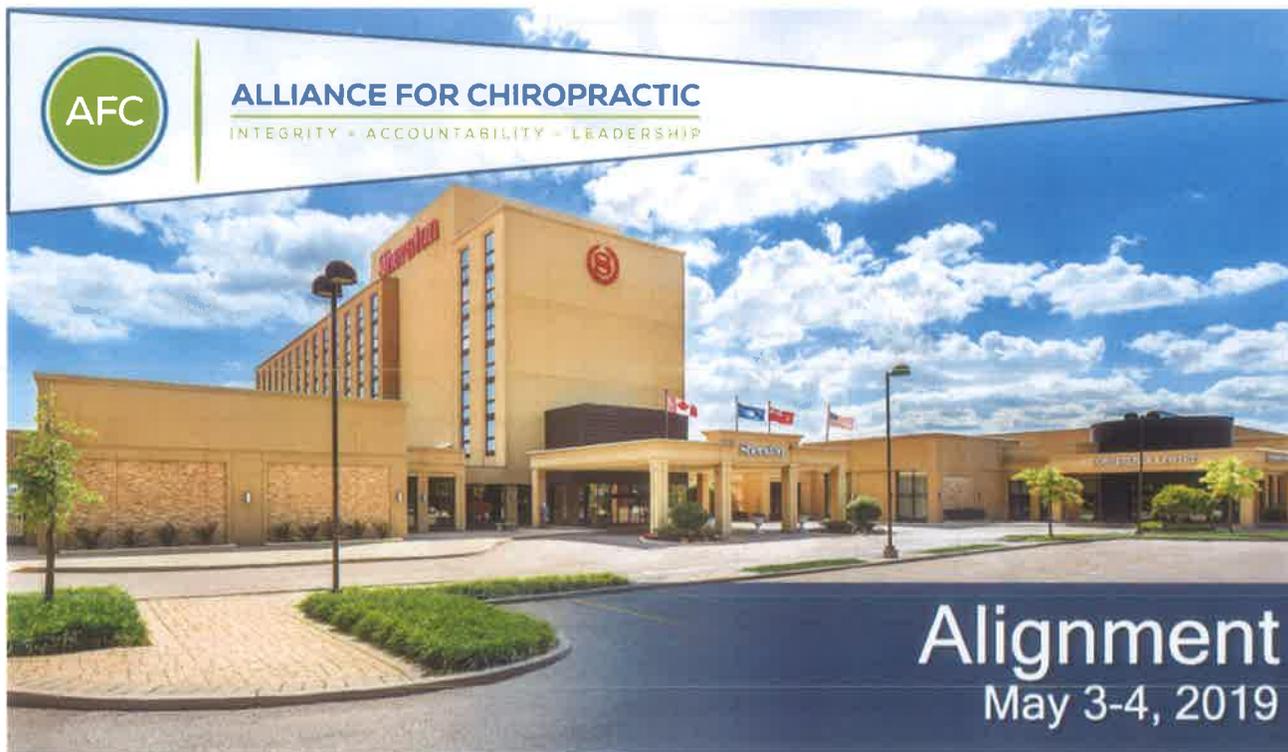
The AFC has made it clear over the past few months that Chiropractic in a neurological model is under attack from within and outside of the profession. The AFC contends that attempts to change the definition of chiropractic and the role of a chiropractor are not in the best interests of the public or the profession.

We ask that if you are within Districts 2, 3 or 4 to take a moment today and vote for the candidate that will support the neurological model of care and ensure that your freedom and rights to practice in this model are heard at the CCO.

We are confident that our colleagues Gerard Arbour (District 4), Paul Groulx (District 2) and Liz Anderson-Peacock (District 3) will do just that.

VOTE TODAY,

Dr. Craig Hazel



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Improving Health Outcomes and Ending Hallway Medicine

The Premier's Council on Improving Healthcare and Ending Hallway Medicine is helping to inform the future of health care in Ontario

Learn more about the council, its members and their work.

Hallway medicine

Hallway medicine (treating patients in the hallway of a hospital when all the rooms are full) is a reality in Ontario. There is no easy solution — it is caused by many large challenges facing the health system.

These challenges include:

- patients with more complex medical needs and chronic issues
- a system that is hard to navigate
- pressure for the system to handle more patients
- health care providers and caregivers who are stressed and overworked

What it means for patients

These complex factors all contribute to overcrowded hospitals where too many patients are:

- waiting for hospital beds in unconventional spaces, such as hallways or meeting rooms
- waiting too long to receive care
- receiving care in places that don't support rest, healing or recovery

Premier's Council

The Premier's Council was created on October 3, 2018. The council will provide the Premier of Ontario and the Deputy Premier and Minister of Health and Long-Term Care with strategic priorities and actions leading to:

- improved health and wellness outcomes for Ontarians
- higher patient satisfaction
- more efficient use of taxpayers' dollars
- lower wait times

Council members

The Premier's Council is led by Dr. Rueben Devlin, Special Advisor and Chair, and is made up of 14 health system leaders. Council members represent a cross-section of health sector professionals, and provide senior administrative and frontline worker perspectives.

[Learn more about the council members](#)

<http://www.health.gov.on.ca/en/public/publications/premiers_council/report.aspx#bios>

Reports

The Premier's Council's first interim report: [Hallway Healthcare: A System Under Strain](#) <http://www.health.gov.on.ca/en/public/publications/premiers_council/report.aspx> (January 2019) identifies key challenges connected to the problem of hallway health care in Ontario.

It is the first of several public reports to come from the Premier's Council.

[Read the full report](#) <http://www.health.gov.on.ca/en/public/publications/premiers_council/report.aspx>

Video

[In this video](#) <<https://youtu.be/nQfqGQd4laY>>, Premier's Council Chair Dr. Rueben Devlin, and Christine Elliott, Deputy Premier and Minister of Health and Long-Term Care talk about the council's first report, Hallway Health Care: A System Under Strain.

Contact us

The Premier's Council wants to hear from you.

[Provide your feedback on their interim report](#) <<mailto:hallwayhealthcare@ontario.ca>>

For More Information

Call **ServiceOntario**, INFOline at:
 1-866-532-3161 (Toll-free in Ontario only)
 TTY 1-800-387-5559.
 In Toronto, TTY 416-327-4282
 Hours of operation : 8:30am - 5:00pm

If you are a member of the media, call Communications and Marketing Branch at 416-314-6197 or visit our News Room section.

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Hallway Health Care: A System Under Strain

1st Interim Report from the Premier's Council on Improving
Healthcare and Ending Hallway Medicine

January 2019



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Letter to the Premier of Ontario and the Minister of Health and Long-Term Care

Dear Premier Ford and Minister Elliott,

As Chair of the Premier's Council on Improving Healthcare and Ending Hallway Medicine, I hear from patients regarding what it's like to receive care in our system. I am impressed by the dedication of health care professionals who deliver high-quality health care throughout our communities; however, I am also concerned.

The concern is that on any given day in the province, there are at least 1000 patients receiving health care in the hallways of our hospitals. At the same time, the wait time to access a bed in a long-term care home is 146 days, and this can vary significantly depending on where you happen to reside in Ontario.

There is much to be proud of within our health care system. There are examples of innovation, and there are teams that are working seamlessly together to provide wrap-around services for patients with complex needs. However, we've also come to understand that there are many barriers within the system that just don't make sense.

This report is the first of a number of public reports the Council will provide to you in order to help inform the future of health care in the province. The next report will contain a series of recommendations, and will be solutions-focused. While each of the reports will contain our best advice for you, these reports are also for the people of Ontario.

Our primary goal is to be transparent and accountable to the public while we consider the current challenges and future needs of the health care system. Over the next three years, the public will be able to track our progress and participate in our work. They will keep us accountable and help us reach our goal. By doing our work well, the public will be able to see the improvement at their local hospital and across the health care system.

Our objective is to help ensure Ontarians have a health care system that has the right mix of health care professionals, the right number of hospital and long-term care beds, and that care is available when and where it's needed.

Tough decisions will be required to address the challenges facing our health care system, while we continue to champion the health care professionals already leading great work in our communities.

A word of thanks to the Council Members – each of whom has brought a wealth of experience and knowledge, enthusiasm and optimism to our discussions. I look forward to our continued partnership in the years to come, and to turning the vision into reality for the people of Ontario.

Dr. Rueben Devlin, Chair

Premier's Council on Improving Healthcare and Ending Hallway Medicine

Executive Summary

Hallway health care is a significant problem in Ontario. The entire health care system is too complicated to navigate, people are waiting too long to receive care and too often are receiving care in the wrong place; as a result, our hospitals are crowded.

The Premier's Council on Improving Healthcare and Ending Hallway Medicine has been tasked with providing advice to government on how to solve this problem and improve health outcomes across the province.

This first report provides an overview of some of the key challenges contributing to hallway health care, and identifies opportunities and emerging themes from the Council's initial work – including the potential to integrate health care and introduce technology solutions to build strong and efficient community and hospital services, support better outcomes for patients, and to fix the problem of hallway health care.

Key Findings

1. Patients and families are having difficulty navigating the health care system and are waiting too long for care. This has a negative impact on their own health and on provider and caregiver well-being.
2. The system is facing capacity pressures today, and it does not have the appropriate mix of services, beds, or digital tools to be ready for the projected increase in complex care needs and capacity pressures in the short and long-term.
3. There needs to be more effective coordination at both the system level, and at the point-of-care. This could achieve better value (i.e. improved health outcomes) for taxpayer money spent throughout the system. As currently designed, the health care system does not always work efficiently.

Chapter 1: The Patient Experience

Patients and families are having a difficult time navigating the health care system. Ontarians cannot always see their primary care provider when they need to, wait times for some procedures and access to specialists and community care are too long, and emergency department use is increasing. A lack of early intervention and prevention is contributing to more patients becoming ill. All of these challenges are connected to the problem of hallway health care.

Chapter 2: Stress on Caregivers and Providers

Health care providers, family members, and friends are feeling the strain of a system that isn't making caregiving easy. This leads to high levels of stress and places a heavy burden on caregivers to act as advocates for timely and high-quality health care services.

Chapter 3: Different Health Care Needs

There are more patients with complex needs and an increase in chronic issues that require careful and coordinated management, like an aging population living longer with high rates of dementia. Fair access to health care across the province continues to be a concern.

Chapter 4: Immediate and Long-Term Capacity Pressures

Ontario does not have an adequate or appropriate mix of services and beds throughout its health care system. This leads to capacity pressures on hospitals and long-term care homes. Demographic projections indicate there will be additional strain on existing capacity in the near future.

Chapter 5: Responsibility and Accountability in the System

Ontario's health care system is large. Responsibility for coordinating high-quality health care is spread across many government agencies, organizations, and the Ministry with no clear point of accountability to keep the focus on improving health outcomes for Ontarians. There is a fundamental lack of clarity about which service provider should be providing what services to patients and how to work together effectively. Ontario could be getting better value for the money it currently spends on the health care system.

Opportunities for Improvement

The health care system can make better use of available technology, and should aim to deliver integrated and efficient services in all parts of the province. People have more access to digital tools and information than ever before, and expectations for high-quality, efficient, and integrated health care have changed.

Next Steps

The Council is working on a second report, which will include recommendations and advice for government on how to remedy the problem of hallway health care in Ontario. Four key themes have emerged through the Council's initial work that will help guide the development of detailed recommendations in its next report:

1. A pressing need to integrate care around the patient and across providers in a way that makes sense in each of our communities in the province, and improves health outcomes for Ontarians.
2. Growing demand and opportunity to innovate in care delivery, particularly in the use of virtual care, apps, and ensuring patients can access their own health data.
3. The potential for greater efficiency in how we streamline and align system goals to support high quality care.
4. The critical role for a long-term plan so that we have right mix of health care professionals, services, and beds to meet our changing health care needs.

Introduction

In Ontario, there are many signs of a health care system under pressure. Patients are: waiting longer than they should in overcrowded emergency departments, receiving health care in hospital hallways, not able to access specialized post-acute hospital care, and unable to transition out of hospital beds due to services not being available in the community.

Hospitals are an important point of intake into the health care system; however, too many patients are going to hospitals for conditions that could be treated in primary or community care settings or prevented altogether. Overcrowding of the emergency department means Ontarians whose care can only be provided in an emergency department are waiting longer to access the health care they need, and are sometimes waiting in unconventional locations – like hallways. On an average day in 2018, there were approximately 1000 patients waiting for a hospital bed in an unconventional space or emergency department stretcher.¹ This should not happen.

The health care system is complex and hospitals receive patients from many different care settings: from primary care (like family doctors or nurse practitioners), long-term care homes, home and community care, mental health and addictions agencies, and from the emergency department.

In fact, the pathway through the health care system is often not a straight or simple line: patients will move between care settings depending on the severity of needs or the kind of care required at each stage of their journey. At the same time, there are other patients who, with just a little more help from a health care provider, could stay in their homes longer, avoid a visit to the emergency department, avoid hospital admission, and maintain their health and independence.

We are seeing the results of a system under pressure in our hospital hallways; however, hallway health care is a symptom of broader challenges facing Ontario's health care system.

We've heard from many Ontarians that the health care system can do better, and that accessing the high-quality health care that's available in Ontario should be a straight-forward process.

Oftentimes, that's just not the case.

Ida and Sara's Story: Scared, Cold, and Exposed

Ida, the caregiver for her elderly aunt Sara, shares her experience spending two days in a hallway of the emergency department at a hospital.



Aunt Sara

When Ida called the ambulance to take her 94-year-old aunt Sara to the hospital, she knew they would probably end up in a hallway. As the main caregiver for Sara for more than 10 years, Ida had accompanied her to the hospital emergency department a few other times and waited for care in a busy hallway, usually for eight or 10 hours.

This time, after being triaged by a nurse, Sara was wheeled in a stretcher into a nearby hallway, where she joined three other patients tucked against the walls of the brightly lit, high-traffic zone. Police were bringing in some people who were causing disturbances. "There was a lot of yelling and cursing," Ida says. "Sara became frightened because there was a police officer there. It made her really uncomfortable and scared. Even if she wanted to sleep, she couldn't."

Ida stayed up all night with Sara. She had a chair but it couldn't fit in front of the stretcher, so she had to sit behind her, out of view of her frightened aunt. Nurses came by to ask questions and do tests. The hallway was in a constant state of frenzied activity and noise.

"Sara was upset the whole time. It was awful to watch. She couldn't figure out what was going on, where she was, and whether she was in trouble because the police officer was there. She kept telling me she was scared and why couldn't she be in a room on her own. She asked can I turn the light out, can I have a sleeping pill."

Sara got very cold in the hallway, but the nurses were so busy that Ida went in search of a blanket herself. Sometimes Sara's IV pole would fall over and Ida would have to fix it. A few times, Ida left to get some tea or go to the washroom and returned to find Sara lying completely exposed to everyone passing by after her hospital gown and bedsheet slipped off.

The next morning, Ida had to leave for a few hours to do some work and when she came back she was shocked to see that Sara was still in the hallway. She stayed by her side through the rest of the day, always afraid that if she left to get tea, that would be when the doctor arrived.

Sara tossed and turned in the uncomfortable stretcher that she had occupied for the last 30 hours. Neither Sara nor Ida had slept in two days. Later that day, doctors determined that Sara would have to be admitted to the hospital. That evening, a hospital bed became available and Sara was finally whisked out of the hallway where she had spent the last 48 hours.

Sara recovered in hospital, and recently moved into a seniors' residence.

Chapter 1: The Patient Experience

In its first four months, the Council heard from over 340 patients, and a recurring theme from their stories is what it feels like to wait for health care services in environments that don't support rest or healing. Many patients described uncomfortably low levels of privacy in emergency departments, and feeling a complete lack of dignity when telling their personal stories and sharing their medical history with a health care provider in a hallway, where everyone could hear. For some people, even something that should be simple – like helping patients get to the washroom on time – was challenging under the current conditions.

What is Hallway Health Care?

Hallway health care is a term used when patients are waiting for a hospital bed in an unconventional or unexpected location. This could be a hallway, or another space within a health facility that was not designed for using the space in this particular way.

Hallway health care is measured by counting the number of people waiting for a hospital bed overnight in an unconventional space or emergency department stretcher. That captures the volume – or size – of the problem, but there are more things going on throughout the system that are connected to hallway health care, like wait times for long-term care homes, that also contribute to how well the system works.

A high-performing health care system should have very few people waiting for a hospital bed if they need one.

Navigation & Access to Health Care

The Council heard that patients and their families find it difficult to navigate the health care system. For some, it's a matter of not being able to find timely health care, due to long wait-times or inconvenient service hours. For others, it can be difficult to know where to go for the right kind of care. For example, Ontarians often go to the emergency department with mental health or addictions issues that could have been dealt with more quickly, and oftentimes more appropriately, in primary care or community mental health and addictions agencies. By not knowing how to access community services or waiting too long for a community service because there are not enough of those services, many people reach a crisis point that leads them to the emergency department.

Either way, it means people are ending up in emergency departments, waiting hours for care that sometimes could have been more appropriately provided in a different care setting, or avoided entirely by proactive and preventative measures. These challenges with navigation and timely access contribute to the problem of hallway health care because the way patients move in and out of hospitals has a significant impact on the efficiency of the entire health care system.

Going to the emergency department for health care that could be provided somewhere else happens frequently in Ontario, sometimes because it's the only health care setting that is open 24/7. According to the 2018 Health Care Experience Survey, 41% of Ontarians who went to the emergency department, and 93% who went to a walk-in clinic received care for a condition that could have been treated by their primary care provider.² Even though 94% of Ontarians have a family doctor or nurse practitioner,³ the data suggests that Ontarians are not always choosing to use, or have timely access to their primary care provider as the first access point to health care.

While the health care system has evolved over the last 15-20 years, the emergency department still remains one of the only health care settings open and available whenever people get sick and need care. Additional focus on preventative measures, and effective engagement with primary care providers could help reduce the inflow of patients to emergency departments and hospitals, and contribute to reducing the problem of hallway health care.

Wait Times & Quality Care

In general, visits to emergency departments across the province increased by about 11% over the last six years, to 5.9 million in 2017/18.⁴ This increase in volume of visits to the emergency department is just one contributing factor to the back-log across the system, since not all visits to the emergency department lead to hospitals admitting patients.

The current recommended target in Ontario – what the province expects from its hospitals – is if a patient is to be admitted, to get the patient to an inpatient room and bed within 8 hours of being seen in the emergency department.⁵ However, in November 2018, only 34% of patients admitted to hospital are admitted to an inpatient bed from the emergency department within that 8 hour target.^{6,7}

Furthermore, patients in Ontario who require admission to an inpatient bed are spending an average of 16 hours in the emergency department before a bed becomes available, which is the longest that wait has been in six years.⁸

Waiting too long for health care isn't just a problem in hospitals; wait times are also longer than they should be in other parts of the health care system. For example, the median wait time for long-term care home placement in Ontario in fiscal year 2017/18 was 146 days, and the median wait time for home care was around six days for patients waiting at home.^{9,10}

When Ontarians can access services and supports, the data generally tells a positive story. For example, survey results for home and community care show high levels of client satisfaction: 92% of respondents

“Half of parents who sought help for mental health services for their child said they faced challenges in getting the services they needed, primarily due to wait times.”
– Children's Mental Health Ontario (November 2017)

rated their overall experience as excellent, very good or good;¹¹ however, long wait-times in some parts of the system are a clear signal that the system isn't running as smoothly as it could. Furthermore, the location of health care services also matters. For example, families describe how complicated it can be to navigate pediatric health care services, and improving access to high quality services closer to home would help families and patients.

In addition to expecting health services to be available to Ontarians within a reasonable time-frame, the province also expects high-quality care to be provided in every care setting. One way to improve access to care is to ensure people don't experience avoidable complications while receiving treatment. For example, evidence shows that patients who get certain infections while in hospital have a length of stay that is two weeks longer than it otherwise would have been.¹² These infections, which can be very costly to treat, may be avoided by following best practices in care.

We intuitively know that a delay in accessing health care – whether it's waiting for a bed to open up in the right care setting, for a diagnostic test, or for a referral to a specialist, means the road to recovery is longer and possibly rougher than it needs to be.

Spotlight: Mental Health and Addictions and Hallway Health Care

The Council is concerned that patients are unable to access mental health and addiction services when they are needed most. For example:

- Approximately 1 in 3 adults who went to the emergency department for mental health and addictions care had not previously accessed physician-based care for their mental illness.¹³
- There was a 72% increase in emergency department visits and a 79% increase in in-patient admissions for children and youth with mental health issues over the last 11 years.¹⁴

Access to health care at the appropriate place and time is crucial for patients with mental health and addictions issues.

Most mental health and addictions issues are more appropriately treated in the community; however, long wait times for community treatment means sometimes patients' conditions worsen as they sit in the queue, giving them no other option but to seek care through the emergency department, and return home to continue to wait for services.

The re-admission rates for mental health and addictions issues is significantly higher than many other health issues.¹⁵

Chelsea's Story: Setbacks and Recovery



Chelsea

Chelsea, a 29-year-old mother of two in Sudbury, struggled for years to access care for her anxiety, panic disorder and depression.

The onset of Chelsea's significant mental health issues began with a panic attack at age 22. "I didn't want to leave the house," Chelsea says. "I didn't want to shower. It just hurt to be alive. The pain is such emotional agony that you just don't know what to do with yourself. You feel alone and scared."

Desperate for help, Chelsea went to the emergency department at her local hospital multiple times within a week, waiting for hours to see a doctor, and each time quickly sent home with no resources or information about where to find help in the community.

Eventually, Chelsea received a prescription for anti-anxiety medication and anti-depressants. She had never taken medication for her mental illness previously despite being diagnosed with generalized anxiety disorder at age 12. The doctor at the hospital also referred her to outpatient cognitive behavioural therapy, but there was a nine-month wait.

Chelsea tried to get her life back on track and was able to see a psychiatrist every three months or so, but she never felt he really got to know her, and he wasn't able to provide the care she needed to recover.

A few years later, Chelsea's dad found the name of a psychotherapist and Chelsea began seeing her every week, and at times three times a week when her symptoms worsened. The psychotherapist really got to know Chelsea as a person and, for the first time, Chelsea felt like she had compassionate care for her illness. "Whatever I needed, she was there," she says.

Chelsea says most people she talks to have very similar experiences to her with the mental health system, if not worse. "People don't know where to go, or what resources are available to them," she says. "The system needs to be much more holistic, patient-centred, and recovery-oriented." And she'd like to see more funding for mental health supports and other services like structured psychotherapy. "It can be difficult financially to pay for psychotherapy services and it can cost people thousands of dollars a year."

Now 29, Chelsea knows she will have to actively work on recovery but is feeling more confident and stronger than ever in her ability to cope with and manage her illness.

Chapter 2: Stress on Caregivers and Providers

Perhaps one of the most troubling indicators that there is something wrong with our health care system is the strain that is being felt by family and friends who are caregivers of patients, as well as some health care providers. There are clear indications throughout the system of provider burnout, including staffing shortages in certain positions and parts of the province, and high levels of stress.

Among patients who received home care for six months or longer, in the first half of 2017/18, approximately 26% had a primary family or friend caregiver who experienced continued distress, anger or depression in relation to their caregiving role – this is up from about 21% in the first half of 2012/13.¹⁶ This strain is also felt among some personal support workers (PSWs). It's difficult and rewarding work, but scheduling can often be unpredictable and can lead to a break-down in care continuity for workers and home care clients.

“It was difficult for my mother who was suffering with Alzheimer’s to be in such a confusing space for so long. We had to stay with her all night to make sure she was warm and knew that someone was there to care for her.”
– Patient Survey Response

This stress on providers is also finding its way into hospitals and other health care settings. For example, a study of four Ontario hospitals found that health care providers often experience role overload (too many responsibilities and too little time), and that 59% of providers reported high levels of stress.¹⁷

Solving hallway health care will not just be a matter of adding more beds to the system. Increasing capacity in the community, staffing levels, training, and support will play an important role in building a high-functioning system that works for all Ontarians – including the ones who work in health care.

Chapter 3: Different Health Care Needs

The health care needs of Ontarians are different than they were even a generation before, and this is contributing to the problem of hallway health care. One example of how patient profiles and health care needs are shifting is among residents in long-term care homes. These patients have changed in recent years, in ways that make caring for them more complex. The typical long-term care home resident in the province is over the age of 85, has chronic health care conditions – like diabetes, high blood pressure, heart or circulatory diseases, and dementia – and generally needs extensive help with personal care.¹⁸ Taken together, these conditions are expected to put significant strain on health care resources.

Hospitals are also experiencing a shift in the health care needs among patients, including an increase in patients admitted to general internal medicine. In a study of seven hospital sites in the Greater Toronto Area, it was found that general internal medicine patients accounted for about 39% of emergency department admissions and roughly 24% of all hospital bed-days. Additionally, those admitted into general internal medicine had a median number of 6 co-existing conditions, which means they require a lot of medical support and resources.¹⁹

In general, there are more patients of all ages and abilities, with complex rehabilitation and mental health and addictions needs who could benefit from additional support in the community. Given the specific health care needs of an aging population, home care services are now supporting an increasingly complex client base that requires more assistance than before. Although the province has invested significant resources in the past to helping Ontarians stay in their home as they age, these patients are living longer and getting to the point now where they are experiencing a decline in their ability to perform activities of daily living.

The Council is committed to ensuring that Ontarians are supported and empowered to live their fullest life. It is important that our health care system contributes in a meaningful way to help individuals – patients, and caregivers alike – to live well and to the best of their abilities. As the population ages, and the profile of patients receiving home and community services changes, the system must respond and provide the right level of support in the right location to achieve these goals.

Spotlight: Fair Access to Health Care

With technological advances, medical breakthroughs, and an increased awareness among the general population about how to live a healthy lifestyle – there’s some good news – the average life expectancy in Ontario has increased across most of the province.²⁰

Unfortunately, health outcomes do not look the same everywhere in Ontario. For example, there are geographic, socio-economic, and sex differences in mortality rates across the province, which is just one way to measure the health of a population.²¹

Another example of where there is still more work to be done to improve health outcomes is in Ontario’s north. In northern communities, the average life expectancy is lower than the rest of the province and people living there are more likely to die prematurely due to circulatory disease, respiratory disease, and suicide.²²

As the Council continues its work and develops recommendations to help improve health outcomes and solve the problem of hallway health care in Ontario, it will consider the unique health care needs and cultural considerations of distinct populations in the province, including, Indigenous people and French-speaking individuals.

Chapter 4: Immediate and Long-Term Capacity Pressures

Capacity pressures are also contributing to the problem of hallway health care in Ontario. There are several causes to the capacity challenge:

1. Ontario may not have the appropriate number of hospital, or long-term care beds to meet the health needs of the population;
2. There is insufficient capacity in community care systems – like home care and mental health and addictions care – to prevent people from needing to go to hospital and to enable them to return home from hospital quickly; and,
3. The province is not using the beds across the system as effectively as possible.

In practice, this means that there are people across the province who are spending time in hospital beds because they can’t access other options for health care.

Waiting for Care in the Wrong Spot: Understanding Alternate Level of Care (ALC)

A common approach for measuring the appropriate use of space for patients is by tracking the number of patients who require an 'Alternate Level of Care.' When a patient is occupying a bed in a hospital and does not require the intensity of resources or services provided, the patient is designated as requiring an alternate level of care.

ALC rates and volumes are just one way to measure how effectively the health care system is flowing patients through to different care settings. It is a designation that refers to patients who remain in hospital although they no longer require hospital-level care.

A high-performing health care system would have a low ALC rate, which would mean that patients are receiving appropriate care for their needs in the right setting.

There are many patients in Ontario who are waiting in the wrong place in the system, and who require an alternate level of care (ALC). For example, in October 2018, almost 16% of days in hospital were spent by patients that were waiting for care in another setting.²³ This rate is high, and it is also increasing despite investments in more beds across the system. As of November 2018, there were approximately 4,665 patients designated as requiring an ALC.²⁴ This represents a 4% increase in absolute volumes compared to the year before.²⁵

In addition to being high, the ALC rate is different depending on where you are in the province, and can change depending on the time of year. As of October 2018, the range of ALC rates across Ontario was between 5% and 34% - with some challenges more pronounced in the northern part of the province and in the Greater Toronto Area.²⁶

There are many examples of people waiting for health care in the wrong spot across the system that could benefit from a different kind of support. For example, over 9% of people designated as requiring an ALC who have been waiting more than 30 days are people who have specialized mental health needs²⁷ who could be served – with appropriate supports – in supportive housing rather than hospital beds.

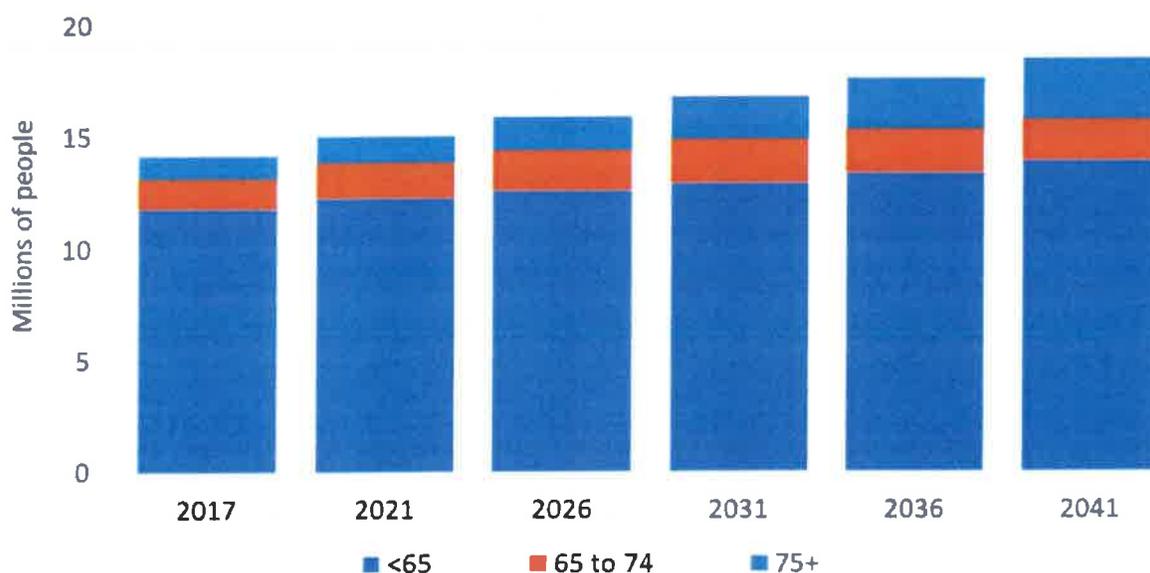
Another area where we can see the direct impact of capacity pressures is in how difficult it can be to find space in long-term care homes. The largest proportion of cumulative ALC days (province-wide), are currently attributed to patients waiting to be discharged to long-term care (59%).²⁸ This means that people are waiting too long in hospitals before moving to an open bed in a long-term care home. This is in part due to the fact that long-term care homes are currently at 98% capacity, with roughly 78,910 residents in 627 long-term care homes across the

province, and also because community supports are not expanding fast enough.²⁹ For example, a 2017 Canadian Institute for Health Information report found that in Canada more than 20% of seniors admitted to residential care could remain at home with appropriate supports; furthermore, seniors assessed in hospital are substantially more likely to be admitted to residential care than those assessed in the community.³⁰ The mis-match of capacity, demand, and use of services is one of the main pressure points facing the health care system, contributing to hallway health care.

Population Aging & Health Care Services

According to population projections, Ontario's senior population (individuals 65+) is expected to almost double from 2.4 million, or almost 17% of the population in 2017 to 4.6 million, or almost 25% by 2041.³¹ As an example of what it means for health care services, consider that 76% of seniors (aged 75+) who require care are currently receiving care at home. To maintain that ratio, the system would need to provide home care services to 97,194 more clients.³²

Population growth by age group, 2017 to 2041



(Source: Ministry of Health and Long-Term Care, 2019)

One of the challenges associated with an aging population is an associated rise in the number of patients with dementia. Close to 228,000 Ontarians are currently living with dementia, and this number will grow to over 430,000 by 2038.³³ Dementia is one of the leading causes of dependency and disability among seniors, and caregiving responsibilities for an individual with dementia can have a significant impact on family and friends.

Between 2008 and 2038, dementia will cost Ontario close to \$325 billion.³⁴ This includes health care and other costs, including lost wages, or out-of-pocket expenses by people with dementia or their care partners. Approximately 64% of residents in long-term care homes have dementia.³⁵ Some long-term care homes cannot care for additional residents with dementia since the numbers are already so high – which can delay admission and cause additional strain on families looking for support.

And while we focus on the rising number of seniors requiring different health care services, it is also important to note that in the next twenty years there will be more than 560,000 more children (0-18 years of age) in Ontario.³⁶ Proactive and early health care interventions will help these children have better lives, and will help reduce health care costs over their lifetime.

Social Determinants of Health

The social determinants of health are the economic and social factors that impact our health. They play a critical long-term role in health care, particularly for those suffering from chronic conditions. Having a job, eating healthy food and having a safe place to sleep are foundations to good health.

Population Growth & Health Care Services

In addition to the anticipated growth among the aging population, Ontario's general population is also growing larger. Demographic projections suggest that the province will see an increase in its population by roughly 30% by 2041.³⁷

This population growth will not occur evenly across the province, which will have an impact on how the health care system plans to handle this future growth, and where it allocates its limited resources to address the anticipated increase in demand for services.

In particular, projections suggest that the Greater Toronto Area (GTA) will be the fastest growing region of the province. By the year 2041, the GTA's population is expected to grow by 41% or by approximately 2.8 million people compared to the year 2017. Similarly, population growth will be slower in certain parts of the province, which will impact the system in different ways.³⁸

If no action is taken, these demographic changes will significantly impact the availability of health care in the province. With no additional capacity created – or no other efficiencies in the system found – the hospital bed rate in Ontario will decline from approximately 222 beds per 100,000 people in 2018 to approximately 173 beds per 100,000 people in 2041.³⁹

The projections are more concerning for the long-term care bed rate, which is projected to decline from 72 beds per 1,000 people aged 75 or older to 29 beds per 1,000 people aged 75 or older by 2041. This is a total decline in the long-term care bed rate of about 60%, or the equivalent of 48,000 bed closures by 2041 if nothing is done.⁴⁰

Simply adding more beds to the system will not solve the problem of hallway health care. For example, community mental health and addictions services, as well as community rehabilitation services are two areas where additional access to services could help relieve some of the pressures causing hallway health care.

Given the current pressures on capacity and the implications of future demographic shifts, the Council will be looking for innovative solutions to remove unnecessary barriers preventing Ontarians from receiving culturally appropriate, timely, and fair access to health care.

Chapter 5: Responsibility and Accountability in Health Care

The final factor contributing to hallway health care is the lack of integration throughout the provision of health care services in Ontario. There are barriers to true integration across different care settings in the province. For example, Ontario's current health care system can be characterized as decentralized, large, and siloed, and it can be difficult at times to know who is responsible and accountable for ensuring Ontarians have access to high-value health care.

This is in part due to the size of the system. There are currently 21 health-related government agencies supporting the design and delivery of health care in Ontario. Many of these agencies were created to tackle specific problems, support research, or to establish quality standards and metrics to help the system as it matured. However, these agencies are not always well-aligned and there is limited strategic oversight to ensure the efficient and coordinated use of resources.

In addition to being over-sized, the system is also decentralized. Of the \$54.6B in provincial health care expenditures, the majority of this funding is allocated by the Ministry of Health and Long-Term Care to transfer payment recipients.⁴¹ Similar to other systems across the country, Ontario's Ministry does not directly provide health care – it pays other people to deliver services to clients. However, the financial incentives and funding models used to pay health care

“There is such a gap in the transitions of care...the interest is not on the patient, but on each individual health service provider's own unique budget and strategic objectives. Why does each agency have their own administration as opposed to a truly regional or provincial coordinated system?”
– Patient Survey Response

providers to coordinate and deliver services need to be appropriately aligned, otherwise the system won't work the way it needs to.

Decentralization can also contribute to duplication in processes and procedures, which can slow down access to health care services. One example of duplication in the health care system is in the assessment process. Approximately 11% of time spent on care coordination is used to conduct assessments and re-assessments for community and home care services.⁴²

Assessments are also done by service providers and hospitals, while primary care providers often have detailed and up-to-date patient records that could be used to inform care planning and delivery, and prevent patients from having to repeat their stories.

“The staff have all been kind and professional...the negative issue would be the constant need to provide basic information like address, date of birth, medications, family doctor, allergies, and more. It is very frustrating for a senior to be asked the same questions.”
– Patient Survey Response

In addition to barriers to information sharing, some of the unnecessary duplication in the assessment process is driven by the separation between the coordinator role and front-line care. These kinds of system-design issues have a real impact on patients, since it is not always clear which service provider is responsible for delivering care.

It is also important to remember that the delivery of children's health care is different from adults. The current system does not recognize this very well, and children receive health care in even more settings, like schools, primary care, home and community care, and

of course with their families. Patients and health care professionals alike are frustrated by the lack of communication between professionals, health care organizations, and patients. This lack of coordination and duplication in some roles and functions is costing the system in both time and money, and may not always translate into getting patients access to the care they need.

Stronger lines of accountability would help make the health care system more efficient, and also help ensure Ontario gets a greater value for what it currently spends on health care. Currently, the government spends about 42 cents of every tax dollar on health care.⁴³ Although this is the lowest per capita spend on health care compared to other provinces and territories, the system could work smarter and use this same amount of money to achieve better health outcomes.⁴⁴ When compared to similar countries in the world, Canada generally spends more on health care, but scores lower on some key performance indicators.⁴⁵ With performance based incentives that link investments to outcomes, Ontario could shift the focus of health care spending to high-value, instead of high-cost. With clearer lines of responsibility and accountability in the health care system, Ontario could move towards strengthening the entire system and solve the problem of hallway health care.

Randy's Story: The Big Picture



Randy

Randy, a retiree from Pickering, says patients like himself could benefit from a comprehensive electronic health record that covers the entire health journey.

Whenever Randy sees a new doctor, he carries a chart he designed himself. Across the page, a line that looks like a heartbeat tells the story of his health over time. When the line spikes up, it pinpoints a serious illness or health emergency at a specific age. There's a concussion and broken nose in his younger years, and more recently, two cases of deep vein thrombosis and an atrial flutter.

Randy has recovered well from his most recent emergency, though he's on blood thinners and is watchful for signs of other illness. While thinking about past health events that he should follow up on, he realized that while all his doctors might have different records that, together, would create a complete history of his care, he didn't have one himself.

So, he made the chart based on memory. Without the complete picture, patients are left with fragments, he says. "There are just too many sectors, too many contact points. The onus comes back to the patient or caregiver to put pen to paper or make some history of this."

Overall, Randy is quite happy with the care he's had – he gave the hospital that fixed his atrial flutter a five-star review on Trip Advisor. But he would like hospitals and physicians to give patients more access to digital records so that they can take the next steps on their health care journey. Health care is a shared responsibility, he points out, and patients can't adjust their behaviour if they don't have the information readily available.

Randy already knows how he would use broader records – he would check on the most pressing things, like his heart health, and review conditions that might need attention, and share some of the genetically important information with his grown children, so they can ask their doctors the right questions. "If we want to look in and see our data, we can. If we don't feel comfortable, wait. To me, it should be a choice, but available."

"The system has different metrics on me but none of them have the full story."

Digital & Modern Health Care

Ontario's health care system has room for improvement when it comes to using technology as a tool to help coordinate and deliver services, and improve outcomes for patients. As the Council continues its work, it will make a focused effort to consider technology solutions to help improve health outcomes for patients across the province. This could look like new partnerships to deliver specific services or to help support the integration of care at the local level. This could also look like identifying options for integrated health information systems that would help facilitate smooth transfers between care settings.

According to the 2018 Health Care Experience Survey, only 16% of Ontarians could make an appointment with their health care provider by email or on a website. Perhaps even more surprising, is that less than 1% of appointments that year were conducted virtually in Ontario.⁴⁶ This is just one example of how Ontario could be doing a better job connecting patients with care. As Ontario's health care costs are projected to rise more closely with aging demographics than inflation it will be more important than ever to explore how adopting technology might help bend the cost curve and unlock potential savings.

Accessing health care doesn't have to be complicated, and the Council will be looking for ways for patients and families to be able to connect easily with a truly integrated health care system.

Integrated Health Care Delivery

The Council is also interested in providing advice that could help inform how health care is delivered in Ontario. Integrated health care has the potential to involve the full continuum of health care services, and connect all health care providers and care settings into one seamless partnership motivated by a common goal: providing wrap-around services to patients and improving health outcomes. This includes considering the impact of the social determinants of health, and providing more proactive health care interventions.

What is Integrated Health Care?

Integrated health care means different things to different people – and may look like a new way of accessing care within your community. Integrated health care is motivated by one main goal: providing coordinated, wrap-around health care services to patients.

Integrated health care means the system doesn't act as a barrier to providing timely health care services to patients. It means that your home care services are working in complete partnership with your local hospital and primary care providers to make sure that everything is ready to go at home once you or your loved one has been discharged.

There are already examples of integrated health care working across the province. The Council will be looking for innovative solutions to support leaders and pioneers in integrated health care, and will consider how to scale up these initiatives so that everyone can benefit from coordinated care. This could include thinking about the roles and functions of health professionals, and reconsidering how to streamline certain functions, like care-coordination. The Council may also provide advice on how Ontario could introduce innovative payment and accountability mechanisms to ensure alignment with service provision and government objectives – including patient self-determination.

Efficiency in the System

Simply adding more hospital or long-term care beds to the system will not solve the problem of hallway health care in Ontario. The Council will consider strategies that include prevention, early intervention, and evidence-based programs that improve health outcomes, and will look at best-practices in Ontario and in other jurisdictions across the world as it develops advice for government.

The Council will ensure recommendations included in its next report will address a balance of both short and long-term needs across the health care system, make the system more efficient for patients, providers, and caregivers, and ultimately help set Ontario up for success in the years to come.

Next Steps

In its second report, the Council will focus on providing recommendations that will help the system deliver better health care in the province.

Four key themes have emerged through the Council's initial work that will help guide the development of detailed recommendations in its next report:

1. A pressing need to integrate care around the patient and across providers in a way that makes sense in each of our communities in the province, and improves health outcomes for Ontarians.
2. Growing demand and opportunity to innovate in care delivery, particularly in the use of virtual care, apps, and ensuring patients can access their own health data.
3. The potential for greater efficiency in how we streamline and align system goals to support high quality care.
4. The critical role for a long-term plan so that we have right mix of health care professionals, services, and beds to meet our changing health care needs.

We want to hear from you!

The Council will be shifting its attention to developing advice for the government on how to fix the problem of hallway health care. The second report will be released in Spring 2019.

Our focus over the next few months will be on identifying innovative, affordable, and evidence-based solutions that will work in Ontario. As we work with you, and health care professionals across the system to develop these recommendations, we will also be giving careful consideration to how to measure our progress on this work. Our intention is for you to track our progress and help keep us accountable as we continue to think about how to improve health care in Ontario.

We will also be on the road holding engagement sessions across the province to make sure the recommendations we develop will work in your community. If we don't get to meet you in person, you can also find us online.

How to reach us: hallwayhealthcare@ontario.ca



Dr. Rueben Devlin

Special Advisor and Chair of the Premier's Council on Improving Healthcare and Ending Hallway Medicine

An orthopaedic surgeon, Dr. Devlin completed his medical school and residency training at the University of Toronto. During Dr. Devlin's 17 years practicing in Newmarket, he held senior hospital positions, including Chief of Surgery and Chair of the Medical Advisory Committee.

Subsequently Dr. Devlin served as the President and Chief Executive Officer of Humber River Hospital in Toronto from 1999 to 2016. Humber River Hospital is one of Canada's largest regional acute care hospitals, serving a catchment area of more than 850,000 people in the northwest GTA. As the CEO of Humber River Hospital he not only led the operational transformation of the hospital, Dr. Devlin was also responsible for the vision and implementation of North America's first fully digital hospital

Dr. Devlin has a record of successfully developing and implementing corporate strategic plans at the highest levels of health care and taking bold steps to use innovation and technology to directly impact patient access care, and satisfaction.

Dr. Devlin was appointed as Special Advisor and Chair of the Premier's Council on Improving Health Care and Ending Hallway Medicine in June 2018.



Adalsteinn Brown

Adalsteinn (Steini) Brown is the Dean of the Dalla Lana School of Public Health at the University of Toronto. Previous experience includes senior leadership in policy and strategy in the Ontario government, founding roles in start-up companies, and global work on how to measure performance in health care. He studied government at Harvard University and Public Health at the University of Oxford.



Connie Clerici

Connie Clerici is a seasoned executive with a long history of leading large teams through Canada's complex and highly regulated health care environment. She is the founder and the Executive Chair of Closing the Gap Healthcare, an organization that focuses resources on the advancement of innovations and on building and supporting a high-quality, publicly-funded health care system that is sustainable for Canadians.

Ms. Clerici's passion is to help those most in need in society, and to accept full accountability for doing so. Her requirement that ethics and compassion accompany sound business practices was founded on her early career experiences, including being responsible for moving severely disabled children out of institutional care at the Christopher Robin Home for Children in Ajax and into the community in the 1980s, and her work with Rose Cherry's Home for Kids (now the Darling Home for Kids).

Ms. Clerici is a life-long learner, participating in extensive training in leadership and business at a variety of business schools and universities. She is currently a board member or advisor for numerous public and private organizations, an Adjunct Lecturer at the University of Toronto's Institute of Health Policy, Management and Evaluation, a leader in the Ivey Business School supporting entrepreneurship and the co-chair of Health Quality Ontario's Quality Standards Committee.



Barb Collins

Barb Collins was appointed the President and Chief Executive Officer of Humber River Hospital on July 1, 2016. Ms. Collins is a Registered Nurse, with an MBA from Queens University in Kingston, Ontario. She has more than 40 years' experience in acute care hospitals, including nursing in Intensive Care, Operating Room and the Emergency Department, and has managed Support and Facilities Services.

Prior to assuming her current responsibilities as President and CEO, Ms. Collins served as the Humber River Hospital's Chief Operating Officer. As COO, she was the senior Executive Lead for Humber River Hospital's redevelopment project, overseeing the design, construction and activation of the new Humber River Hospital. This 656 bed, 1.8M square-foot acute care facility provided Humber with a unique opportunity to optimize design, incorporate technology and reinvent processes to deliver more effective and efficient patient-centered care, supported by some of the world's finest medical technology.

Humber River Hospital has been recognized as North America's first fully digital hospital. That journey continues with the opening of the first Hospital Command Centre in the world focused on both patient flow and high reliability patient care. Most recently Humber River introduced a Humanoid Robot, yet another step in transformational care.



Michael Decter

Michael B. Decter is the President and Chief Executive Officer of LDIC Inc. Currently he is also Chair of Medavie Blue Cross, Board Member of Blue Cross Life and Auto Sector Retiree Health Care Trust and Chancellor of Brandon University.

Previously, Mr. Decter served as Deputy Minister of Health for Ontario, Cabinet Secretary in the Government of Manitoba and Chair of the Health Council of Canada.

Mr. Decter is a graduate of Harvard University with a major in economics. He is also the author of three health books, *Healing Medicare*, *Four Strong Winds* and *Navigating Canada's Health Care*, co-authored with Francesca Grosso.



Dr. Suzanne Filion

Dr. Filion is an experienced clinical psychologist and change leader with an ardent commitment to public and community service. She obtained her PhD in Psychology from the Université de Montréal and her master's degree in Education from the University of Ottawa. She also holds a Mental Health Law certificate from the Osgoode Hall Law School at York University.

As past director of the Mental Health and Addictions (MHA) program at the Hawkesbury and District General Hospital (HGH), Dr. Filion deployed over 15 innovative community programs in MHA to improve access to services and increase efficiency. She is currently Vice-President of Development and Integration at HGH and President and CEO of her own private practice in Eastern Ontario. Dr. Filion has taught at the University of Ottawa and Saint Paul University.

Nationally, she is known for her work in psychological trauma and with minority groups. In recognition of her outstanding achievements in the fields of mental health and addictions during more than 25 years, Dr. Filion recently received the Canadian Psychological Association Award for Distinguished Contributions to Public or Community Service.



Dr. Lisa Habermehl

Dr. Habermehl is a rural family physician living in Northwestern Ontario. She is currently practicing in Red Lake where, over the better part of two decades, she has provided care in a variety of settings, including long-term care, clinic, hospital and the emergency room.

Dr. Habermehl has been a faculty member of the Northern Ontario School of Medicine since early in its inception and is currently an Assistant Professor, mentoring medical students and residents as they expand their knowledge of medicine while immersed in rural communities.

She was previously Chair of the Rural Expert Panel at the Ontario Medical Association, whose mandate is to advocate for an equitable health system for rural physicians and patients.

Dr. Habermehl completed her residency in family medicine at Family Medicine North in Thunder Bay, upon graduation from the University of Western Ontario. She has since received her Fellowship in Family Medicine from the College of Family Physicians of Canada.



Peter Harris

Peter Harris Q.C. has a varied legal background in tax matters and general corporate advice. His tax practice places some emphasis on tax litigation, cross border and international transactions and he has provided tax and business counsel to some of Canada's major industrial and financial institutions.

Mr. Harris has been a special advisor to the Canada Revenue and the federal Department of Finance and has acted as an advisor to the Ontario Government with respect to various financial matters. Mr. Harris is currently on the board of the Central West LHIN.

Apart from his income tax practice Mr. Harris has served on the boards of directors of Atomic Energy of Canada Limited, the Ontario Sports Centre (Chair), Director of Toronto General & Headwaters Hospital (Chair). Mr. Harris is currently the Chair of the Chamber of Commerce Taxation and Economics Committee.



Dr. Gillian Kernaghan

Dr. Kernaghan was appointed the President and Chief Executive Officer of St. Joseph's Health Care London (St. Joseph's) in 2010. St. Joseph's is a multi-sited, academic health care organization serving London and region.

Prior to assuming this role, Dr. Kernaghan served for 17 years as the Vice President, Medical for various hospitals in London and led the medical staff during complex restructuring in which four hospitals merged to form St. Joseph's. Through this restructuring and various program transfers between organizations, the roles of the London hospitals dramatically changed. In 1984, Dr. Kernaghan joined the medical staff of St. Joseph's, Parkwood Hospital and London Health Sciences Centre as a family physician. She completed her residency at St. Joseph's Hospital in 1984 upon graduation from Western University and was awarded her Fellowship in 2000.

Gillian currently serves on the Ontario Hospital Association Board, the Council of Academic Hospitals of Ontario Executive and Council and is the Chair of the Board of the Catholic Health Association of Ontario. She served as the Co-Chair of CHLNet from 2014-2018 and as President of the Canadian Society of Physician Executives for 2010-2012.



Dr. Jack Kitts

Dr. Jack Kitts is President and Chief Executive Officer of The Ottawa Hospital. Dr. Kitts received his medical degree from the University of Ottawa in 1980 and completed specialty training in anesthesia in 1987. He spent one year as a research fellow at the University of California in San Francisco.

Dr. Kitts then joined the medical staff at the Ottawa Civic Hospital as an anesthesiologist and Research Director for the Department of Anesthesia. In 1995 he was appointed Chief of Anesthesia at the Ottawa Civic Hospital and Associate Professor at the University of Ottawa. In 1998, Dr. Kitts was appointed Vice-President of Medical Affairs and led the medical staff during a complex restructuring in which three hospitals and five large programs were merged into The Ottawa Hospital.



Kimberly Moran

Kimberly Moran is dedicated to improving the lives of children and youth with a focus on strengthening health care policy, systems and patient outcomes in Canada and internationally. Her passion for improving the delivery of child and youth mental health treatment runs deep and is rooted in her family's lived experience with mental health as a mother of a daughter who became seriously ill.

Ms. Moran is currently Chief Executive Officer of Children's Mental Health Ontario, representing the province's largest provider of child and youth mental health services, supporting 120,000 children, youth and their families. She serves on the board of the Canadian Mental Health Association Toronto, and previously contributed to the North York General Hospital and SIM-one Simulation Healthcare Network boards.

Ms. Moran brings more than thirty years of senior leadership experience in the private and not-for-profit sectors. She is also a Chartered Professional Accountant which underlies her passion for developing effective and affordable health care systems.

Prior to CMHO, she held positions as Special Advisor to the Dean of the Faculty of Medicine, University of Toronto, Acting CEO and Chief Operating Officer at UNICEF Canada, and senior finance positions with TD Bank and Ernst & Young.

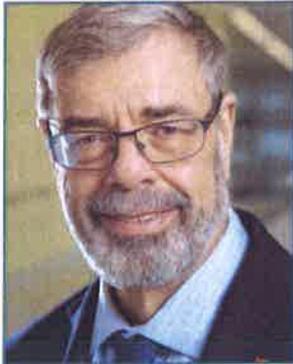


David Murray

David Murray is Executive Director of Northwest Health Alliance (NWA). Mr. Murray has had a long and distinguished career in health care administration spanning many years and multiple organizations and sectors.

Before joining the NWA, Mr. Murray was the Chief Executive Officer of Sioux Lookout Meno-Ya-Win Health Centre for seven years. Mr. Murray has also served as the CEO of the Waterloo Wellington Community Care Access Centre (CCAC), the CEO of the North East LHIN, President and CEO of the nationally recognized Group Health Centre in Sault Ste. Marie, and CEO of the Kenora Rainy River CCAC.

Mr. Murray has an Honours Bachelor of Commerce, MBA and designations in CBNA, CHE.



Dr. Richard Reznick

Dr. Reznick is the Dean of the Faculty of Health Sciences at Queen's University and a professor in the Department of Surgery. He is also Chief Executive Officer of the Southeastern Ontario Academic Medical Organization.



Shirlee Sharkey

Shirlee Sharkey is the President and Chief Executive Officer of SE Health. Under Ms. Sharkey's leadership, the social enterprise has enjoyed exponential growth and expansion, and facilitated transformative solutions in areas such as Indigenous health, end of life care, and caregiver wellness and support. Today, SE Health delivers 20,000 care exchanges daily through its team of 9,000 leaders and professionals.

Active in public service, Ms. Sharkey is the current Chair of Excellence Canada, and a board member of the C.D. Howe Institute and the Canadian Frailty Network.

Academically, she is cross-appointed to the University of Toronto's Lawrence S. Bloomberg Faculty of Nursing and the Institute of Health Policy, Management and Evaluation as an adjunct professor.

In 2017, Ms. Sharkey was presented with an honorary Doctor of Laws degree from the University of Ontario Institute of Technology for her breakthrough leadership in community-based health care.

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- Health Quality Ontario for their work conducting patient interviews, and the patients for sharing their stories;
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- Members of the six sub-committees of the Premier's Council, on: primary care, home and community care, hospital care, long-term care, mental health and addictions and digital innovation, for sharing key insights from across the health care system.

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- ²⁶ Cancer Care Ontario – Access to Care. (2018). Provincial Monthly Alternate Level of Care Performance Summary, November 2018.

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ITEM 6.1.10

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News Release

Ontario's Government for the People to Break Down Barriers to Better Patient Care

Renewed, connected and sustainable health care system will reduce hallway health care by focusing resources on patient needs

February 26, 2019 9:00 A.M. | [Ministry of Health and Long-Term Care](#)

TORONTO — Today, Christine Elliott, Deputy Premier and Minister of Health and Long-Term Care, delivered the Government of Ontario's long-term plan to fix and strengthen the public health care system by focusing directly on the needs of Ontario's patients and families.

"The people of Ontario deserve a connected health care system that puts their needs first," said Elliott. "At the same time the people of Ontario deserve peace of mind that this system is sustainable and accessible for all patients and their families, regardless of where you live, how much you make, or the kind of care you require."

Ontario's new plan would improve access to services and patient experience by:

- Organizing health care providers to work as one coordinated team, focused on patients and specific local needs. Patients would experience easy transitions from one health provider to another (for example, between hospitals and home care providers, with one patient story, one patient record and one care plan).
- Providing patients, families and caregivers help in navigating the public health care system, 24/7.
- Integrating multiple provincial agencies and specialized provincial programs into a single agency to provide a central point of accountability and oversight for the health care system. This would improve clinical guidance and support for providers and enable better quality care for patients.
- Improving access to secure digital tools, including online health records and virtual care options for patients - a 21st-century approach to health care.

"If we expect real improvements that patients will experience first-hand, we must better coordinate the public health care system, so it is organized around people's needs and outcomes. This will

enable local teams of health care providers to know and understand each patient's needs and provide the appropriate, high-quality connected care Ontarians expect and deserve," said Elliott.

Ontario's renewed patient-centric approach is paired with historic investments in long-term care for seniors and improved mental health and addictions services for families. Ontario is investing \$3.8 billion over 10 years to establish a comprehensive and connected system for mental health and addictions treatment, and adding 15,000 new long-term care beds over five years and 30,000 beds over 10 years.

"Our government is taking a comprehensive, pragmatic approach to addressing the public health care system," said Elliott. "By relentlessly focusing on patient experience, and on better connected care, we will reduce wait times and end hallway health care. Ontarians can be confident that there will be a sustainable health care system for them when and where they need it."

Quick Facts

- The government intends to introduce legislation that would, if passed, support the establishment of local Ontario Health Teams that connect health care providers and services around patients and families, and integrate multiple existing provincial agencies into a single health agency – Ontario Health.
- The entire process will be seamlessly phased in to ensure that Ontarians can continue to contact their health care providers as usual throughout the transition process.
- The government has consulted with patients, families, nurses, doctors and others who provide direct patient care, including the Premier's Council on Improving Healthcare and Ending Hallway Medicine and its working groups, the Minister's Patient and Family Advisory Council, and health system and academic experts.
- Ontario currently has a large network of provincial and regional agencies, clinical oversight bodies and 1,800 health service provider organizations. This creates confusion for both patients and providers trying to navigate the health care system.

Background Information

- [Building a Connected Public Health Care System for the Patient](#)
- [Minister Christine Elliott's remarks for the announcement of The People's Health Care Act, 2019](#)

Additional Resources

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- Read the Premier's Council report: [Hallway Health Care: A System Under Strain](#)
 - Ontario's plan to build a connected public health care system. [Learn more.](#)
-

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Hayley Chazan

Deputy Premier & Minister of Health and Long-
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hayley.chazan@ontario.ca

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Building a Connected Public Health Care System for the Patient

February 26, 2019 9:00 A.M.

Ontario has world-class health care services provided by some of the best health care workers. However, over time the province's health system has become fractured and disconnected, and as a result patients have been left to suffer on wait lists and navigate the system on their own. The government is making necessary changes now to address these issues and build a connected, sustainable public health care system that will improve access to care and centre it on the needs of the patient.

The government is transforming the public health care system to improve patient experience and strengthen local services. This means that patients and families will have access to better and more connected services, and will wait less for these services. They will not have to stay in beds in hospital hallways or be left to navigate between providers on their own.

When care is funded in silos, care ends up being delivered in silos. When providers are asked to partner to work together as one connected team, care will be integrated. Integrated care looks at the whole person, not just the illness. It means patients and their caregivers will have someone to call to help them navigate the system, to answer questions and to understand their circumstances. Health care providers will be accountable for the patients they serve and will partner to effectively coordinate their care.

Ontario Health Teams

Ontario Health Teams are a new way of organizing and delivering services for patients. Local health care providers will be empowered to work as a connected team, taking on the work of easing transitions for patients across the continuum of care. Ontario Health Teams will be responsible for delivering all of the care for their patients, understanding their health care history and needs, and directly connecting them to the different types of care they need.

Patients would have help in navigating the public health care system 24/7. These teams would support continuous access to care and smooth transitions as patients move between one provider to another, and receive care in different locations or health care settings. Over time,

Ontario Health Teams would provide seamless access to various types of health services, which could include:

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- Primary care
- Hospitals
- Home and community care
- Palliative care
- Residential long-term care
- Mental health and addictions

Ontario Health Teams will be funded and held accountable for improving patient experience and people's health.

As Ontario Health Teams are established, people will continue to be able to choose who provides their care and will have more care choices available through technology. With safeguards in place to protect personal health information, patients will also have an option to securely access digital health services, such as having access to their electronic health records and virtual care options for patients.

Care providers will also benefit from the expansion of digital tools, enabling them to more quickly and comprehensively access the information they need, such as specialist advice and clinical supports.

Ontario Health Teams will be established in phases across the province. More information on how providers can become an Ontario Health Team will be made available in early March. Ontario Health Teams will focus on existing local health care providers partnering or working together to provide coordinated care, or teams of providers serving a specialized patient population such as specialty pediatric or patients with complex health needs. Health care providers can participate in a readiness assessment process to become an Ontario Health Team in their specific geographical area. There will be an ongoing process to support interested groups to become an Ontario Health Team.

Ontario Health

There are multiple provincial agencies that offer clinical guidance, evaluation, public information and health sector analysis. Many of these agencies have established world-class standards that the government is seeking to replicate and amplify across the health system. Each of these agencies also has a full senior management team and back office support, and over time some of this work has become duplicative. To achieve true integrated and coordinated care, Ontario is proposing to streamline the important work of these health agencies so it can be performed

more effectively and collaboratively, provide more value for tax dollars and enable people to work together instead of in silos.

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The government will introduce legislation that, if passed, will consolidate multiple health care agencies and organizations within a single agency - Ontario Health. Ontario Health will oversee health care delivery, and improve clinical guidance and provide support for providers to enable better quality care for patients.

Establishing a single accountable Ontario Health agency would enable:

- Expansion of the current exceptional clinical guidance and quality improvement practices in existing agencies into other critical areas of the health care sector.
- Application of current best-in-class models to parts of the health sector historically left behind (such as mental health supports).
- Consistent oversight of high quality health care delivery across Ontario, including a more efficient approach to coordinating health care services for patients, improving the patient experience and enabling innovation.
- Advancement of digital first approaches to health care, such as virtual care, and improving the integration and efficiency of digital health assets across the entire health system, which would support more evidence-based advice on delivering health services and clinical care.
- Clear accountability for monitoring and evaluating the quality of health care services, and providing clinical leadership, consistent clinical guidance, knowledge sharing and support for health care providers.
- More efficient use of public health care dollars by eliminating duplicative back office infrastructure and administration.

If the legislation is passed, the consolidation of agencies and provincial services and programs into the Ontario Health agency would be implemented over a number of years. The organizations which would be slated for transition include:

- Cancer Care Ontario
- Health Quality Ontario
- eHealth Ontario
- Trillium Gift of Life Network
- Health Shared Services Ontario
- HealthForce Ontario Marketing and Recruitment Agency
- Local health integration networks

The 14 local health integration networks and their functions would be reorganized.

This transition would roll out in phases to ensure the continuity of patient care.

The government would also improve patient care and respect health care dollars by establishing a single province-wide supply chain management model for the entire health care sector. Providers and patients will also be engaged on the procurement of medical products and services to help ensure the ones being used are delivering the best patient outcomes.

Ongoing engagement with patient and caregivers: a permanent Patient and Family Advisory Council

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The Minister's Patient and Family Advisory Council will also be turned into a permanent advisory body. This Council provides advice on key health care priorities that have an impact on patient care and experience, and drive meaningful changes to provincial health care planning, programs and policies. The creation of a permanent Council will ensure the government partners with patients to gain critical insights into how they experience the health care system and reflect those insights in decision making.

Information for patients

As the province begins work to build a health care system centred around patients, Ontarians will continue as usual to contact their health care providers directly to get the services they need.

Contact information for health care services remains the same:

- Contact and visit your doctor, nurse practitioner, community health centre, family health team or Aboriginal health access centre as the first step for your day-to-day health care needs.
- For medical emergencies, call 911 or go to the emergency department.
- To get health care support, 24 hours a day and 7 days a week, call Telehealth Ontario toll free at 1-866-797-0000 or toll free TTY at 1-866-797-0007.
- Home and community care: contact your care coordinator for any questions about your care. For information about the services in your local community and referrals call 310-2222 (English) or 310-2272 (French), no area code is required.
- For information on community-based mental health and addictions services, call Connex Ontario at 1-866-531-2600 or Kids Help Phone at 1-800-668-6868.

LEARN MORE

- Read the Premier's Council report: [Hallway Health Care: A System Under Strain](#)
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Available Online
Disponible en Français

Ontario's Government for the People to Break Down Barriers to Better Patient Care

Renewed, connected and sustainable health care system will reduce hallway health care by focusing resources on patient needs

February 26, 2019 9:00 A.M.

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QUICK FACTS

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LEARN MORE

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Subject: FW: Building a Connected Public Health Care System for the Patient

From: Jo-Ann Willson
Sent: Tuesday, February 26, 2019 12:07 PM
To: Rose Bustria <RBustria@cco.on.ca>
Subject: FW: Building a Connected Public Health Care System for the Patient

Exec and Council.

Jo-Ann Willson, B.Sc., M.S.W., LL.B.
Registrar & General Counsel

From: Mckelvey, Stephen (MOHLTC) [<mailto:Stephen.Mckelvey@ontario.ca>] **On Behalf Of** Elliott, Christine (MOHLTC)
Sent: Tuesday, February 26, 2019 12:01 PM
Cc: Brazill, Laurel (MOHLTC) <Laurel.Brazill@ontario.ca>
Subject: Building a Connected Public Health Care System for the Patient

To: Health Care Partners
From: Christine Elliott, Deputy Premier and Minister of Health and Long-Term Care,
RE: Building a Connected Public Health Care System for the Patient

As you know, our government was elected on a clear mandate to put people at the centre of government. This has been the guiding principle as I have spent the last number of months meeting with patients, families, nurses, doctors and the people who plan and work on the front lines of our health care system.

We currently have a system where too many patients are on waiting lists, more than 1,000 patients are receiving care in hallways every day and the average wait time to access a bed in a long-term care home is 146 days. Patients and families are finding it difficult to navigate the health care system and are waiting too long for care. In addition, the health care system is facing capacity pressures today, and it does not have the right mix of services, beds, or digital tools to be ready for a growing and aging population with more complex care needs.

The people of Ontario deserve better. Our health care teams deserve better. We must do better.

That is why I am proud to say that we are moving forward with a plan to build a modern, sustainable and connected public health care system that is finally centered around the patient, and redirect money to front-line services – where it belongs – to improve patient experience, and provide better, connected care and capturing better value for our health dollars.

We are going to build a public health care system where patients and families will have access to faster, better and more connected services. A system where family doctors, hospitals and home and community care providers work together as a team. Where within these teams, providers can communicate directly back and forth with each other to create a seamless care experience for patients and their families. A system where patients are supported when transitioning from one health care service to another. A system that truly puts the patient at the centre of care, where and when it's needed. Transforming the health system will take time, but we will continue to listen to the people who plan and work on the front lines as we implement our public health care strategy.

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Over the coming weeks and months, you can expect us to show continued progress on some of the other portions of our plan. We will endeavor to keep our partners apprised of these and other significant milestones as we continue to implement our plan for building a connected and sustainable public health care system.

However, to begin this process, we invite you to participate in a webinar where I will welcome you to join our Deputy Minister and our Ministry to discuss our plan. The details are as follows:

Date: Tuesday, February 26, 2019
Time: 1:45 – 2:30 p.m.
Webcast Link: vvcnetwork.ca/MOHLTCstakeholderwebcast

Should you have any questions about the webinar or our plan, please feel free to contact Laurel Brazill, Director of Stakeholder Relations at laurel.brazill@ontario.ca

Sincerely,

The Hon. Christine Elliott
Deputy Premier and Minister of Health and Long-Term Care

**Ministry of Health
and Long-Term Care**

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Bureau du sous-ministre

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Tél. : 416 327-4300
Télééc. : 416 326-1570

February 26, 2019

FROM: **Helen Angus**
Deputy Minister
Ministry of Health and Long-Term Care

RE: Letter from Deputy Minister, Helen Angus, Regarding
Connecting Care in Ontario

Today, Christine Elliott, Deputy Premier and Minister of Health and Long-Term Care, delivered the Government of Ontario's long-term plan to fix and strengthen the public health care system by focusing directly on the needs of Ontario's patients and families.

The key focus of Ontario's transformative plan is improving the patient experience and enabling better connected public health care.

The government intends to introduce legislation that would, if passed, support the establishment of local Ontario Health Teams that connect health care providers and services around patients and families, and integrate existing multiple provincial agencies into a single health agency – Ontario Health.

Under the new Ontario Health Teams delivery model, health care providers will work as one coordinated team – focusing on the needs of patients at a local level, so people can more easily navigate the system and experience simple transitions from one service provider to another.

When Ontario Health Teams are established, people's choice of providers would remain but they would also have more available care options through technology. As well, with safeguards in place to protect personal health information, patients would have an option to securely access digital health services, such as having access to their electronic health records and virtual care options for patients.

I have seen many projects across the province that have started integration processes and I am confident that many of you, as dedicated care providers and planners, would see a role in better connecting health care for your local communities.

To help achieve an improved experience for both patients and health care providers and planners, the government would integrate multiple provincial agencies and specialized provincial programs into a single agency – Ontario Health. This agency would act as a central point of accountability and oversight of the province's public health care system.

The continuity of patient care remains the top priority. This is why this transition would be done carefully and roll out in phases.

We will continue to work as we are currently doing and you can continue to reach out to your ministry representative and/or key contact.

We will make sure to provide regular communication during this transformation through the ontario.ca/connectedcare page and through emails. I invite you to sign up to receive regular email updates at [Connected Care Updates](#)

I am inviting you to a webcast later today, where ministry leaders and I will discuss this health care system announcement.

Date: Tuesday, February 26, 2019

Time: 1:45 – 2:30 p.m.

Webcast Link: vvcnetwork.ca/MOHLTCstakeholderwebcast/

The video of this webcast will be posted online if you are not able to attend.

The changes ahead of us are significant but necessary to build a modern, sustainable system that is organized around people's needs and outcomes. I would like to take this opportunity to acknowledge and thank you for your ongoing professionalism and the excellent work you have been doing, which we truly rely on.

I look forward to working together to improve our health care system and to give each and every Ontarian the high quality care they deserve.

Helen Angus

Subject: FW: Bill 74, "The People's Health Care Act, 2019"

From: Jo-Ann Willson
Sent: Wednesday, February 27, 2019 7:35 AM
To: Rose Bustria <RBustria@cco.on.ca>
Cc: David Starmer <drstarmer@gmail.com>; President <President@cco.on.ca>; Liz Anderson-Peacock <drliz@bellnet.ca>
Subject: FW: Bill 74, "The People's Health Care Act, 2019"

Exec and Council.

Jo-Ann Willson, B.Sc., M.S.W., LL.B.
Registrar & General Counsel

From: bakenny@regulatedhealthprofessions.on.ca [<mailto:bakenny@regulatedhealthprofessions.on.ca>]
Sent: Wednesday, February 27, 2019 6:52 AM
To: bakenny@regulatedhealthprofessions.on.ca
Cc: 'Richard Steinecke' <rsteinecke@sml-law.com>
Subject: Bill 74, "The People's Health Care Act, 2019"

Hi All:

The following has been provided by FHRCO's legal counsel Richard Steinecke as an overview of Bill 74, "The People's Health Care Act, 2019", introduced yesterday. As Richard notes, it's "a developing story" with certainly more to follow.

Take care!
Beth Ann

On Tuesday, February 26, 2019, the Ontario Government announced plans to implement a significant restructuring of the provision of health care services in Ontario. The move was billed as a centralization of 20 agencies into one body called Ontario Health that will include the 14 LHINs, and:

- Cancer Care Ontario.
- eHealth Ontario.
- Trillium Gift of Life Network.
- Health Shared Services.
- Health Quality Ontario.
- HealthForce Ontario Marketing and Recruitment Agency.

However, the plan also envisions decentralization in the form of 30-50 provider groups each providing coordinated care to about 300,000 persons each on average. The government is anticipating health care providers (likely anchored by at least one hospital) will make proposals that will be accepted by the government.

Details are scarce and so the impact on RHPA Colleges is unclear at this time. The most likely sources of impact are:

1. the push to finally develop centralized electronic health records for patients,
2. competition with Ontario Health as to who sets standards of practice,
3. competition as to who provides quality assurance, and
4. overlap between Ontario Health's investigative powers (re quality of care provided) and the investigative and disciplinary power of RHPA Colleges.

For more information you can view the following:

1. Two detailed summaries in the Toronto Star: <https://www.thestar.com/politics/provincial/2019/02/26/massive-health-care-overhaul-called-biggest-change-since-medicare.html> and <https://www.thestar.com/politics/provincial/2019/02/25/new-ontario-health-agency-would-overhaul-disconnected-medical-system-minister-says.html>
2. A summary on CBC: <https://www.cbc.ca/news/canada/toronto/doug-ford-ontario-health-super-agency-lhin-cancer-care-1.5032830>
3. The Ontario Government Newsroom release: https://news.ontario.ca/mohltc/en/2019/02/ontarios-government-for-the-people-to-break-down-barriers-to-better-patient-care.html?utm_source=ondemand&utm_medium=email&utm_campaign=p
4. The enabling legislation: https://www.ola.org/sites/default/files/node-files/bill/document/pdf/2019/2019-02/b074_e.pdf. (See also <https://www.ola.org/en/legislative-business/bills/parliament-42/session-1/bill-74#Sched18> for page where link to pdf is located.)

This is a developing story.

Richard

Richard Steinecke
Counsel

SML
Steinecke Maciura LeBlanc

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ITEM 6.1.12

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Jagmeet Singh wins crucial byelection



'Not Canadian enough!' Alta. woman's...



Omar Khadr back in court to ask for...



Nevin's family won't forgive 'monster' who...



Son of Ior Winnipeg

>



Ford government creating 'Ontario Health' super-agency: sources

Mike Crawley 5 hrs ago



© Darren Bernhardt/CBC Elliott will also unveil details of her plans to encourage hospitals, long-term care facilities and home-care agencies to join together as a team that would receive a single block of funding to deliver health-care services.

The Ford government will create a central agency called Ontario Health to oversee the province's \$60-billion health-care system, CBC News has learned.

The super-agency — to be unveiled Tuesday by Health Minister Christine Elliott — will be formed by dissolving the 14 Local Health Integration Networks (LHINs) and merging their duties with those of six provincial health agencies, including Cancer Care Ontario and eHealth Ontario, according to senior government sources.

CBC News was first to reveal the health-system merger plans with a report in January on the government's intention to dissolve the LHINs. Since then, leaked documents obtained by the NDP, including draft legislation, revealed more about the changes the government was considering.

The sources say the six agencies that will be consolidated under Ontario Health, in addition to the 14 LHINs, are:

Cancer Care Ontario.
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eHealth Ontario.

Trillium Gift of Life Network.

Health Shared Services.

Health Quality Ontario.

HealthForce Ontario Marketing and Recruitment Agency.

The government sources would not provide a target date for dissolving these agencies and creating Ontario Health, but "it will take time," one said.

"We're going to implement this on a timeline that ensures the patient experience is protected," said the source, who was granted anonymity to provide advance details of the government's announcement.



© Chris Young/Canadian Press Chris Young/Canadian Press

Elliott will also unveil details of her plans to encourage hospitals, long-term care facilities, home-care agencies and other health service providers to form "integrated care entities."

The plan is that each newly formed grouping would receive a single block of funding and work together to deliver a range of health-care services, according to sources in the health sector.

The sources say the new Ontario Health super-agency will ask health providers to make proposals for forming the groups, rather than forcing them together.

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In theory, these groups would be responsible for the integration of care, helping each patient navigate between hospital and community-based care.

"You would have a home base for care and it would be the responsibility of the group to make sure you are routed through the system with ease," said a source in the health system with knowledge of the reforms.

What remains to be seen is what role family doctors will play in the groups, if any.

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One of the leaked sets of documents said these would be called "MyCare Groups," but multiple sources both in government and in the health sector tell CBC News that the MyCare name is being dropped. One source says they will instead be dubbed "Ontario Health Teams."

On Monday, Elliott spoke to reporters at Queen's Park, and while she acknowledged she would be announcing her health restructuring plans, she did not reveal details.

"It's going to significantly reduce hallway medicine by making sure that people find the care that they need," Elliott said.

"This is something that we have thought about long and hard," she added.

"What we really need to do is focus our health-care system on the patient. That's what the centre of all of this is about, is to make sure that patients' needs are considered and thought of first and foremost."

NDP Leader Andrea Horwath said Monday she is worried that the super-agency model will allow for contracting of health services to the private sector.

The looming changes as well as complaints the previous government failed to tackle the hospital overcrowding problem have the Liberals on the defensive.

"I'm not going to say that we solved everything," said interim Liberal Leader John Fraser.

"Anyone who tells you that they've got the solution to health care, they're not being truthful with you, because it's constant work," he said.

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THE CANADIAN PRESS 

Ontario notifies OPP of health bill leak

29 mins ago

TORONTO - Ontario has identified a public servant responsible for leaking government health-care documents to the Opposition and has notified the provincial police.

A memo circulated today to the public sector says the person is no longer employed.

That comes as the NDP today released a second set of confidential documents relating to the government's health-care transformation plans.

The New Democrats say the documents show a plan to create a health "super agency" is final, despite the health minister saying proposed changes to the system are still being drafted.

The NDP will not say how they obtained today's documents, which appear to be government presentations, but they said last week that draft health-care legislation was delivered to their offices in a manila envelope.

The documents also reference outsourcing services such as laboratories — many of which are already privately run — inspections, and the province's air ambulance service.

They also say a new model of "integrated care delivery" is being created, called MyCare groups, and the NDP say those groups would be given power to contract out front-line health care to private, for-profit entities.

Health Minister Christine Elliott has said her plan to transform the health-care system isn't final yet, but will not include two-tier care.

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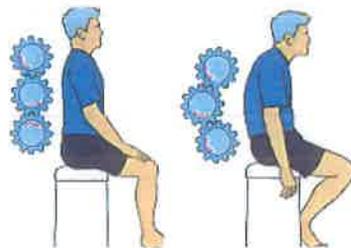
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Health January 31, 2019 8:18 am

Updated: January 31, 2019 9:41 pm

Ontario government considers creation of health super agency; NDP warns of privatization

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By Allison Jones The Canadian Press

Dr. Reuben Devlin, an advisor to Doug Ford has submitted a report that says roughly 1,000 patients are being treated in hospital hallways due to a lack of beds to accommodate them. Travis Danraj is joined by Dr. Devlin on what has been outlined in his report.

TORONTO – A leaked draft bill revealed Thursday by the New Democrats shows the Ontario government is considering creating a “super agency” to manage health-care services in the province as part of a transformation the Opposition says could open the door to privatization.

Health Minister Christine Elliott said the leaked document was an early draft, but repeatedly refused to rule out further health system privatization by the Progressive Conservative government.

“We are committed to our public health-care system,” she said at a hastily called news conference.

“The way the system operates now is a mixture...but what we want to do is make sure that as we develop our transformational strategy we are looking at strengthening the public part of the system.”

READ MORE: Get patients out of the hospital hallways, says Ontario hospital union

The “super agency,” according to the draft bill, would be in charge of managing health service needs across Ontario, health system operational management and co-ordination, quality improvement, knowledge dissemination, patient relations, digital health and activities relating to tissue donation and transplants.

It would allow the government to transfer “all or part of the assets, liabilities, rights and obligations” of organizations including any local health integration network, Cancer Care Ontario, eHealth Ontario and the Trillium Gift of Life Network to the super agency.

The section that NDP Leader Andrea Horwath warned would lead to privatization says that the super agency “may designate a person or entity, or a group of persons or entities, as an integrated care delivery system” as long as they have the ability to deliver at least two types of health services, including hospital, primary care, home care or long-term care services.

“If there was any doubt that this government is committed to massive privatization in health care, that doubt vanishes with this bill,” Horwath said. “If (Premier) Doug Ford plows ahead with this health-care privatization bill he has got one hell of a fight on his hands.”

Elliott said Horwath’s interpretation of that section was incorrect, but she would not say what it is actually intended to do.

VIDEO: Ontario government introduces new measures to address hospital overcrowding

“She got pretty much everything wrong,” Elliott said. “We will have more to say about our transformational strategy in due course, but for the purposes of today it’s important to remember it’s not all finalized. What was seen was a draft.”

650

The leak came as the premier’s special adviser on health care released a report saying that “tough decisions” will be required to address hospital overcrowding, which sees at least 1,000 people treated in the hallways of the province’s hospitals on any given day.

The report by adviser Dr. Rueben Devlin and the premier’s council on improving health care touched on the current 21 health-related government agencies that support the design and delivery of health care in the province.

Ontario’s health-care system can be characterized as decentralized, large and siloed, the report said. The agencies are not always well-aligned “and there is limited strategic oversight to ensure the efficient and coordinated use of resources,” it said.

VIDEO: Draft bill leaked shows Ontario government considering health ‘super agency’. Travis Dhanraj reports.

READ MORE: Ontario government announces \$90M to address hospital overcrowding

Devlin’s next report is set to contain a series of recommendations, but some themes identified in the first document included a greater need for innovation and efficiency to decrease hospital overcrowding.

“Tough decisions will be required to address the challenges facing our health-care system, while we continue to champion the health-care professionals already leading great work in our communities,” Devlin wrote in the report.

Eliminating hallway health care will require dealing with other areas where people get treatment, Devlin said.

VIDEO: Ontario Health Coalition warns of hospital amalgamation consequences

“Hallway medicine is not a hospital issue, it’s a systems issue,” he said in an interview. “We know that we need to improve on primary care, we need to improve on access to long-term care, better home care and a real focus on mental health and addictions.”

A government health-care survey found that 41 per cent of people who went to the emergency department could have been treated by their primary care doctor, and just one-third of hospital patients are admitted to an in-patient bed from the ER within the eight-hour target.

The report defines hallway beds as those in hallways, emergency department stretchers or other unconventional spaces such as alcoves that are not properly equipped to treat patients, Devlin said.

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In October, almost 16 per cent of days spent in hospital were by patients waiting for care elsewhere. The largest proportion of that was people waiting to be transferred to long-term care, the report said, where the average wait time to access a bed is 146 days.

Natalie Mehra of the Ontario Health Coalition said claiming that those patients waiting for other spaces are blocking beds is a partial explanation, at best, and Ontario needs more hospital beds.

“What happens in Ontario’s overcrowded hospitals is that all the beds in the wards are full because so many beds have been closed down,” she said.

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Ontario health minister downplays confidential draft bill that would create 'super agency' and allow more privatization

By **ROB FERGUSON** Queen's Park Bureau

AND THERESA BOYLE Health Reporter

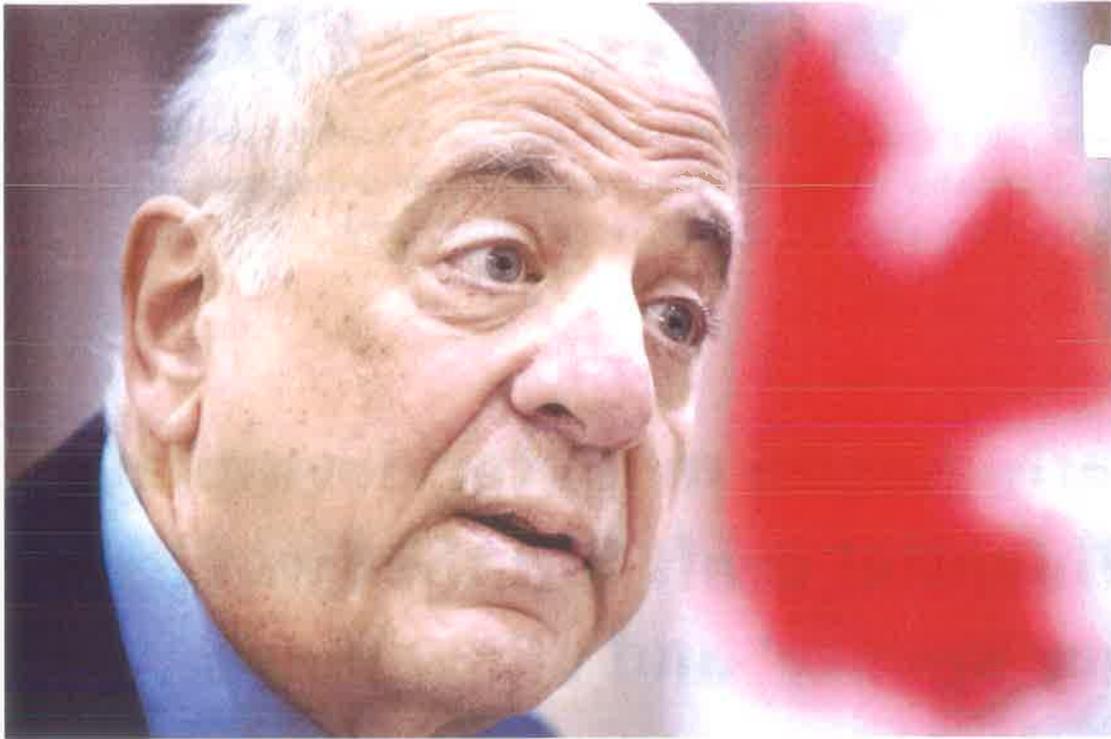
Thu., Jan. 31, 2019

Ontario Health Minister Christine Elliott is accusing NDP Leader Andrea Horwath of “crying wolf” following the leak of a confidential draft bill that would establish a health care “super agency” to create “efficiencies” in the system and empower the Ford government to privatize more services.

“This is a very early draft of legislation,” Elliott said Thursday. “It’s not been finalized.”

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Dr. Rueben Devlin, who was asked by Premier Doug Ford to look into Ontario's health-care system, discusses his first report on ending hallway medicine in the province on Jan. 31, 2019. (ANDREW FRANCIS WALLACE / TORONTO STAR)

The new “super agency” to oversee health care was [first revealed](#) by the Star on Jan. 17, with sources saying the intent is to improve services for patients by streamlining and integrating the vast system, and putting agencies such as Cancer Care Ontario under one layer of control.

“If there was any doubt that this government is committed to massive privatization in health care that doubt vanishes with this bill,” NDP Leader Andrea Horwath said after her staff released a draft copy of the Health System Efficiency Act, 2019, obtained Wednesday evening.

Elliott acknowledged the health system needs “transformative change” and said “the status quo is not acceptable,” pointing to the 32,000 Ontarians on waiting lists for long-term care beds and the more than 1,000 patients being treated in hallways daily because of hospital overcrowding.

“We will have more to say about our transformational strategy in due course,” she told reporters, saying “the health system was built for bureaucracy, not for patients.”

Have your say

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- Yes - it sounds like it would be efficient.
- No - it will open up to privatization.
- Not sure - we have yet to see the official plan.

654

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Elliott would not reveal whether the plan will lead to more privatized delivery of health-care services, but said “what people receive now is through OHIP and that will continue.”

The bill is marked “confidential” and contains notes from staff involved in writing it. There is no specific date on the document.

Horwath said the legislation makes a “sham” of Ford health-care czar Dr. Rueben Devlin’s consultations with patients and the health-care sector. Those consultations have the goal of providing recommendations this spring to improve the system and eliminate “hallway medicine.”

Devlin’s first [report](#) was released Thursday, with the orthopedic surgeon and retired president of Humber River Hospital noting the complex health-care system is “difficult” for patients to navigate and pointing to the need to make treatment paths smoother.

“While the Ford government is publicly pretending to consult on health care, in the backroom legislation designed to privatize our health-care system has already been drawn up,” Horwath said.

Dr. Danyaal Raza, a Toronto family doctor and chair of Canadian Doctors for Medicare, said the draft legislation makes him wonder how serious the government is about seeking advice from [Devlin](#), a former president of the Progressive Conservative party and a member of Ford’s campaign team last spring.

“It seems this government’s mind is already made up.”

Under the draft bill, the super agency would have the powers to “designate” providers of integrated care providing a mix of at least two of the following: hospital care, primary care, mental health, addictions, home care, long-term care, and palliative care.

Horwath said this opens the door to private corporations, with Ford “friends and...insiders reaping the profits.”

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Also under the draft bill, Elliott would be given the power to dissolve Cancer Care Ontario, eHealth Ontario, the Ontario Health Quality Council, Trillium Gift of Life Network, any local health integration network, the HealthForce Ontario marketing and recruitment agency and “any other prescribed organization.”

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A cabinet document obtained by the Star in January suggested such agencies would be blended into the new super agency.

In terms of funding, the bill would give Elliott the power to “consider whether to adjust the funding (of the super agency) to take into account a portion of the savings from efficiencies... in the previous fiscal year and that the super agency proposes to spend on patient care in subsequent fiscal years.”

That could mean “reckless cuts,” Horwath warned. Ford promised during the election not to cut health-care spending, but to find efficiencies as his government cuts a total of \$6 billion spending on the way to eliminating annual deficits.

Elliott said at her news conference that the government “is committed to building a health-care system centred around the patient and redirecting money to front-line services... capturing better value for our health dollars.”

A source told the Star an official announcement on the super agency, which the legislation says will have a 15-member board of directors, is expected in late February.

Liberal MPP Mitzie Hunter said it’s time for the Ford government “to come clean and tell Ontarians what the true agenda is.”

In an interview with the Star earlier Thursday, Devlin was asked about the prospect of a super agency and said there are “barriers in the system with regard to the agencies,” which have been under review by Elliott.

“When people say they couldn’t navigate the system well, it’s that when you leave one part of the system and go to the other, it’s like you have to jump over a hurdle.”

He cited the example of a patient being discharged from hospital, needing home care and getting it without a time lag or hassles.

“The ideal situation is you are discharged from hospital and driving home you get a call on your cellphone saying, ‘this is home care calling, what time would you like me to be there today.’ That’s what I want. I want things to be seamless.”

Rob Ferguson is a Toronto-based reporter covering Ontario politics. Follow him on Twitter: @robferguson1

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EDITORIAL: Ontario health care needs major surgery

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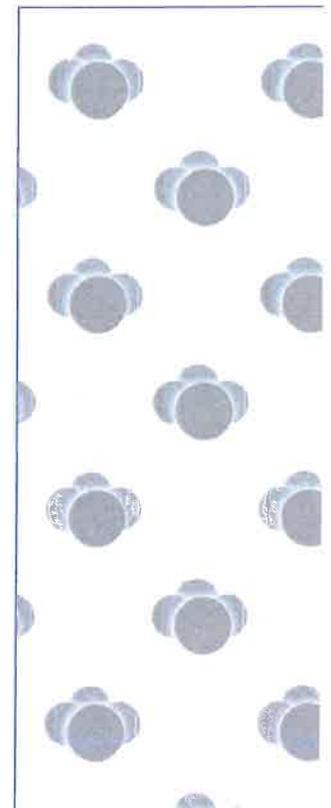


Thursday's report by Dr. Rueben Devlin, chair of Premier Doug Ford's council on improving health care and ending hallway medicine, succinctly describes a major and long-standing problem with Ontario's health care system.

It starts with a lack of long-term care facilities for patients who can no longer live at home.

Because there aren't enough long-term care beds, many patients who require them occupy acute care beds in hospitals across the province, because there's no where else for them to go.

The average wait time for being transferred to a long-term care facility is 146 days.



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They're called "bed-blockers," which is unfair because it's not their fault there aren't enough long-term care beds in the system to which they can be transferred.

Due to the backlog of these patients in acute care hospitals, the hospitals don't have enough beds to treat patients admitted through their emergency wards.

As a result, at least 1,000 patients a day across Ontario are being treated in hospital hallways.



Patients wait in the hallway at the overcrowded Queensway-Carleton Hospital in Ottawa in 2016. (Errol McGihon/Postmedia)

Only 35% are assigned a hospital bed within the recommended time frame of eight hours following admission.

Meanwhile, 41% of patients who go to hospital emergency rooms for treatment could be treated by a family doctor.

Mentally ill patients also often end up in emergency rooms in acute distress because they can't access appropriate care in the community.

Part of the problem, the report says, is that there's too much government bureaucracy presiding over health care – 21 agencies that don't communicate with each other effectively, making it harder for patients to access timely and appropriate care.

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Ontario health-care system 'too complicated to navigate'

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Hours after Devlin's report was made public, NDP leader Andrew Horwath released a leaked copy of a draft government bill to create a super-agency overseeing Ontario's health care system, which she said means the Ford government intends to privatize more health care services.

Health Minister Christine Elliott wouldn't comment on the bill's specifics, except to say the Progressive Conservatives are committed to improving the public health care system.

What the Devlin report clearly shows – there will be a follow-up report in the spring recommending reforms – is that the status quo in health care is not an option.

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get rid of all of the bureaucracy, red tape and fiscal rigidity. the solution to every problem for the liberals is more of their buddies making fat paychecks while doing nothing but gumming up the works. end this madness

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Benjamin David

Yet the buffoon government wants to create a super agency, how bureaucratic is that ?

Like · Reply · 1 · 3d



Ali

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Richard Burns

Benjamin David Sure sounds like a larger even more bloated system doesn't it?

And coming from the Conservatives makes it even more confusing how this is a good idea.

Like · Reply · 2d



Matthew Wilson

One thing that could help us regarding financing health care is to mandate that anyone visiting our county have health coverage so they are not a burden and would end health tourism.

Like · Reply · 4 · 2d



Janet Wright

Liberal Eric Hoskins drove Ontario's health care system into the ground. It will not recover overnight. NDP latest media release offers fearmongering...not productive. Yes, cuts will have to made. Cuts to duplication of service and red tape will afford Ontario a better health care system.

Like · Reply · 4 · 3d



Benjamin David

Every government for a generation played their part with healthcare, besides Ms Elliott didn't really answer Ms Horwath's allegations so what are we to think when private sector loving Tories are in charge.

Like · Reply · 3d



Dennis Clarence

Riyaj Khan Riyaj Khan FU

Like · Reply · 2d



James Turcott

Benjamin David 1) you're the buffoon,2)nobody cares what hogwart says.

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James Turcott

Just start by eliminating the useless LHINS...

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Mark Black

A centralized system will accomplish that

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Pat Doyle

660



661

nothing more . It's disgusting what the real Canada has become. Corrupt bankrupt and broken !

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Dudley Dufart

I would love to see a study with real honest numbers about individual health care users .. ie who, age, how long they have been in Canada, services used, location, cost, contribution to the 'system'(\$\$), etc etc. They have the numbers and all the info because YOU must have a health care card to recieve services! They won't because it would SHOCK the country! But .. WE have right to know the data!

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Steve Dillman

The health care system has been diagnosed and found to have stage 4 terminal cancer. The governous tumor has spread throughout the system and surgery will not help. The patient should be allowed to pass away quietly.

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John Prayers

The biggest problem with the health syatem? Nobody knows or understands how much procedure costs are and what the private secor bills the public sector for.

In the US if you say hurt your knee doing something, and you need sulgery, you process a claim with your insurance get a claim number with a fixed dollar allotment.

From there you have to then shop medical facilities to get the attention you need with the dollars you now have. Here's the kicker.....American hospitals have menus with pricing for procedured! So THEY must be transparent to be affordable!

Here we have none of the above. We have free health care so why worry how much right?

WRONG!... See More

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James Donaldson

Angrea Hoonwrath is at it again. Screaming at the top of her shrill annoying voice but saying nothing.

Like · Reply · 2d



Walt Knox

Watch the unions, communists and socialist go behind closed doors where there will be much weeping and gnashing of teeth. They will then bombard us with a doomsday warning and point to the the US model of health care. What they can't seem to do is to get their heads out of their butts and look beyond the US such as Australia and Europe, especially Switzerland and Sweden!

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Ontario considers creation of health super agency; NDP warns of privatization

Health Minister Christine Elliott said the document was only a draft and stresses the government is committed to public healthcare



Ontario Deputy Premier Christine Elliott talks with journalists following Question Period at the Ontario Legislature in Toronto on Wednesday, August 1, 2018. *Chris Young/THE CANADIAN PRESS*

THE CANADIAN PRESS

ALLISON JONES

January 31, 2019
8:02 AM EST

Last Updated
February 1, 2019
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TORONTO — A leaked draft bill revealed Thursday by the New Democrats shows the Ontario government is considering creating a “super agency” to manage health-care services in the province as part of a transformation the Opposition says could open the door to privatization.

Health Minister Christine Elliott said the leaked document was an early draft, but repeatedly refused to rule out further health system privatization by the Progressive Conservative government.

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Randall Denley: So-called 'super agency' not a magic cure for Ontario's health-care woes

The "super agency," according to the draft bill, would be in charge of managing health service needs across Ontario, health system operational management and co-ordination, quality improvement, knowledge dissemination, patient relations, digital health and activities relating to tissue donation and transplants.

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It would allow the government to transfer "all or part of the assets, liabilities, rights and obligations" of organizations including any local health integration network, Cancer Care Ontario, eHealth Ontario and the Trillium Gift of Life Network to the super agency.

The section that NDP Leader Andrea Horwath warned would lead to privatization says that the super agency "may designate a person or entity, or a group of persons or entities, as an integrated care

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Horwath said. "If (Premier) Doug Ford plows ahead with this health-care privatization bill he has got one hell of a fight on his hands."



Ontario NDP Leader Andrea Horwath speaks during a press conference at Queen's Park in Toronto on Monday, Dec. 17, 2018. *Frank Gunn/THE CANADIAN PRESS*

Elliott said Horwath's interpretation of that section was incorrect, but she would not say what it is actually intended to do.

"She got pretty much everything wrong," Elliott said. "We will have more to say about our transformational strategy in due course, but for the purposes of today it's important to remember it's not all finalized. What was seen was a draft."

The leak came as the premier's special adviser on health care released a report saying that "tough decisions" will be required to address hospital overcrowding, which sees at least 1,000 people treated in the hallways of the province's hospitals on any given day.

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Devlin's next report is set to contain a series of recommendations, but some themes identified in the first document included a greater

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Doug Ford's plan to cut public health care and turn it into a cash cow for private corporations is wrong, and I'm not letting it happen without a fight.

Ontarians deserve a govt that invests in front-line health care, to shorten wait times and end hallway medicine. #onpoli

Ontario NDP @OntarioNDP

Internal govt documents obtained by the NDP lay out Doug Ford's plan to create a new "Super Agency health bureaucracy," with a specific mandate to privatize health services such as hospitals. ontariondp.ca/news/ndp-revea... #ONpoli #onhealth

2,191 4:15 PM - Jan 31, 2019

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"Tough decisions will be required to address the challenges facing our health-care system, while we continue to champion the health-care professionals already leading great work in our communities," Devlin wrote in the report.

Eliminating hallway health care will require dealing with other areas where people get treatment, Devlin said.

"Hallway medicine is not a hospital issue, it's a systems issue," he said in an interview. "We know that we need to improve on primary care, we need to improve on access to long-term care, better home care and a real focus on mental health and addictions."

A government health-care survey found that 41 per cent of people who went to the emergency department could have been treated by their primary care doctor, and just one-third of hospital patients are admitted to an in-patient bed from the ER within the eight-hour target.

The report defines hallway beds as those in hallways, emergency department stretchers or other unconventional spaces such as alcoves that are not properly equipped to treat patients, Devlin said.

In October, almost 16 per cent of days spent in hospital were by patients waiting for care elsewhere. The largest proportion of that was people waiting to be transferred to long-term care, the report said, where the average wait time to access a bed is 146 days.

Natalie Mehra of the Ontario Health Coalition said claiming that those patients waiting for other spaces are blocking beds is a partial explanation, at best, and Ontario needs more hospital beds.

"What happens in Ontario's overcrowded hospitals is that all the beds in the wards are full because so many beds have been closed down," she said.

TORONTO WEATHER

6 °C



Partly cloudy
Feels like 5 °C

Tuesday	0 °C
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Thursday	0 °C
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Leaked Draft Health Care Legislation a "Gargantuan Nightmare Scenario": Community and Labour Groups Join Forces for Major Fightback

Posted: February 1, 2019



(TORONTO, ON) – Calling it a “bombshell”: the Ontario Health Coalition and the Ontario Federation of Labour responded to a leaked document revealing a draft health care legislation written by the Ford government in secret that would create a “super agency” with extraordinary powers to restructure Ontario’s entire health care system. The Ontario NDP opened up the document to public scrutiny by providing it to the Ontario media on Thursday.

The draft legislation takes most of the worst elements of the existing Local Health Integration Networks (LHINs) and piles them into one new centralized super agency, warned the Ontario Health Coalition.

“It is like a gargantuan nightmare scenario,” said Health Coalition Board Member Sara Labelle. “It gives the Ford government massive powers to restructure virtually every part of health

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care with no democracy, no consultation, no checks and balances, and no recourse. It gives sweeping power to privatize entire sectors at will. This would be devastating for Ontario."

"This draft legislation eliminates the progressive amendments we won to the LHINs legislation, including open Board meetings, requirements for community consultation, requirements to measure and plan for population health needs, appeals, and I could go on and on," added Executive Director of the Health Coalition Natalie Mehra. "It contains not one single mention of the principles that govern our public health care system. It contains no goals. It's just a truly massive power grab to restructure and privatize with the stroke of a pen without any ethics."

The Ontario Federation of Labour vowed to use its million-member might to work with the Ontario Health Coalition to safeguard public health care and local health care services like public hospitals and public non-profit homecare.

"The people of Ontario are vehemently opposed to any plans to reduce or privatize our public services," said Ontario Federation of Labour President Chris Buckley. "Ontarians certainly didn't give Doug Ford a mandate to privatize our health care system, and we are going to fight like hell at every step, and across this entire province to make sure that he doesn't."

Both organizations reported that the plans outlined in the draft legislation have been hatched in secret. There has been no public consultation whatsoever on the central ideas of the legislation: mega-mergers of health care providers like hospitals and privatization of entire categories of services.

"The Ford government has no mandate for any of this. They never once mentioned it in the provincial election," noted Labelle.

"This is like the Harris era restructuring on steroids," warned Mehra noting that the Provincial Auditor's assessment of the last round of hospital restructuring found it cost \$3.9 billion and threw health care into crisis. "The bill reads like a blueprint for empire-building CEOs and expansionist private health care corporations. Like the last round of mass amalgamations, the prime beneficiaries are CEOs, consultants, and planners. Local communities found their services were devastated and their local Boards gone. They no longer had any voice."

"Forced mergers and closures are not what Ontario needs. What we need is a plan for better publicly funded health care," said Buckley. "We need a health care system that provides for every person in this province, with sufficient infrastructure to support the number of beds that are actually needed to care for Ontarians when they are sick."

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About OHC

The Ontario Health Coalition is a network of over 400 grassroots community organizations representing virtually all areas of Ontario.

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New Ontario Health agency would overhaul 'disconnected' medical system, minister says

By **ROB FERGUSON** Queen's Park Bureau
Tues., Feb. 26, 2019

Getting medical care in Ontario will become "seamless" under proposed new legislative reforms to erase bureaucratic barriers between hospitals, doctors, home care and dozens of other providers, Health Minister Christine Elliott says.

The promise to make a complicated system easier for patients to navigate came with the acknowledgement from Elliott and senior officials that the "transformation" will take at least three years — coinciding with the next provincial election — and with many details yet to be worked out.



Christine Elliott, Deputy Premier and Minister of Health and Long-Term Care, chats with patients at Bridgepoint Active Healthcare before making an announcement in Toronto on Tuesday. (TIJANA MARTIN / THE CANADIAN PRESS)

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“This is not going to happen overnight,” Elliott said Tuesday at the Bridgepoint rehabilitation hospital, where she announced between 30 and 50 “Ontario Health Teams” will form across the province to better co-ordinate all levels of care.

Each will serve about 300,000 people in a geographic area or a specific group of patients across the province, such as children with fragile medical conditions.

Premier Doug Ford’s Progressive Conservative government is relying on health-care providers — from hospitals down the line to doctors, home-care agencies, mental health and addiction services, labs and more — to devise their own service models meeting provincial standards.

“It will be up to the local health-care providers in each community to come together to form a plan about how they can connect care for patients in their community,” Elliott told a news conference.

In one example to fix what she called a “disconnected” system, patients discharged from hospital needing home care should get it immediately to make sure they don’t end up back in emergency departments with costly and potentially dangerous complications.

During an hour-long technical briefing on the People’s Health Care Act, ministry officials said on background that the new system will likely start with a handful of small, local teams to test what works best before growing bigger, providing valuable lessons for others to follow. Targets for improvement in wait times and care levels will be set. Typically, government background briefings include slide decks and other materials to explain complex changes, but only the framework legislation was provided.

Elliott said reform is needed because 1,200 patients a day typically get treatment in hospital hallways because of overcrowding and 30,000 people are on the waiting list for nursing home beds.

Representing doctors across the province, the Ontario Medical Association agreed change is essential but is awaiting more information.

“The details matter,” said president Dr. Nadia Alam. “The biggest question the OMA has is the ‘how’ of it.”

New Democrat Leader Andrea Horwath, who raised alarm bells about the pending changes by releasing a leaked copy of draft government legislation last month pointing to the new Ontario Health “super agency,” said she remains skeptical.

“The minister has not clearly stated there will be no privatization ... that’s our biggest worry,” she told reporters before the legislation was introduced.

“A lot of this has been done behind closed doors.”

Ontario Hospital Association president Anthony Dale applauded the new direction, saying different parts of the system don’t co-ordinate care well.

“What the minister’s doing today is basically lifting some of that inappropriate oversight and red tape and third-party intermediaries that get in the way of care providers actually working together,” he said.

“The health provider community knows what has to be done at the local level, especially. It’s just that, right now, they are in many instances actually prohibited from working together to deal with them.”

Dr. Joshua Tepper, chief executive of North York General Hospital, said he already holds meetings bi-weekly with family doctors, home-care agencies, a neighbouring nursing home and other providers in the area, with the new Ontario Health Teams looking like an extension of that.

“It’s about getting together and looking at our community and saying ‘what can we collectively do for our patients and being given the freedom and the opportunity to do that, removing those gaps that patients experience.’”

The risk is that patients will “fall between the cracks” as the system is re-engineered, interim Liberal leader John Fraser warned.

Elliott said “tinkering around the edges” will no longer work in fixing the massive health-care system and stated publicly funded universal access to care remains a priority.

“That means paying for services with your OHIP card.”

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Christine Elliott to unveil sweeping health-care revamp Tuesday

Province eyeing creation of 'super health agency,' sources say

As the Star first reported Jan. 17, the government has been planning a new health care "super agency" that will eventually swallow 20 health agencies to provide for streamlined accountability.

Under the legislation, those agencies include Cancer Care Ontario, eHealth Ontario, various Local Health Integration Networks created by a previous Liberal government, and Trillium Gift of Life Network.

It's not known how many jobs will be lost when back-office administrative functions at the agencies are folded into Health Ontario, but Elliott said any savings will be put into "front-line care."

Officials said the new Ontario Health Teams will not have headquarters and instead operate using people at various health facilities like hospitals or primary care offices to answer phones and emails to help patients navigate the system with access to their health-care records.

20 agencies to be absorbed into Ontario Health super agency:

- Cancer Care Ontario: Advises the province on how to improve the performance of health systems for cancer, chronic kidney disease and access to care.
- Health Quality Ontario: Acts as an independent watchdog on quality in health care with the aim of improving quality.
- eHealth Ontario: Oversees the province's electronic health record system, allowing patient information to be safely shared among providers.
- Trillium Gift of Life Network: co-ordinates organ and tissue donation and transplantation.
- HealthForce Ontario Marketing and Recruitment Agency: Provides health human resource services and support.
- 14 Local Health Integration Networks: Co-ordinate health services in distinct geographic regions of the province.
- Health Shared Services Ontario: Provides business and IT support to LHINs.

With file from Theresa Boyle

Rob Ferguson is a Toronto-based reporter covering Ontario politics. Follow him on Twitter: @robferguson1

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 JOURNALISTIC STANDARDS

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Ford government creating Ontario Health super-agency



Health Minister Christine Elliott announced plans Tuesday to consolidate Cancer Care Ontario, eHealth, LHINs

Mike Crawley, Andrea Janus · CBC News ·

Posted: Feb 26, 2019 4:00 AM ET | Last Updated: February 26



Ontario Health Minister Christine Elliott announced sweeping changes to the province's health-care system on Tuesday morning. (Tijana Martin/The Canadian Press)

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The Doug Ford government is creating a central agency called Ontario Health to oversee the province's \$60-billion health-care system.

The super-agency — unveiled Tuesday by Health Minister Christine Elliott — will be formed by dissolving the 14 Local Health Integration Networks (LHINs) and merging their duties with those of six provincial health agencies, including Cancer Care Ontario and eHealth Ontario.

- **Ford government's super-agency plans will mean complete overhaul of health bureaucracy**

CBC News was first to [reveal](#) the health-system merger plans with a report in January on the provincial government's intention to dissolve the LHINs. Since then, [leaked documents](#) obtained by the NDP, including draft legislation, revealed more about the changes the government was considering.

Six agencies that will be consolidated under Ontario Health, in addition to the 14 LHINs, are:

- Cancer Care Ontario.
- eHealth Ontario.
- Trillium Gift of Life Network.
- Health Shared Services.
- Health Quality Ontario.
- HealthForce Ontario Marketing and Recruitment Agency.

Elliott said Tuesday that work overhauling the system will begin in the spring, but it will take years for it "to become mature."

The changes will be contained in new legislation, the People's Health Care Act, 2019, which Elliott will table in the legislature Tuesday afternoon.

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Elliott also unveiled details of her plans to encourage hospitals, long-term care facilities, home-care agencies and other health service providers to form "integrated care entities."

Watch Christine Elliott describe Ontario's new health-care system:

Expect changes to begin 'within the next few weeks,' says provincial health minister Christine Elliott.
7:52

The Ontario Health Teams will be made up of local health-care providers and organized to work as a co-ordinated group, Elliott said. The teams will be built to "guide patients" among various care providers and help families through transitions between providers.

"They would take the guesswork out of navigating the health-care system," Elliott said.

Under the plan, each newly formed grouping would receive a single block of funding and work together to deliver a range of health-care services for the region they cover.

• Ford's 'hallway health care' experts point to problems in the system

The government is asking health providers to make proposals for forming the groups, rather than force them together. The goal is to have between 30 and 50 health teams in the province, Elliott said. Each team will be responsible for about 300,000 people, but that could vary based on factors such as population and geography.

Asked how the changes will affect family health teams, which were formed years ago to bring together family doctors and other practitioners, Elliott said they will continue to operate and Ontarians' ability to access their family physician will not change.

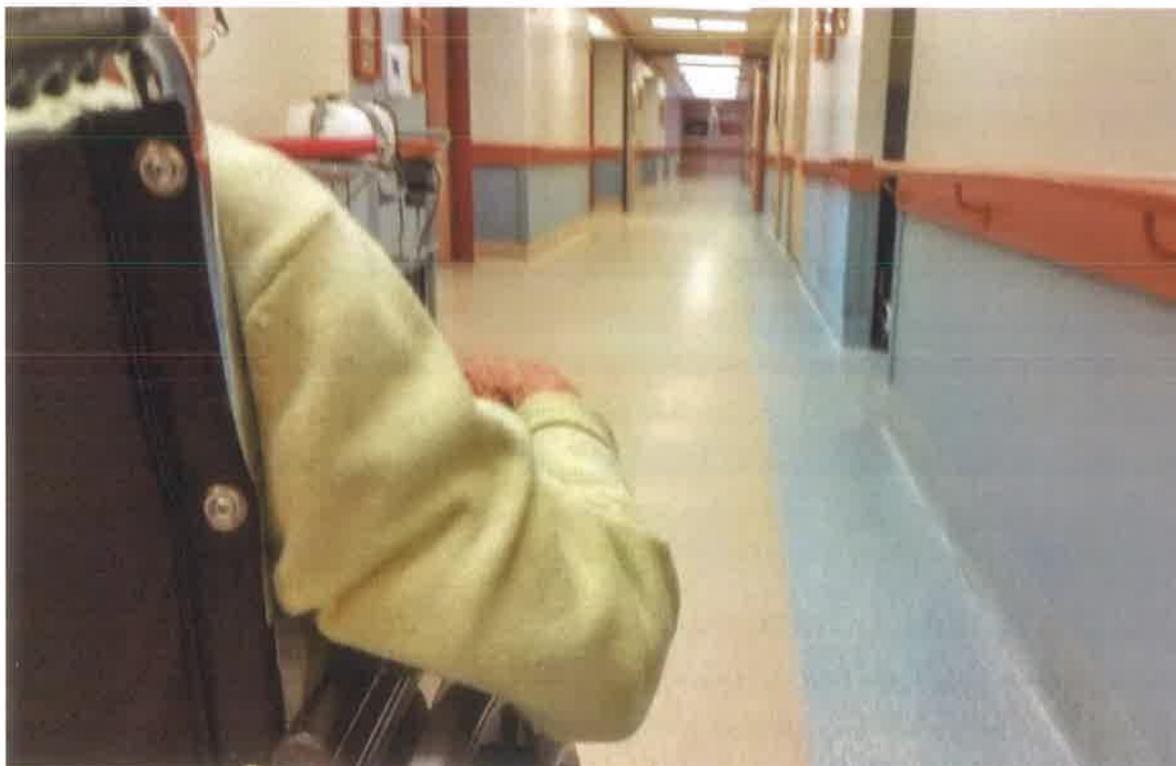
The new Ontario Health Teams will be responsible for managing all care in a specific region, she said. But people will continue to get home care as they always have, they will continue to see their physician as they always have."

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Asked repeatedly what the changes mean in terms of cost savings or administrative job losses, Elliott would not provide specifics on either point. The news release touting the changes does mention "eliminating duplicative back office infrastructure and administration."

In background materials provided by the government, it says that each of the six agencies being rolled into Ontario Health has a full senior management team and administrative support, "and over time some of this work has become duplicative."

Elliott also announced new digital health-care tools, including secure access to various tools such as virtual specialist appointments and secure access to electronic health records.



Elliott also unveiled details of her plans to encourage hospitals, long-term care facilities and home-care agencies to join together as a team that would receive a single block of funding to deliver health-care services. (Darren Bernhardt/CBC)

On Monday, Elliott spoke to reporters at Queen's Park in Toronto and said the changes will "significantly reduce hallway medicine by making sure that people find the care that they need."

- **Ontario doctors awarded 4-year contract through arbitration**

"This is something that we have thought about long and hard," she said.

"What we really need to do is focus our health-care system on the patient. That's what the centre of all of this is about, is to make sure that patients' needs are considered and thought of first and foremost."

NDP Leader Andrea Horwath said Monday she is worried that the super-agency model will allow for contracting of health services to the private sector.

The looming changes, as well as complaints the previous government failed to tackle the hospital overcrowding problem, have the Liberals on the defensive.

"I'm not going to say that we solved everything," said interim Liberal Leader John Fraser.

"Anyone who tells you that they've got the solution to health care, they're not being truthful with you, because it's constant work. You're never done."

With files from the Canadian Press

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Halifax chiropractor gives up licence, admits to professional incompetence

Michael Gorman 2 days ago



© Facebook Dena Churchill formerly operated Oxford Chiropractic Inc. in Halifax.

A Halifax-based chiropractor who attracted attention for her unfounded views on vaccines is no longer licensed to practise in Nova Scotia.

A notice on the Nova Scotia College of Chiropractors' website says Dena Churchill surrendered her licence in January and entered into a settlement agreement with the

college in which she admits the charge of being "professionally incompetent as a result of incompetence arising out of mental incapacity."

A hearing on the charge scheduled for next week will no longer go ahead.

The settlement agreement says Churchill underwent a psychological assessment in the fall. She cannot reapply for a licence to practise in Nova Scotia unless she provides a qualified medical opinion to the college's satisfaction that she is competent and fit to practise.

Regulator filed complaint

She also agreed to pay the college costs of \$6,000.

Churchill, who operated Oxford Chiropractic Inc. until she closed the practice last fall, posted extensively on various social media platforms about a variety of health-care subjects outside her scope of practice.

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Most notably, she repeatedly made disproved and unfounded links between autism and vaccines. Chiropractors in Canada are told explicitly by their governing authorities not to comment on vaccines in any capacity.

The complaint about Churchill that led to the investigation was filed by the regulator last May.

Misconduct hearing in May

The college's executive director, John Sutherland, said he thinks the matter was handled expeditiously and within the appropriate legal process, given the gravity of the situation and potential implications for Churchill.

"I would think that for any regulator to essentially remove the ability for someone to work with a licence, it should be arduous for the regulator to be able to do that."

While the agreement resolves the matter of whether Churchill can practise in Nova Scotia, she still faces a professional misconduct hearing in May related to her online activity.

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Chiropractic treatment for children to face 'rigorous' review in B.C.

Bethany Lindsay 3 hrs ago



© Facebook Vancouver chiropractor Avtar Jassal resigned his position as vice-chair of the college board after he created a video in which he falsely suggested smoothies are more effective than vaccination at preventing the flu.

The body that regulates chiropractors in B.C. is promising a thorough review of the scientific evidence about chiropractic treatments for children.

The move comes after the College of Chiropractors of B.C. received a complaint from a health-care professional about a chiropractor advertising therapies for kids, according to interim college registrar Richard Simpson.

"There is a significant body of evidence concerning the benefits of chiropractic treatment for patients of all ages. Still, the CCBC is committed to evidence-informed practice, best practices and standards in marketing," Simpson wrote in an email.

"As such, the board has decided to proceed with a rigorous review and evaluation of research and evidence concerning this issue and other topics."

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He added that the college is interested in establishing a review of the evidence for chiropractic therapies involving patients of all ages.

"The college has received a number of documents from citizens and registrants purporting to be acceptable evidence for one form of treatment or another. It is my view, even as a layperson, that most, if not all, of the documents

would not meet the test of acceptable evidence," Simpson wrote.

These reviews have not yet begun, and the college has not settled on a process for analyzing the current evidence. Simpson said it's possible the reviews will be part of a national process, which the college believes is "in the best interests of the profession."

'Zero evidence' supporting treatment of babies

The news comes as some chiropractors in other parts of the country are facing scrutiny over their treatment of babies, including newborns.

In an interview with CBC, Bernie Garrett, a UBC nursing professor who studies deception in health care, described the college's proposed review of chiropractic treatment for children as "excellent news."

"There's practically zero evidence of any benefits, particularly in infants," Garrett said. "If you ask any pediatrician or pediatrics society as well, they'll confirm that there is no indication for chiropractic in infants or in children, unless there's obviously some [spinal] issues."

According to a position paper from the Canadian Pediatric Society, there have been no satisfactory studies of chiropractic treatments for back pain in children. Some studies have suggested that chiropractic manipulation of the neck can provide short-term relief of neck pain in children, but its efficacy hasn't been compared to other therapies, the paper says.

Garrett said he'd like to see chiropractic for infants banned in B.C., as well as strict guidelines for treatment of other children.

67 chiropractors under investigation

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The college has already barred chiropractors from claiming to treat a long list of childhood conditions as part of its new efficacy claims policy. That policy, which came into effect last October, forbids chiropractors from making unscientific and unsupported claims about treating everything from Alzheimer's disease and cancer to autism, ear infections and ADHD.

All practitioners were given until Nov. 1 to bring their advertising in line with the new policy or face investigation and potential discipline.

To date, 67 chiropractors have been investigated for possible violations of the policy, and 53 have consented to reprimands, agreed to pay fines and signed undertakings promising to follow the rules from now on. Another 13 have hired lawyers, and one has yet to respond.

"Overall, I am satisfied that the vast majority of B.C.'s 1,200-plus chiropractors understand the importance of a clear, focused efficacy claims policy. For the handful of registrants who may not be in compliance, the college has been quick to identify them, communicated directly with them to discuss the issue, and forwarded concerns to the inquiry committee for consideration," Simpson said.

He said all the violations of policy were identified by the college, which has developed a scanning program that sweeps websites and social media for keywords. The college plans to continue updating the policy as it reviews scientific evidence about treatments.



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Unproven claims by B.C. chiropractors became a public issue last year, after CBC reported on a Facebook video created by then-vice-chair of the college board, Avtar Jassal. In the video, he falsely claimed that smoothies are more effective than vaccination at preventing influenza.

That video violated the college's policy on immunization, which forbids chiropractors from providing any advice on vaccination issues. The video was removed from Facebook and Jassal resigned from the board following CBC's reporting.

On Monday, the college revealed that Jassal agreed to a reprimand and a fine last summer after an investigation by an independent inspector.

Is there more to this story? Reach the reporter by email at bethany.lindsay@cbc.ca

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Ministry considered options for handling 'dysfunctional' chiropractors college after CBC report, FOI shows



College ignored complaint about board members' anti-vaccination posts, letter to health minister says

Bethany Lindsay · CBC News · Posted: Mar 18, 2019 4:00 AM PT | Last Updated: March 18



The B.C. Chiropractic Association says it began raising concerns about Avtar Jassal's 'problematic actions' in November 2016. (Facebook)



For nearly two years, a group of B.C. chiropractors say they rang alarm bells about "outlandish claims regarding vaccination and treatment of children" made by three board members at the College of Chiropractors.

They say they tried to file a complaint against Avtar Jassal, Parm Rai and Gil Desaulniers, but the college would not accept their evidence, according to a letter to Health Minister Adrian Dix from Jay Robinson, who was then president of the B.C. Chiropractic Association (BCCA).

The BCCA, a voluntary professional organization, also repeatedly raised its concerns with officials at the health ministry, but saw no evidence of action, the letter says.

"In fact, it has taken ... until the CBC brought forward the entirely unacceptable actions of Dr. Avtar Jassal, just one of the three chiropractors involved, to the public and subsequently your attention, for any action," Robinson writes in the May 25, 2018 letter, obtained as part of a Freedom of Information request to the health ministry.

- **[Chiropractic treatment for children to face 'rigorous' review in B.C.](#)**

The college says it has no record of a written complaint from the BCCA about the three former board members. Robinson says that's because the regulator refused to accept it.

Jassal [resigned from his post](#) as vice-chair of the college's board last May, after CBC reported on an anti-vaccination video he'd created and posted on Facebook in violation of college rules.

In the video, Jassal suggested that fruit smoothies are more effective than the flu shot at preventing influenza.

Jassal's activities had been the subject of previous complaints from members of the public.

Options for dealing with 'dysfunctional' college

In a written statement, Dix told CBC the messages spread by the three board members were intolerable.

"It is simply unacceptable when people spread information that is inaccurate and beyond the scope of their practice, professional codes of conduct, while having the credibility of being part of a regulated health college," Dix said.

A trove of ministry emails released last week details the government's response after CBC's first story on Jassal was published on May 2, 2018.

The emails suggest the story set off a scramble at the health ministry to come up with a plan for dealing with a professional college that wasn't operating as it should, though Robinson's letter, from the chiropractic association, contends the province had plenty of prior warning.

- **VIDEO** [Province directs removal of anti-vaccine posts that broke B.C. rules for chiropractors](#)

The day after the CBC's story about Jassal, the ministry's director of regulatory initiatives, Brian Westgate, writes that he was asked to outline "what options we have when a college is not meeting its legal obligation as set out under the HPA [Health Professions Act]."

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A May 3, 2018 email from an official at B.C.'s health ministry about the options for dealing with a college that "is not meeting its legal obligation." (CBC)

He titled his first draft "Options to Act when College dysfunctional." The contents of that document and subsequent drafts have been redacted.

But Robinson argues the ministry shouldn't have been caught off guard by CBC's reporting.

According to his letter, the BCCA first contacted the health ministry in November 2016 about Jassal, Rai and Desaulniers, alleging they were "pursuing a private non-evidence based agenda that we believed could negatively impact the profession and public safety."

- [**Researcher wants oversight of alternative health care to ensure 'science-based' practices**](#)

Not only were all three men members of the college board, but Jassal was the board's vice-chair and sat on the college's inquiry committee, which investigates complaints against chiropractors.

According to Robinson, the BCCA attempted to file a complaint against the three men over their anti-vaccination posts in April 2017 and then again in May.

College policy explicitly prohibits chiropractors from providing any advice on immunization.

From: Westgate, Brian A HLTH:EX
Sent: Thursday, May 3, 2018 8:45 AM
To: MacKinnon, Mark HLTH:EX; Younker, Katherine E HLTH:EX; Thorneloe, Meghan HLTH:EX
Subject: Options to Act when College disfunctional

Hi folks.

Mark asked me to put together some stuff last night about what options we have when a college is not meeting its legal obligation as set out under the HPA.

I have put together those options (in relation to the most recent chiro news). I haven't had time to fine tune it so please any comments would be great.

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These misleading anti-vaccination social media posts were all removed by chiropractors Avtar Jassal, Parm Rai and Gil Desaulniers after a complaint from a member of the public. (CBC)

Robinson says ministry officials promised him someone was working on the problem, but he saw no change.

That November, a member of the public complained to the ministry about Jassal, Rai and Desaulniers' anti-vaccination posts. Most of the materials were removed from the chiropractors' websites in response, but Jassal's video remained on his Facebook page.

Jassal resigned as vice-chair in May, but Rai and Desaulniers remained on the college board until a new election was held in the fall, when they were disqualified from running because they were under investigation.

Relationship on the mend

In the time since Robinson's letter, the college has improved its process for handling complaints about marketing and communication issues, according to interim registrar Richard Simpson.



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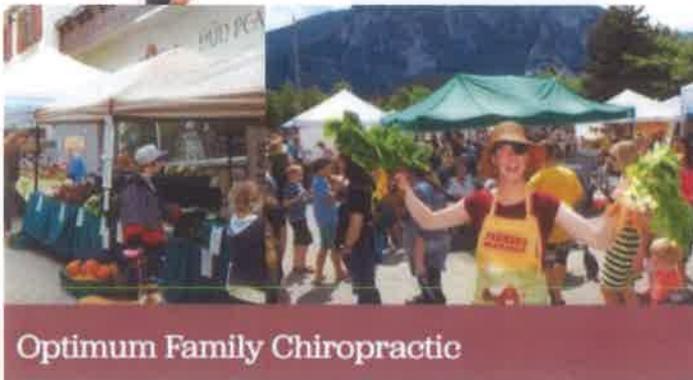
Dr. Avtar Jassal @JassalChiro · 30 Jan 2013

Is the Flu Vaccine Always the Answer? fb.me/1SZ59dvZw

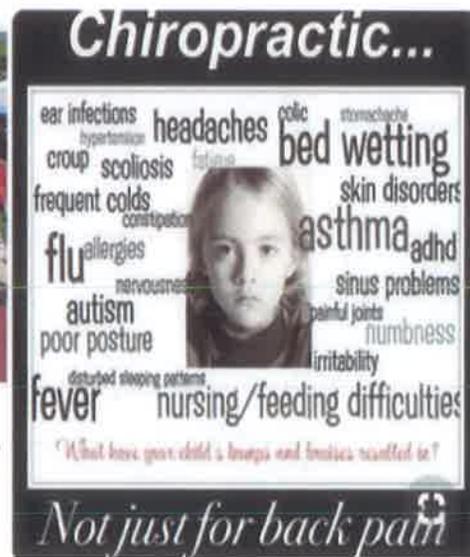


Dr. Avtar Jassal @JassalChiro · 30 Jan 2013

Vaccine Court Awards Millions to Two Children With Autism fb.me/2i94H2hSd



family wellness chiropractic care Special emphasize on Pre/postnatal care : specific and gentle chiropractic care throughout pregnancy and beyond (swelling, pubic bone pain, hip pain, lower back pain, tingling in hands, headache, shoulder tension, insomnia, abnormal fetal positioning) Paediatric chiropractic (breast feeding difficulties, colic, torticollis, constipation, delay in milestones, asthma, allergies, ADD/ADHD, autism and spectrum, growing pain



Posts like these, from chiropractors Gil Desaulniers and Parm Rai, were deleted after the college banned registrants from advertising treatments for conditions like autism and ADHD. (CBC)

The college has also developed a new efficacy claims policy, which makes it clear that chiropractors can't make false claims about being able to treat conditions like Alzheimer's, cancer, autism and ADHD. It's developed a web-scraping tool to identify potential violations, and as of early March, 67 chiropractors were under investigation over alleged violations.

- [50 B.C. chiropractors refuse to remove misleading claims from websites, face possible discipline](#)

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And the college has also promised a thorough review of the scientific evidence about chiropractic treatments for children.

There have been changes at the provincial level, too. Dix says the government has amended the Health Professions Act, giving the health minister more power to intervene in regulatory matters to protect the public.

The province has also commissioned an expert to review regulation of B.C.'s health professions and recommend changes to the current system.

May 25, 2018 letter to Adrian Dix from B.C. Chiropractic Association

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National Post

Wayne MacPhail and Paul Benedetti

March 15, 2019

12:47 PM EDT

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Three senior members of the council that regulates Ontario chiropractors have made anti-vaccination statements

Presented with the information, Ontario's Ministry of Health said it will take no action because chiropractic is a self-regulated health profession



Doctors (from left) Elizabeth Anderson-Peacock, Peter Amlinger and Clifford Hardick are members of the council of the College of Chiropractors of Ontario. Marketplace speakers ; @pureandpowerful / Facebook ; @drcliffhardick / Facebook

Three senior members of the professional organization that regulates Ontario's chiropractors have espoused or endorsed anti-vaccine views, the National Post has learned.

Drs. Elizabeth Anderson-Peacock, Peter Amlinger and Clifford Hardick, all members of the council of the College of Chiropractors of Ontario (CCO), have each written online posts, endorsed anti-vaccine books and documentaries or have made statements that encourage the notion that vaccination is dangerous.

Anderson-Peacock is the the current vice-president of the CCO. Both Amlinger and Hardick are past presidents. Their anti-vaccination endorsements, writings and appearances stand in contrast to the CCO's own position on vaccination, which states that "immunizations and vaccinations are outside the scope of chiropractic practice" and any discussions about them with patients must be "accurate, professional and balanced."

- [Ontario's mandatory class for parents seeking vaccine exemptions has 'zero conversions'](#)

Chiropractors are one of the largest primary-contact health care professions in the country. About 4.5 million Canadians visit the country's 9,000 licensed chiropractors each year. A 2018 Health

Canada survey found that 84 per cent of parents cited health care professionals as their primary source of information on vaccinations.

In response to questions from the Post, Anderson-Peacock denied she endorsed “any ‘anti-vaccination’ position.” Amlinger declined to say whether he believes vaccines are safe and effective, saying only that he believes vaccination is “a public health issue.” Both Amlinger and Anderson-Peacock said their personal opinions were separate from their duties with the CCO. Hardick did not respond to a request for comment.

STORY CONTINUES BELOW



NDP

health critic France Gélinas, shown at a press conference in Sudbury, Ont. on November 27, 2018, is calling on the Ontario government to investigate the College of Chiropractors of Ontario. John Lappa /Postmedia Network

The revelation comes amid an outbreak of measles in Ontario and B.C. and a renewed vaccination campaign by Ontario’s Ministry of Health. Presented with the information, the ministry told the Post it will take no action as chiropractic is a self-regulated health profession. Ontario NDP health critic France Gélinas, meanwhile, responded to the information with a call for the ministry to launch an immediate investigation of the entire CCO. “The minister has to step in right now,” she told the Post. “The college as a whole has to be held accountable. The college failed in its basic function to protect the public.”

The CCO has never taken an official position against vaccination. When the Post contacted the CCO for comment, it received a response that did not address the specific problems addressed in the story. However, less than 24 hours later the CCO issued an advisory in which it stated: “As part of its role to protect the public interest, the College of Chiropractors of Ontario (CCO) recognizes that vaccinations, as mandated in the Province of Ontario, provide a safe and effective means to protect individuals from infectious diseases.”

It also said the council “will be reviewing Standard of Practice S-001: Chiropractic Scope of Practice and some amendments are anticipated in making the standard more explicit that members not conduct seminars on vaccination or publish information on vaccination on their websites or social media accounts.”

“I would be concerned about any health care professional who is providing their patients with vaccine information that does not align with the peer-reviewed scientific evidence and the recommendations of Canada’s National Advisory Committee on Immunization,” said Dr. Julie Bettinger, a professor in the Vaccine Evaluation Centre at the University of British Columbia.

I do not endorse any 'anti-vaccination' position. Rather, I personally believe individuals should obtain informed-consent whenever receiving treatment of any kind from the appropriate provider.

Dr. Elizabeth Anderson-Peacock

Anderson-Peacock has endorsed an anti-vaccine book, *Immunization: History, Ethics, Law and Health* by Catherine Diodati. In the book, Diodati writes, “All vaccines are capable of causing disease and death ... some vaccines appear to render people more susceptible to disease.” The appendix references an array of anti-vaccination groups and organizations.

In a review on Amazon, Anderson-Peacock wrote: “A must read for those who wish to be aware, responsible and informed ... especially parents and physicians prior to injection.”

She also offered online praise for the documentary *Vaxxed: From Cover-Up to Catastrophe*. The film is directed by Andrew Wakefield and is produced by prominent anti-vaccination activist, Del Bigtree. Wakefield is a disgraced former British doctor who was the lead author of a fraudulent research paper that linked the measles, mumps and rubella (MMR) vaccine to autism. The documentary claims the Centers for Disease Control in the U.S. covered up a purported link between the MMR vaccine and autism.



This photo taken on January 28, 2010, shows British doctor Andrew Wakefield, the first clinician to suggest a link between autism in children and the triple vaccination for measles, mumps and rubella in a study that has since been disproven. (SHAUN CURRY/AFP/Getty Images)

On Facebook, Anderson-Peacock wrote: “It’s an awesome movie. Saw it yesterday in Atlanta with a q and a afterwards with the producer and one mom featured, Polly. They asked the audience please stand if you have anyone in your family, not friends but family who has autism and half the audience stood. The newest projected stat is that if the rates continue as is will be 1 in 2 body will have a DC of autism by 2023.”

She was also a guest on the Healthy Alternatives to Vaccination podcast around late 2016 — though her appearance on the podcast is no longer online — and has appeared as a guest speaker at conferences organized by the International Chiropractic Pediatric Association (ICPA). On its website the ICPA claims that current evidence suggests mercury in vaccines causes autism, and past ICPA conferences have featured Wakefield, Bigtree and Barbara Loe Fisher, an anti-vaccine advocate and the co-founder and president of the National Vaccine Information Center, which has sponsored ICPA events.

In a statement emailed to the Post, Anderson-Peacock said, “I stand with the policies of our regulatory college in the interest of public health. I stand with public health initiatives. Period.”

In a further statement provided via her lawyer, she added: “I do not endorse any ‘anti-vaccination’ position. Rather, I personally believe individuals should obtain informed-consent whenever receiving treatment of any kind from the appropriate provider. My personal opinions

are completely separate from the professional obligations I uphold as a chiropractor; and completely separate from my chiropractic practice, which is also aligned with my professional obligations.”

Anderson-Peacock did not explain her endorsements, appearances or associations.

Amlinger, a former CCO president, has also been outspoken online about vaccination.

A 2015 post on the Amlinger Family Chiropractic Facebook page encouraged patients to get a chiropractic adjustment instead of a flu shot, claiming, mercury and aluminium in the shots may increase the chances of Alzheimer’s. Amlinger also wrote a piece for the Justine Blainey Wellness Centre’s website last year in which he discussed a document that claims pharmaceutical companies are colluding with health authorities to hide the “multiple dangers associated with vaccines.”

When I became aware that there was an article with my name on it on another person’s website, I acted to have it removed immediately

Dr. Peter Amlinger

Amlinger wrote: “Perhaps it is time more people start taking fewer drugs and start seeing a chiropractor on a regular basis. It is time for humanity to wake up and stop blindly poisoning themselves.”

While the statements are no longer available online, the Post had obtained screenshots and recovered archived versions of them after their disappearance.

Asked about the posts, Amlinger said, “When I became aware of both the Facebook post, which was made by a former associate, I removed it immediately. When I became aware that there was an article with my name on it on another person’s website, I acted to have it removed immediately.

“I believe that vaccination is a public health issue. I believe the public is entitled to a robust informed consent process for any type of care they are entertaining.” Amlinger also said he “was commenting in my personal capacity and not in my capacity as a CCO council member.”

In recent speeches, meanwhile, Hardick has praised a chiropractor who drove around town in a hearse with a sign featuring a hypodermic needle dripping blood and the slogan, “Drugs Kill — Whether Pushed or Prescribed!” Hardick has also been a speaker at the California-based chiropractic conference Cal Jam and has appeared on Cal Jam podcasts. This year Cal Jam features appearances by anti-vaccine advocate Bigtree and Dr. James Chestnut, a B.C.- based chiropractor who questions the legitimacy of the data behind widespread public flu vaccination.

Hardick did not vaccinate his son, B.J. Hardick, himself a high-profile chiropractor who has expressed concern online about mercury in vaccines. Clifford Hardick did not respond to the Post's request for comment.



University of Alberta professor Timothy Caulfield, shown in Edmonton on July 20, 2016, said the chiropractic community has a history of anti-vaxx rhetoric. Ed Kaiser/Postmedia Network

Timothy Caulfield, a University of Alberta professor and author of *The Vaccination Picture*, said these kinds of postings and comments don't help the public.

"This is tremendously frustrating — but, unfortunately, not terribly surprising. There is a history of anti-vaxx rhetoric among the chiropractic community. Despite recent efforts to push the profession toward a more science-based approach, this harmful noise persists."

Dr. Murray Katz, a Montreal-based physician and longtime critic of chiropractic says confusing the public about vaccination must stop. "This is dangerous, irresponsible and clearly shows they and the board which accepted them should all be replaced by the Minister of Health, who should impose a scientific standard on the profession."

Like opposition critic Gélinas, Caulfield says the situation in the CCO demands that the Ontario government investigate.

“These are individuals involved in the governance of the chiropractic profession,” he said. “Can people who embrace pseudoscience weed out pseudoscience? Nope. Clearly action is needed.”

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Chiropractors college refused complaint a members' anti-vaccination posts, lett

Bethany Lindsay 4 hrs ago



© CBC Posts like these, from chiropractors Gil Desaulniers and Parm Rai, were deleted after the college banned registrants from advertising treatments for conditions like autism and ADHD.

For nearly two years, a group of B.C. chiropractors say they rang alarm bells about "outlandish claims regarding vaccination and treatment of children" made by three board members at the College of Chiropractors.

They say they tried to file a complaint against Avtar Jassal, Parm Rai and Gil Desaulniers, but the college would not accept their evidence, according to a letter to Health Minister Adrian Dix

from Jay Robinson, who was then president of the B.C. Chiropractic Association (BCCA).

The BCCA, a voluntary professional organization, also repeatedly raised its concerns with officials at the health ministry, but saw no evidence of action, the letter says.

"In fact, it has taken ... until the CBC brought forward the entirely unacceptable actions of Dr. Avtar Jassal, just one of the three chiropractors involved, to the public and subsequently your attention, for any action," Robinson writes in the May 25, 2018 letter, obtained as part of a Freedom of Information request to the health ministry.

The college says it has no record of a written complaint from the BCCA about the three former board members. Robinson says that's because the regulator refused to accept it.

Jassal resigned from his post as vice-chair of the college's board last May, after CBC reported on an anti-vaccination video he'd created and posted on Facebook in violation of college rules.

In the video, Jassal suggested that fruit smoothies are more effective than the flu shot at preventing influenza. >

Jassal's activities had been the subject of previous complaints from members of the public.

Options for dealing with 'dysfunctional' college

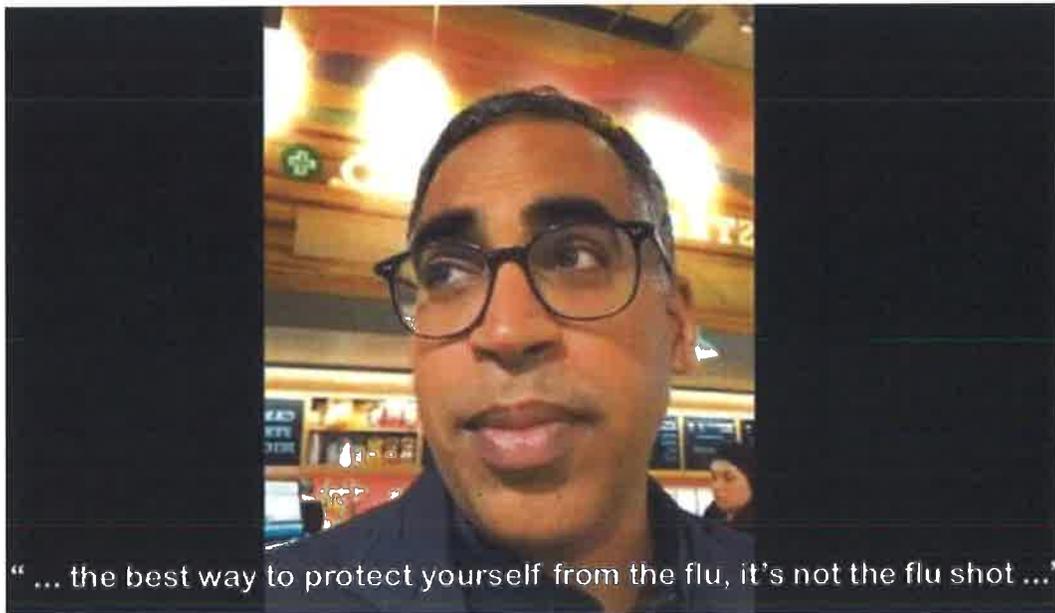
In a written statement, Dix told CBC the messages spread by the three board members were intolerable.

"It is simply unacceptable when people spread information that is inaccurate and beyond the scope of their practice, professional codes of conduct, while having the credibility of being part of a regulated health college," Dix said.

A trove of ministry emails released last week details the government's response after CBC's first story on Jassal was published on May 2, 2018.

The emails suggest the story set off a scramble at the health ministry to come up with a plan for dealing with a professional college that wasn't operating as it should, though Robinson's letter, from the chiropractic association, contends the province had plenty of prior warning.

The day after the CBC's story about Jassal, the ministry's director of regulatory initiatives, Brian Westgate, writes that he was asked to outline "what options we have when a college is not meeting its legal obligation as set out under the HPA [Health Professions Act]."



© Facebook The B.C. Chiropractic Association says it began raising concerns about Avtar Jassal's 'problematic actions' in November 2016.

His titled his first draft "Options to Act when College dysfunctional." The contents of that document and subsequent drafts have been redacted.

But Robinson argues the ministry shouldn't have been caught off guard by CBC's reporting.

According to his letter, the BCCA first contacted the health ministry in November 2016 about Jassal, Rai and Desaulniers, alleging they were "pursuing a private non-

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evidence based agenda that we believed could negatively impact the profession and public safety."

Not only were all three men members of the college board, but Jassal was the board's vice-chair and sat on the college's inquiry committee, which investigates complaints against chiropractors.

According to Robinson, the BCCA attempted to file a complaint against the three men over their anti-vaccination posts in April 2017 and then again in May.

College policy explicitly prohibits chiropractors from providing any advice on immunization.

"We were advised the college would not accept our complaint and that nothing would be done," Robinson writes.

From: Westgate, Brian A HLTH:EX
Sent: Thursday, May 3, 2018 8:45 AM
To: MacKinnon, Mark HLTH:EX; Younker, Katherine E HLTH:EX; Thorneloe, Meghan HLTH:EX
Subject: Options to Act when College dysfunctional

Hi folks.

Mark asked me to put together some stuff last night about what options we have when a college is not meeting its legal obligation as set out under the HPA.

I have put together those options (in relation to the most recent chiro news). I haven't had time to fine tune it so please any comments would be great.

s.13

© CBC A May 3, 2018 email from an official at B.C.'s health ministry about the options for dealing with a college that "is not meeting its legal obligation."

Robinson says ministry officials promised him someone was working on the problem, but he saw no change.

That November, a member of the public complained to the ministry about Jassal, Rai and Desaulniers' anti-vaccination posts. Most of the materials were removed from the chiropractors' websites in response, but Jassal's video remained on his Facebook page.

Jassal resigned as vice-chair in May, but Rai and Desaulniers remained on the college board until a new election was held in the fall, when they were disqualified from running because they were under investigation.

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Relationship on the mend

In the time since Robinson's letter, the college has improved its process for handling complaints about marketing and communication issues, according to interim registrar Richard Simpson.

"Both the college and the BCCA have worked hard to improve their collaborative relationship, so that issues identified and brought to the attention of the college are addressed in a timely and fully-responsive manner," Simpson wrote.

Jassal and seven other chiropractors received fines and reprimands last year for spreading anti-vaccination misinformation.



© CBC These misleading anti-vaccination social media posts were all removed by chiropractors Avtar Jassal, Parm Rai and Gil Desaulniers after a complaint from a member of the public.

The college has also developed a new efficacy claims policy, which makes it clear that chiropractors can't make false claims about being able to treat conditions like Alzheimer's, cancer, autism and ADHD. It's developed a web-scraping tool to identify potential violations, and as of early March, 67 chiropractors were under investigation over alleged violations.

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Subject: FW: lapresse

From: Jo-Ann Willson
Sent: Friday, April 12, 2019 9:23 AM
To: Rose Bustria <RBustria@cco.on.ca>
Subject: Fwd: lapresse

Council.

Jo-Ann Willson, B.Sc., M.S.W., LL.B.
Registrar & General Counsel

Begin forwarded message:

From: Dave Starmer <drstarmer@gmail.com>
Date: April 12, 2019 at 9:05:01 AM GMT-4
To: Jo - Ann Willson <jpwilson@cco.on.ca>, Dave Starmer <drstarmer@gmail.com>
Subject: lapresse

<https://www.lapresse.ca/actualites/sante/201904/11/01-5221890-un-professeur-de-luqtr-multiplie-les-propos-anti-vaccins.php>

--

Dr. David J. Starmer
drstarmer@gmail.com

A professor at UQTR multiplies the anti-vaccine remarks



PHOTOMONTAGE THE PRESS



[Philippe Mercure](#)

The Press

As New York City tries to stem a measles epidemic and Canada's public health authorities say they want to take action against the anti-vaccine movement, a professor of biochemistry at the Université du Québec à Trois-Rivières, Christian Linard, multiplies the remarks against the vaccination on his personal Facebook page. A situation denounced by several stakeholders.

"Irresponsible" publications

Vaccination is linked to autism. It has already been used to sterilize populations in Africa. It represents an operation "irreversible, dangerous and not studied".

While the World Health Organization views mistrust of vaccines as one of the top 10 threats this year, a professor at the University of Quebec in Trois-Rivières has been making negative comments about vaccination on his personal Facebook page.

Between March 14 and April 11, Christian Linard, Professor of Clinical Biochemistry attached to the Department of Chiropractic, published or shared 17 comments or studies that address the issue of the alleged dangers of vaccines, question their effectiveness or advocate free choice of the population in the face of vaccination. No positive comments about the vaccines were relayed during this period. In fact, *La Presse* found none in all of Linard's Facebook publications.

These publications raise the concern of immunology experts consulted by *La Presse*.

"It's irresponsible of him to relay only the articles that show that the vaccines are terrible. We know that vaccines save lives, it's indisputable," said Dr. Brian Ward, professor in the Department of Medicine and Vaccine Expert at McGill University. Dr. Ward believes "unacceptable" that Christian Linard is a professor at a Quebec university.

"He must lose his job," he says.

"This is a position that is neither nuanced nor balanced," also denounces Caroline Quach, pediatrician and microbiologist-infectiologist CHU Sainte-Justine and Professor at the University of Montreal, after reading the publications of Christian Linard on Facebook.

"Like any position that shows only one side of the coin, it's problematic - especially when people have a posture like a teaching position," says Dr. Quach.

"We have a responsibility to the community for the messages we receive. "

- Dr. Caroline Quach, pediatrician and microbiologist-infectiologist

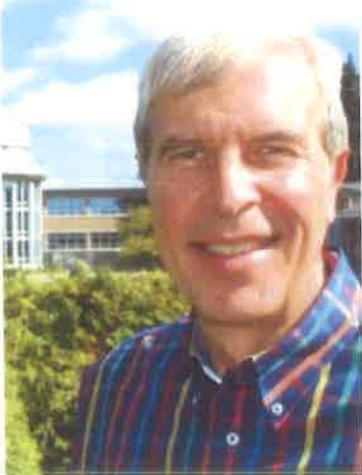
Around the world, mistrust of vaccines causes headaches for public health authorities. The World Health Organization (WHO) reports that measles cases have increased by 30% worldwide since 2016, including in several countries where

the disease was eradicated or was in the process of being eradicated. Several factors are involved, but the "false information" circulating on vaccines is being blamed by WHO.

New York City is currently fighting a measles epidemic. Yesterday, in *La Presse*, Canada's Chief Public Health Officer, Dr. Theresa Tam, affirmed her desire to act "quickly and better" to respond to anti-vaccine groups.

Christian Linard, however, defends himself to be "anti-vaccines".

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Christian Linard, professor of clinical biochemistry
PHOTO FROM THE UQTR WEBSITE

"What I'm trying to do is turn people on so they think. And, as a precautionary principle, say: you have to be careful. "

- Christian Linard

It does not give credibility to WHO's warnings that misinformation about vaccines puts people at risk.

"If you look at the heads of the WHO, those on the board, many come from the pharmaceutical industry," he says. Christian Linard also said he doubted that the recent measles outbreaks were due to a drop in vaccination, saying instead that they were due to a deficient vitamin A diet. "I am studying this," he said. he.

Legitimate questions

Brian Ward of McGill University agrees that it is legitimate to raise scientific questions about vaccination.

"I agree that everything is not white or black. There are gray regions. There are real important questions that need to be answered," he says.

Professor Linard relays in particular on his Facebook page studies on what are called the "non-specific effects" of vaccines. This new field of study seems to show that vaccines are more complex than previously thought and that they can influence, positively or negatively, how the body defends itself against other diseases or pathogens for which the vaccine was not designed (see other tab).

Brian Ward, however, denounces the fact that Christian Linard reports only the negative effects noted by these studies, without ever mentioning the positive effects - nor, especially, the immense benefits of vaccines in general.

"When we talk about vaccination, it's a lot, a lot more white than black. "

- Dr. Brian Ward

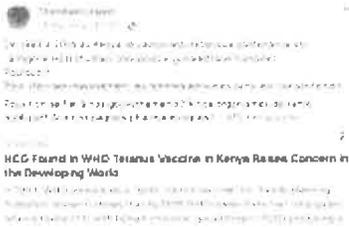
Dr. Caroline Quach recalls that the decision to be vaccinated must go beyond individual considerations.

"The problem is that people look at everything from an individual point of view - what is good for my child, regardless of the rest of the population," she says.

Sterilization of women?

Dr. Ward is particularly concerned that Professor Linard is relaying on Facebook a thesis that the World Health Organization (WHO) has attempted to sterilize 2.3 million women in Kenya under the guise of a vaccination campaign against tetanus.

"Vaccines and crimes against humanity! Vaccinate to eliminate some populations = Eugenics," wrote Christian Linard on Facebook on March 14th.



screenshots taken from Christian Linard's Facebook page, anti-vaccine professor UQTR
SCREENSHOT

WHO and UNICEF have vigorously denied these rumors by Kenyan Catholic organizations, which have also been dismantled by many fact-finders.

"That's when the gentleman falls into ridicule," said Dr. Ward.

"When we start saying that vaccines are an effort to sterilize or control populations, we really fall into the dark. "

- Dr. Brian Ward

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"There is eugenics in many African countries, it has been demonstrated. It was published and it was not contradicted. So I'm suspicious. I say to myself: one can vaccinate me, but one can very well put a product in this vaccine which will harm me," reiterated Professor Linard at *La Presse* .

"Academic Freedom"

La Presse told Christian Linard about Facebook, the University of Quebec at Trois-Rivières said it did not intend to act.

"In communication policy, according to the principle of academic freedom, one does not study the personal or professional accounts of professors. That means that what teachers publish on their Facebook, Instagram or other account is their responsibility," says Yvon Laplante, Director of Communications at UQTR.

Jean-Marie Lafortune, president of the Quebec Federation of University Teachers, confirms that there are few tools to intervene in this type of situation. However, he believes that Christian Linard holds "a statement that does not reflect the responsibility of scientists in society."

"Academic freedom is the ability to say truths that can offend economic, political, religious or other powers, but that must be based on an honest search for the truth," he says. He believes that by posting his title of professor at UQTR on his personal Facebook page, Christian Linard "maintains the confusion of the genres".

"He claims to be a science, a university institution, and it's supposedly from the top of that that we should believe it," says Mr. Lafortune. We are also dealing with someone who is very close to the point. If a professor of art history tells us that the budget does not look good, we can take it lightly. But here, it sows even more confusion, because this person is from sciences that have yet demonstrated the relevance of vaccination. "

Christian Linard's allegations under the microscope

On his Facebook page and in an interview with *La Presse* , Professor UQTR Christian Linard relayed many theories and studies that question the safety and effectiveness of vaccines. The point on some of them.

Links between vaccines and autism

This old controversy stems from the infamous study by researcher Andrew Wakefield, published in *The Lancet* in 1998, which linked autism to the MMR (rubella-measles-mumps) vaccine. The rest of the story is known: it was discovered that the study contained errors and that the researcher was in a conflict of interest, and the publication was withdrawn.

Christian Linard relays another study that claims to establish an association between vaccines and autism. The study is signed by Gayle DeLong, a finance professor who has previously been associated with the SafeMinds anti-vaccine group. "It's purely correlation [unlike a cause-and-effect relationship] and statistical analysis does not even work," says microbiologist-infectiologist Caroline Quach, who reviewed the study.

Many other studies have concluded that there is no link between vaccines and autism. In 2018, a large meta-analysis of 10 studies with more than 1.25 million children confirmed this lack of linkage.

Eradication of infectious diseases



Professor Christian Linard multiplies anti-vaccine pronouncements on his personal Facebook page.
SCREENSHOT

In an interview with *La Presse*, Christian Linard says that it is not thanks to vaccines that several infectious diseases like polio or measles have been virtually eradicated in Western countries.

"It's not vaccines that have reduced infectious diseases. The incidence of major illnesses decreased well before the emergence of vaccines. Why? Because of sanitary measures. [...] In some cases, vaccination has even led to an increase in incidence for a certain period of time," he told *La Presse*.

"Hygiene, nutrition and modern medicine have clearly helped to reduce the incidence

and severity of many infectious diseases. But denying that vaccines played a major role is Trumpian logic at its worst."

- Dr. Brian Ward of McGill University

"If today a child with measles coughs near you and you have not been vaccinated, you will get measles and it will be very serious - 30% of hospitalization rates in North America at home, adults, and it's even higher in children. And it does not matter if your home is clean or you have taken your vitamins," continues Dr. Ward.

Increase in mortality

Christian Linard also relays on Facebook and mentioned in an interview studies that show an increase in infant mortality after vaccination in developing countries, including a study conducted in Guinea-Bissau after the administration of the diphtheria-tetanus vaccine, whooping cough

This serious study touches on the so-called "non-specific effects" of vaccines. New discoveries tend to show that a vaccine has effects that go beyond the disease for which it was designed. By modifying our immune system, the vaccine would affect our protection, positively or negatively, against other viruses and pathogens. The mechanisms of these effects are still poorly understood.

It should be noted that the majority of studies on these non-specific effects have been conducted in developing countries, where people's immune systems are much more in demand. The pioneer in this field is Peter Aaby, a Danish researcher working in Guinea-Bissau.

"Considering the enormous effect that some vaccines have had in developing countries, I find it sad to see people in rich countries developing mistrust of all vaccines," Aaby said in a statement, e-mail exchange with *La Presse*. That said, I find it even more sad that public health authorities have developed a religious belief that all vaccines are safe, as this evidence does not exist."

"Vaccinated people have a huge advantage over unvaccinated people," says Dr. Brian Ward of McGill, who is following this work closely. Are vaccination schedules ideal? Can we eliminate these subtle effects with a different schedule? These studies are in progress."

Partager 2,2

Tweeter



April 16, 2019
2:21 PM EDT

As one anti-vaccination sympathizer is voted off Ontario's chiropractic regulatory body, another is voted on

Dr. Anderson-Peacock, who lost her council seat, spoke at a recent conference that also hosted prominent anti-vaccination chiropractor Del Bigtree



pureandpowerful / Facebook ; @drcliffhardick / Facebook

Doctors (from left) Elizabeth Anderson-Peacock, Peter Amlinger and Clifford Hardick are members of the council of the College of Chiropractors of Ontario.

Wayne MacPhail and Paul Benedetti

April 16, 2019

2:21 PM EDT

As one anti-vaccination sympathizer is voted off Ontario's chiropractic regulatory body, another is voted on

A chiropractor exposed last month as an anti-vaccination sympathizer has lost her bid for re-election to the regulatory body that governs the profession in Ontario. However, the province's chiropractors have elected a new councillor who has posted a swath of anti-vaccination material on Facebook.

Dr. Elizabeth Anderson-Peacock, who lost her seat on council, was a featured speaker at a recent Montreal conference that also hosted prominent anti-vaccination chiropractor Del Bigtree. And the Post has confirmed that Ontario chiropractors could count attendance at the conference towards continuing education credits from the College of Chiropractors of Ontario, the body that regulates the province's chiropractors.

In a March 15 story, the National Post revealed that three chiropractors who sat on the executive of the College of Chiropractors of Ontario (CCO), including Anderson-Peacock, had made anti-vaccination statements or endorsements. The Post reported that Anderson-Peacock endorsed an anti-vaccine movie produced by disgraced former physician Andrew Wakefield, and published a positive online review to an anti-vaccine book. In a statement to the Post, Anderson-Peacock denied she endorsed "any 'anti-vaccination' position" and said her personal views were separate from her duties with the CCO.

Earlier this month, the CCO released unofficial results for the district in which Anderson-Peacock was running for re-election. She was narrowly defeated by chiropractor Dr. Steven Lester. Unless there's a recount, she will lose her seat on the CCO council. However, one of the new councillors elected last week, Dr. Paul Groulx, also has a history of promoting anti-vaccination views.

In 2015 Groulx posted a promotion by Vaccine Choice Canada, an anti-vax group, to his Facebook page. He also mocked the effectiveness of flu vaccines on Facebook in 2017, and in 2016 announced his daughter had not been vaccinated. (While these posts have now been removed, the Post has archived copies.)

If a professional regulator is allowed to be so wrong about a basic building block of public health, the public should demand change for its own protection

Groulx told the Post that he has changed his position on chiropractors discussing vaccination: "Personally, I used to question vaccines but years ago I realized it had nothing to do with our

practice. I have been outspoken for quite some time that the vaccine issue needs to be shut down. By shut down I mean zero tolerance on speaking about vaccinations. It's none of our business."

On March 10, Ryan Armstrong, a London-based health activist, filed a formal written complaint to the CCO about Anderson-Peacock's anti-vaccination statements. The CCO would not confirm to the Post whether it was investigating Anderson-Peacock or the other two members of the CCO executive, Dr. Peter Amlinger and Dr. Clifford Hardick, whom the Post identified as having made anti-vaccination statements.

The Regulated Health Care Professions Act that governs all regulated health professionals in the province does not require an external formal complaint to launch an investigation if there are "reasonable and probable grounds that the member has committed an act of professional misconduct." However, CCO Registrar and General Counsel Jo-Ann Willson told the Post that confidentiality provisions prevent her from discussing any inquiries, complaints, reports or disciplinary matters that are in their early stages. Though she has the power to unilaterally launch an investigation, Willson would neither confirm nor deny that she was undertaking any such inquiry.

The Canadian Chiropractic Association and the Ontario Chiropractic Association have both said they both support "vaccination and immunization as established public health practices in the prevention of infectious diseases," but neither association responded to a question from the Post asking whether they had a zero-tolerance policy regarding members who make anti-vaccination statements or endorsements.

Jonathan Jarry, a science communicator in the Office for Science and Society at McGill University said, "Anti-vaccination views seem to be innate to a certain persistent strain of chiropractic. What is particularly worrisome is that these unscientific opinions are not only held by some practicing chiropractors, they are being publicly espoused by many of the leaders of their regulatory body."

- [Three senior members of the council that regulates Ontario chiropractors have made anti-vaccination statements](#)
- ['I'm pro informed consent': Teacher guilty of pushing anti-vaccine views suspended for talking to media](#)
- [Queen's University professor under fire for anti-vaccine teachings granted leave from course](#)

"If a professional regulator is allowed to be so wrong about a basic building block of public health, the public should demand change for its own protection," he said. "Swift action is needed to correct this dangerous misfire."

In an interview with the Post, Ontario NDP health critic France Gélinas said she believes the anti-vaccination problem in chiropractic goes far beyond the leadership, and that she was surprised at the extent of anti-vax sentiment among rank-and-file chiropractors. "I realized that a lot of them were reluctant to say vaccination saves lives, that vaccination was an important part of public health," she told the Post

“I pushed quite hard and some of them would not say vaccination was a good public health measure,” said Gelinas. “And it didn’t matter how hard I pushed ... I thought all health professionals were in favour of vaccination, but apparently, it is not so.”

Gelinas said that she discussed the issue with the Minister of Health, Christine Elliott, and “(the minister) did not reassure me that she is going to act. I am hoping she changes her mind.” The Ministry of Health had previously told the Post it would not intervene as chiropractic is a self-regulated profession in Ontario.

The Life Vision Conference in Montreal advertised its events as good for “CE credits in Ontario.” When contacted by the Post, Willson did not deny that the seminars would count towards continuing education credits.

After Willson was made aware that the conference organizers were advertising its sessions in that way, she responded in a letter saying that in future, “CCO will continue to review its CE requirements and make appropriate changes as necessary, which may include the introduction of additional mandatory elements to the program and/or approval/disapproval of specific programs.”

CCO council member Dr. Peter Amlinger was also a presenter at the Montreal event in late March, at which BigTree mocked recent media concerns in Canada about anti-vaccination campaigns. He told the chiropractors in attendance that vaccines could harm or kill children and then quoted the vaccine manufacturers warning that vaccines “could cause death, auto-immune disease, guillain-barré syndrome, paralysis,” to the amusement of some members of the audience.

Subject: FW: „Chiropractic: One big unhappy family-better together or apart“ - BMA article
Attachments: s12998-018-0221-z.pdf; ATT00001.txt

-----Original Message-----

From: Jo-Ann Willson
Sent: Saturday, February 23, 2019 8:06 AM
To: Rose Bustria <RBustria@cco.on.ca>
Cc: David Starmer <drstarmer@gmail.com>; Liz Anderson-Peacock <drliz@bellnet.ca>; Doug Cressman <doug.cressman@gmail.com>
Subject: FW: „Chiropractic: One big unhappy family-better together or apart“ - BMA article

Council.

Jo-Ann Willson, B.Sc., M.S.W., LL.B.
Registrar & General Counsel

-----Original Message-----

From: Harald Simon [mailto:drharaldsimon@chiropractic.cc]
Sent: Saturday, February 23, 2019 7:56 AM
To: Dr David Starmer <drstarmer@gmail.com>
Cc: Dr Kristina Peterson <kristyp@tbaytel.net>; bbudgell@cmcc.ca; Dr Carlo Ammendolia <cammendolia@mtsinai.on.ca>; Dr Deborah Kopansky-Giles <KopanskyGilD@smh.ca>; Jo-Ann Willson <jpwillson@cco.on.ca>; Dr Bryan Wolfe <bwolfe@bellnet.ca>; Dr Shawn Thistle <shawn@rrseducation.com>
Subject: „Chiropractic: One big unhappy family-better together or apart“ - BMA article

Good, timely recently published article.
Dr Harald Simon



Chiropractic, one big unhappy family: better together or apart?

Charlotte Leboeuf-Yde¹, Stanley I. Innes^{2*} , Kenneth J. Young², Gregory Neil Kawchuk³ and Jan Hartvigsen^{4,5}

Abstract

Background: The chiropractic profession has a long history of internal conflict. Today, the division is between the 'evidence-friendly' faction that focuses on musculoskeletal problems based on a contemporary and evidence-based paradigm, and the 'traditional' group that subscribes to concepts such as 'subluxation' and the spine as the centre of good health. This difference is becoming increasingly obvious and problematic from both within and outside of the profession in light of the general acceptance of evidence-based practice as the basis for health care. Because this is an issue with many factors to consider, we decided to illustrate it with an analogy. We aimed to examine the chiropractic profession from the perspective of an unhappy marriage by defining key elements in happy and unhappy marriages and by identifying factors that may determine why couples stay together or split up.

Main body: We argue here that the situation within the chiropractic profession corresponds very much to that of an unhappy couple that stays together for reasons that are unconnected with love or even mutual respect. We also contend that the profession could be conceptualised as existing on a spectrum with the 'evidence-friendly' and the 'traditional' groups inhabiting the end points, with the majority of chiropractors in the middle. This middle group does not appear to be greatly concerned with either faction and seems comfortable taking an approach of 'you never know who and what will respond to spinal manipulation'. We believe that this 'silent majority' makes it possible for groups of chiropractors to practice outside the logical framework of today's scientific concepts.

Conclusion: There is a need to pause and consider if the many reasons for disharmony within the chiropractic profession are, in fact, irreconcilable. It is time to openly debate the issue of a professional split by engaging in formal and courageous discussions. This item should be prioritised on the agendas of national associations, conferences, teaching institutions, and licensing/registration as well as accreditation bodies. However, for this to happen, the middle group of chiropractors will have to become engaged and consider the benefits and risks of respectively staying together or breaking up.

Keywords: Allied health, Attitude of health Personnel, Chiropractic, Professionalisation, Social perception, Trends

Background

Health care is becoming increasingly evidence-based

Over the past decades, governments, society and patients have an increasing expectation of an evidence-based approach to health care and as the knowledge base has become larger and more widely accepted, the space available for alternative modalities has become smaller [1–4]. This has resulted in a greater contrast between mainstream and fringe medicine. Also, in the musculoskeletal area there are now different demands on indications for treatment and positive outcomes than what was seen only a few

decades ago [5]. Increasingly legislation is being brought to bear to enforce such approaches. Chiropractors have for many years balanced at the crossroads between main stream and alternative medicine, so this development poses particular challenges for chiropractic organisations, who have tried to cater for both [6–8]. Although chiropractors, officially, are part of the evidence-based movement in relation to musculoskeletal problems, we were late adopters, and some are not prepared to adopt this approach at all.

The consequences for chiropractors

To the public, chiropractors are known to be 'back pain clinicians' [9–12]. This is potentially a good niche, beca

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use back pain is one of the largest public health problems, negatively affecting hundreds of millions of people. The number of years people live with disability has increased globally by 52% since 1990 [13, 14]. The recent Lancet Low Back Pain Series pointed to the gap between what is known and what is being practiced, and called for a de-medicalisation of back pain and promotion of public health approaches in order to reverse this trajectory [15, 16]. Chiropractors appear to be well placed to respond to this call and become relevant in mainstream healthcare globally.

Divisions within the chiropractic profession

As is the case with professions generally, chiropractic has always had subgroups, some further toward the fringe and others closer to mainstream healthcare. Chiropractic arose out of a vitalistic tradition. D.D. Palmer, the founder of chiropractic, declared that 95% of all disease was caused by subluxated vertebrae and that the remaining 5% was caused by slight displacements of bones other than those in the spine [17]. An early split developed between the vitalists and those who developed towards a more scientific approach, and divisions remain. It is estimated that approximately 20% of the profession in Canada still adheres to a vitalistic explanation for how they practice [18, 19]. Despite the presence of these factions, chiropractic has gradually become a global healthcare profession [20], and in some jurisdictions chiropractors are regarded as mainstream healthcare providers, as part of national health systems or reimbursed with public or private insurance funds. In places where chiropractors have adopted modern evidence-based principles, external stakeholders have determined that chiropractic practice accords with modern healthcare principles and should be included among legitimate healthcare practitioners [21, 22]. Nevertheless, there is a continuing divide between 'evidence-friendly' and 'traditional' chiropractors, which has become more visible in recent years, as the focus on back pain and musculoskeletal health has increased and a wealth of new evidence in the area has emerged. Unfortunately, these disparate voices reflecting different approaches confuse external stakeholders and threaten the credibility of the chiropractic profession.

Describing this division is not simply academic; those aligned with evidence-based ideals have the greatest probability of being further integrated into healthcare systems in the years to come. In contrast, chiropractors, who have traditional ideas of the spine being a source of all or most diseases, are unlikely to make this journey, in the absence of evidence to substantiate their claims. The result is a profession torn between those looking to the future and those wedded to the founding claims of the past. The evidence-friendly chiropractors feel that the claims and activities by the 'traditionalists' slows or

hinders the development of the profession and there is evidence to substantiate this.

Here are some examples of this problem, as seen from the perspective of the evidence-friendly group:

- In Canada, vitalist practitioners have been shown to be more likely to have anti-vaccination beliefs, and their attitudes about radiographic imaging are inconsistent with current evidence/ guideline-based care [19]. As such, vitalistic providers were less likely to receive referrals from other health providers [23].
- In Florida, U.S.A., attempts to establish a university-based education in chiropractic were stopped in 2005 because of opposition and lobbying from the traditional group [24].
- In 2009 in the UK, a systematic survey of chiropractic websites was done by a group motivated by displeasure at unsupported claims of chiropractors, and formal complaints were lodged with the General Chiropractic Council. Although most chiropractors were found not guilty, thousands of work-hours and much stress was caused [25, 26]. The content of these web sites was subsequently changed.
- In 2012, the treatment of children based on traditional chiropractic 'diagnoses' at the student chiropractic clinics at the Royal Melbourne Institute of Technology in Australia, a university-based chiropractic course, at the time led by a well-known traditionally-oriented chiropractor, brought down both fury and ridicule on chiropractic. It also resulted in a new movement called 'Friends of Science', who wage war on university education involving non-evidence-based alternative medicine, notably chiropractic. This severely threatened at least two chiropractic undergraduate courses [27, 28].
- In 2013, attempts to establish a university-based education in chiropractic in Sweden were stopped following a debate that exposed unsupported claims on the websites of some chiropractors [29].

There is also evidence that traditional chiropractors feel aggrieved by the evidence-friendly group, because they think that 'real' chiropractic is being denigrated or squandered.

And here are some examples of the problem as seen from the perspective of the traditional group:

- Evidence-friendly chiropractors are seen as unfaithful to the traditional tenets of chiropractic (i.e. subluxation as a basis for changes in health).
- Evidence-friendly chiropractors side with the 'enemy', i.e. medical doctors, research scientists, sceptics, etc.

Evidence for this is extensive, but a few examples from current chiropractic websites include the following:

- 'Straight [traditional] chiropractors consider the medical diagnosis of disease to be unnecessary because they view these conditions as secondary effects of vertebral subluxations. In essence, they believe that disease symptoms will disappear once the underlying subluxations have been corrected properly. Most straight chiropractors do not wish to have any association with mainstream health care' [30].
- 'Chiropractic's new normal should look a lot like its old normal. You know, the one centered on our only unique service to mankind: the detection, correction and management of vertebral subluxation' [31].
- 'If you choose the more allopathic path of chiropractic medicine, your practice style will be different. You'll befriend orthopedists and other medical practitioners, supplying a form of physical medicine. You'll add various therapies, decompression, orthotics, stretches, exercises, rehab and other adjunctive services to support your spinal manipulations.you will be reduced to proper lifting, pillow recommendations and maybe even weight loss' [32].

Given the slates of problems observed by these two groups, the question for the profession to face is, what can be done about it?

One solution: Trying to unite a divided profession

In response to this division, various chiropractic organisations have since long made great efforts to try to bring the various factions closer together by appreciating and respecting each other's differences. One such unifying attempt from the European Chiropractors' Union (ECU) was the slogan 'celebrating diversity' used in connection for the 2016 ECU conference [33]. However, it is not evident that this diversity should be celebrated. We do not see 'diversity' as a strength for either of the two main factions of chiropractors, or more importantly for patients, who must employ a caveat emptor approach to finding a chiropractor.

A more recent approach that we are seeing now is that various organisations, who for decades have supported unity between factions at all costs, are now focusing strongly on evidence as the basis for chiropractic practice rather than on unity. One example is the American Chiropractic Association (ACA) that recently adopted the mainstream, broad-consensus 'Choosing Wisely' campaign, and the World Federation of Chiropractic (WFC) that recently signaled a policy shift by abandoning attempts at 'unity' [7] and focusing on 'on the creation of trust, legitimacy and promoting the best available care'

[34, 35]. This tactic changes the focus from the chiropractor, to where the focus of any legitimate healthcare profession should be, on the patient. The end results should, hopefully, be a general shift towards a more modern approach and away from old traditions.

Another solution: Creating a permanent division through "professional divorce"

In this commentary, we explore another solution to this historic division. One that does not involve uniting both sides, but one that acknowledges that when a division is too great to reconcile, decoupling may be the best way forward for all involved. In this paper, we explore the similarities between couples and professions, examine what happens when they become estranged, and consider how the solutions established by our society for marital disagreement may also be the key to doing what is best for both groups. Uppermost in our minds in this process is what is best for the 'children,' i.e. patients.

What makes spouses happy, or at least content, in their marriages?

Obviously, there are many and varied reasons for making married couples happy and functional. Love, affection, and sex [36] are important initiators for many marriages and helpful to maintain the relationship also in the long run. To produce, provide for, and ensure the survival of offspring is another unifying aspect [37]. A feeling of togetherness, defined as easy communication, similar habits, hobbies, activities, and the ability for constructive problem-solving makes living together pleasant, as does a common history, and a similar background [36, 38]. Solidarity provides a strong cornerstone in successful marriages [39], as does the concept of being a happy family and the status associated with this in society [40]. Clearly, being in a stable financial situation would help make a couple more trouble-free and hence invite fewer problems and result in less risk of disenchantment and disagreements that potentially can lead to a split [41, 42].

Why may couples stay together when things go bad?

These reasons for content marriages are hardly surprising. However, why some couples choose to stay together, when the relationship has gone sour and there is no love left between the parties, is relevant to this discussion.

Respect for each other, morality, religion, politics, and business interests may be some reasons for remaining, as well as the wish not to hurt the other partner [37]. Some prefer to wait 'till the children have grown up' [39] and in others it is the fear of the unknown including concerns about potential economic hardship [42]. It is also well known that feelings and relationships can have their ups and downs, so some may simply 'hang around' hoping for better times [41].

Additionally, when marriages are clearly dysfunctional and the two partners would be better off on their own, it is not uncommon for one of the two to make promises to change (e.g. no more extra-marital sex, more time spent with the family, no more fighting, no more violence) [43, 44]. Kindness, wishful thinking, memories of happy early days, and financial weakness could also be reasons why the aggrieved partner may give the marriage another chance, and perhaps another and another.

Finally, when things go wrong in a marriage, another strategy is that one partner has too much to lose so they simply tolerate the problem – perhaps this is the closest analogy of where the chiropractic profession has been in the past 25 years. Doubtlessly though, both parts are unhappy with the present arrangement.

Why may couples choose to divorce?

Instead of choosing to remain in a relationship for any number of reasons, there are obviously many couples who decide to separate [45, 46]. The reasons for divorce have been a major topic of research and have been comprehensively reviewed elsewhere [46]. This review summarises longitudinal studies that identify the predictors of marital disruption as being domestic violence, frequent conflict, and infidelity, the number of perceived relationship problems, and low levels of love, trust and commitment between spouses. Minimising the difficulties, confronting relationships by using benevolent cognitions such as 'better the devil you know' only allows relationships to worsen over time [47]. Although divorces are always difficult, the outcome is often better for both partners in the long run, offering possibilities for a more self-actualised existence [48–50].

Signs that the chiropractic profession is an unhappy marriage

The two main factions in the chiropractic profession still 'live at the same address'. By this we mean that they present themselves to others under the same family name, have institutions that try to enforce the same international and national Standards of Accreditation of chiropractic programmes for both so that patients are dealt with in fairly standardised ways, and there are regulations for chiropractic educations to ensure a reasonable common level of graduates.

Nevertheless, there are definite signs that the situation may be intolerable for many chiropractors on both sides. We have identified reasons for unhappiness, and listed those in Table 1. These reasons are based on our observations of what happens in the field and are thus personal opinions, not easily documented from scientific evidence. Therefore, the items listed have not been referenced. Nevertheless we believe that most of our

colleagues will acknowledge these issues and that they resemble very much those described above in reasons for divorce among couples.

Why then are these two groups still joined together in their professional marriage?

Although there are many indications of unhappiness and also great attempts to improve the chiropractic marriage, no obvious signs of a *formal* splitting up are visible. Nevertheless, there are many reasons for some marriages to persist despite obvious difficulties and differences. The reasons for the chiropractic profession staying together may be analogous, and, as seen from our viewpoint, some of these are listed in Table 2 below:

The 'middle group'

Chiropractors sit on a spectrum, and the majority fall in the middle and practice with a 'you-never-know who and what will respond to spinal manipulation' attitude, yet with only some attachments to chiropractic tradition. Chiropractors in this group probably just want to get on with their work, not paying too much attention to the bickering going on. They do not engage politically, they rarely appear at seminars or general assemblies, and they do not take sides. Thus this middle group accepts or at least tolerates much of the statements and activities by the traditionalist groups. Importantly, the middle group does not seem to consider illogical and unsubstantiated claims to be of real danger to the profession and if they are troubled by them, they do not voice this publically, maybe because they think that 'the more the stronger' or simply because of apathy.

In our opinion, this middle ground is becoming increasingly harder to reconcile and thus difficult to hold, as the marital difficulties inevitably play out more openly, because of the increasing general public interest in chiropractic [51–54]. Therefore, we contend that members of the middle group will eventually have to choose sides between adhering to a scope of evidence-friendly practice relating to musculoskeletal problems or to a traditional approach aiming at treating a multitude of conditions through spinal manipulation. Increasingly, this position reminds us of the saying 'The standard you walk past is the standard you accept', since acquiescence makes it possible for groups of chiropractors to practice outside the logical framework of today's scientific concepts and sometimes even outside the law. Virtually every chiropractor knows of other chiropractors who x-ray every patient, or sign patients up to long contracts, or dubious 'family plans', or pre-payment plans, or use high-pressure sales tactics, or advertise unsubstantiated claims, yet very few report these breaches [55]. This 'silent majority' may in fact be responsible for the inertia and acceptance of traditionalist paradigms (seen from

Table 1 A list of signs of incompatibility between the evidence-friendly and traditional factions in chiropractic, described as it would be in an unhappy marriage, as seen from the evidence-friendly view point

Important ingredients in a marriage	Signs of unhappiness in the chiropractic 'marriage' between evidence-friendly and traditional chiropractors
Love	<ul style="list-style-type: none"> • It is evident that there is no love between two groups. Neither wishes to spend time or more intimate moments with the other.
Respect	<ul style="list-style-type: none"> • There is little tolerance between the two factions.
Agreement on common basic concepts	<ul style="list-style-type: none"> • The evidence-friendly group adopt a natural sciences critical thinking approach and more easily accepts good quality scientific studies, regardless the results, while the others disregard evidence, if it does not confirm their prior beliefs. Traditional chiropractors are also prepared to accept substandard research such as case-reports as evidence.
Easy communication; togetherness; similar interests	<ul style="list-style-type: none"> • The two factions find it difficult to communicate because the evidence-friendly groups seek to use contemporary mainstream language, whilst the others stick to traditional language, e.g. 'subluxation', 'innate intelligence', 'adjustment', 'the power that made the body heals the body', and 'treat the cause not the symptoms'. • There is no problem-solving mechanism. Therefore, central collaborative problems will rarely be discussed in order not to rock the boat too much. • Explanations to the patients about illness and health are different in the two camps; therefore it is difficult to exchange patients.
Extra-marital sex / infidelity	<ul style="list-style-type: none"> • The evidence-friendly chiropractors are seen as unfaithful by the traditionalists, as they 'sleep' with or have been seduced by members of external conventional health professions such as medicine and physiotherapy.
Intellectual differences	<ul style="list-style-type: none"> • The two groups do not attend the same type of seminars or conferences nor sit at the same table, when they are in the same room. • The improved status of the chiropractic profession depends largely on their participation in producing new evidence and this is done by the evidence-friendly group. • Very little of the research produced so far has succeeded in showing that treatment by chiropractors is superior to that delivered by other healthcare professions. Although the evidence-friendly group finds this disappointing, they maintain a patient-centered focus, confident that acceptance of truth is a necessary path to the best treatment options for patients as well as to mainstream acceptance of chiropractic methods. The traditional chiropractors seem unable to come to terms with this situation and build their professional activities and discourse on idealistic assumptions that either cannot be tested scientifically or are based on outdated health care models.
Disrespect, rudeness and nastiness	<ul style="list-style-type: none"> • Virulent attacks in social media are apparent when a scientific publication produced by evidence-friendly members fail to 'prove' what the traditionalists consider obvious, because they see proofs of this "every day in their clinics".
Economic situation	<ul style="list-style-type: none"> • Evidence-friendly chiropractors are concerned about the traditional chiropractors' exaggerated claims about cures, prevention and even longevity, which they consider deceptive. They think that biologically implausible claims and the resultant practice behaviours will have or have already affected the economic situation of the chiropractic family by creating distrust of the public and limiting the growth of the profession (i.e., the proportion of people seeking care).

the evidence-friendly side) and the gradual destruction of traditional values (seen by the traditional chiropractors).

Chiropractors are not the only family in the neighbourhood. There are other families i.e., other manual therapeutic professions, who are engaged in ongoing positive positioning, who are willing, able and evidence centred to fill the societal need for conservative approaches to musculoskeletal care. It is likely that this time window of opportunity for chiropractors is limited and closing. Much like climate change perhaps the tipping point has already been breached. The time for action may never be more appropriate than now.

Conclusions and perspectives

We acknowledge that vitalism and other idealistic concepts based on theories and beliefs rather than scientifically accepted logic and evidence have a role to play

in the public domain. They are, however, not compatible with the 'official' evidence-friendly chiropractic profession, and to accept and protect such an approach, is a serious issue, potentially one of public safety.

We have argued that the situation within the chiropractic profession corresponds very much to that of an unhappy couple that stays together for reasons that are unconnected with love or even mutual respect. The current marital disharmony clearly goes beyond the scope of continuing to live unhappily with 'another person' of a differing world view. The alternative to this unhappy family structure would be an amicable divorce.

Although it might be painful, difficult and unsettling, in the long run it might make it possible for the two main groups to develop their full potentials, as they both deserve a happy professional life. The evidence-friendly group would be free to progress and collaborate in agreement with developing research findings and trends within public health, whereas the

Table 2 Possible reasons for the continued marriage between evidence-friendly and traditionalist chiropractors

Solidarity	<ul style="list-style-type: none"> • In front of authorities, the two factions often have to work together in order to appear to be a large and united profession, for which reason they attempt to reach a common ground, for example, when 'officially' defining chiropractic. Thus broad nebulous terms such as 'prevention', 'spinal health', 'patient centered' are used to prevent complete insight into what is really going on. • The past history (i.e. the concept that they have had a hard time, that they have fought together, and the feeling that they are 'special') seems to hold the two factions together against common 'enemies'. • Personal friendships, often dating from formative years, also make it difficult to confront colleagues who we consider practising too much on the fringes of credibility.
Economy	<ul style="list-style-type: none"> • The evidence-friendly group has a financial interest in not being associated with the traditional chiropractors. However the latter group is riding on the credibility provided by the evidence-friendly group, which allows participation in legislation and reimbursement schemes and educational acceptance for their schools. • Being a large group rather than two smaller groups makes it easier to negotiate and deal with insurance agencies, government regulators, and health authorities.
Happy family	<ul style="list-style-type: none"> • Chiropractors have, traditionally, been socially isolated in the health care community but over the past decades the evidence-friendly chiropractors have been made welcome to join forces with traditional health care practitioners such as medicine and physiotherapy. However, when this occurs, the traditionalists are discretely kept in the background, not to scare policy makers and other stake holders off, which could stop this development.
Fear of unknown, weaker partner	<ul style="list-style-type: none"> • To separate the chiropractors into two professions would entail many changes, new political fights and an important task in relation to information and branding that doubtlessly requires careful consideration and a lot of work. • Clearly, the traditionalist group is most vulnerable because they would have to assume their true nature. Their approach is unlikely to appeal to authorities, third party payers and a large portion of the general public.
Hope of future improvements	<ul style="list-style-type: none"> • Many chiropractors do not see the problem as permanent, but view it as more of a short-lasting challenge, thinking that it is better to stay together, in order to be a large group and to have an influence on 'the fringes'. • Many believe that extremists on both sides in the end will get to see the light and come and join 'the middle ground'.
Family name	<ul style="list-style-type: none"> • Finally and very importantly, the family name ("chiropractor") is central. To find another name would mean re-establishing connections with the public, insurance agencies, and government regulators and health authorities, which would not be easy. Therefore, both groups may well be hanging in there, mainly, in order to keep the name.

traditional groups can flourish in the wellness market, as there is a demand in the public also for more 'mysterious' and all-encompassing therapies and movements. For us it appears obvious that stakeholders, public, and the chiropractors would be better off, if the two factions and the middle group clearly stated where they belong. In addition, if patient interests are given true primacy, the arguments for unity, in our opinion, seem less significant than those for divorce.

Therefore, chiropractors and chiropractic leaders, regardless of values and persuasion, need to pause and consider, if they are able to live and develop as they would like to in this century-old unhappy marriage.

It is hoped that this paper opens a discussion among all parties that can eventually lead to an equitable arrangement for stakeholders and a sustainable future for chiropractic.

Abbreviations

ACA: American Chiropractic Association; ECU: European chiropractic union; WFC: World Federation of Chiropractic

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Authors' contributions

CLY and JH conceptualised the manuscript and wrote the initial draft, SI was responsible for the psychological aspects and KY for the historical perspectives. GNK was responsible for the over-arching structure. All debated and contributed to the subsequent drafts and final version. All authors read and approved the final manuscript.

Ethics approval and consent to participate

Not applicable

Consent for publication

Not applicable

Competing interests

Charlotte Leboeuf-Yde is a senior editorial adviser for *Chiropractic & Manual Therapies* but played no part in the administration of this submission which was independently peer reviewed.

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CHIROPRACTICE

GOVERNING THE PRACTICE OF CHIROPRACTIC IN THE PUBLIC INTEREST

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President's Message



Dr. David Starmer
President
April 2018 - Present

When I look ahead in 2019, I am reminded why I ran for Council five years ago. I knew the rights and obligations of self-regulation are designed to serve and protect patients. It is a privilege and responsibility shared by all in the profession and I wanted to do my part.

Through my time on Council, I have been proud to see CCO demonstrating its commitment to addressing issues raised by the public and members as they relate to the effective regulation of chiropractic in the public interest - and I know the hard work is not over.

For that reason, instead of reminiscing about the history and reflecting on our accomplishments, I want to face forward and focus this communication on some of the initiatives ahead of us.

Patient Care and Chiropractic Practice

CCO will be working through some ambitious efforts to reinforce the relevant regulations and guidelines that enable members to understand what they can and can't claim in the course of providing safe and ethical patient care in their chiropractic practice. This will require ongoing work from several CCO committees. Highlights include:

- Use of social media is a topic being seriously addressed by CCO. During a member's peer assessment, CCO's peer assessors will review the member's website(s), advertising, and social media posts and report any apparent breaches to the CCO's Quality Assurance Committee. Consideration is also being given to implementing new ways to support peer assessors in ensuring the appropriate advisory and remedial actions are taken to address issues arising during their peer assessments.
- The Inquiries, Complaints and Reports Committee (ICRC) is accelerating its processes for addressing public complaints against members about their websites, advertising, and social media sites such as making claims for treatments that may fall outside the chiropractic scope of practice.
- CCO is analyzing web-scanning technology currently being used by the College of Chiropractors of British Columbia and others to assess its merits

MISSION

The College of Chiropractors of Ontario regulates the profession in the public interest to assure ethical and competent chiropractic care.

VISION

Committed to Regulatory Excellence in the Public Interest in a Diverse Environment

VALUES

- Integrity
- Respect
- Collaborative
- Innovative
- Transparent
- Responsive

STRATEGIC OBJECTIVES

1. Build public trust and confidence and promote understanding of the role of CCO amongst all stakeholders.
2. Ensure the practice of members is safe, ethical, and patient-centered.
3. Ensure standards and core competencies promote excellence of care while responding to emerging developments.
4. Optimize the use of technology to facilitate regulatory functions and communications.
5. Continue to meet CCO's statutory mandate and resource priorities in a fiscally responsible manner.

Developed at the strategic planning session: September 2017

Acronyms

BDC	Board of Directors of Chiropractic
CCO, the College	College of Chiropractors of Ontario
CE	Continuing education
the Code	Ontario Human Rights Code
CMCC	Canadian Memorial Chiropractic College
CMRTO	College of Medical Radiation Technologists of Ontario
CTCMPAO	College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario
FHRCO	Federation of Health Regulatory Colleges of Ontario
ICRC	Inquiries, Complaints and Reports Committee
MOHLTC	Ministry of Health and Long-Term Care
NGO	Non-governmental Organization
PPA	Peer and Practice Assessment
QA	Quality assurance
RHPA	Regulated Health Professions Act, 1991
SCERP	Specified continuing education or remedial program
TUP	Technology Upgrade Project

EXTRACT FROM THE CHIROPRACTIC ACT

Scope of Practice

3. The practice of chiropractic is the assessment of conditions related to the spine, nervous system and joints and the diagnosis, prevention and treatment, primarily by adjustment, of,
 - (a) dysfunctions or disorders arising from the structures or functions of the spine and the effects of those dysfunctions or disorders on the nervous system; and
 - (b) dysfunctions or disorders arising from the structure or functions of the joints.

Authorized Acts

4. In the course of engaging in the practice of chiropractic, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:
 1. Communicating a diagnosis identifying, as the cause of a person's symptoms,
 - i. a disorder arising from the structures or functions of the spine and their effects on the nervous system, or
 - ii. a disorder arising from the structures or functions of the joints of the extremities.
 2. Moving the joints of the spine beyond a person's usual physiological range of motion using a fast, low amplitude thrust.
 3. Putting a finger beyond the anal verge for the purpose of manipulating the tailbone.

(CONT. FROM PAGE 1)

for use in Ontario as a way to bring to light any failures by chiropractors to comply with existing provisions.

- Discussions have already taken place at both the CCO's Executive Committee and the Advertising Committee to consider whether the Advertising Committee's mandate is sufficiently robust in ensuring it can adequately monitor and productively enforce the standards of practice as they relate to advertising, including social media.

Collaboration with Stakeholders

I am pleased to see our enhanced efforts in reaching out to stakeholders such as the Ontario Chiropractic Association and the Federation of Health Regulatory Colleges of Ontario. Efforts have resulted in some tangible action such as fostering relationships to enhance our public interest focus and our communications vehicles to all stakeholders.

Harmonizing Standards of Practice and Sharing Best Practices across Canada

By design, all health care professionals are separately regulated at the provincial and territorial levels in Canada. With constant changes in health care dynamics, individual regulators are always adapting their provisions to best serve the public in the new landscape. This is a challenging role.

In the harmonization of standards of practice and the sharing of best practices across Canada, CCO will strive to enhance discussions aimed at ensuring consistency in the patient experience from coast to coast, including processes for examination, history taking, diagnosis, treatment, and plan of management.

Evaluating Regulatory Governance

The current model of self-regulation as articulated in the *Regulated Health Professions Act, 1991* is not the only model for self-regulation. What the public needs and expects from its regulators is always evolving. Therefore, the CCO must also continually evolve to best serve the public. As other Ontario health regulators are discussing regulatory reform to shift towards competency-based selection criteria for board members, smaller boards, and enhanced oversight, it is imperative that CCO is part of this conversation. It is essential that we discuss and debate the merits of different systems and processes, with a focus on determining how best to serve our

role and mandate as we move forward.

Defining/Measuring Regulatory Performance

I am pleased to report that Council has had fulsome discussion on enhancing its regulatory performance and how accountability and success can be measured. Council is looking at best practices, how it can be measured, and also how CCO can continue building trust with members, stakeholders and the public.

CCO on the Move!

Thanks to CCO's history of due diligence and fiscal responsibility, CCO will be moving into a new home this summer. Considerable care has been expended by CCO to look at best practices followed by other health regulators in making the office space accessible to the public and to take advantage of opportunities to redefine some processes and to enhance its corporate responsibilities and commitment to environmental sustainability.

Not far from CCO's current offices, the new location is easily accessible for visitors and members who use public transportation.

In Appreciation

I am grateful to both our publicly-appointed members and our elected professional members who serve on Council and have allowed me to serve as President. Their collective dedication to serving our public interest mandate is first and foremost in all of Council's deliberations and actions. Our Council and committee meeting agendas are characterized by open discussions and proactive action.

Supporting us in our dedicated work in serving the public of Ontario would never be possible without the supportive staff team, led by Ms Jo-Ann Willson, Registrar and General Counsel.

I am also very proud of the high level of engagement in self-regulation and the desire to serve the public interest. Clearly, this is demonstrated throughout various activities that support our efforts both internally and externally. I encourage members to continue to participate with us in enhancing self-regulation in the public interest through respectful discussion.

Thanks for being engaged!

Registrar's Report



Ms Jo-Ann Willson
Registrar and General Counsel

This issue's "hot" topics: Advertising, Websites, Social Media

I found an extract from a newsletter from the former Board of Directors of Chiropractic (BDC) dated April 1991:

ADVERTISING GUIDELINES FOR CHIROPRACTORS AND RELATED CORPORATIONS

Registrants have a responsibility to the public, the profession and the Board to ensure that advertising copy in any media is:

Factual, objectively verifiable, and based on facts independent of personal beliefs, opinions or interpretations.

References to the cure of symptoms, diseases or appealing to a lay person's fears are not considered to meet the foregoing criteria.

Some members (with early registrant numbers!) will also recall that there was a time when the BDC had a "yellow pages" advertising policy, as well as a prohibition on the size (including font size) of any office advertising.

Historically, CCO has received few complaints about advertising, except from one chiropractor against another. In 2017 for example, CCO received a total of four complaints about advertising, two complaints about scope of practice and one complaint about social media (reference the 2017 Annual Report). Those numbers will be different in 2018 and in 2019. Members are reminded that not all complaints come from chiropractic patients. Any member of the public can file a complaint and CCO's Inquiries, Complaints and Reports Committee will exercise its discretion in accordance with the *Regulated Health Professions Act, 1991* with each and every complaint that is received.

So what's changed? The fundamental message from CCO hasn't changed. What has changed is the methods by which members communicate, the speed at which information is transmitted and the increase in reach of what the public sees. CCO's obligation is to ensure existing standards are either revised, enforced differently, or that the balance between reactive (complaints and discipline) versus proactive measures (quality assurance) needs to be shifted to reflect this new landscape. Another aspect that seems to have changed is an apparent lack of professional respect or courtesy that has crept in between and amongst

colleagues. That doesn't reflect well on the health of the profession, nor does it help in building public trust and confidence. There is, of course, room for and a need for healthy debate and discourse but that comes with an expectation that stakeholders including members will communicate in an informed, respectful manner.

On November 29, 2018, a number of chiropractic stakeholders, some media and various other members of the public attended CCO's Council meeting at which a number of options were presented to and considered by Council. CCO has committed to continuing to enhance both its proactive and reactive processes relating to scope of practice and advertising, including websites. The Advertising and Quality Assurance Committees in particular have been working for a number of months preparing comprehensive recommendations for Council's consideration. Watch CCO's website for news about changes to standards, policies and guidelines.

My recommendation is that every member put the "self" in self-regulation by reviewing his/her own advertising, website(s) and social media communications. That means making sure you are not making unsupported claims. It also means ensuring you are complying with the provisions as they relate to specialties or the use of protected titles like medicine, physiotherapy or acupuncturist unless you are a member of a college which has those protected titles. Know that there are individuals keenly interested in finding false or misleading claims, and in bringing that information to the attention of CCO. Know too that CCO will be stepping up its efforts in reviewing existing standards, policies, guidelines and processes, and in reviewing members' public information including through the use of appropriate technology. CCO's statutory responsibility is to regulate the profession in the public interest. Many people feel passionately about the issues relating to advertising, social media and websites, and CCO remains interested in and committed to considering all feedback as it reviews existing provisions and processes **through the lens of public protection.**

Welcome

Registry Update

Please check the website or contact CCO about any changes in the registration status of a CCO member.

WELCOME NEW MEMBERS

CCO welcomes the following new members (registered from January 1, 2018 to January 31, 2019) and wishes them a long and successful career in chiropractic.

Ryan J. Abrams
 Sean P.E. Adam
 Meghan J.E. Adams
 Therese Agayby Ghobrial
 Adam Alexander
 Bettina M. Ambuehl Honegger
 James S. Anderson
 Kyle J. Aram
 Ali-Massud Asgary
 Catherine Askander
 Nooralhuda Bakaa
 Stephen J. Bako
 Jarod R. Balog
 Matthew A. Barden
 Antoine D. Barrier
 Angele F. Beauclair
 Nardine Bekhit
 Shannon J. Bloch
 Mary E. Bogumil
 Lindsay E. Bonas
 Taylor Bonner
 Brittany N. Boot
 Corinne E.M. Brookhuis
 Mary N. Brown
 Colin D. Brown
 Kevin J. Brownell
 Patricia L. Brum
 Mikaela E. Buchli-Kelly
 Rozina Budhwani
 Alan N.H. Bui
 Katelynn Bulmer
 Stacey A. Cairns
 Mitchell S. Campbell
 Sarah L. Campbell
 Eric P.P. Caron
 Jenna M. Casuccio
 Nicholas M. Centritto
 Alexandria R.Y. Chen
 Daniel L. Cherubini
 Sherman Chiu
 Grand S. Choi

Felix P.H. Chu
 Emily H.C. Chung
 Lydia M. Colacino
 Courtney L.A. Cole
 Kayla M. Cole
 Lisa A. Costa
 John A. Coulson
 Laura A. Custode
 Allyshia L. Daley
 Marian Daoud
 Angela C. Dares
 Michelle DaSilva
 Brooke A. Deschamps
 Christopher Di Natale
 Matthew J. Diston
 Heather M.L. Dryburgh
 Christopher A. Duong
 Carissa E. DuPuis
 Brooke L.A. Earley
 Amr O. El Bouse
 Mariusz J. Fajfer
 Josef A. Fediurek
 Vivianne J. Fortin
 Ryan S. Garcia
 Rebecca M. Gaudry
 Darrin D. Germann
 William T. Giancoulas
 Erica L.Gifford
 Joseph A. Gigliotti
 Manuel S. Gil
 Katelyn N. Good
 Kassandre G. Goupil
 Joseph P. Greenwood
 Michelle A. Grybko
 Dominique M. Harmath
 John W. Harmon
 Kara A. Harnish
 Sarah C.C. Heath
 Katie P.Y. Heung
 Kevin D.G. Hong
 Zachary D.F. Howard

Spiro P. Ioannidis
 Nicole A.L. Insley
 Jessica L. Jarrell
 Eun-Yong Jeong
 Amanda R. Johnson
 Mackensie D. Jordan
 Stephanie C. Juff
 Carmen Jweda
 Rebecca Kang
 Devon Keys
 David P. Kim
 Youngwook Kim
 Evin P. Kolm
 Constance Z. Kontos
 Justin M. Kutasiewicz
 Jason Lacroix
 Tessa C. Lam
 Iris Y.Y. Lau
 Tim W.H. Lau
 Thanh Le
 Chantel J. LeClair
 Melody K.Y. Lee
 Eric Lee
 Cassandra M. Leigh
 Madeleine Levine
 Michael K.S. Liang
 Rebecca Lima
 Mateo Lino
 Ryan J. Lisowski
 Yi Liu
 Andrea D. Luke
 Benjamin M. Mahoney
 Erin K. Mailloux
 Fabrice Mallard
 Laleh Maroufi
 Richelle-Faith Martins
 Pamela J. Masse
 Elliot L. Mayhew
 Jesse J.T. McAleese
 Sarah N.H. McAteer
 Shawn P.M. McDonald

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Kirstie A. McDowell	Kaitlyn M. Pepper	Gillian A. Sawa	Payam Vala
Michael P. McGahey	Kimberly M. Perryman	Sarah V. Seaborn	Vanessa E. Van Dyke
Andrew J. McManus	Theery Piche	Rula A. Shaar	Grant H. Van Dyke
Andrew D.W. Mercer	Jessica N. Pludwinski	Jordan Shnier	Maranda M. Vanderbeek
Laura E. Mercuriano	Colleen N. Prendergast	Kyle J. Simpson	David B.B. Veltman-Robert
George Mikhail	Daniel E. Prinsen	Devika Singh	Khushboo Vora
Larysa Mikhailava	Lauren A. Pruner	Adam N. Sisti	Shannon M. Webster
Andrew I. Miller	Yu Qin	Ellen T. Smith	Phillip F. Wessel
Rebecca L. Muzos	Jordan N. Rabinowitz	Alexandra R. Smith	Emma H. Whelpton
Sabrina Narula	Isaiah D.C. Redfern	Brandon M. Somlo	Katherine E.R. Whitton
Brianna L. Newman	Parisa C. Ricciardelli	David P. Song	Tracy Wong
Myla Nguyen	Meghann J. Robinson	Evan A. Stibbard	Robert S. Woodland
Kim T. Nguyen	Kathleen T. Rodgers	Andrew J. Synnott	Brian A. Wright
Edward A. Nigro	Kirstyn P. Ross	Kaitlyn M. Szabo	Trevan D.D. Wright
Shivinder S.O. Oberoi	Jacqueline M. Ross	Rishi Tayal	Jonathan D.K. Yu
Michael G. O'Handley	Alena C. Russo	Jennifer L. Thomson	Theodora C. Zacharia
Taranjit Ohson	Arash Saleki	Rachel N. Tomlin	Boyan Zhang
Bohdan Osoba	Andrew P. Sauer	Kyle S. Tront	
Amjed W. Osman	Marie-Pier Sauriol	Aviv Tsimerman	

IN MEMORIAM (JANUARY 1, 2018 – FEBRUARY 15, 2019)



Name	Year of Initial Registration	Date of Death
Dr. David Jongsma	1991	January 2, 2018
Dr. Kenneth Oldaker	1975	January 15, 2018
Dr. Judy Ben-Israel	1980	February 13, 2018
Dr. William S. Baird	1956	February 17, 2018
Dr. Eugene Track	1975	March 27, 2018
Dr. Donald Verne Thomson	1958	April 12, 2018
Dr. Tanya Tucker	2014	May 1, 2018
Dr. John M. Thyret	1966	June 28, 2018
Dr. Michael Beaton	1965	Unknown
Dr. Vijay Gopalakrishnan	2012	November 17, 2018
Dr. Michelle Prince	1998	November 18, 2018
Dr. Daniel Gleeson	1963	November 22, 2018
Dr. William C. Pamer	1994	February 7, 2019

CCO extends its condolences to the families, friends, and colleagues of these members.

DR. HAROLD BEASLEY MEMORIAL AWARD GOES TO...

The winner of the 2018 Dr. Harold Beasley Memorial Award is **Janet Belliveau**. Awarded annually to a Canadian Memorial Chiropractic College student, the award encourages chiropractic students to develop a greater understanding of Ontario jurisprudence relating to chiropractic practice.

Council Member Terms

as at January 2, 2019

Name	District	Date First Elected/ Appointed	Date Re-elected/ Re-appointed	Date of Expiry of Election/ Appointment of Current Term
Elected Members				
Dr. Peter Amlinger	5 (Central West)	April 2017	N/A	April 2020
Dr. Elizabeth Anderson-Peacock	3 (Central East)	April 2013	April 2016	April 2019
Dr. Brian Budgell	4 (Central)	April 2018	N/A	April 2021
Dr. Clifford Hardick	6 (Western)	May 2011	April 2014 April 2017	April 2020
Dr. Dennis Mizel	5 (Central West)	April 2018	N/A	April 2021
Dr. Kristina Peterson	1 (Northern)	April 2017	N/A	April 2020
Dr. Brian Schut	4 (Central)	April 2016	N/A	April 2019
Dr. Gauri Shankar	2 (Eastern)	April 2010	April 2013 April 2016	April 2019
Dr. David Starmer	4 (Central)	April 2014	April 2017	April 2020
Appointed Members				
Ms Georgia Allan	Smiths Falls	September 8, 2014	September 8, 2017	September 7, 2020
Ms Karoline Bourdeau	Toronto	July 17, 2017	N/A	July 17, 2020
Mr. Douglas Cressman	Kitchener	June 30, 2016	N/A	June 29, 2019
Ms Tamara Gottlieb	Toronto	December 31, 2018	N/A	December 31, 2021
Mr. Robert MacKay	Thunder Bay	November 28, 2018	N/A	November 27, 2021
Ms Sheryn Posen	Toronto	November 28, 2018	N/A	November 27, 2021
Vacant				

IN APPRECIATION

CCO expresses its gratitude to the following members who served on committees and worked diligently to uphold CCO's public interest mandate. Their commitment is sincerely appreciated, and CCO wishes them every success in their future endeavours.

DR. REGINALD GATES, DISTRICT 5 (CENTRAL EAST): April 2015 - April 2018

DR. PATRICIA TAVARES, DISTRICT 4 (CENTRAL): April 2012 - April 2018

MR. SHAKIL AKHTER, PUBLIC MEMBER: April 2010 - May 2018

MS JUDITH MCCUTCHEON, PUBLIC MEMBER: August 2009 - August 2018

MS WENDY LAWRENCE, PUBLIC MEMBER: September 2015 - September 2018

MS PATRICE BURKE, PUBLIC MEMBER: April 2015 - December 31, 2018

Council Meeting Dates

2019

Tuesday, April 30	8:30am – 4:30pm
Wednesday, June 19	8:30am – 4:30pm
Saturday, September 14	8:30am – 4:30pm
Thursday, November 28	8:30am – 4:30pm

Confirmed Council meeting dates are posted on the CCO website.

Council Meeting Highlights

Council meetings are open to the public, although Council occasionally goes in camera to discuss matters such as finances or to receive legal advice. Council’s practice is to arrange the agenda to minimize any inconvenience to guests arising from in-camera sessions.

At all meetings, Council reviews information from the Ministry of Health and Long-Term Care (MOHLTC), other chiropractic organizations, other health regulatory colleges and the Federation of Health Regulatory Colleges of Ontario (FHRCO). Council also monitors legislative changes to ensure it is informed about recent developments that relate to CCO’s mandate to regulate chiropractic in the public interest.

All Council meetings involve a report from every committee as well as the Treasurer, and consideration of the recommendations of each committee. Meeting items that appear not to be controversial are included on a consent agenda as a mechanism for ensuring time efficiency. Any Council member wishing discussion of a consent agenda item may move the item to the main agenda. CCO has regular attendees at its Council meetings, such as representatives from the Ontario Chiropractic Association, the Canadian Chiropractic Association and, occasionally, government representatives. Attendees receive comprehensive public information packages.

The public portion highlights of five Council meetings held since publication of the last newsletter follow.

FEBRUARY 6, 2018

Council noted/reviewed the following:

- Positive update on recent Technology Upgrade Project (TUP) milestones, including online registration renewals for members and holding the 2018 CCO elections online
- Greater than anticipated participation by members in PPA 2.0 peer assessments

Council approved the following:

- Minor amendments to:
 - Standard of Practice S-019: Conflict of Interest in Commercial Ventures
 - Guideline G-007: Communication with Patients

APRIL 24, 2018

Council noted/reviewed the following:

- New Council members, Dr. Brian Budgell and Dr. Dennis Mizel, were welcomed
- Re-appointment of Ms Patrice Burke, public member, to December 31, 2018
- Positive feedback from members regarding the new online election held in March 2018

Council approved the following:

- Guideline G-013: Chiropractic Assessments
- Guideline G-014: Delegation, Assignment and Referral of Care

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COUNCIL MEETING HIGHLIGHTS

(CONT. FROM PAGE 8)

- Revocation of Guideline G-004: Documentation of a Chiropractic Visit
- Amendments to:
 - o By-law 6: Election of Council Members
 - o By-law 17: Public Register
- Minor amendments to:
 - o Standard of Practice S-001: Chiropractic Scope of Practice
 - o Standard of Practice S-002: Record Keeping
 - o Standard of Practice S-014: Prohibition of a Sexual Relationship with a Patient

JUNE 20, 2018

Council noted/reviewed the following:

- The well-attended and positively received Roadshows held in various Ontario locations
- Continued positive feedback on the enhanced capabilities offered through CCO's Technology Upgrade Project
- Recognized the efforts of Mr. Shakil Akhter, Ms Judith McCutcheon, and Ms Wendy Lawrence, public members, upon their departure from CCO

SEPTEMBER 14-15, 2018

Council noted/reviewed the following:

- CCO continues to be in a sound financial position
- CCO has proactively engaged with other health regulators to discuss important regulatory issues

Council approved the following:

- Minor amendments to:
 - o Standard of Practice S-013: Consent
 - o Standard of Practice S-014: Prohibition of a Sexual Relationship with a Patient
 - o Standard of Practice S-022: Ownership, Storage, Security and Destruction of Records of Personal Health Information
 - o Policy P-051: Peer Assessors

NOVEMBER 29-30, 2018

Council noted/reviewed the following:

- Considered opportunities for CCO to engage the public in getting feedback and input on various initiatives under consideration

Council approved the following:

- Minor amendments to:
 - Standard of Practice S-021: Assistive Devices
 - Guideline G-008: Business Practices
 - Guideline G-009: Code of Ethics
 - Policy P-009: Dr. Harold Beasley Memorial Award
 - Policy P-011: Conflict of Interest for Council and Non-Council Committee Members
 - Policy P-045: Legislation & Ethics Examination
 - Policy P-050: Supervision and Direction of Chiropractors in Training
 - Policy on Public Screenings

CCO Council and Committees Continue to Increase Efficiencies and Reduce Costs through Use of Technology

CCO Conducts Online Elections to Council

In an effort to increase its use of technology, reduce reliance on paper and increase voter turnout, CCO conducted online elections to Council for the first time in March 2018. Following a by-law amendment allowing for online voting, CCO launched an online platform for voting in elections to Council in District 4 and District 5 elections.

Following the use of online voting for the first time, voter number turnout from 2017 to 2018 in District 4 increased from 322 to 465 and in District 5 increased from 492 to 573.

CCO encourages all members to vote in elections in their districts in an effort to continue to increase voter turnout.

CCO Launches Continuing Education and Professional Development (CE) Reporting in Member Portal

CCO Council and Committees continue to explore methods of increasing efficiencies and reducing costs through the use of technology. Following the launch of online renewal for 2018, CCO has added the Quality Assurance portal for members to submit their CE hours for the July 1, 2016 – June 30, 2018 CE Cycle and begin logging their hours for the July 1, 2018 – June 30, 2020 CE Cycle.

CCO's Quality Assurance Committee will continue to explore methods of incorporating additional areas of the Quality Assurance Program into the online member portal.

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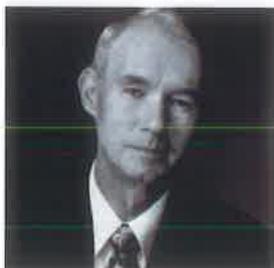
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CCO Distributes Meeting Materials Online and Conducts Teleconferences Whenever Possible

CCO continues to reduce its use of paper through the production and distribution of electronic Council and Committee materials. In addition, certain committees, such as the Registration and Patient Relations Committees continue to use teleconference meetings to review referrals for applications for registration and applications for funding for therapy and counselling in an effort to reduce costs.

CCO is Developing an Online Portal and Payment Mechanism for Initial Application and Examination and Workshop Registration

To reduce paper applications involved in the initial registration process, CCO is developing online mechanisms for initial registration and registration for the Legislation and Ethics Examination and Record Keeping Workshop. CCO will be launching this application later in 2019.

CCO WELCOMES NEW COUNCIL MEMBERS

Dr. Brian Budgell
District 4 (Central)

Elected to Council in 2018, Dr. Brian Budgell is the Director of Life Sciences Laboratories at the Canadian Memorial Chiropractic College (CMCC). He was in full-time clinical practice for approximately six years before turning to a career in research.

From 1993-2000, Brian worked under the late Professor Akio Sato in the Department of the Autonomic Nervous System at the Tokyo Metropolitan Institute of Gerontology. The focus of his research was the neurobiological basis of somatic therapies, most particularly somatoautonomic and spinovisceral reflexes.

Brian was an associate professor for approximately seven years in the Faculty of Medicine at Kyoto University, working on both human and animal investigations. His most recent work concerns the effects of somatic stimulation on spinal cord blood flow, and the influence of spinal cord compression on the modulation of somatoautonomic reflexes.

Brian has a strong interest in biomedical and health linguistics, and has published a number of peer-reviewed papers in this field. He is also president of Global Peace Network, a Canadian NGO building a network of rehabilitation clinics across East Africa.

"I am honoured to have been elected to the CCO and will work hard to see that our decisions in the interest of the public are based on the best available evidence."



Dr. Dennis Mizel
District 5 (Central East)

Congratulations to Dr. Dennis Mizel on his election to Council. Dennis served as President from June 2008 - June 2009 and April 2014 - April 2015.

Dennis brings 40 years of chiropractic practice to CCO. He has a sound perspective on the diversity of the profession and the role of the College in protecting the public interest. He has also served in various roles for the Ontario Chiropractic Association, the Federation of Canadian Chiropractic, and the Council on Chiropractic Education Canada.

Dennis served as a CCO peer assessor from 2001 - 2015. "It was exciting and very satisfying to be involved in the peer assessment program through visiting colleagues in District 5 and helping them identify areas where they excelled or needed improvement." He particularly enjoys the opportunity to work collaboratively with others in ensuring the public receives competent and ethical chiropractic care. To sharpen his own skills, Dennis is committed to regular participation in continuing education opportunities.

Dennis and his wife, Maxine, have become huge fans of travelling. When he's not practising chiropractic at his clinic in St. Catharines, they are on interesting trips that include diverse destinations such as Europe and Australia.

"I have a deeply-rooted passion in helping to uphold the public interest in Ontario and assuring the public that they can get the best chiropractic care possible."



Mr. Robert MacKay
Public Member
Thunder Bay

CCO Council is pleased to welcome back Mr. Robert MacKay as a public member.

Having previously served three consecutive appointments to CCO Council from 2006 to 2015, Rob is returning with 13 years of experience in regulatory governance in health and non-health fields. Born and raised in Thunder Bay, he is a retired dental sales representative and practice management consultant.

With primary interests in ethics, discipline and adjudication, Rob brings years of experience in conducting hearings and decision writing. His experience and keen interest are supported by significant formal training in this area including a Certificate in Adjudication from Osgoode Hall Law School and the Society of Ontario Adjudicators and Regulators (SOAR).

Rob brings over 20 years experience in public speaking to both small and large groups and an extensive list of not-for-profit volunteerism.

"In all that I do, I hold myself to a high standard of competence and ethics, as this is what is expected of the registrants of regulatory bodies. Specifically, I strive to assist the organization in fulfilling its function of regulating in the public interest, always."



Ms Sheryn Posen
Public Member
Toronto

Sheryn Posen has over 35 years' experience in project management, fundraising, public education, marketing, event management, and public and media relations. She has worked extensively with Foundations and not-for-profit organizations to realize monetary, educational and marketing goals.

Early in her career, Sheryn served as Public Relations and Development Officer at the Canadian Memorial Chiropractic College. Following her departure from CMCC, she continued to develop her Development and Management career at a variety of Foundations and corporations.

Sheryn began her own corporate communications company in 1992, providing project management services, which included fundraising, event management, national public and media relations, communications, government relations and facilities development for corporate and not-for-profit clients. In 2005, Sheryn was appointed Chief Operating Officer of Canada's Sports Hall of Fame with the key focus to rejuvenate the Hall and re-establish its presence in Canada. To honour Sheryn at the time of her retirement from Canada's Sports Hall of Fame in 2010, the *Sheryn Posen Entrance Scholarship* was established in the Faculty of Physical Education and Health, University of Toronto by colleagues and friends. In 2013, Sheryn authored the book, *From Shame to Fame*, a memoir about her term as Chief Operating Officer of Canada's Sports Hall of Fame.

Since her retirement, Sheryn has continued to produce a handful of charity events. She now looks forward to returning to her roots by contributing to the integral work of Council in regulating chiropractic in the public interest.



Ms Tamara Gottlieb
Public Member, Toronto

Tamara Gottlieb is the founder and CEO of The Listening Post, a boutique management-consulting firm providing data-driven strategies. Tamara has extensive experience in serving highly regulated sectors and understanding their unique governance challenges. Formerly Vice President of a national research firm, Tamara has also worked in communications and media relations. A graduate of Western University and an Ottawa native, Tamara has called Toronto home for over 20 years. A mother of four, she is an active volunteer in her children's schools.

UPDATES TO STANDARDS OF PRACTICE, POLICIES AND GUIDELINES

CCO has made several amendments to standards of practice, policies and guidelines since the last issue of *ChiroPractice*. The most up-to-date documents are available on the CCO website once the corresponding Council minutes are approved. Below is a summary of the updated documents.

Approved on September 16, 2017, Came into Effect November 30, 2017

Minor Amendments to Standard of Practice S-014: Prohibition of a Sexual Relationship with a Patient

CCO Council approved amendments to Standard of Practice S-014: Prohibition of a Sexual Relationship with a Patient to ensure the standard of practice is consistent with amendments to the *Regulated Health Professions Act, 1991 (RHPA)* resulting from Bill 87. These amendments apply to all regulated health professionals governed under the *RHPA*.

These amendments include:

- Expanding the list of acts of sexual abuse that results in the revocation of a member's license to include:
 - Touching of a sexual nature of the patient's genital, anus, breast or buttocks,
 - Other conduct of a sexual nature prescribed in regulations made pursuant to clause 43 (1) (u) of the *RHPA*.
- Defining a patient to include an individual who was a member's patient within one year from the date on which the individual ceased to be the member's patient. Therefore in accordance with the *RHPA*, a member may not commence any sort of sexual relationship with a former patient until at least one year has passed from the date of termination of the doctor/patient relationship.

CCO reminds members that there is a principle of zero tolerance for acts of sexual abuse.

Minor Amendments to Policy P-018: Funding for Therapy and Counselling for Patients Sexually Abused by Members

CCO Council approved amendments to Policy P-018: Funding for Therapy and Counselling for Patients Sexually Abused by Members, to ensure the policy is consistent with the amendments to the *RHPA* from Bill 87. These amendments will ensure more timely patient access to funding for therapy and counselling at the time a complaint is filed.

Additional amendments have deleted several redundant sections of the policy which are not consistent with CCO practices in reviewing and providing funding for therapy and counselling.

Approved on February 6, 2018, Came into Effect April 24, 2018

Minor Amendments to Standard of Practice S-019: Conflict of Interest in Commercial Ventures

CCO Council approved minor amendments to Standard of Practice S-019: Conflict of Interest in Commercial Ventures. Amendments expand the duty to disclose to the patient and record any benefit that is given to or received from a supplier of health care products or service, or to or from a health, legal or any other professional for a patient referral.

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Amendments also emphasize:

- A patient's need for health care must always be the first priority over any financial considerations;
- The appearance of a conflict of interest may damage the reputation of the profession;
- Any rebate, gift or benefit given or received for a patient referral must be disclosed to the patient and recorded in the patient health record, in accordance with the standard of practice; and
- A patient must never be subjected to any undue pressure or duress in the course of providing a referral. The choice of health care services and products must always be the patient's, after making a fully informed decision.

Minor Amendments to Guideline G-001: Communication with Patients

Following recent amendments to the *RHPA*, CCO Council approved minor amendments to Guideline G-001: Communication with Patients intended to reiterate the Ontario Government and CCO's policy of zero tolerance to sexual abuse.

Council approved amendments to Guideline G-001 to:

- Reorganize the objectives for improved readability;
- Remind members to avoid certain grooming behaviour and boundary crossings that may lead to allegations of sexual abuse;
- Encourage members to ask themselves certain questions before participating in behaviour that may be considered grooming behaviour or boundary crossings; and
- Update the legislative context section for consistency with amendments to the *RHPA*.

Approved on April 24, 2018, Came into Effect on June 20, 2018

Amendments to By-law 6: Election of Council Members

CCO approved a 12-month "cooling off" period for members who are employees, officers and directors of any professional chiropractic association such that a real or apparent conflict of interest may arise, before being eligible for election to CCO Council. Please see By-law 6 for more details.

This cooling off period will assist in avoiding any real or perceived conflict of interest for members who were previously involved in senior roles with other chiropractic associations. This requirement is also consistent with the practices of several Ontario health regulatory colleges.

Any other changes to By-law 6 would be subject to further review and approval for distribution.

Amendments to By-law 17: Public Register

The public register requirements of the *RHPA* were amended by Bill 87: *Protecting Patients Act, 2017*. CCO, like other health regulatory colleges, is required to maintain a public register consistent with the requirements of the *RHPA*. Approved amendments to By-law 17: Public Register ensure that CCO by-laws are consistent with the requirements of the *RHPA* as follows:

- Including the public register requirements of the *RHPA* as an endnote to By-law 17: Public Register;
- Repealing several sections of By-law 17: Public Register that are addressed in the *RHPA* to avoid redundancies;
- Ensuring that the posting of oral cautions and specified continuing education or remediation programs required by the Inquiries, Complaints and Reports Committee are consistent with the requirements of the *RHPA*, and that they be posted on the public register indefinitely; and
- Ensuring that the posting of undertakings required by the Inquiries, Complaints and Reports Committee are consistent with the requirement of the *RHPA*, and are to be posted until the terms of undertaking are completed.

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CCO approved further amendments to By-law 17 to clarify the requirements of the *RHPA* to post offences and to expand information that is available on the public register. This practice is consistent with the transparency initiatives of the Ministry of Health and Long-Term Care and the practices of many other Ontario health regulatory colleges. These amendments include:

- Clarifying that the posting of offences is to include criminal offences and offences under the *Health Insurance Act, 1990*;
- Requiring every bail condition or other restriction related to a criminal offence or an offence under the *Health Insurance Act, 1990* that is known to CCO to be posted on the public register; and
- Including a notation of a member's license to practise a profession inside or outside of Ontario to be posted on the public register.

Minor Amendments to Standard of Practice S-001: Chiropractic Scope of Practice

CCO Council approved minor amendments to incorporate material from Guideline G-004: Documentation of a Chiropractic Visit relating to the expectations of a chiropractic visit. Although this content is not new, it is important that the public has an understanding of what to expect from a chiropractic visit.

Minor Amendments to Standard of Practice S-002: Record Keeping

CCO Council approved minor amendments to incorporate material from Guideline G-004: Documentation of a Chiropractic Visit relating to the expectations that patient health records should "tell the story" and be unique to a particular patient experience, and avoid "template-like" records, particularly in electronic record keeping.

Amendments also include minor clerical changes, expanded expectations relating to chiropractic assessments, and a requirement that the record include information of who provided care and the location of where care was delivered.

Revocation of Guideline G-004: Documentation of a Chiropractic Visit

CCO Council revoked Guideline G-004: Documentation of a Chiropractic Visit and incorporated its content into Standard of Practice S-001: Chiropractic Scope of Practice and S-002: Record Keeping to reduce redundancies in CCO policy.

New Guideline G-013: Chiropractic Assessments

The objective of this guideline is to further clarify the role, importance and reasons for different types of assessments as part of the chiropractic plan of care. Assessments and re-assessments are a critical component in evaluating a patient's condition, assessing the effectiveness of chiropractic care, influencing clinical decision-making, discussing the patient's goals and expectations, and affirming or revising care or a plan of care.

Current CCO standards of practice require a re-assessment to be conducted when clinically necessary, and in any event, no later than each 24th visit. However, this guideline expands the expectations involved in different types of assessments, including:

- Initial assessment
- Subsequent visits
- Comparative assessments
- New condition/goal assessments
- Updated condition/goal assessment
- Discharge assessment (where applicable)

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New Guideline G-014: Delegation, Assignment and Referral of Care

The objective of this guideline is to:

- Clarify that a chiropractor is not permitted to delegate a controlled act;
- Outline policies and procedures for the assigning of certain clinical procedures that are in the public domain to a properly trained clinical staff person; and
- Outline policies and procedures in the referral of care to another health care provider.

This guideline proposes to further clarify which professional activities may or may not be assigned to a staff person and the policies and procedures around assignment and referral of care. This includes requirements relating to: communication with patients, provision of clinical services, business practices, and record keeping.

Approved on September 15, 2018, Came into Effect November 29, 2018

Minor Amendments to Standard of Practice S-013: Consent

Summary of Amendments

CCO Council approved minor amendments to Standard of Practice S-013: Consent, which expands the intent of the standard to ensure patients are fully informed and in agreement to the examination, care, and plan of care. The consent process also requires members to accommodate reasonable patient requests and preferences, while ensuring that safe, ethical chiropractic care can be provided. Amendments also emphasize that members take appropriate measures to communicate to the patient and ensure informed consent is obtained for any touching related to examination or treatment of sensitive body parts.

How this Affects Members

Members shall ensure that the consent process with patients involves a discussion of the examination, care, and plan of care, touching of any sensitive body areas, and reasonable accommodation of patient requests and preferences.

Minor Amendments to Standard of Practice S-014: Prohibition of a Sexual Relationship with a Patient

Summary of Amendments

CCO Council approved minor amendments to Standard of Practice S-014: Prohibition of a Sexual Relationship with a Patient to ensure the standard of practice is consistent with regulatory amendments that define a patient under the *Regulated Health Professions Act, 1991 (RHPA)*.

How this Affects Members

It is strictly against the law for member to have a concurrent doctor/patient relationship and sexual relationship with a patient. Members shall be aware of the regulatory criteria for defining a patient and the regulations around providing emergency or incidental health care services and referring that individual for further services. There is no "spousal exemption" for providing chiropractic care to a spouse.

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Minor Amendments to Standard of Practice S-022: Ownership, Storage, Security and Destruction of Records of Personal Health Information

Summary of Amendments

CCO Council approved minor amendments that emphasize that members should ensure there is a written contract, agreement or arrangement concerning the ownership of physical records of patient personal health information, and custody of those records upon dissolution of a practice.

How this Affects Members

Members should ensure that when practising in a group setting, there is a written contract, agreement or arrangement that establishes responsibility for maintaining and transferring records upon dissolution of a practice. Patients always have a right to be informed of where their records are being maintained in the case of dissolution of a practice and request a copy of their records be transferred to the chiropractor of their choosing.

Minor Amendments to Policy P-051: Peer Assessors

Summary of Amendments

CCO Council approved minor amendments to the eligibility of a member to be appointed as a peer assessor to include that an applicant for a peer assessor position:

- Is currently actively providing direct care to patients;
- Is otherwise a member in good standing with CCO;
- Declares that all content on their professional websites and social media accounts are in compliance with CCO standards of practice, policies and guidelines; and
- Successfully completes both the internal and field training portions of the Assessor-In-Training program.

How this Affects Members

Members interested in becoming peer assessors should review the full policy to ensure that they meet the eligibility requirements. CCO is not currently looking for new peer assessors; however, please look out for any future calls for new peer assessors.

Revocation of Policy P-017: Concurrent Treatment: Physiotherapy

Summary of Amendments

CCO Council revoked this policy due to the language of this policy being outdated.

How this Affects Members

Members shall always engage in respectful and collaborative inter-professional communication for the benefit of the patient. It is an object of the *RHPA* and CCO's Code of Ethics that members work collaboratively with other health professionals in terms of providing patient care.

Approved on November 29, 2018, Came into Effect February 27, 2019

Minor Amendments to By-law 6: Election of Council Members

CCO Council approved minor amendments that will bring the elections in District 1 in sync by having an election for a one-year term in March 2020.

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Minor Amendments to Standard of Practice S-021: Assistive Devices**Summary of Amendments**

CCO Council approved minor amendments to:

- Address the dispensing of assistive devices that may have been prescribed by another health professional
- Emphasize that members must have achieved, maintain, and be able to demonstrate clinical competency to prescribe and dispense assistive devices, consistent with standards for the use of diagnostic and therapeutic procedures
- Communicate that the dispensing of assistive devices is an adjunct to chiropractic care
- Update examples of assistive devices

How this Affects Members

Members who prescribe and/or dispense assistive devices must ensure that there has been a thorough examination and diagnosis or clinical impression that would indicate the benefit of the assistive device for the patient, consistent with the chiropractic scope of practice. This would apply whether the examination was conducted by the member or another health professional.

As with any use of diagnosis or therapeutic procedure, a member who prescribes or dispenses assistive devices must ensure that they have achieved, maintain, and are able to demonstrate clinical competency in the examination, prescription, and dispensing of assistive devices.

Minor Amendments to Policy P-011: Conflict of Interest for Council and Non-Council Committee Members**Summary of Amendments**

CCO Council approved minor amendments that require Council and non-Council committee members serving on a Discipline or Fitness to Practise panel to disclose any professional or personal connection, including a connection on social media, to a member who is before the panel. This disclosure will then be assessed for any real or perceived conflict of interest.

How this Affects Members

Members serving on CCO Discipline or Fitness to Practise panels must consider any real or perceived conflict of interest that may arise through a professional or personal connection to a member before a panel.

Minor Amendments to Policy P-045: CCO's Legislation and Ethics Examination**Summary of Amendments**

CCO Council approved minor amendments to reflect the practice of offering the Legislation and Ethics Examination three times per year in conjunction with the Record Keeping Workshop.

How this Affects Members

Prospective members and applicants for registration should consult the CCO website for the date and location of any upcoming examinations.

Minor Amendments to Policy P-050: Supervision and Direction of Chiropractors in Training**Summary of Amendments**

CCO Council approved minor amendments to establish principles for the supervision of chiropractic students in practice, including prioritizing:

- Safe and effective chiropractic care
- Proper training
- Joint decision-making

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- The exchange of information
- The demonstration of professionalism

How this Affects Members

Members who participate in an accredited chiropractic program's preceptorship program must ensure they have reviewed and comply with Policy P-050.

Minor Amendments to Guideline G-008: Business Practices

Summary of Amendments

CCO Council approved minor amendments to:

- Use the term "billing arrangements" to include any fee arrangement where the patient is charged for multiple services and/or treatments at any time other than when the services and/or treatments are provided
- Ensure that any billing arrangement reflects the plan and nature of care, the patient's objectives, goals, requests, comfort level, and understanding
- Prohibit a member from subjecting a patient to any undue pressure, duress or coercion to agree to a billing arrangement or suggesting that refusing a billing arrangement will affect the quality of care
- Ensure there are protections for the patient to receive a refund for any unused portion of the billing arrangement in case of bankruptcy, death, dissolution of practice, and other incidences which may interrupt a course of care
- Respect and comply with a patient's request to pay for each service as it is provided

CCO continues to review Guideline G-008: Business Practices.

How this Affects Members

Members who offer any billing arrangements other than fee for service must ensure that they have read and comply with Guideline G-008: Business Practices. The safe and ethical care of patients must always be paramount to any billing arrangement.

Minor Amendments to Guideline G-009: Code of Ethics

Summary of Amendments

CCO Council approved minor amendments to:

- Ensure the anti-discrimination provisions of the Code of Ethics are consistent with the Ontario Human Rights Code
- Emphasize that as part of being an ethical chiropractor, a member is required to clearly communicate to patients practices relating to fees and business practices and not apply pressure or duress to patients to agree to any billing arrangement or treatment plan

How this Affects Members

Chiropractors have been granted the privilege of self-regulation, a privilege that obliges them to act competently and ethically in the practice of chiropractic to ensure public trust, collaboration with colleagues, and the integrity and dignity of the profession. The Code of Ethics outlines many of those responsibilities to patients and the public, professional colleagues, and CCO.

QUALITY ASSURANCE COMMITTEE

1030

CCO Annual Peer Assessor Workshop: Guiding Compliance And Embracing Diversity

By: Dr. Elizabeth Anderson-Peacock, Chair, Quality Assurance Committee

On Saturday, January 26, 2019, the Quality Assurance (QA) Committee hosted the team of CCO Peer Assessors for the annual Peer Assessor (PA) workshop. The team of assessors traveled from all parts of the province: from Sault Ste. Marie to Sundridge, Windsor to London, Timmins to Huntsville, Ottawa to Whitby, and all over the Greater Toronto Area and the Golden Horseshoe. Everyone was eager to receive feedback on the past cycle of assessments, get updates on the program, and to participate in the ongoing evolution and development of important CCO QA initiatives.

General welcome introductions were facilitated by QA Committee Chair and CCO Vice-President, Dr. Anderson-Peacock. Welcoming words and a regulatory overview were presented by CCO President, Dr. David Starmer, and Ms Karoline Bourdeau, public member of the QA Committee, brought greetings on behalf of the public.

The day's program included an overview and examples of recent media attention on the regulation of chiropractic, along with CCO's responses and communications, by Ms Jo-Ann Willson, Registrar and General Counsel. Ms Willson addressed the importance of building on the strength of CCO's QA Program and on hearing feedback from the peer assessors about how CCO could better ensure public protection as it relates to advertising, social media and scope of practice issues. As a regulator, CCO's activities must be viewed through a public interest lens.

This set the stage for tasking the assessors to break out into small groups to review current CCO mechanisms of handling member advertising, including websites and social media, and coming up with possible solutions to consider in enhancing CCO's efforts at ensuring members are complying with regulatory expectations related to advertising. Needless to say, this group had lots of great suggestions for the QA Committee to consider and work towards implementing.

A second small group break-out session focused on coming up with ideas that could enhance the statutory mandate

that members undergo regular and periodic self-assessment. The ideas took into account current research on measuring continuing competency in health professions, what other regulated health professions are doing for self-assessments, and the practicalities, applicability, reliability and validity of various self-assessment tools and options. Once again, the assessors provided a plethora of good ideas for the QA Committee to consider moving forward.

Mr. Joel Friedman and Dr. J. Bruce Walton provided the assessors with updates to the current standards of practice, policies and guidelines and how those updates translate into changes in both PPA 1.0 and PPA 2.0. Dr. Walton provided the assessors with both generalized and individualized performance feedback based on the assessments completed in the most recent cycle.

When asked what they liked best about being a CCO peer assessor, responses were very consistent (comments paraphrased from verbal feedback provided at the workshop):

- I like meeting chiropractors in their offices and providing them proactive guidance that might keep them out of trouble and help them provide better care to their patients.
- It's great to see how many different styles of practice there are and yet all seem to fall within the scope of chiropractic practice.
- It is awesome to see that everyone really does want to do their best to comply with CCO and they appreciate that this assessment process really does want to help them do better, proactively!

When asked for feedback on how well the program is performing, responses were overwhelmingly positive (comments paraphrased from verbal feedback provided at the workshop):

- PPA 2.0 is a great next version and encourages deeper proactive conversations about a variety of topics that concern members or on which they would like more clarity.

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- The program and our peer assessor training encourages objectivity, providing guidance and honestly helping members to do the best they can in the care of their patients.
- It's great to see that both PPA 1.0 and 2.0, while focusing on evidence of compliance with CCO regulations, standards of practice, policies and guidelines, still has plenty of room to embrace the diversity of practice styles evidenced in the real world of chiropractic practice.

Overall, the day was a great success. The objectives were met and the QA Committee has lots of good feedback and information to help inform further revisions to future versions of the program as well as possibly develop new QA initiatives to help member's comply with CCO expectations while continuing to provide great care to their patients and to ensure that the public is being protected.

What does this mean for the profession? One example is the Committee's regular review of CCO's standards of practice as they relate to protecting the public. For example, Standard of Practice S-002: Record Keeping serves the public interest in enhancing clarity for patients, third-party

payors and others who may be reviewing chiropractic care that has been provided to patients. A clear and fulsome record of who provided the care and where it was delivered is important information that should be reflected in the clinical notes.

When asked: "What did you find most beneficial at today's workshop?", some final thoughts shared by the peer assessors perhaps provides the best evidence about the ongoing success of this CCO quality assurance initiative:

- Collegial camaraderie!
- Meeting with other assessors and discussing issues, concerns and brainstorming. Connecting with other peer assessors and sharing experiences to further our knowledge.
- Clarification and directions for us as peer assessors to improve our processes and make the experience better for the members.

Thank you to the peer assessors who participated in the workshop and continue to work on the front lines in helping all members of CCO provide the best possible care to the public of Ontario.

REMINDER: REQUIRING A PATIENT TO BRING A SPOUSE OR FAMILY MEMBER IS A BREACH OF PRIVACY

Members should be aware that requiring a patient to bring a spouse or family member to a report of findings or a follow-up appointment is not permitted. This practice is considered to be forcing a patient to breach their privacy and confidentiality. It is a patient's choice whether to disclose receiving chiropractic care to a family member, and it is inappropriate for a member to insist that a patient bring a spouse or family member as a condition to receiving chiropractic care.

REMINDER: IF OFFERING A BILLING ARRANGEMENT THAT INCLUDES A BLOCK FEE OR PAYMENT PLAN, REVIEW AND COMPLY WITH GUIDELINE G-008: BUSINESS PRACTICES

If offering any billing arrangement other than a "pay-per-visit" option, members are required to comply with the requirements of the professional misconduct regulation and Guideline G-008: Business Practices. There are three main requirements that are identified in the regulation and that are explained further in the guideline.

These requirements are:

1) *The patient is given the option of paying for each service as it is provided*

Communication around billing arrangements always requires the member to disclose to the patient that they have the option to pay for each service as it is provided. This option must not affect the quality of chiropractic care provided and the member must not subject the patient to any undue pressure or duress to agree to any billing arrangement.

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2) A unit cost per service is specified

No matter what the billing arrangement is, there must always be a unit cost per service specified and agreed to. Both the member and patient must have an agreement evidenced in a signed written contract, as to what the unit cost per service is. This agreement is essential in ensuring there is a full understanding of what each treatment or service costs in the event the patient opts out of the billing arrangement.

3) The member agrees to refund to the patient the unspent portion of the block fee, calculated by reference to the number of services provided multiplied by the unit cost per service

Members must always disclose to patients their right to opt out of any billing arrangement, block fee or payment plan at any time and must not subject patients to any undue pressure or duress to continue with the plan of care. The choice must always be that of the patient.

Any refund must be calculated with reference to the unit cost per service agreed upon. It is not permissible to apply any financial penalties or revert back to an original fee if a patient chooses to opt out of a billing arrangement. Please see Guideline G-008: Business Practices for a detailed explanation of how a refund is calculated.

* Please review the amendments to Guideline G-008: Business Practices in the "Policy Update" section of the newsletter.

Continuing Education: It's a New Cycle. It's All On-Line. Where Should You Be?

By: Dr. J. Bruce Walton, Director of Professional Practice

Any questions or clarification needed, please contact:

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It's now official: all your CE activities can be tracked and logged through your personal CCO on-line access into the CCO member's portal. While there were a few glitches with the launch of this process at the end of last year, member feedback has been very positive and we have also appreciated the feedback on how the process could be improved. While some members experienced problems, most challenges were due to compatibility issues between the portal and whatever platform the member might have been using. CCO has made and is making ongoing improvements to the system and process to ensure things continue to proceed smoothly.

We acknowledge that it may have been somewhat time-consuming to initially input all the data from your most recent cycle of accumulated activities. This was necessary to bring the system and, in particular, your data up-to-date. Now, moving forward, as you participate in and complete your various CE activities, you can log directly into the portal and note those activities for this current cycle. As you proceed through this cycle, you will see the accumulation of your activities and the system will count down the hours and requirements that remain in order for you to be in compliance with CCO Standard of Practice S-003: Professional Portfolio.

So, where should you be right now?

- At a minimum, you should have recorded all your CE activities for the most recent CE cycle, which ended June 30, 2018. The reporting for these activities was due at the end of 2018.
- You should have completed your Self-Assessment for this current CE cycle and developed a Self-Assessment Summary Plan of Action to inform and direct your CE activities for this current cycle (running July 1, 2018 - June 30, 2020).
- If you have completed some CE activities in this current cycle, you should be logging those directly into your profile on the CCO member's database.
- You should be tracking all other CE-related information in your Professional Portfolio, which you likely keep close at hand either at home or in your office.

As always, all up-to-date information and documentation related to your Professional Portfolio can be found at www.cco.on.ca by specifically exploring the Quality Assurance areas of the CCO website. There you can find templates for completing your self-assessment, creating a plan of action summary, and building your Professional Portfolio.

Consent: It's An Ongoing Conversation!

Members will be very familiar with the requirements of CCO Standard of Practice S-013: Consent as well as all other places where the topic of consent arises (e.g., when providing acupuncture or orthotic services). The objectives of this standard include ensuring that patients receive appropriate information about the benefits and risks of examinations, care, and plans of care, as well as to facilitate discussion and dialogue between members and patients relating to chiropractic care. The most up-to-date versions of all CCO standards of practice, policies, and guidelines are always found on the CCO website.

Members regularly ask questions of clarification about handling consent in a variety of situations that, at times, may seem unique. These questions often come up in the context of conducting peer and practice assessments or when members call CCO. We welcome and encourage members to always ask questions.

Here is a sampling of some common questions and our typical responses in offering guidance:

Do I really have to get two informed consents signed?

This is usually asked in reference to the expectation that members are obtaining consent to examination and to care or plan of care. Yes, these are two unique and distinct conversations that take place in the course of patient care and evidence that these conversations took place should be recorded in the patient health record. **Do they always take place near the beginning of care?** No. There certainly may be other opportunities to re-visit both - for example, when well into care, a patient presents with a new complaint in an area not previously examined. It would be expected that a new conversation takes place about examining this area and, once a diagnosis is formed and related to the patient, a subsequent conversation related to consenting to the care of that area takes place. Again, evidence of these conversations should be found in the patient health record.

What steps should I take when a patient says "I don't think I want you to treat that today" or when you might say "I'd like to suggest a different approach today"?

The patient health record should clearly show that these conversations took place and all the relevant details

are recorded. This really constitutes a key part of the ongoing conversation related to consent. Members should be continually and clearly explaining to patients what is involved with care, what approaches they are recommending, and what options are available for patient care. Patients need to be provided with lots of opportunities to ask questions and get clarification and, when necessary, express concerns. Key elements of the ongoing conversation with patients should always be about what you are proposing, describing and even demonstrating the proposed technique, and talking about the potential risks and benefits. In the end, members must honour a patient's expressed wishes for care and only proceed when consent is obtained. Members should always be sensitive to the fact that consent to examination and care is ongoing throughout the patient care process and not just when the patient initially presents in the office.

Yes, we are a high-touch, high-contact and interactive professional health care discipline.

Touching patients for the purposes of providing patient health care is integral to what we do as chiropractors. It becomes second nature to chiropractors over the course of their education and is developed throughout their careers. Members must always be aware of the fact that the reasons for touching a patient, especially in certain sensitive areas, may not be understood or even welcomed by patients. The simple act of performing a routine examination may, for some patients, be uncomfortable not only from a pain and function standpoint but also because a patient may have a history of experiences that makes them very sensitive.

It behooves all members to regularly communicate with patients what they are proposing to do in any patient encounter. This could be simply demonstrating how a side-posture adjustment is made on a spinal model before asking the patient to put themselves into that posture. It may be explaining why and how you are going to palpate and assess suspected groin injury in order to recommend the appropriate course of care. Ongoing clear and open communication and providing plenty of opportunities for patients to ask for clarification go a long way to helping members provide the best and safest care possible.

Achieving and Maintaining Clinical Competency in all Diagnostic and Therapeutic Procedures and Services Provided

As members graduate, develop, and expand their skills, it can be tempting to quickly add new techniques of diagnosis and treatment into their clinical toolbox. Members are reminded that all techniques of diagnosis and treatment must be applied to patient care within the chiropractic scope of practice.

Chiropractic Scope of Practice and Authorized Acts as outlined in CCO Standard of Practice S-001: Chiropractic Scope of Practice and derived from the Chiropractic Act, 1991:

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

- (a) dysfunctions or disorders arising from the structures or functions of the spine and the effects of those dysfunctions or disorders on the nervous system; and
- (b) dysfunctions or disorders arising from the structures or functions of the joints.

Authorized Acts

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

1. Communicating a diagnosis identifying, as the cause of a person's symptoms,
 - i. A disorder arising from the structures or functions of the spine and their effects on the nervous system, or
 - ii. A disorder arising from the structures or functions of the joints of the extremities.
2. Moving the joints of the spine beyond a person's usual physiological range of motion using a fast, low amplitude thrust.
3. Putting a finger beyond the anal verge for the purpose of manipulating the tailbone.

Members who wish to add new techniques of diagnosis and treatment into their practices must show that they achieve and maintain competency in those techniques. This training must be recorded and reflected in the member's Professional Portfolio.

Two good examples of these concepts, as applied to the regulation of chiropractors in Ontario, follow:

- When providing acupuncture services as an adjunct to their typical chiropractic service, there is an expectation that members have achieved the appropriate and expected training, skill and competence in providing acupuncture services as an adjunct to their chiropractic service. This would be reflected in the member's Professional Portfolio and follow the requirements outlined in CCO Standard of Practice S-017: Acupuncture. Then, the patient health record would reflect how those techniques were applied in the clinical setting, according to the expectations of CCO Standard of Practice S-017: Acupuncture and Standard of Practice S-002: Record Keeping.
- All of the same information outlined above applies, especially the expectation that a member demonstrates that they have achieved and maintain their clinical competencies in that particular area. Specifically, it would be good to review the following CCO standards of practice: S-012: Orthotics and S-021: Assistive Devices.

Making a Referral: Is There a Real or Potential Conflict of Interest?

In the course of caring for patients and ensuring their needs are met, it may be appropriate to make a referral for further diagnostic procedures, for additional advice or for adjunctive therapies that may or may not fall outside the scope of chiropractic practice and/or a member's skillset. In any case, where a referral is made, it is important to declare any real or potential conflicts of interest that may arise. Members must be aware that it is a potential conflict of interest to solicit patients for commercial ventures, such as self-referral and selling or dispensing of products.

A common scenario that might arise, which is not always seen by members as a perceived conflict of interest, is when a member refers a patient for massage therapy with a Registered Massage Therapist who also pays rent to the member for space for their practice in the member's office. This may be further complicated if the rent is based on a percentage rental agreement.

All real or perceived conflicts must be declared to patients and details of this conversation should be recorded in the patient health record. Members must appreciate that there is an inherent power imbalance that exists in the doctor/patient relationship and that members must protect the interest of patients above any commercial interests of the member.

It is always best practice, when making any referral, that patients are given choices of a variety of practitioners, venues, or products that could appropriately serve their needs. Openly discussing the pros and cons of each option will go a long way to serving the patient's best interests and avoiding any potential conflict of interest.

Further details can always be reviewed on the CCO website with specific reference to CCO Standard of Practice S-019: Conflict of Interest in Commercial Ventures and Guideline G-014: Delegation, Assignment and Referral of Care.

CCO Roadshows: Let's Talk!



CCO continues to reach out to members across the province by conducting evening or Saturday morning Roadshow presentations. Feedback has been overwhelmingly positive and members continue to appreciate the efforts made to come and speak directly to them on current topics related to regulation of the profession and serving the public interest.

In 2018, CCO hosted the following Roadshows:

- Ottawa, May 1
- Mississauga, June 16
- Peterborough, November 6

These interactive events provide valuable opportunities to connect with CCO Council members, CCO staff and your local colleagues. Each presentation is geared towards reviewing current events and issues in the world of chiropractic regulation and provides plenty of opportunity for questions/answers and discussions of topics that may be of importance to specific members.

If your local group of chiropractors or society would like to book a Roadshow, please contact Dr. J. Bruce Walton, Director of Professional Practice, at bwalton@cco.on.ca or by calling 416-922-6355, ext. 106.

Titles and Representation to the Public

One of the objectives of the regulation of health care professionals in Ontario is to ensure that the public can make an informed decision about their health care. This includes knowing which health professional they are seeing and what type of care they are receiving. For this reason, the *Regulated Health Professions Act, 1991* and Ontario profession-specific legislation have specific rules and regulations about the use of titles and representations to the public.

Chiropractors in Ontario must clearly communicate to their patients and the public that they are a chiropractor. Communications and representations must not be misleading. This applies to all areas of practice, including record keeping, financial records and invoices, and communication to the public, including advertising, websites, and social media,

Members of the public may not have a comprehensive understanding of regulated health professions and the different titles and terminology used by professionals. Therefore, it must always be clear to the public and patients that they are seeking care from a chiropractor. It is advisable for members to review their communications and representations to the public to ensure that there are not misrepresentations or uses of inappropriate titles or terminology.

The following sources of law are applicable to the use of titles and professional representations to the public.

Use of the Title “Doctor”

Chiropractors in Ontario are one of the professions authorized to use the “Doctor” title in the course of providing or offering to provide, in Ontario, health care services to individuals. However, since other professions, such as physicians and surgeons, naturopaths and acupuncturists may use the doctor title, it must be clear to the public, including through advertising, websites, and social media, record keeping, and business practices, that a member of CCO is providing health care services as a chiropractor.

Indicating a Specialty

Members may only indicate chiropractic specialties listed in Policy P-029: Chiropractic Specialties:

- FCCS(C) - Fellow of the College of Chiropractic Sciences (Canada)
- FCCR(C) - Fellow of the Chiropractic College of Radiologists (Canada)
- FRCCSS(C) - Fellow of the Royal College of Chiropractic Sports Sciences (Canada)
- FCCOS(C) - Fellow of the College of Chiropractic Orthopaedic Specialists (Canada)
- FCCPOR(C) - Fellow of the Canadian Chiropractic Specialty College of Physical and Occupational Rehabilitation (Canada)

Therefore, members may not use the term “specialist” or “specialty” or imply that they hold any other specialty. Examples include using titles such as “pediatric specialist” or “geriatric specialist”. Members may communicate practice areas by using terminology such as “interest in” or “focusing in”.

Prohibited Titles

Ontario health profession-specific acts have provisions that prohibit the use of certain titles and representations to members of those professions. A few examples are as follows:

- The titles of “osteopath”, “physician” or “surgeon”, a variation or abbreviation or an equivalent in another language or representation as a person who is qualified to practise in Ontario as an osteopath, physician or surgeon or in a specialty of medicine is restricted to members of the College of Physicians and Surgeons of Ontario under the *Medicine Act, 1991*.
- The titles of “physiotherapist” or “physical therapist”, a variation or abbreviation or an equivalent in another language or representation as a person who is qualified to practise in Ontario as a physiotherapist or in a specialty of physiotherapy is restricted to members of the College of Physiotherapists of Ontario under the *Physiotherapy Act, 1991*.

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- The titles of “traditional Chinese medicine practitioner” or “acupuncturist”, a variation or abbreviation or an equivalent in another language or representation as a person who is qualified to practise in Ontario as a traditional Chinese medicine practitioner or acupuncturist or in a specialty of traditional Chinese medicine are restricted to members of the College of Traditional Chinese Medicine Practitioners

and Acupuncturists of Ontario under the *Traditional Chinese Medicine Act, 2006*.

Using titles or representations which include the terms “medicine”, “neurologist” or “acupuncture provider” may be perceived as using a title or making a representation that is contrary to profession-specific legislation.

Reminder: Think Before Posting

Social media can be an effective tool in disseminating information to the public. However, once something is online, it can remain there forever, even if deleted.

Before posting to social media, members should consider the following:

- Does this posting breach the duty to maintain patient privacy and confidentiality?
- Does this posting provide clinical advice, communicate a diagnosis or guarantee results?
- Does this posting provide advice that is outside of the chiropractic scope of practice?
- Does this posting include links to material that is outside

of the chiropractic scope of practice?

- Does this posting infringe on any copyrighted material?
- Does this posting include information that may be considered as disgraceful, dishonourable, or unprofessional?
- Does this posting include harassment, bullying or inflammatory comments?
- Does this posting breach CCO standards of practice, policies and guidelines, including S-001: Chiropractic Scope of Practice or S-016: Advertising?

If the answer to any of these is “yes”, members must not make this posting to social media. Please see Guideline G-012: Use of Social Media for further information.

Reminder: Your Website and Social Media Posts Must Comply With Standard of Practice S-016: Advertising and Guideline G-016: Advertising

Advertising is defined as “any message communicated outside a member’s office through a public medium, including electronic media such as websites and social media, and that can be seen or heard by the public at large with the intent of influencing a person’s choice of service or service provider. This standard applies equally to members acting individually, as a group, or as a professional health corporation.”

The provisions of the advertising standard of practice and guideline apply to both traditional advertisements in print, signs, radio, and television, as well as online communications such as websites and social media. It is the responsibility of all members to ensure their advertising, including websites

and social media, complies with the advertising standard and guideline.

The following is a summary of several of the provisions of Standard of Practice S-016: Advertising, and how they apply to advertisements, including websites and social media:

1. An advertisement must be:
 - (a) accurate, factual and contain information that is verifiable; and
 - (b) readily comprehensible by the persons to whom it is directed.

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Guideline G-016: Advertising explains further that the public is entitled to accurate, factual, and verifiable information that is readily understandable to make an informed choice in health care. Subjective opinions, inaccurate information and unverifiable claims must be avoided.

2. An advertisement may:

- (a) name a specific diagnostic or therapeutic procedure or modality but cannot claim superiority or endorse the exclusive use of such procedures, services, techniques, modalities or products. References to specific diagnostic or therapeutic procedures must comply with the Standard of Practice S-001: Chiropractic Scope of Practice;

Members may list the diagnostic and therapeutic procedures that they use in their practice. This may include chiropractic techniques, as well as adjunctive modalities such as acupuncture, ultrasound, radiography, exercise and nutritional counselling. All diagnostic and therapeutic procedures must be within the chiropractic scope of practice and used in accordance with Standard of Practice S-001: Chiropractic Scope of Practice.

To avoid making claims of superiority or endorsing the exclusive use of services and products, advertisements must avoid terminology such as “revolutionary or advanced technology”, “state-of-the-art”, “highest success rate”, “best trained doctors”, “most effective” and other phrases that imply superiority.

Members must also avoid communicating outside of the chiropractic scope of practice. This includes making statements or claims related to prescription drugs, performing surgery or administering vaccinations, and other controlled acts outside of the chiropractic scope of practice. Members must not make any statements advising patients not to see certain health professionals or claiming superiority over any other health profession or member of CCO. Rather, advertising statements should focus on a member's practice.

Members may not make claims to treat or cure conditions that are beyond the chiropractic scope of practice.

- (b) make reference to the member being a specialist, provided the member is recognized pursuant to CCO's

policy as a specialist, and the specialty is disclosed. Refer to Policy P-029: Chiropractic Specialties, for the list of specialties currently recognized by CCO;

The term “specialist” or “specialty” is a protected title in reference to the five approved specialties in Policy P-029: Chiropractic Specialties. Members may only communicate that they are a specialist or hold a specialty if they hold one or more of the following specialties:

- FCCS(C) - Fellow of the College of Chiropractic Sciences (Canada)
- FCCR(C) - Fellow of the Chiropractic College of Radiologists (Canada)
- FRCCSS(C) - Fellow of the Royal College of Chiropractic Sports Sciences (Canada)
- FCCOS(C) - Fellow of the College of Chiropractic Orthopaedic Specialists (Canada)
- FCCPOR(C) - Fellow of the Canadian Chiropractic Specialty College of Physical and Occupational Rehabilitation (Canada)

Therefore, a member must not use terms such as “pediatric specialist” or “geriatric specialist”. Members may communicate chiropractic practice areas by using terminology such as “interest in” or “focusing in”.

- (c) make reference to the member being affiliated with any professional association, society or body, other than CCO, only on curriculum vitae, business stationery and recognized public displays;

Advertising a member's professional affiliations may cause confusion to the public and communicate comparisons to other members. In electronic media, a member may include professional associations other than CCO only in the curriculum vitae/biography section of a website or social media home page.

- (d) allow an individual or organization to endorse a member, provided:

- (i) the individual or organization proposing the endorsement has sufficient expertise, according to CCO, relevant to the subject matter being endorsed;
- (ii) the member has been appropriately assessed as providing the subject matter being endorsed;

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An unqualified endorsement from a source with little or no expertise may confuse the public and undermine the public's trust. Endorsements must only be from sources with sufficient expertise in an area.

(e) *offer an initial complimentary consultation.*

Any advertisement for discounted or complimentary services must be accurate, complete and clear, not include any hidden costs or fees, and be accurately recorded in the financial record.

(f) *include testimonials that refer only to the benefits of chiropractic and not to a particular member or office, with the exception of a member's website which may include testimonials that refer to a particular member or office, provided the testimonials are:*

- (i) *accurate, verifiable, and recorded in the patient health record;*
- (ii) *used only in accordance with the written consent of the patient, which may be withdrawn at any time;*
- (iii) *not obtained using any undue pressure, duress, coercion or incentives; and*
- (iv) *otherwise compliant and consistent with Standard of Practice S-016: Advertising, the chiropractic scope of practice, other CCO standards of practice, policies and guidelines and privacy legislation.*

Testimonials in advertising that refer to a specific member or office may only be used on a member's website. Any testimonial must be truthful and verifiable, as evidenced in the patient health record and obtained only with documented, specific consent of the patient under the patient's own free will without any coercion or compensation.

As with all advertising, any testimonial must comply with the advertising and scope of practice standards of practice. A testimonial must not state anything false or misleading, unverifiable, or make a claim that chiropractic treatments cure conditions beyond the chiropractic scope of practice.

3. *Any advertisement with respect to a member's practice must not contain:*

(a) *anything false or misleading.*

False or misleading statements, including the misuse of titles and terminology, can undermine the public trust and cause confusion to the public. Certain titles, terms and representations are limited by profession-specific acts to members of particular regulated health professions. As an example, only members of CCO may use the title "chiropractor" or represent themselves to the public as someone who is qualified in Ontario to practise chiropractic or in a specialty of chiropractic.

Using titles such as "chiropractic physician", "osteopath", "medicine" "neurologist" "physiotherapist or physical therapist", "chiropractic veterinarian" and "acupuncturist or acupuncture provider" may be perceived as a misrepresentation to the public and may cause public confusion.

Members must comply with the use of titles and representations that are restricted for members of other professions under profession-specific legislation, such as the *Medicine Act, 1991* and the *Traditional Chinese Medicine Act, 2006*. The public must always know which regulated health care provider they are seeing and there must not be any confusion in this area.

Members may advertise the services they provide within the chiropractic scope of practice, such as acupuncture and physical therapy; however, it must always be clear to the public that they are providing these services as a chiropractor. Please see the article "Titles and Representation to the Public" for more details.

(b) *a guaranteed success of care.*

Guarantees of success that are unverifiable may mislead the public and are unprofessional. Members should avoid using expressions such as "will help, cure or relieve" and "guaranteed success". Expressions such as "patients have benefited", "may be able to help" and "has been shown to relieve" are more appropriate.

(c) *any comparison to another member's or other health care provider's practice, qualifications or expertise;*

Comparisons to other members and other regulated health professionals are unprofessional. Members should avoid using expressions such as "better", "more effective"

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and “gentle” or making claims comparing their services to other members or regulated health professionals. Using positive language such as “safe” and “effective” is more appropriate.

(d) *any expressed or implied endorsement or recommendation for the exclusive use of a product or brand of equipment used to provide services;*

Exclusive endorsements of products is a form of comparison that implies superiority and must be avoided.

(e) *material that, having regard to all the circumstances, would reasonably be regarded as disgraceful, dishonourable or unprofessional.*

All advertisements must maintain professional integrity and serve the public’s best interest. It is an act of professional misconduct to engage in conduct or perform an act that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

Cannabis Legalization - What Does This Mean For You?

On October 17 2018, the use of recreational cannabis was legalized and regulated in accordance with the *Cannabis Act, 2018*.

Cannabis is Regulated under the Cannabis Act, 2018

The *Cannabis Act, 2018* sets the legal requirements for the sale, distribution and use of cannabis in Canada.

The Recommendation of Cannabis for Medical Purposes is Outside of the Chiropractic Scope of Practice

Cannabis use for medical purposes is a pharmacological treatment and is therefore outside of the chiropractic scope of practice. The regulations made under the *Cannabis Act, 2018* authorize only medical doctors and nurse practitioners to issue an authorization for medical cannabis.

If a patient questions a member about the use of or recommendations for cannabis for medical purposes, the member shall advise the patient that cannabis for medical purposes is outside of the chiropractic scope of practice and the patient should consult with a health professional who has this act within their scope of practice.

Consent and Capacity Issues with Cannabis

Cannabis, when consumed, may impair behaviour and judgment. Standard of Practice S-013: Consent and the *Health care Consent Act, 1996* require that a patient have the capacity to consent to chiropractic examination and care.



If a member has reason to believe that a patient is using cannabis, the member must assess the capacity of the patient to ensure they are capable of giving consent to chiropractic examination and/or care. The member must not provide a patient with a chiropractic examination or care if the member has a reasonable belief that the capacity of the patient to consent to a chiropractic examination or care is sufficiently weakened.

Additionally, members must always ensure they are fully capable of delivering safe and ethical chiropractic care. Members shall not be involved in the practice of chiropractic if their behaviour or judgment is impaired by cannabis.

REGISTRATION COMMITTEE

Dual Registrants: An Emerging Trend

CCO has noticed an upward trend in the number of registrants who practise both chiropractic and another regulated health profession – such as massage therapy, physiotherapy, naturopathy, traditional Chinese medicine, and nursing, to name a few. These dual registrants are required to comply with the applicable regulations, standards of practice, and guidelines, etc. and it must be clear to their patients in which capacity they are providing treatment.

Several dual registrants generously offered to share their decisions to be trained in another profession besides chiropractic. It should be noted that some candidates chose chiropractic after practising another profession and continue to provide care to patients in both disciplines.

Here are their stories.



Dr. Sarah Hopkins
St. Catharines

PROFESSIONAL AFFILIATIONS: Chiropractor and Registered Massage Therapist

Growing up in Kapuskasing, at the age of 12 Sarah saw her first chiropractor – who also happened to be her ski instructor. After high school, Sarah completed a kinesiology degree at Dalhousie University, followed by her acceptance to and then graduation from the Canadian Memorial Chiropractic College in 2012. Sarah was encouraged by her sister to move to St. Catharines, and she did, setting up a practice that also includes several massage therapists. In watching the massage therapists' interactions with patients and recognizing that she could offer more to her chiropractic patients, Sarah decided she wanted to become a massage therapist, enabling her to have “more freedom” in treating her patients. She became a massage therapist in 2014.

Currently, Sarah is a sole practitioner with a busy chiropractic and massage therapy practice in downtown St. Catharines.

OPPORTUNITIES

- Ability to provide a greater and diverse range of diagnostic tools and services to patients
- Enabling a practitioner to deliver complementary treatments to patients by one practitioner

CHALLENGES

- “Keeping things separate” – record keeping, billing, and separate treatment rooms
- Meeting the separate requirements of continuing education from both the College of Chiropractors of Ontario and the College of Registered Massage Therapists of Ontario

“The opportunity to start my own practice has enabled me to provide a level of services that the public appreciates. It is a comfort for the patient to know they are being treated by one person who understands what is going on in both areas. My patients definitely benefit from the diversity of my skillset.”



Dr. Marcel Reux
Toronto

PROFESSIONAL AFFILIATIONS: Physiotherapist and Chiropractor

In 1977, Marcel graduated from Memorial University of Newfoundland with a Bachelor of Science degree and, three years later, obtained his Bachelor of Science degree in physical therapy from the University of Toronto. Marcel worked for two years as a physiotherapist at St. Michael's Hospital and the Workers Compensation Board. In 1982, he returned to school to study chiropractic at the Canadian Memorial Chiropractic College (CMCC), and graduated as a chiropractor in 1986.

In 1986, Marcel and his classmate, Dr. Vince Ricciardi, opened Davisville Yonge Clinics in Toronto.

Since 1991, Marcel has been on CMCC's faculty as an instructor in the Clinical Diagnosis Division and he has also been featured on CBC Radio and TV Ontario.

OPPORTUNITIES

- Being able to deliver two types of care to patients is positive
- Knowing the scopes of practice for physiotherapy and chiropractic are "similar" provides "options" for patients

CHALLENGES

- Ensure the separation of business operations – such as billing and filing – is distinct and separate, and clearly understood by members of the public

"I became a physiotherapist because I met one who impressed me and it sparked an interest in me to do that. When I started practising physiotherapy, I began to see the benefits of spinal manipulation and entertained the idea of going back to school for chiropractic. I was accepted at CMCC and, in 1986, I graduated as a chiropractor and opened my practice. The advantage of having two designations is hugely beneficial for patients because it gives them options."



Dr. Ryan Desjardins
Alliston

PROFESSIONAL AFFILIATIONS: Radiographer and Chiropractor

Ryan grew up on a sod farm in Timmins and left for Sudbury to study radiography. He was licensed by the College of Medical Radiation Technologists of Ontario (CMRTO) in 2010, and got his first job as an x-ray technologist at Stevenson Memorial Hospital in Alliston.

At the back of his mind, Ryan had been seriously considering an additional career: chiropractic. So when he was accepted at the Canadian Memorial Chiropractic College (CMCC), he was delighted. While studying at CMCC, Ryan worked weekend day shifts and worked full-time night shifts while studying university courses (by correspondence) from Laurentian University in order to acquire the 90 credits required for applying to CMCC. In 2015, Ryan was licensed as a chiropractor.

Currently, Ryan works as a chiropractor at Physiomed Alliston and, when needed, at Stevenson Memorial Hospital.

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OPPORTUNITIES

- Being able to deliver two types of care to patients in the community is positive for the public
- Creating inter-professional relationships with local physicians, including demonstrating the knowledge base that chiropractors have

CHALLENGES

- “Be mindful to work within my scope [of practice], depending on which hat I’m wearing”
- Continuing education: ensuring compliance with each college’s requirements (some requirements apply to both professions)
- Record keeping: adhering to each college’s requirements

“The path that I have chosen is very different but it was very smooth. Where there was some overlap in my education, it has continued to help me in my career. Consider the people component - an x-ray is a brief encounter by a patient with a professional but in chiropractic there is more interaction between the patient and the chiropractor. In the end, it’s very rewarding.”



Dr. Kaitlyn Pepper
Toronto

PROFESSIONAL AFFILIATIONS: Nurse and Chiropractor

A graduate of McMaster University with a Bachelor of Science in nursing, Kaitlyn was working as a registered nurse for approximately one year before she started her chiropractic studies at the Canadian Memorial Chiropractic College (CMCC). She continued to do nursing while studying.

Kaitlyn is a 2018 chiropractic graduate and started in a new position soon after. It would be too soon for her to assess any long-term career plans as a dual registrant but she intends to “keep up” with both professions and may one day consider moving into public education.

Currently, Kaitlyn is working at Accelerated Health & Wellness Centre in Fonthill.

OPPORTUNITIES

- “A foot in both camps is positive. There are two different perspectives and ways to tackle solutions for patients”
- “Having more dual registrants gives a bigger voice in the [health care] system and there is a role for chiropractors in the system

CHALLENGES

- Patients think you can combine your scopes of practice and they can ask for advice in either area of your expertise. While you have dual knowledge, it can’t always be applied.”
- “I would like to see chiropractors more integrated into health teams and visiting patients in facilities.”

“I started seeing a chiropractor when I was young. At the time, I did not think of it as a career. As I like working with people, nursing was a good first step, including giving me exposure to many different things. While it isn’t common to combine a career of nursing and chiropractic, I saw complementary opportunities in both professions. Overall, the whole process of graduating from two professions has been very interesting and rewarding.”

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Dr. Inger Simonsen
Toronto

PROFESSIONAL AFFILIATIONS: Chiropractor and Acupuncturist

Growing up in Denmark, Inger witnessed the positive experiences and successes her parents had with chiropractic and, by the time she was a teenager, realized that she wanted to be a chiropractor. "Through my parents, I understood the benefits of chiropractic and later learned its history in Denmark, which goes back to 1920, and its widespread use in Europe."

Inger came to Canada to study chiropractic at the Canadian Memorial Chiropractic College (CMCC). After graduating in 1984, she returned to Denmark to practise for a year before moving permanently to Canada. Inger married a Canadian chiropractor and credits his influence in developing her interest in acupuncture, leading to obtaining her license and becoming a member of the College of Traditional Chinese Medical Practitioners and Acupuncturists of Ontario (CTCMPAO) in 2013.

As co-founder and co-owner of Annex Clinic in Toronto since 1985, Inger's practice is comprised of patients of all ages. A chiropractic orthopaedic fellow, Inger is also an assistant professor and course coordinator at CMCC, and she has authored an orthopaedic examination manual for the extremities.

OPPORTUNITIES

- Being able to provide a wider range of services to patients is positive in terms of their accessibility to the appropriate care
- Offering both chiropractic and acupuncture, which are complementary in the management of pain and many other conditions

CHALLENGES

- Maintaining distinct and clear patient files for each profession
- Ensuring compliance with the distinct regulations and maintaining CE requirements for CCO and the CTCMPAO

"Being able to provide a broader range of services to help patients has been very important to me throughout my career. Over the years, patients have been amazed when they understand how my background, training, and care can make a difference in how they feel."

CCO COMMUNICATIONS NOW THROUGH EMAIL

CCO is now communicating with members through email on important regulatory matters such as registration renewal, updates to standards of practice, policies and guidelines, ChiroPractice newsletters and information bulletins. Log into your member portal to ensure your email address is up-to-date.

Please check your spam/junk mail folder for any email communications from CCO.

PATIENT RELATIONS COMMITTEE

Partnership of Care - New Tent Cards Coming Soon!

The *Partnership of Care*, the Patients' Chart of Rights and Responsibilities, outlines the rights and responsibilities of chiropractors and patients within the doctor/patient relationship. These include both responsibilities of the chiropractor, such as respectful, honest and clear communication and relevant safe and patient-centred care, and responsibilities of the patient, such as a cooperative commitment to the chiropractor's treatment plan and constructive feedback regarding all aspects of care.

CCO has previously distributed tent cards with the *Partnership of Care* in English and French and will soon be distributing an updated version of it. In addition, translations in 10 languages of the updated *Partnership of Care* will be posted on the CCO website.

The *Partnership of Care* document can be accessed [here](#).

CCO encourages members to make use of the *Partnership of Care* document in their communication with patients.

Changes to Regulated Health Professions Act, 1991 (RHPA) as a Result of the Protecting Patients Act, 2017¹

Effective May 1, 2018, there were significant amendments made to the RHPA and its regulations. These changes relate to the definition of a patient, the availability of funding for therapy and counselling, mandatory reporting requirements and public register requirements. These changes were made as result of the *Protecting Patients Act, 2017*.

These amendments affect all colleges governed under the RHPA.

CCO brings the following amendments to your attention:

- There is a new definition of patient for the purposes of the prohibition of sexual abuse.

Regulation 260/18 under the RHPA provides criteria for defining who is considered a patient for the purposes of the sexual abuse provisions of the RHPA. These criteria include direct interaction between member and patient which includes charging or receiving payment from the patient or a third party on behalf of that patient, contributing to a health record or file, and patient consent to health care services. The regulation provides an exception for emergency circumstances or circumstances where the service is minor in nature.

CCO has approved amendments to Standard of Practice S-014: Standard of Practice S-014: Prohibition of a Sexual Relationship with a Patient to reflect these regulatory amendments and add them to the definition of a patient as described in case law.

There continues to be no spousal exemption to the sexual abuse provisions of the RHPA. There will be notification to stakeholders including members if this changes.

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- Complainants with sexual abuse allegations have immediate access to funding for therapy or counselling (and do not need to wait for a finding of professional misconduct to access funding under section 85.7 of the Health Professions Procedural Code, schedule 2 of the *RHPA*).

CCO has approved amendments to Policy P-018: Funding for Therapy or Counselling for Patients Sexually Abused by Members to ensure that an individual is eligible for funding for therapy or counselling when a complaint or report is made.

- The mandatory reporting requirements have been expanded (sections 85.6.3 and 85.6.4 of the Health Professions Procedural Code, schedule 2 of the *RHPA*).

Members are now required to report to CCO membership and professional misconduct or incompetence findings in other regulated health professions inside or outside of Ontario, as well as charges and bail conditions under the *Criminal Code (Canada)* or the *Controlled Drugs and Substances Act (Canada)*. These amendments have been incorporated into CCO's renewal process.

- The information colleges must maintain on the public register has been expanded.

Regulation 261/18 under the *RHPA* expands the public register to include findings of guilty, currently existing conditions of release and charges under the *Criminal Code (Canada)* or the *Controlled Drugs and Substances Act (Canada)*, as well as findings of professional misconduct or incompetence by another regulatory or licensing authority in any jurisdiction.

CCO has approved amendments to By-law 17: Public Register to include the new public register requirement.

- The types of criminal offences that require the mandatory revocation of a member's certificate of registration have been expanded. Please see Regulation 262/18 under the *RHPA* for more details.

Please monitor the CCO website for the most up-to-date information concerning regulations, standards of practice, policies, guidelines and by-laws.

¹ The law governs to the extent of any inconsistency with this article.

What to Expect When Attending a Chiropractor Appointment

By: Dr. Dennis Mizel



In today's health care climate, it should be clear to all chiropractors in Ontario that we must put our patients' interests ahead of our own interests when caring for them.

What can and should we be doing to put patients first?

It is important, of course, to listen carefully to what our patients have to say, and to understand and care for them in a way that addresses and meets their needs. We must also respect that the patient brings to the encounter his/her own personal preferences and unique concerns, expectations, and values. These must all be considered when developing a treatment plan and on each encounter.

Patients present to a chiropractor for a variety of reasons. However, patients should expect basic procedures, rooted in the chiropractor's core competencies, to be followed and which represent the chiropractor's unique role in the collaborative health care framework. The results and observations should be recorded in the record of personal health

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information in such a way as to accurately re-create the doctor/patient interaction.

There are varied reasons as to why a doctor/patient relationship may need to be terminated including the type of practice the chiropractor has, the specific technique that the chiropractor utilizes, the type of treatment required (e.g., out of the chiropractic scope of practice and appropriately found within another health care provider's scope of practice; within the chiropractic scope of practice although not offered with the particular provider the patient is seeing), or the patient chooses to leave for medical or personal reasons or is satisfied with the care they have already received and wants to stop care and be discharged.

It is appropriate for a chiropractor to discharge a patient if the chiropractor is not providing the patient with what they are seeking. It is important to remember that when a patient continues to need our professional services, the patient may at any time request they be discharged for any reason. If you for some reason wish to discharge a patient who still needs chiropractic care, it is necessary to arrange or attempt to arrange alternative services for the patient. It is not appropriate to abandon a patient that you no longer wish to take care of without attempting to arrange alternative services. The patient should be given a reasonable opportunity to arrange alternative services before you discharge the patient from care, should they continue to need care.

Further, it is incumbent upon chiropractors to terminate a doctor/patient relationship with reasonable notice or explanation along with a referral to a qualified and acceptable practitioner. Professional misconduct for patient abandonment would result if these types of steps are not taken.

Members should always comply with CCO's standards of practice, policies, and guidelines, which contain important principles to protect the public interest and ensure the appropriate provision and continuity of care. To view the documents online, click here.

Extract from Core Competencies for CCO Members

What to expect when attending a chiropractor appointment...an application of the core competencies:

Chiropractors offer a variety of approaches to care within the scope of practice. CCO regulates the full range of chiropractic approaches and it is expected that members are always practising within the chiropractic scope of practice.

Patients present to a chiropractor for a variety of reasons. However, patients should expect basic procedures, rooted in the chiropractor's core competencies, to be followed and which represent the chiropractor's unique role in the collaborative health care framework. The results and observations, based upon the performance of these basic procedures, should be recorded in the record of personal health information in such a way as to accurately re-create the doctor/patient interaction.

Initial visit(s) to a chiropractor (Consultation, Examination, Report of Findings)

- A clean and organized and welcoming environment.
- A careful explanation of any paperwork to be completed.
- A clear and complete explanation of the costs of the services to be provided.
- A private consultation with the doctor to provide the opportunity to review the case history, ask questions, review all the paperwork and any available reports.
- A verbal summary by the chiropractor demonstrating that he/she has understood what has been discussed and what the patient's goals are for attending the office.

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- An explanation of the physical examination, in order that consent to examine is obtained.
- A physical examination is conducted in order to assess conditions related to the spine, nervous system and joints or dysfunctions or disorders arising from the structures or functions of the spine and the effects of those dysfunctions or disorders on the nervous system and dysfunctions or disorders arising from the functions of the joints.
- Based upon the findings of the consultation and a physical examination, the chiropractor may make a referral for further investigations which might include (but not be limited to): a radiographic study or a referral to another specialist.
- Once all the appropriate and necessary information has been obtained, the chiropractor will provide a complete explanation, including diagnosis of what has been found.
- Recommendations for care, based on findings, will be communicated to the patient and recorded in the record of personal health information. Such recommendations may include (but are not limited to): a course of chiropractic care (including an explanation of the style of adjusting that is recommended), any modalities that will be used, the frequency of visits and the appropriate time in which a re-evaluation will take place, along with expected outcomes and the approximate cost of care, suggestions for home care, or, if appropriate, referral for further consultation and/or care with another health professional.
- Only after the report of findings and all recommendations have been delivered and there has been an opportunity for questions will the patient be given the opportunity to provide their informed consent to undergo a course of care.

Subsequent Visit(s)

- Care should begin within a reasonable time of the scheduled appointment.
- The chiropractor should review his/her record of the previous visit(s) with the patient along with reviewing what the patient has experienced, subjectively, since the last visit.
- As appropriate and related to the most recent evaluation and recommendations for the patient's care, the chiropractor will conduct an examination in order to assess conditions related to the spine, nervous system and joints or dysfunctions or disorders arising from the structures or functions of the spine and the effects of those dysfunctions or disorders on the nervous system and dysfunctions or disorders arising from the functions of the joints.
- Appropriate care is delivered in accordance with the findings at each visit and with the overall goals and plan of management based on the most recent evaluation.
- Records of all patient interactions are to be kept contemporaneously.
- Care should continue to be given in a caring yet professional manner with any comments about the process and the progress explained in a patient-centred manner.
- If the care is substantially different from previous care or, if a new condition is presented, informed consent to care should be revisited and updated in the patient health record after an appropriate examination has been conducted and report of findings has been delivered.
- Re-evaluations of progress should be done at appropriate intervals and further recommendations for care based upon those findings and the patient's goals.
- If, at any time, further investigations or referrals are warranted (e.g., those that fall outside the practitioner's scope), those recommendations should be made and noted in the patient record.
- Chiropractors are encouraged to participate in inter-professional, collaborative care when appropriate, in the patient's best interests.
- When applicable, chiropractors shall make every effort to monitor and record patient compliance with any recommended adjunctive procedures, e.g., exercise or nutritional advice.

FITNESS TO PRACTISE COMMITTEE

INCAPACITY

Under the *Regulated Health Professions Act, 1991*, incapacity is described as suffering from a physical and/or mental condition that impairs a health care professional's professional function.

The Inquiries, Complaints and Reports Committee (ICRC) can form a separate health inquiries panel to investigate a member's capacity to function as a chiropractor. If the health inquiries panel believes on reasonable and probable grounds that the member's mental and/or physical health will affect their professional practice and pose a threat of harm to the public, the panel can refer the matter to the Fitness to Practise Committee.

The Fitness to Practise Committee then conducts a hearing to determine whether a member is suffering from a physical and/or mental condition that impairs their professional function as a chiropractor.

Procedurally, incapacity and discipline proceedings are similar. Incapacity hearings focus on the physical and/or mental state of a member and their ability to perform their professional role as a chiropractor, whereas discipline proceedings focus on a member's conduct and whether or not the member has committed an act of professional misconduct or whether their conduct has breached a standard of practice of the profession.

Unlike a discipline hearing, a fitness to practise hearing is generally closed to the public, as it involves the review and reveal of personal health information. A fitness to practise hearing will only be open to the public if the member involved makes a written request in advance to the Registrar. Before agreeing to an open hearing, the panel must be satisfied that any negative consequences of revealing the information will not outweigh the benefits of an open hearing.

The Fitness to Practise Committee is represented at the hearing by a panel of the Committee members appointed by the Chair of the Fitness to Practise Committee. A panel is composed of at least three (3) members of the Fitness to Practise Committee, including at least one (1) public member of Council. If a panel of the Fitness to Practise Committee finds a member is incapacitated, it shall make an order doing any one or more of the following:

1. Directing the Registrar to revoke the member's certificate of registration;
2. Directing the Registrar to suspend the member's certificate of registration; or
3. Directing the Registrar to impose specified terms, conditions and limitations on the member's certificate of registration for a specified period of time or indefinite period of time.

The results of a fitness to practise hearing where a member was revoked or suspended, or had terms, limitations or conditions applied to their certificate of registration, is published on the member profile of the public register.

Decisions of the Fitness to Practise Committee can be appealed to Ontario's Divisional Court for judicial review within 90 days of the decision being issued. There must be a question of law, fact, or both, in order for an appeal to be granted. The court may affirm, rescind, or re-hear the matter, in whole or in part. A notation of the appeal and its outcome will appear on the public register.

IN TOUCH

Is Your *ChiroCare* Binder Out-of-Date?

All up-to-date legislation, regulations, standards of practice, policies and guidelines are available at www.cco.on.ca, and can be printed to update your *ChiroCare* binder.

To order an up-to-date *ChiroCare* binder, please contact Ms Madeline Cheng at mcheng@cco.on.ca.



Reminder: Have you provided your email address to CCO?

Mindful of its obligations to enable efficient and timely communication with members, members are required to provide an email address to CCO. If you have not already done so, please provide it during your next renewal or by email to reception@cco.on.ca.

CCO Needs Your Current Contact Information

Have you recently moved? By law, it is your responsibility to provide CCO with a written notification of any address changes – work and/or home – within 30 days of your move. All members registered in the General class are required to have a business address and telephone number listed on CCO's public register.

Reporting Deceased Members

To help keep member records and the public register as up-to-date as possible, CCO requests that death of a member be communicated to CCO in a timely manner. Details can be forwarded to CCO by email to cco.info@cco.on.ca or by fax to 416-925-9610.

Your Feedback is Important!

CCO welcomes your feedback and comments about articles and features in this newsletter. Please forward an email to cco.info@cco.on.ca or by fax to 416-925-9610.

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Ontario
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Today, the **National Post** [published a story by Wayne MacPhail and Paul Benedetti](#), regarding the purported positions on vaccinations by three individual Council members of the College of Chiropractors of Ontario (CCO).

Our great profession is at a watershed moment. Together, we must practice to the CCO standard and we must unite on this public health issue. Negative national news stories hurt the reputation and public trust of our profession, which performs exemplary care for patients across Ontario.

The position of the CCO is clear. *"The College of Chiropractors of Ontario (CCO) recognizes that vaccinations, as mandated in the Province of Ontario, provide a safe and effective means to protect individuals from infectious diseases. CCO reminds members and the public that treating or advising in relation to vaccination is outside of the chiropractic scope of practice."*

We cannot delay further. Let us stand united for our profession. We ask you to share the CCO's statement in your social media channels, your website, blogs and in your daily interactions with patients. And we ask you to end your statements with **#VaccinesWork** and **#Chiros4VaccinesWork**.

#VaccinesWork is a powerful hashtag for a global public safety movement launched by the World Health Organization and is supported by the Centers for Disease Control and Prevention, the American Academy of Pediatrics, the European Commission, UNICEF, International Federation of Red Cross and Red Crescent Societies, physicians, media outlets and other health professionals around the world. It recognizes immunization prevents 2-3 million deaths, additional illness and disabilities from 26 vaccine-preventable diseases. Using this common hashtag connects us to a broad public audience, including our health professional colleagues and the Ontario government.

By using **#Chiros4VaccinesWork**, we acknowledge and comply with our regulator's standards. Using the words from CCO's advisory that was published March 14, we suggest you post, tweet, write or share the following sentence:

"I recognize that vaccinations provide a safe and effective means to protect individuals from infectious diseases. **#VaccinesWork #Chiros4VaccinesWork.**"

If you need support to use those Twitter hashtags or have any questions, please contact Nancy Gale directly at ngale@chiropractic.on.ca.

Together, we stand proud of our profession.

National Post article

We're here for you. Call us:

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Ontario
Chiropractic
Association

Change and Clarification of Earlier Message Regarding the *National Post* Article

Earlier you received a message regarding the *National Post* story published today.

The Ontario Chiropractic Association's [position statement on immunization and vaccination](#), supports the CCO's position statement that "*The College of Chiropractors of Ontario (CCO) recognizes that vaccinations, as mandated in the Province of Ontario, provide a safe and effective means to protect individuals from infectious diseases.*"

However, the CCO standard on vaccination and immunization, as written today, precludes any comment by members on this issue. "**CCO reminds members and the public that treating or advising in relation to vaccination is outside of the chiropractic scope of practice.**"

As a result, we ask you to **disregard our earlier request for you to make any statement on any social platforms** and adhere to the existing CCO standard.

As it indicated in its message on March 14, the CCO will be reviewing the Standard of Practice S-001: Chiropractic Scope of Practice.

If you have any questions, please contact Nancy Gale directly at ngale@chiropractic.on.ca.

National Post article

We're here for you. Call us:

Local: [416-860-0070](tel:416-860-0070) | Toll-free: [1-877-327-2273](tel:1-877-327-2273)

Our mailing address is:

Ontario Chiropractic Association

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From: Jo-Ann Willson
Sent: Tuesday, April 02, 2019 4:18 PM
To: Rose Bustria
Subject: FW: OCA at WFC Berlin Congress, World Health Day 2019 + Webinars

Council.

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Web Site: www.cco.on.ca

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From: OCA [<mailto:OCA@chiropractic.on.ca>]
Sent: Tuesday, April 02, 2019 4:15 PM
To: Jo-Ann Willson <jpwillson@cco.on.ca>
Subject: OCA at WFC Berlin Congress, World Health Day 2019 + Webinars

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Caroline Brereton's Message from EPIC2019

The Chair of the OCA Board of Directors Dr. Ken Brough and I attended the [World Federation of Chiropractic \(WFC\) EPIC Congress](#) in Berlin. Many Ontario chiropractors presented research and hosted sessions. Congratulations to OCA members Dr. Pierre Côté and Dr. Deborah Kopansky-Giles for winning the prestigious David Chapman-Smith Honour Award. Congratulations to Dr. Ayla Azad on her recent appointment to the WFC board of directors; on behalf of CMCC she presented on the topic of Values and Preferences: the many faces of individualized care.

We also hosted a well attended reception for Ontario delegates during Congress. Delegates expressed enthusiasm for a greater OCA presence at these global events, as Ontario has so much to offer. We will plan to support more of our members at future conferences.

At Congress there were a number of panel discussions on the future of chiropractic. An important question was raised about who and what should shape the future of chiropractic and a diverse group of panelists answered the question with remarkable consistency.

The future of chiropractic should be defined by the needs of the population being served, and shaped by the educational preparation and skills of the professionals, the evidence available and policy makers. In a consumer driven society, such as we have here in Ontario, patients have expectations of how and who they receive care from, and policy makers have responded to these expectations in a number of ways that include chiropractors in the system of care.

- The inclusion of chiropractors in the Health Quality Ontario standards for low back pain, osteoarthritis and opioid prescribing for acute and chronic pain management for instance.
- The successful recruitment of chiropractors in Inter-professional Spine Assessment and Education Clinics (ISAEC).
- The investment in patient-centered Primary Care Low Back Pain programs (PCLBP).
- The recently launched Health2Work program to assist Ontario Works participants return to work.

- The invitation for the OCA to be part of the Federal Task Force on Pain.

We are currently working with government and policy makers to ensure that chiropractors have the tools to serve all patients, within a full scope of practice that supports efficient collaboration with patients and other members of a care team.

With these advances the entire profession moves forward as trust grows in the profession. The adoption of the evidence-based framework in Canada a number of years ago will help the profession grow and contribute to the care of Ontarians, as this framework captures all of the elements important to shaping the future of the profession. As a result of our conversations, it is clear that we need a thoughtful approach to enable all our members to see how this framework can be a benefit.

In the coming weeks watch for emails about:

- **Member Consultations:** April to June schedule of meetings around Ontario to engage directly with members
- The establishment of an **Advisory Committee** to work with the OCA leadership on a change management approach that will support members to work within a flexible evidence-based framework. Our work will be to support a long-term vision for a strong profession and to assist all our members to see how this can be a valuable approach
- The establishment of **Communities of Practice or Special Interest Groups** to better engage with members who have different practice areas of focus

Sincerely,

Caroline Brereton

Chief Executive Officer, Ontario Chiropractic Association

The OCA, represented by our CEO Caroline Brereton and Chair of the OCA Board of Directors Dr. Ken Brough, along with a large contingent of Ontario delegates, attended EPIC2019 – the World Federation of Chiropractic's (WFC) and the European Chiropractors' Union's (ECU) influential congress.



Celebrate World Health Day April 7!

April 7 of each year marks the celebration of **World Health Day**, a World Health Organization (WHO) initiative.

On World Health Day, let's shout about the positive impact chiropractic care contributes to quality health care. More than ever chiropractors are in collaborative care settings, involved in interprofessional teams, part of a full spectrum of health care services – from prevention, treatment to rehabilitation.

World Health Day is an opportunity to highlight success stories involving chiropractors.

- **[Globe and Mail](#)**: A news series focusing on the pros of a collaborative team approach in patient treatment and recovery.
 - **[Health2Work](#)**: People receiving support from Ontario Works now have access to care that can help them return to work.
 - **[Primary Care Low Back Pain Program \(PCLBP\)](#)**: A provincial program that helps many people gain access to care for low back pain.
 - **[Inter-professional Spine Assessment and Education Clinics \(ISAEC\)](#)**: A shared-care model of care in which patients receive rapid low back pain assessment, education and self-management plans.
-



Livin' La Vida Locum (Rebroadcast)

Wed. April 3, 12-1 PM

Drs. Shima Shahidy and Dean Wright,
CCPA

Many chiropractors choose to start careers with locums, as they offer clinical skills and insights into the business side of chiropractic. However they are not without risk. CCPA will advise how to manage risk regarding: travelling and locums; managing expectations; when to reassess and reconfirm informed consent; and manage transition of care from one DC to another.

Register Now

How To Connect And Build Trust With Strategic Questions & Active Listening (Rebroadcast)

Wed. April 10, 12-1 PM

Ivan Wanis Ruiz, Dale Carnegie Training

Webinar on how to use strategic questions and active listening to effectively communicate with patients. Learn how to better use questions with patients: improve rapport, better identify ailments and issues and create a more open environment for sharing. Understand how active listening impacts patient perception and patient outcomes.

Register Now

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Subject: FW: CCO Professional Advisory on Vaccination and Immunization

From: Jo-Ann Willson
Sent: Thursday, March 14, 2019 5:33 PM
To: Rose Bustria <RBustria@cco.on.ca>
Cc: David Starmer <drstarmer@gmail.com>; Liz Anderson-Peacock <drliz@bellnet.ca>; Doug Cressman <doug.cressman@gmail.com>
Subject: Fwd: CCO Professional Advisory on Vaccination and Immunization

Council - OCA.

Jo-Ann Willson, B.Sc., M.S.W., LL.B.
Registrar & General Counsel

Begin forwarded message:

From: Ontario Chiropractic Association <OCA@chiropractic.on.ca>
Date: March 14, 2019 at 4:00:21 PM EDT
To: <jpwillson@cco.on.ca>
Subject: CCO Professional Advisory on Vaccination and Immunization
Reply-To: Ontario Chiropractic Association <OCA@chiropractic.on.ca>

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The College of Chiropractors of Ontario (CCO) issued a [Professional Advisory on Vaccination and Immunization](#).

Specifically, it states, *"The College of Chiropractors of Ontario (CCO) recognizes that vaccinations, as mandated in the Province of Ontario, provide a safe and effective means to protect individuals from infectious diseases. CCO reminds members and the public that treating or advising in relation to vaccination is outside of the chiropractic scope of practice.*

Members must refer patients who ask questions related to vaccination to consult with a health professional who has the act within their scope of practice, such as a member of the College of Physicians and Surgeons of Ontario, a member of the College of Nurses of Ontario who holds a certificate of registration in the extended class, or a member of the Ontario College of Pharmacists of Ontario. A member who fails to comply with this professional advisory may be the subject of an inquiry, complaint or report for a potential act of professional misconduct.”

This complements the message from CCO’s Registrar published in the **CHIROPRACTICE** winter 2019 issue that states, “CCO will be stepping up its efforts in reviewing existing standards, policies, guidelines and processes, and in reviewing members’ public information including through the use of appropriate technology.”

The CCO noted that it will be reviewing the [Standard of Practice S-001: Chiropractic Scope of Practice](#). Some amendments are anticipated in making the standard more explicit that members not conduct seminars on vaccination or publish information on vaccination on their websites or social media accounts.

We remind you that the Ontario Chiropractic Association also has a [position statement on immunization and vaccination](#), which supports vaccination and immunization as established public health practices in the prevention of infectious diseases.

CCO Professional Advisory

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Subject: FW: 2019 Fee Schedule, Ontario Health Agency Announcement, RSI Awareness Day

From: Jo-Ann Willson
Sent: Tuesday, February 26, 2019 5:42 PM
To: Rose Bustria <RBustria@cco.on.ca>
Cc: David Starmer <drstarmer@gmail.com>; Liz Anderson-Peacock <drliz@bellnet.ca>
Subject: Fwd: 2019 Fee Schedule, Ontario Health Agency Announcement, RSI Awareness Day

Exec and Council.

Jo-Ann Willson, B.Sc., M.S.W., LL.B.
Registrar & General Counsel

Begin forwarded message:

From: OCA <OCA@chiropractic.on.ca>
Date: February 26, 2019 at 5:18:25 PM EST
To: <jpwillson@cco.on.ca>
Subject: 2019 Fee Schedule, Ontario Health Agency Announcement, RSI Awareness Day
Reply-To: OCA <OCA@chiropractic.on.ca>

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Ontario
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OCA Recommended
Service Codes
& Fee Schedule

Refreshing the Annual Fee Schedule

For decades, our *Recommended Service Codes and Fee Schedule* has been a reference for fair and reasonable billing for general and specialist chiropractic services.

There will be no change to The Fee Schedule for 2019. We plan to undertake a thorough review and evaluation of the entire fee schedule process. This will be a significant project that will take some time to complete. Aside from any adjustments for the inflation

index, other influencing factors such as marketplace trends, regional cost of living variances and the benchmarking of related organizations and fraternal partners' fee structures will be considered, with an overall objective of simplifying the schedule and making it more user-friendly, in order to reflect the current needs of practitioners, patients and payers.

We welcome your feedback and questions at oca@chiropractic.on.ca.

The Fee Schedule



Ontario Health Announcement

Earlier today, Health Minister Christine Elliot unveiled a [proposal for health care in Ontario](#), focused on the creation of a super agency that will be formed by dissolving the 14 Local Health Integration Networks (LHINs) and merging their duties with six provincial health agencies, including Cancer Care Ontario, eHealth Ontario, Trillium Gift of Life Network, Health Shared Services, Health Quality Ontario and HealthForce Ontario Marketing and Recruitment Agency. Minister Elliott also unveiled details of plans to encourage hospitals, long-term care facilities, home-care agencies and other service providers to form "integrated care entities" called Ontario Health Teams.

Those teams will be made up of local health-care providers and organized to work as coordinated groups. The teams will be designed to coordinate care for patients among various care providers and help families through transitions between providers. Under the plan, each Ontario Health Team would receive a block of funding and work together to deliver a range of health-care services for the region they cover.

What Does This Mean For Chiropractors?

The implementation of this announcement will take a significant amount of time, and will focus first on administrative and procedural changes to the health care system before impacting any front line delivery of care.

If your practice revolves around privately-funded payments such as out-of-pocket, extended health benefits, Workplace Safety and Insurance Board (WSIB) or auto insurance, we do not anticipate that this announcement will impact you or your patients in any meaningful way, as this announcement is focused on restructuring Ontario's publicly-funded health care system.

If you are currently providing care within a publicly-funded model such as a Family Health Team, or within an *Inter-professional Spine Assessment and Education Clinic (ISAEC)* or *Primary Care Low Back Pain* program, with the little information shared today, we do not anticipate any changes to those programs within this fiscal year.

We remain engaged with the Ministry of Health and Long-Term Care and will continue to advocate for chiropractors to play a pivotal role in managing the health challenges of patients across our province. We will share any relevant details on the implementation of the *People's Health Care Act 2019* as they become available to us.

If you are currently participating in any Local Health Integration Network (LHIN) committees, working groups or otherwise involved in publicly-funded organizations and have questions or information you wish to share with us, please contact us at oca@chiropractic.on.ca.

Government of Ontario News Release



February 28 is Repetitive Strain Injury Awareness Day!

Use [RSI Awareness Day](#) to focus attention on the issue of back health at work. Share tips on healthy workplace ergonomics with patients.

To help we've created a toolkit on repetitive strain and workplace ergonomics you can [print](#)

[and share](#) – because work shouldn't hurt.

1065

Share with Patients

- [Repetitive Strain Injuries](#): covers how repetitive actions add physical stress to every day work.
- [Office Ergonomics Presentation](#): points on why good MSK health is important in the workplace. Tips for good posture and exercises to increase flexibility and build strength.
- [Stretches For Your Whole Body](#): shareable 4-page print out detailing exercises to help the body deal with day-to-day pain at work and home.
- [Back Health at Work - Office Ergonomics](#): 5 tips to make an office work station comfortable; a reminder to move and change up positions throughout the day.

RSI Awareness Day Resources



Chiropractic on Trial: A Case Study with CCPA (Rebroadcast)

Wed. Feb. 27, 12-1 PM

Dr. Greg Dunn & Dr. Shima Shahidy,
CCPA

CCPA will provide an overview of the main issue at play in a recent, real-world trial, in which they defended a chiropractor facing a herniation disc claim. The key issues discussed are: shared care, 'stale' informed consent, record keeping and expert testimony.

Breaking the Ice: Techniques for Instantly Building a Connection (Rebroadcast)

Wed. Mar. 6, 12-1 PM

Ivan Wanis Ruiz, Dale Carnegie Training

Learn techniques to connect instantly and authentically with potential patients and colleagues. Dale Carnegie principles are applied to enhance the way you communicate with new people and build mutually beneficial relationships.

Register Now

Register Now

1066

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Subject: FW: Globe and Mail Follow Up + Webinars

From: Jo-Ann Willson
Sent: Tuesday, February 19, 2019 8:07 PM
To: Rose Bustria <RBustria@cco.on.ca>
Cc: David Starmer <dirstarmer@gmail.com>; drliz@drliz.ca; Doug Cressman <doug.cressman@gmail.com>
Subject: Fwd: Globe and Mail Follow Up + Webinars

Council.

Jo-Ann Willson, B.Sc., M.S.W., LL.B.
Registrar & General Counsel

From: OCA <OCA@chiropractic.on.ca>
Date: February 19, 2019 at 5:05:29 PM EST
Subject: **Globe and Mail Follow Up + Webinars**
Reply-To: OCA <OCA@chiropractic.on.ca>

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Ontario
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Message from the CEO

Caroline Brereton sets the record straight

Dr. Dwight Chapin, our Chiropractor of the Year, set the record straight in his [published Globe and Mail article](#).

The article states that musculoskeletal conditions are best managed by a team approach to care – with the team consisting of a chiropractor. There is evidence that demonstrates the effectiveness of chiropractic for MSK conditions. Here are some relevant studies that

may help if you're approached by health care providers or patients on the issue, and can be easily shared on your website or social media.

- [Nonpharmacologic Therapies for Low Back Pain: A Systematic Review for an American College of Physicians Clinical Practice Guideline](#)
- [Manipulation and Mobilization for Treating Chronic Low Back Pain: A Systematic Review and Meta-Analysis. The Spine Journal](#)
- [An update of the Bone and Joint Decade Task Force on Neck Pain and Its Associated Disorders by the oPTIMa Collaboration. The Spine Journal](#)

We are aware that conversations on social media have been diverse. Many of you have expressed your support for the article and I encourage you to share this positive message with your network. Some critics of chiropractic have voiced concern about out of scope claims. Please see our position statements below:

Immunization and Vaccination

We support vaccination and immunization as established public health practices in the prevention of infectious diseases. **Vaccination is not within the scope of chiropractic practice.** The appropriate sources for patient consultation and education regarding vaccination and immunization are public health authorities and health professionals with a scope of practice that includes vaccination.

Evidence-Based Care

Ontario's chiropractors adopt evidence-based practice principles to guide clinical decision making by integrating the best available scientific evidence, clinical expertise and patient preferences. This is a widely accepted approach that is not unique to our profession.

Moving forward, we will continue to tell the story of how chiropractors are impacting the lives of Ontarians, to government, the public and the organizations we collaborate with.

If you have questions, ideas or concerns, I invite you to contact me at cbreton@chiropractic.on.ca.

Sincerely,

Caroline Brereton
OCA CEO

1069



Difficult Conversations with Patients (Rebroadcast)

Wed. Feb. 20, 12-1 PM

Ivan Wanis-Ruiz, Dale Carnegie Training

This webinar will focus on two frameworks for having difficult conversations and addressing sensitive topics. Participants will have an opportunity to provide real life examples and apply the frameworks to them.

[Register Now](#)

Chiropractic on Trial: A Case Study with CCPA (Rebroadcast)

Wed. Feb. 27, 12-1 PM

Dr. Greg Dunn & Dr. Shima Shahidy, CCPA

CCPA will provide an overview of the main issue at play in a recent, real-world trial, in which they defended a chiropractor facing a herniation disc claim. The key issues discussed are: shared care, 'stale' informed consent, record keeping and expert testimony.

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The Canadian dollar's spindly legs could soon give out

1070

OPINION

Despite the tired narratives, chiropractic is backed by evidence

DWIGHT CHAPIN

CONTRIBUTED TO THE GLOBE AND MAIL

PUBLISHED FEBRUARY 16, 2019

UPDATED 2 DAYS AGO

Dr. Dwight Chapin, B.Sc., D.C., is the on-site chiropractor for The Globe and Mail and the Ontario Chiropractic Association's 2018 Chiropractor of the Year.

Let's say that one day, picking up your newspaper, you tweak your back, or wake up with a sore neck. You should call a chiropractor.

If you are looking for a cure for attention deficit disorder, asthma or lupus, you should not. There is no chiropractic treatment that will reverse these conditions.

This may all seem painfully obvious. But it appears that confusion still exists regarding what a chiropractor can and cannot do.

To be clear, chiropractors are musculoskeletal experts who are governed by a very clear scope of practice that is defined by the diagnosis, prevention, and treatment of biomechanical disorders originating from the muscular, skeletal, and nervous systems. Chiropractors complete more than 4,200 hours of core competency training in this discipline. This is the profession's specialty, where it is supported by research and where chiropractors are viewed as a trusted health care partner.

1071

The Canadian dollar's spindly legs could soon give out. The 2017 Canadian Guideline for Opioid Therapy and Chronic Non-Cancer pain recommends the optimization of nonopioid medication and non-drug therapy. This includes health care provided by chiropractors and other professionals who treat back, neck, and shoulder pain, before considering opioids.

Translation: back pain is best managed by a team approach to care, with the team consisting of a chiropractor, family doctor or nurse practitioner, and others such as a physiotherapist and registered massage therapist. Professionals aware of these current clinical guidelines, who are open to collaborating or even better, have existing professional relationships to help co-ordinate your care, will serve you well. You should be wary of clinicians who discourage collaboration.

People with back pain need timely access to non-drug pain management, provided by musculoskeletal experts, and chiropractors are answering this call. Lower back pain is still the number one cause of disability in Canada, and it is also one of the top-four reasons why people visit emergency departments. This contributes to overcrowding in hospitals, despite the fact that the majority of back-pain patients do not require hospital care and will be sent home. Back-pain patients are also more likely to end up with an opioid prescription. In recent articles in The BMJ and the Canadian Medical Association Journal, back pain is reported to be the most common diagnosis for opioid prescriptions by both emergency and family physicians and is reported in more than half of regular opioid users.

Chiropractors can provide a drug-free, alternative approach to Canada's opioid crisis and help end overcrowding and hallway medicine in hospitals. Best-practice models of care are already widely in practice.

Yet, despite research in strong support of the chiropractic profession's well-defined scope of practice and the trend of chiropractic integration into the

The Canadian dollar's spindly legs could soon give out mainstream, public confusion surrounding the scope and value of the profession continues.

Critics like to propagate an old narrative that the chiropractic profession is not evidence-based. Canada's new guideline for opioid therapy and chronic non-cancer pain, which includes recommendations of first-line therapies provided by chiropractors, demonstrates this is not the case. This criticism is antiquated, revealing potential bias, and lacks awareness of current clinical studies.

Attempting to define any profession by the individual actions of a few is at best misleading. Not all practitioners can be painted with the same brush.

Stories of clinicians that breach the public trust are alarming and inexcusable, but unfortunately they do happen. Healthcare professionals across Canada, including chiropractors, rely on their regulatory body to govern their profession in the public interest and assure competent and ethical care. Such bodies set professional, evidence-based standards and best practices, monitor compliance with these standards and provide enforcement to ensure strong public trust.

This is a difficult and meaningful responsibility. Efforts from these organizations to improve must continue. Under the banner of evidence-based, patient-centred, interprofessional and collaborative care, the chiropractic profession will break through the same old narrative and protect public trust.

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351 King Street East, Suite 1600, Toronto, ON Canada, M5A 0N1

Phillip Crawley, Publisher

Subject: FW: BREAKING NEWS: Setting the Record Straight in the Globe and Mail Today

From: Jo-Ann Willson
Sent: Saturday, February 16, 2019 12:34 PM
To: Rose Bustria <RBustria@cco.on.ca>
Cc: David Starmer <drstarmer@gmail.com>; Liz Anderson-Peacock <drliz@bellnet.ca>
Subject: Fwd: BREAKING NEWS: Setting the Record Straight in the Globe and Mail Today

Council (February 27, 2019).

Jo-Ann Willson, B.Sc., M.S.W., LL.B.
Registrar & General Counsel

Begin forwarded message:

From: OCA <OCA@chiropractic.on.ca>
Date: February 16, 2019 at 1:34:55 PM GMT-3
To: <jpwillson@cco.on.ca>
Subject: **BREAKING NEWS: Setting the Record Straight in the Globe and Mail Today**
Reply-To: OCA <OCA@chiropractic.on.ca>

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Ontario
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BREAKING NEWS

Setting the record straight in the Globe and Mail today

Dr. Dwight Chapin, our Chiropractor of the Year, is published in the Globe and Mail today.

Titled, "[Despite tired narratives, chiropractic is backed by evidence](#)," Dr. Chapin positions our profession for the public, for the health care system, and for the

record.

If you have comments or questions, contact Nancy Gale at ngale@chiropractic.on.ca.

Here is his article.

[Despite the tired narratives, chiropractic is backed by evidence](#)

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ALBERTA
COLLEGE AND ASSOCIATION
OF
CHIROPRACTORS

1160

MEDIA RELEASE

March 6, 2019

COLLEGE PROVIDES CLARITY TO MEMBERS REGARDING STANDARD OF PRACTICE ON ADVERTISING, PROMOTIONS & PRESENTATIONS

Edmonton, AB – The Alberta College and Association of Chiropractors (ACAC) is providing clarity to its members regarding its Standard of Practice on Advertising, Promotions and Presentations.

As part of this effort, the ACAC is directing its members to remove all claims of chiropractic efficacy that may be perceived as misleading, exaggerated and unsubstantiated from their social media profiles, websites and in-office material.

“Chiropractic provides a range of benefits to patients. Some benefits, while present and observable, are still being evaluated scientifically,” said Dr. Brad Kane, President of the ACAC Council. “As patient safety and public confidence are paramount, we are taking a proactive approach in ensuring chiropractors focus their advertising on claims that are understood scientifically.”

The ACAC Council issued an Advertising Directive to members as a supplement to its existing Standard of Practice on Advertising, Promotions and Presentations. The Directive outlines the specific information that chiropractors cannot represent to the public or their patients through digital or traditional advertising.

For example, chiropractors cannot suggest that chiropractic care can treat, relieve or cure conditions such as allergies, ADHD or cancer. Additionally, it prohibits chiropractors from making any statements regarding immunizations or vaccinations.

Chiropractors have until April 14, 2019 to remove all references from their digital and traditional marketing material that do not comply with the directive. Chiropractors found in violation of the directive will be considered for investigation and possible disciplinary action, including financial penalties.

The Alberta College and Association of Chiropractors (ACAC) regulates the chiropractic profession in Alberta under the Health Professions Act. The ACAC is committed to protection of the public and advancement of the chiropractic profession.

-30-

For more information, please contact:

Kyla Stocks
Director, Communications and Marketing
kstocks@albertachiro.com | 780.420.0932



DIRECTIVE

ADVERTISING DIRECTIVE

To ensure compliance with the advertising requirements set out in the *Health Professions Act* Section 102 on Advertising, and sections 1, 1a, 1e, 8 and 11 of the *Canadian Code of Advertising Standards* regulated by Advertising Standards Canada, and ACAC SP 1.0 *Advertising, Promotions and Presentations* registrants must NOT represent to patients or the public the following:

1. Any statement which suggests that the following conditions, or symptoms of the following conditions, can be treated, relieved or cured with chiropractic care:
 - a) Allergies
 - b) Alzheimer's disease and/or dementia
 - c) Asperger's Syndrome
 - d) Asthma
 - e) Attention Deficit Disorder (ADD)
 - f) Attention Deficit Hyperactivity Disorder (ADHD)
 - g) Autism or autism-spectrum related disorders
 - h) Cancer
 - i) Cerebral Palsy
 - j) Cognitive impairment
 - k) Developmental and speech disorders
 - l) Diabetes
 - m) Down Syndrome
 - n) Family planning
 - o) Fertility
 - p) Fetal alcohol syndrome
 - q) Flu
 - r) Immunity
 - s) Infantile Colic
 - t) Infections
 - u) Infertility
 - v) Multiple Sclerosis/MS
 - w) Nocturnal Enuresis (bedwetting)
 - x) Otitis Media (ear infection)
 - y) Parkinson's Disease
 - z) Tourette's Syndrome
2. Any information related to vaccination and immunization.
3. Patient testimonials that reference the above diseases, disorders or conditions.

The above list of diseases, disorders or conditions is neither final nor conclusive. Absent acceptable evidence, registrants are not free to make claims about the effectiveness of chiropractic in treating a disorder, disease or condition simply because it is not included in the list.

Materials, links or posts identified that may offend the Advertising Directive will be forwarded to the Deputy Registrar, Complaints and Compliance, for investigation and possible disciplinary action, including financial penalties.

Effective March 1, 2019

New Advertising Directive and Digital Media Screening Program

As shared in previous Registrar's Reports and at the Annual General Meeting in September, there have been ongoing media reports and insurance industry articles across the country regarding misleading, exaggerated and unsubstantiated claims of chiropractic efficacy. Following are samples of the most recent articles:

1. *"Chiropractors at a crossroads: The fight for evidence-based treatment and a profession's reputation,"*
2. *"Calls Grow for Outside Regulation of Chiropractors"*
3. *"In an era of misinformation alternative medicine needs to be regulated."*
4. *In the News: Some Chiropractors are Promoting Unscientific Treatments (page 7)*
5. *Dubious Chiropractic Claims Show Need for More Scrutiny on Paramedical Expenses*

These media reports and insurance industry articles claim that the chiropractic profession is not capable of self-regulation due to the Colleges' unwillingness to proactively respond to false or misleading claims about the benefits of chiropractic.

In Alberta, the public, other health professionals, and our own registrants have voiced concerns about treatment claims that are misleading, exaggerated or unsubstantiated.

While there are many documented and evidence-informed benefits to chiropractic care, some chiropractors continue to advertise misleading, exaggerated or unsubstantiated claims. Claims of this nature are in violation of the *Health Professions Act* Section 102 on Advertising as well as sections 1, 1a, 1e, 8 and 11 of the *Canadian Code of Advertising Standards* regulated by Advertising Standards Canada (<https://adstandards.ca/wp-content/uploads/2018/11/Canadian-Code-of-Advertising-Standards.pdf>), and ACAC SP 1.0 *Advertising, Promotions and Presentations*. In turn, claims of this nature both violate the ACAC's mandate of protection of the public and threaten the profession's ability to remain self-regulating.

Additionally, these claims threaten the ability of chiropractic care to be covered under third-party insurance, as some insurance companies are already scrutinizing chiropractic care and considering not covering it anymore.

The ACAC does not want our members to be in violation of provincial and federal advertising regulations, lose our ability to self-regulate, or lose the opportunity to be included in third-party insurance benefits. Therefore, Council has adopted a proactive approach to address potential advertising concerns regarding material on member websites, social media sites, traditional advertising and in-office materials.

Advertising Directive

An advertising directive was passed by Council that went into effect on March 1, 2019. The directive outlines specific information that chiropractors can not represent to the public or their patients through digital or traditional advertising and marketing.

For example, **chiropractors can not suggest that chiropractic care can treat, relieve or cure** conditions including, but not limited to, allergies, asthma, diabetes, infertility or the flu. [Read the full Advertising](#)

Directive here.

Additionally, chiropractors cannot communicate patient testimonials that suggest chiropractic care treated, relieved or cured the conditions listed.

The advertising directive also prohibits chiropractors from making **any** statements regarding vaccinations or immunizations. This is consistent with the ACAC's Position Statement on Vaccination and Immunization that has been in place since January 2015.

The list is not final nor conclusive. Just because a condition is not included on the list, does not mean a chiropractor can claim to treat, relieve or cure that condition through chiropractic care.

What You Need to Do (Time Sensitive)

Please immediately review your website(s) and social media accounts and remove any materials that do not comply with the Advertising Directive. This includes blogs, posts, messages, videos, downloadable PDFs and links to other sites, posts and messages.

Please also review the printed materials, brochures and posters displayed or available in your offices and remove noncompliant material as appropriate.

The following are some tips and tools you may find useful in ensuring that your website(s), social media and other online materials comply with the Advertising Directive:

- Carefully review the content of all of your online materials;
- Search your online materials for the terms found in the Advertising Directive as follows:
 - Google search your website using the "site" function.
 - <https://blog.hubspot.com/marketing/how-to-do-a-google-site-search>
- Search Facebook pages by term using "choose a source"
 - <https://www.howtogeek.com/282908/how-to-use-facebooks-search-to-find-anyone-or-anything/>
- Search Twitter pages with filters for tweets
 - <https://help.twitter.com/en/using-twitter/twitter-search>
- Contact your IT providers for specific assistance and explanations;

All such materials must be removed regardless of when they were created or posted.

To allow members time to do a complete review, you have until April 14, 2019 to remove *all* material that does not comply.

College Follow-Up

The ACAC will be completing a thorough review of registrants' online marketing material to ensure misleading, exaggerated or unsubstantiated claims are not being made about the diseases, disorders or conditions listed and information about vaccination and immunization is not being published.

Council has approved an ongoing Digital Media Screening Program that will launch April 15, 2019. All

registrants' digital media will be screened on an ongoing basis to ensure compliance, with any issues of non-compliance forwarded to the Deputy Registrar for investigation and possible disciplinary action, including financial penalties.

While the ACAC's focus will be on registrants' professional digital media, any inappropriate posts on registrants' personal social media profiles that identify them as a chiropractor are also subject to screening and follow-up.

Compliance regarding printed materials, brochures and posters displayed or available in offices will be assessed during practice reviews and random on-site audits.

Questions?

Email us at registrar@albertachiro.com with any questions, comments or concerns you have regarding the advertising directive or digital media screening program.

Thank you for your attention and cooperation.

Sincerely,

Sheila J. Steger
Interim Registrar

Subject: FW: Dr. Todd Halowski named Registrar of Alberta College and Association of Chiropractors

From: Jo-Ann Willson
Sent: Wednesday, February 20, 2019 5:27 PM
To: Rose Bustria <RBustria@cco.on.ca>
Cc: David Starmer <drstarmer@gmail.com>; drliz@drliz.ca
Subject: Fwd: Dr. Todd Halowski named Registrar of Alberta College and Association of Chiropractors

Council.

Jo-Ann Willson, B.Sc., M.S.W., LL.B.
Registrar & General Counsel

College of Chiropractors of Ontario
[130 Bloor St. West, Suite 902](#)
[Toronto, ON M5S 1N5](#)
Tel: [\(416\) 922-6355 ext. 111](#)
Fax: [\(416\) 925-9610](#)
E-mail: jpwilson@cco.on.ca
Web Site: www.cco.on.ca

CONFIDENTIALITY WARNING:

This e-mail including any attachments may contain confidential information and is intended only for the person(s) named above. Any other distribution, copying or disclosure is strictly prohibited. If you have received this e-mail in error, please notify me immediately by reply e-mail and delete all copies including any attachments without reading it or making a copy. Thank you.

Begin forwarded message:

From: Sheila Steger <ssteger@albertachiro.com>
Date: February 20, 2019 at 6:27:39 PM GMT-3
To: Alison Dantas <ADantas@chiropractic.ca>, 'John Sutherland' <jsutherland@chirofed.ca>, Greg Dunn <gdunn@ccpaonline.ca>, Gemma Beierback <gbeierback@cceb.ca>, "Dr. Richard Brown" <rbrown@wfc.org>, "david.hayes@dr.com" <david.hayes@dr.com>, "denise@saskchiro.ca" <denise@saskchiro.ca>, "plariviere@ordredeschiropraticiens.qc.ca" <plariviere@ordredeschiropraticiens.qc.ca>, "fhainsdc@videotron.ca" <fhainsdc@videotron.ca>, "lynn.e.shaw80@gmail.com" <lynn.e.shaw80@gmail.com>, "jsutherland@chirofed.ca" <jsutherland@chirofed.ca>, "drlarichard@hotmail.com" <drlarichard@hotmail.com>, Sheila Steger <ssteger@albertachiro.com>, "jpwilson@cco.on.ca" <jpwilson@cco.on.ca>, "jfhenry@ordredeschiropraticiens.qc.ca" <jfhenry@ordredeschiropraticiens.qc.ca>, "danica.brousseau@uqtr.ca" <danica.brousseau@uqtr.ca>, "drmegmcdonald@gmail.com" <drmegmcdonald@gmail.com>, "drcjlevere.nbca@rogers.com" <drcjlevere.nbca@rogers.com>, "drjanisdc@gmail.com" <drjanisdc@gmail.com>, "dwickes@cmcc.ca" <dwickes@cmcc.ca>, "Doug.shatford@cshlaw.ca" <Doug.shatford@cshlaw.ca>, "registrar@mbchiro.org" <registrar@mbchiro.org>

"deputyregistrar@chirobc.com" <deputyregistrar@chirobc.com>,
"jjsuchdev@hotmail.com" <jjsuchdev@hotmail.com>, "registrar@chirobc.com"
<registrar@chirobc.com>, "rgwatkin@hotmail.com" <rgwatkin@hotmail.com>,
"dr.kane@spine.ca" <dr.kane@spine.ca>, "drstarmer@gmail.com"
<drstarmer@gmail.com>

1166

Cc: Todd Halowski <drhalowski@haloclinic.ca>

Subject: Dr. Todd Halowski named Registrar of Alberta College and Association of Chiropractors

On behalf of the Council of the Alberta College and Association of Chiropractors, we are pleased to announce that Dr. Todd Halowski has been selected as Registrar.

Dr. Halowski is a graduate of both Palmer College of Chiropractic and the University of Calgary, and has practiced in multidisciplinary clinic settings in Calgary since 2005. In addition to his practice, Dr. Halowski has actively served the profession and the ACAC through numerous volunteer roles including as an investigator, inspector, hearing tribunal/complaints review committee member, and as a member of the MLA matching program and fee negotiation committee. Dr. Halowski also served as a pilot site for the Netcare access development project.

Dr. Halowski is in process of relocating from Calgary to Edmonton and will begin his role no later than June 17, 2019.

We are delighted to have someone of Dr. Halowski's caliber and experience serving as Registrar. Please join us in welcoming Dr. Halowski to his new role!

Warmest regards,

Dr. Brad Kane
President

Sheila Steger
CEO & Interim Registrar

Subject: FW: CCPA Communiqué January 2019

From: Jo-Ann Willson

Sent: Wednesday, January 30, 2019 8:24 AM

To: Rose Bustria <RBustria@cco.on.ca>

Cc: David Starmer <drstarmer@gmail.com>; President <President@cco.on.ca>; Liz Anderson-Peacock <drliz@bellnet.ca>

Subject: FW: CCPA Communiqué January 2019

Council.

Jo-Ann Willson, B.Sc., M.S.W., LL.B.



CANADIAN
CHIROPRACTIC
PROTECTIVE
ASSOCIATION

CCPA Communiqué

January 2019

Happy New Year from CCPA! We hope you had a safe and happy holiday season. The entire staff at CCPA is looking forward to a successful 2019 in which we work hard to ensure our members are protected and supported with their practices.



Starting the year off right

The start of a new year is ripe for fresh opportunities and possibilities. A time of resolutions and taking stock of things in our lives. In your practice, it's also a great time to ensure your staff protocols and record-keeping procedures are effective. That way, you can ease into 2019 knowing you and your patients are well-protected in the case of any incidents that may (but hopefully not) arise. To help you start the new year off on the right footing, we've listed some things to consider to ensure you have managed risk in your practice.

- 1. Review your office protocols for new patients.** For example, ensure your staff members remind patients not to sign the informed consent document until they have spoken to their DC about diagnosis and treatment. Or consider training staff to double-check any paper files (before they are refiled) for any obvious blank spaces.
- 2. Make sure your SOAP notes are written contemporaneously.** As you go through your upcoming patient files, you shouldn't see any missing notes where you've planned to fill the rest in when there's more time.

3. Review your office privacy policy. This includes insuring the protection and safety of not just recorded patient information, but also of in-office conversations. Be sure everyone knows to keep these conversations out of earshot of patients.

4. Review emergency and patient crisis protocols. Ensure all staff members and providers know the drill, because after all, patient wellbeing is our number one concern.

CCPA welcomes a new claims officer, Dr. Wheatley

January 14 was an exciting day for CCPA, as we welcomed a new member to our Claims Team - Dr. Kathryn Wheatley. Dr. Wheatley practiced in Hamilton, Ontario from 2006 to 2017, helping patients of all ages with a wide range of conditions. At the end of 2018, Dr. Wheatley finished a term as Director on the Ontario Chiropractic Association Board.

Dr. Wheatley is using her education and experience both as a Doctor of Chiropractic and in the insurance industry to enhance the Claims Team, ensuring we have the breadth and strength we need to serve our members. She holds a BSc in Biology from the University of Maryland Baltimore County and graduated from the Canadian Memorial College of Chiropractic (CMCC) in 2006.

New on the CCPA website

Visit the CCPA member portal to watch a new video about the peace of mind that comes from calling our Claims Team early and often when you think something might not be quite right with a patient. To watch now, [click here](#), sign in with your CCPA login, and find the "This is Jane" video on the News & C.E. page.



As always, we are here to take your call and discuss any questions or concerns you may have. Don't wait for something to go wrong. Many members call us when they are in the planning stages of a change or considering adding something new to their practice. We're here to help.

1170

Our records indicate you prefer receiving correspondence in English. To update your communication preferences please contact us at admin@ccpaonline.ca.

CCPA
802 The Queensway
Etobicoke, ON M8Z 1N5
admin@ccpaonline.ca
Local: 416-781-5656
Toll-free: 1-800-668-2076

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CANADIAN CHIROPRACTIC EXAMINING BOARD
CONSEIL CANADIEN DES EXAMENS CHIROPRATIQUES

ANNUAL REPORT

RAPPORT ANNUEL

2017/2018

ACCURACY
EXACTITUDE

DEFENSIBILITY
DÉFENDABILITÉ

FAIRNESS
JUSTICE

INTEGRITY
INTÉGRITÉ

1172



Suite 230, 1209 – 59th Avenue SE Calgary, Alberta T2H 2P6

403-230-3321
www.cceb.ca

BOG & Staff Photo Credit / Source de photo des Gouverneurs et du personnel, Suzan McEvoy
www.photoswithfinesse.com

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2017/2018 BOARD OF GOVERNORS 2017/2018 CONSEIL DES GOUVERNEURS

Dr. Moe Baloo, Board Chair / Président du Conseil des Gouverneurs

Dr. Elli Morton, Vice Chair / Vice-Présidente du Conseil des Gouverneurs

Ms. Brenda Hendrickson, Past Chair, Public Member / Présidente antérieure, Membre public

Mr. Trevor Paramchuk, Treasurer, Public Member / Trésorier, Membre public

Dr. Paul Nolet

Dr. David Millar

Dr. Lisa L. Dickson

Dr. Jason Guben

Ms. Gemma Beierback, CEO / Directrice Générale

Top, left to right:

Dr. Elli Morton, Dr. Moe Baloo,
Dr. Paul Nolet, Ms. Brenda Hendrickson,
Dr. Jason Guben

Bottom, left to right:

Ms. Gemma Beierback, Dr. David Millar,
Mr. Trevor Paramchuk, Dr. Lisa Dickson



MESSAGE FROM THE CEO

The staff team at the CCEB has had a busy, productive and successful exam year. We had our largest number of exam writers in all exam components this year including administering the June Component C (OSCE) to nearly 300 candidates in two centres, requiring the coordination and oversight of hundreds of candidates, staff and volunteers. As always, the team is focused on our mission: to ensure fair and defensible evaluation of candidates using psychometrically valid and reliable examinations as part of the licensing requirements of Canadian chiropractic regulatory authorities. In furtherance of this role we have contracted Dr. Anthony Marini, who is our examination psychometrician. Having Anthony on the team has permitted us to focus on advancing and enhancing our practices and processes to ensure that we are continuously improving and optimally prepared for the future of high stakes examinations.

The team is also dedicated to operational enhancements with a particular focus on ensuring our ability to support our francophone members, volunteers and candidates to the fullest. You will notice this commitment in your interactions with our office, and notably in this annual report. We have also endeavoured to enhance our annual reporting to members, with a broader look at the work the CCEB does and how we do it. A big part of 'how we do it' is leveraging a large and committed volunteer base; chiropractors from across Canada who give of their time, training and talents.

We had our largest number of exam writers in all exam components this year"

The Board of Governors is pleased to present the new 2018-2021 strategic plan. A graphic representation of the plan is included in this report. We want to strive to continuously improve and ensure we are providing the calibre of service and quality of examinations that you rely on us to deliver. Part of this readiness is our commitment to supporting the movement toward competency-based education in chiropractic. We are proactively ensuring we are able to respond as required.

We are open to your feedback and thoughts, so please don't hesitate to contact me directly at gbeierback@cceb.ca.

Kind regards,



Gemma

MESSAGE DE LA DIRECTRICE GÉNÉRALE

Le personnel de l'équipe du CCEB a eu une année d'examens chargée, productive et réussie. Nous avons eu notre plus grand nombre de candidats pour toutes les composantes d'examens cette année, y compris l'administration de l'examen de juin pour la composante C (ECOS) pour presque 300 candidats dans deux centres. Ceci exige la coordination et la supervision des centaines de candidats, membres du personnel et bénévoles. L'équipe se concentre depuis toujours sur notre mission : assurer l'évaluation équitable et défendable des candidats, en utilisant des examens psychométriques fiables et valides, dans le cadre des exigences de permis de pratique des autorités réglementaires canadiennes chiropratiques. Dans le cadre de ce rôle, nous avons embauché Dr. Anthony Marini à titre de psychométricien. L'intégration d'Anthony à l'équipe nous a permis de nous focaliser sur l'avancement et l'amélioration de nos pratiques et nos processus afin d'assurer

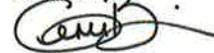
que nous nous améliorons continuellement et que nous sommes préparés de façon optimale pour l'avenir des examens à enjeux élevés.

L'équipe se consacre également aux perfectionnements opérationnels en veillant particulièrement à assurer notre capacité de soutenir pleinement nos membres, bénévoles et candidats francophones. Vous remarquerez cet engagement lors de vos interactions avec notre bureau et notamment dans ce rapport annuel. Nous nous sommes également efforcés d'améliorer nos rapports annuels aux membres, en examinant plus en détail le travail du CCEB et nos procédures. Une grande partie de notre modus operandi consiste à tirer profit d'une base de bénévoles importante et engagée; des chiropracticiens sur l'ensemble du Canada qui donnent de leur temps, formation et talents.

Le conseil d'administration est heureux de présenter le nouveau plan stratégique de 2018-2021 dont une représentation graphique est incluse dans ce rapport. Nous nous efforçons de nous améliorer continuellement et d'assurer que nous fournissons le niveau de service et la qualité des examens que vous nous confiez. Notre engagement à soutenir le mouvement vers une formation basée sur les compétences dans la chiropratique fait partie de cette préparation et nous veillons de manière proactive à répondre aux besoins.

Vos commentaires et réflexions sont les bienvenus. N'hésitez pas à me contacter directement à gbeierback@cceb.com.

Cordialement,



Gemma

MESSAGE FROM THE CHAIR

Dear Members,

Welcome to this inaugural Annual Report from the CCEB. It has been a busy year at the organization, both for the Board of the Directors and for our staff at the head office. As many of you know, Pat Frank retired in January after 11 years as CEO. We wish to take this opportunity to thank Pat once again for her many years of dedicated leadership towards strengthening and advancing the standard of national chiropractic examinations in Canada.

We wish to sincerely thank our volunteers for the critical role they play and for their valuable time and service to the profession."

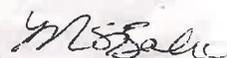
In March, we hired a new CEO, Gemma Belerback, who has hit the ground running. Over the past seven months, Gemma, the CCEB staff, and our volunteers, have worked diligently and effectively to ensure that the security, reliability, and validity of our examinations has remained at the same high quality our members have come to expect. Our new CEO has also added bench strength to the organization with the hiring of a psychometrician, a chief financial officer, and a fully bilingual assistant and translator. To this end, we wish to thank Gemma and the staff at the head office for their excellent work.

We also recognize that the 'backbone' of the CCEB are its volunteers. To date, we have 821 chiropractic doctors from across Canada who volunteer in a vari-

ety of roles. Their combined efforts have resulted in 4,076 volunteer hours or almost 60 volunteer days for the 2017/18 period. Without this level of professional commitment and dedication, the CCEB would not be able to carry out its mission and mandate.

Lastly, and on behalf of the Board of Directors, we wish to sincerely thank our volunteers for the critical role they play and for their valuable time and service to the profession.

Respectfully submitted,



Moe Baloo, BSc, DC, MHA
Board Chair

MESSAGE DU PRÉSIDENT DU CONSEIL DES GOUVERNEURS

Chers membres,

Bienvenue à ce rapport annuel inaugural du CCEB. L'année a été chargée pour l'organisation, tant pour le conseil d'administration que pour notre personnel au bureau principal. Comme bon nombre d'entre vous le savent, Pat Frank a pris sa retraite ce janvier après onze ans comme Directrice générale. Nous souhaitons profiter de cette occasion pour remercier Pat encore une fois pour ses nombreuses années de leadership dévoué au renforcement et à l'avancement de la norme des examens nationaux de chiropratique au Canada.

Nous tenons à remercier sincèrement nos bénévoles pour le rôle essentiel qu'ils jouent, ainsi que pour leur temps précieux et leur service à la profession."

En mars, nous avons embauché une nouvelle Directrice générale, Gemma Beierback, qui s'est mise immédiatement au travail. Au cours des sept derniers mois, Gemma, les employés du CCEB et nos bénévoles ont travaillé avec diligence et efficacité pour veiller à ce que la sécurité, la fiabilité et la validité de nos examens restent au même niveau de qualité attendu par nos membres. Notre nouvelle Directrice générale a également renforcé la structure de l'organisation en recrutant un psychométricien, un directeur financier et une assistante et traductrice entièrement bilingue. À cette fin, nous souhaitons remercier Gemma et le personnel du bureau principal pour leur excellent travail.

Nous reconnaissons également que la « colonne vertébrale » du CCEB se compose de ses bénévoles. À ce jour, 821

docteurs en chiropratique de partout au Canada font du bénévolat dans divers rôles. Leurs efforts combinés ont abouti à 4 076 heures de bénévolat, soit près de 60 jours de bénévolat pour la période de 2017-2018. Sans ce niveau d'engagement et de dévouement professionnels, le CCEB ne serait pas en mesure de s'acquitter de sa mission et de son mandat.

Enfin, et au nom du conseil d'administration, nous tenons à remercier sincèrement nos bénévoles pour le rôle essentiel qu'ils jouent, ainsi que pour leur temps précieux et leur service à la profession.

Le tout respectueusement soumis.



Dr. Moe Baloo
Président du Conseil d'administration

WHO WE ARE AND WHAT WE DO

MISSION

To ensure fair and defensible evaluation of candidates, using psychometrically valid and reliable examinations, as part of the licensing requirements of Canadian chiropractic regulatory authorities.



The Canadian Chiropractic Examining Board (CCEB) serves our members, the provincial regulators, by assessing the competency of chiropractors for entry to practice in Canada. This is the gateway that ensures public protection and professional integrity. The CCEB administers three examinations, three times per year, component A, B and C.

Component A & B examinations are multiple choice and consist of approximately 220 items, written in two sections with three hours to complete each

section. Component C is an OSCE, an Objective Structured Clinical Examination. It tests the candidate's clinical skill in a scenario-based clinic setting. There are 10 stations and multiple patient presentations. SP's, Standardized Patients, act to portray the role of the patient and experienced chiropractors are trained as examiners.

The examination composition is based on an exam blueprint which was the result of a national job analysis which provided evidence of the knowledge, skills,

and aptitudes required in daily practice along with the frequency and criticality of patient presentations seen in practice across Canada. The exam blueprint identifies the content, presentation and weighting within the examinations. The exam items are continuously reviewed and validated by our psychometrician and practicing chiropractors from across Canada, to ensure their continued validity and relevance.

QUI SOMMES-NOUS ET QUE FAISONS-NOUS?

MISSION

Assurer l'évaluation équitable et défensible des candidats, en utilisant des examens psychométriques fiables et valides, dans le cadre des exigences de permis de pratique des autorités réglementaires canadiennes chiropratiques.

Le Conseil canadien des examens chiropratiques sert nos membres, les autorités réglementaires provinciales, en évaluant la compétence des chiropraticiens en matière d'admission à la pratique au Canada. Cette porte d'entrée assure à la fois la protection du public et l'intégrité professionnelle. Le CCEB administre trois examens trois fois par an : les composantes A, B et C.

Les examens de la composante A et B sont à choix multiples et comprennent environ 220 items, rédigés en deux

sections. Les candidats ont trois heures pour compléter chaque section. La composante C est un examen clinique objectif structuré (ECOS) qui évalue les compétences cliniques du candidat dans un environnement clinique basé sur des scénarios. Il y a 10 stations et différentes présentations de cas cliniques. Des PS, les patients standardisés, jouent le rôle de patients et des chiropraticiens expérimentés reçoivent une formation d'examineur.

La composition de l'examen est basée sur

un plan d'évaluation venant d'une analyse d'emploi nationale qui a démontré les connaissances, compétences et aptitudes requises dans la pratique quotidienne ainsi que la fréquence et la criticité des présentations de patients observées en pratique au Canada. Le plan d'examen identifie le contenu, la présentation et la pondération des examens. Les items d'examen sont continuellement révisés et validés par nos psychométriciens et chiropraticiens en pratique sur tout le territoire du Canada afin d'assurer qu'ils demeurent valides et pertinents.

CANDIDATES CANDIDATS

2017/2018

Candidates by component and location of examination

Distribution des candidats selon leur composante et lieu d'examen

	Ontario	Québec	Alberta	International
Component A / Composante A	280	109	99	10
Component B / Composante B	204	195	51	2
Component C / Composante C	172	211	47	n/a

CCEB certificates Issued / Certificats CCEB délivrés

Year / Année	# of certs. issued / certs. délivrés
2014-2015	361
2015-2016	357
2016-2017	361
2017-2018	352

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VOLUNTEERS BÉNÉVOLES

Total volunteer hours in
2017/2018

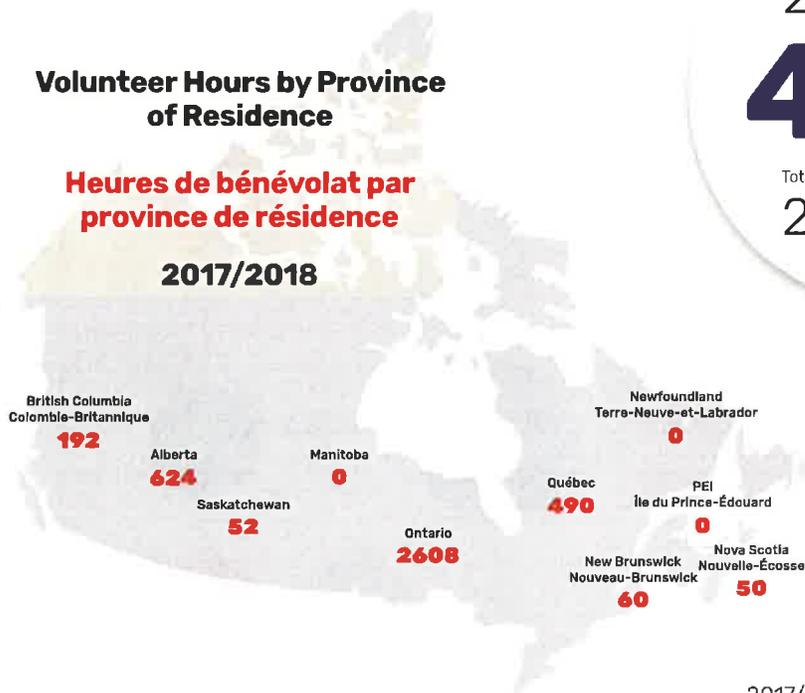
4076

Total des heures de bénévolat en
2017/2018

Volunteer Hours by Province of Residence

Heures de bénévolat par province de résidence

2017/2018



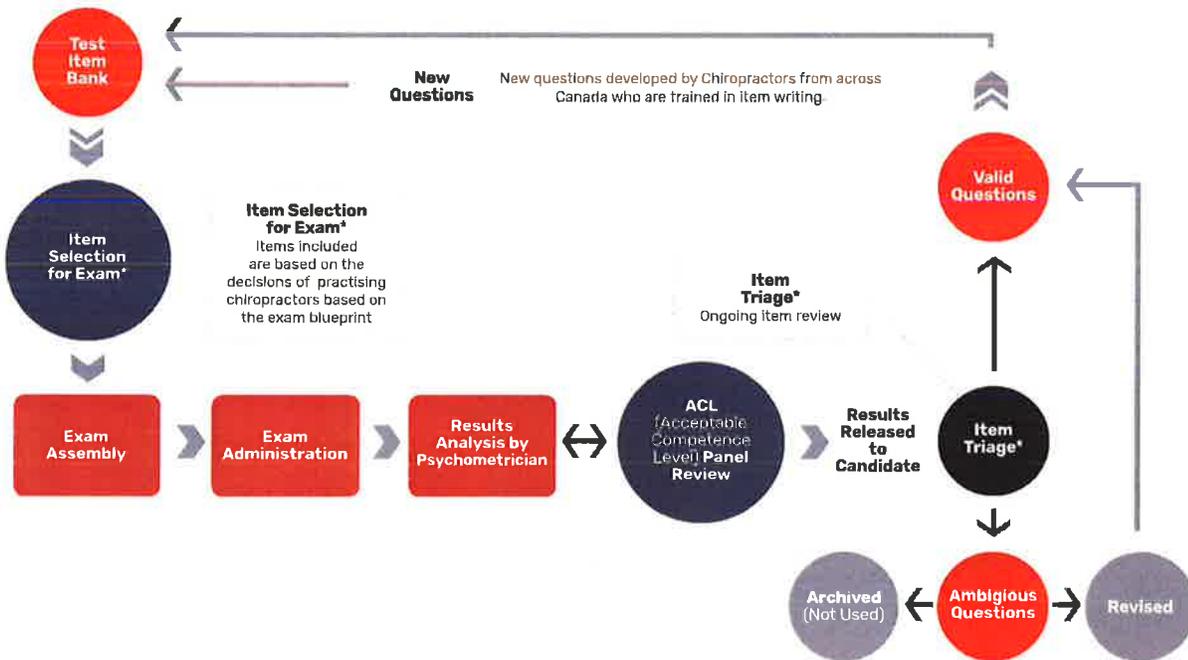
Total active volunteers
in the CCEB database **from all
provinces and the Yukon**

821

Nombre total de bénévoles actifs
dans la base de données du CCEB
**personnes de toutes les
provinces et le Yukon**

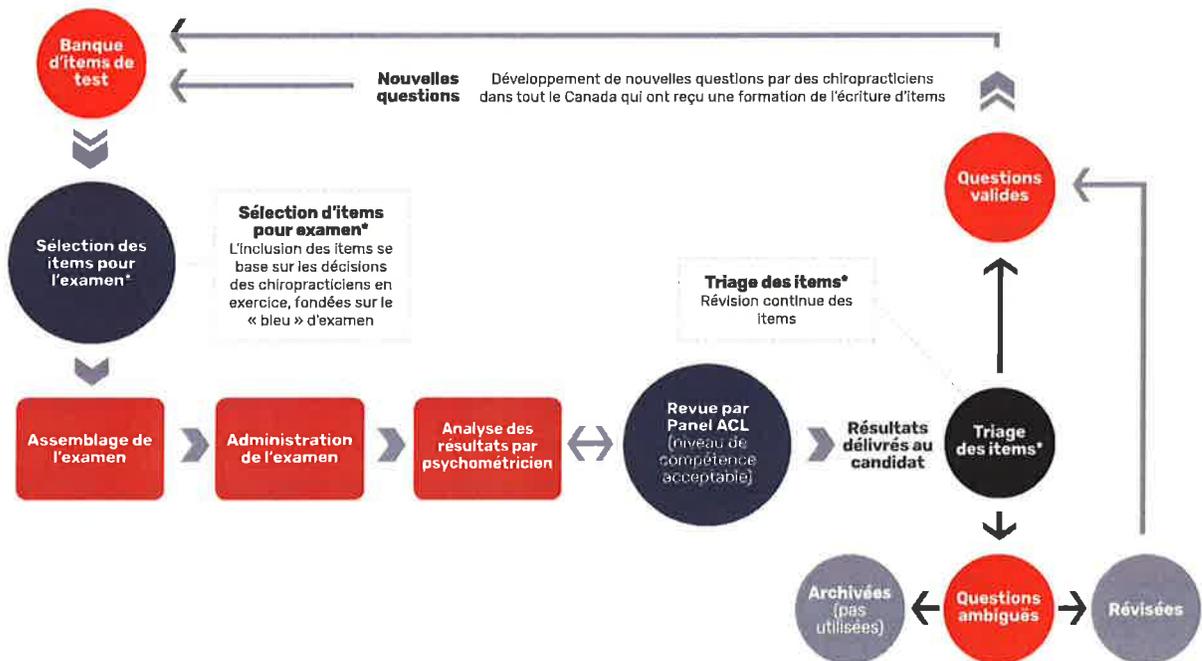
EXAM DEVELOPMENT

CHOOSING AND USING TEST ITEMS



DÉVELOPPEMENT DES EXAMENS

LA SÉLECTION ET UTILISATION DES ITEMS DE TEST





TESTIMONIAL

When I graduated nearly 40 years ago, I couldn't have imagined that I would see the positive changes in the profession that have become a reality. A goal that I have always had, is to leave the profession in a better place than where I found it so many years ago. I can't think of a better way of impacting the outcome than to volunteer with the CCEB. I highly recommend it. The profession will be benefitted greatly by your help."

- Dr. Richard Stover



TÉMOIGNAGE D'APPRÉCIATION

Lorsque j'ai obtenu mon diplôme il y a 40 ans, je n'aurais pas pu imaginer que je verrais les changements positifs dans la profession qui sont devenus réels. Un de mes objectifs a toujours été de quitter la profession à un endroit qui est meilleur que celui où je l'ai trouvé il y a tant d'années. Je ne peux pas penser à un moyen de mieux impacter ce résultat que de faire du bénévolat avec le CCEB. Je le recommande vivement. La profession bénéficiera grandement de votre aide."

- Dr. Richard Stover

STRATEGIC PLAN

EXAMINATION LEADERSHIP

- Future-focused and continuous enhancement of CCEB examination
- Preserve examination security, validity and psychometric soundness

OPERATIONAL EXCELLENCE

- Maintain and develop strong operational and governance policies and procedures
- Drive financially responsible practices
- Ensure business continuity & risk mitigation



ACCURACY



DEFENSIBILITY



FAIRNESS



INTEGRITY

STAKEHOLDER CONNECTION

- Build and maintain strong relationship with all chiropractic stakeholders
- Enhance the volunteer experience

VISION:

Driven by excellence, quality, and the highest ethical standards, the Canadian Chiropractic Examining Board will lead the development and delivery of national standardized chiropractic examinations.

PLAN STRATÉGIQUE

LEADERSHIP EN MATIÈRE DES EXAMENS

- Axé sur le futur et l'amélioration continue des examens CCEB
- Préserver la sécurité, validité et solidité psychométrique des examens

EXCELLENCE OPÉRATIONNELLE

- Maintenir et développer de fortes politiques et procédures opérationnelles et de gouvernance
- Propulser des pratiques financièrement responsables
- Assurer la continuité des opérations et l'atténuation des risques



EXACTITUDE



DÉFENDABILITÉ



JUSTICE



INTÉGRITÉ

CONNEXION AVEC LES PARTIES PRENANTES

- Construire et maintenir de fortes relations avec toutes les parties prenantes chiropratiques
- Améliorer l'expérience des bénévoles

VISION:

Poussé par l'excellence, la qualité et les éthiques les plus élevées, le Conseil canadien des examens chiropratiques dirigera le développement et la prestation des examens chiropratiques nationaux standardisés.

1190



Suite 230, 1209 - 59th Avenue SE Calgary, Alberta T2H 2P6

www.cceb.ca

Subject: FW: Upcoming BOG vacancies
Attachments: Letter to registrar CCO.pdf; ATT00001.htm; Individual Board Member JD - attachment.pdf; ATT00002.htm

From: Jo-Ann Willson
Sent: Tuesday, April 09, 2019 6:28 PM
To: Rose Bustria <RBustria@cco.on.ca>
Cc: David Starmer <drstarmer@gmail.com>; Liz Anderson-Peacock <drliz@bellnet.ca>
Subject: Fwd: Upcoming BOG vacancies

Council - stakeholders.

Jo-Ann Willson, B.Sc., M.S.W., LL.B.
Registrar & General Counsel

Begin forwarded message:

From: Suzette Martin-Johnson <admin1@cceb.ca>
Date: April 9, 2019 at 4:54:57 PM EDT
To: <jpwillson@cco.on.ca>
Cc: Joel Friedman <JFriedman@cco.on.ca>, Rose Bustria <rbustria@cco.on.ca>
Subject: Upcoming BOG vacancies

Dear Jo-Ann,

I hope this email finds you well.

Please see attached letter and information for the CCO.

Sincerely | Bien cordialement,

Suzette Martin-Johnson

Executive Assistant | Assistante de Direction

CANADIAN CHIROPRACTIC EXAMINING BOARD
CONSEIL CANADIEN DES EXAMENS CHIROPRATIQUES

230, 1209 – 59 Avenue SE, Calgary, AB T2H 2P6
Tel: (403) 230-5997
Fax: (403) 230-3321
www.cceb.ca

This message and any documents attached hereto are intended only for the addressee and may contain privileged or confidential information. Any unauthorized disclosure is strictly prohibited. If you have received this message in error, please notify us immediately

so that we may correct our internal records. Please then delete the original message.
Thank you.

1192

Ce message et tous les documents joints sont destinés uniquement au destinataire et peuvent contenir des informations privilégiées ou confidentielles. Toute divulgation non autorisée est strictement interdite. Si vous avez reçu ce message par erreur, veuillez nous en aviser immédiatement afin que nous puissions corriger nos dossiers internes. Veuillez ensuite supprimer le message d'origine. Je vous remercie.



CANADIAN CHIROPRACTIC EXAMINING BOARD

230, 1209 – 59 Avenue SE

Calgary, AB T2H 2P6

Email: board@cceb.ca Phone: (403) 230-5997

1193

April 9, 2019

Ms. Jo-Ann Willson
Registrar and General Counsel
College of Chiropractors of Ontario
130 Bloor St. West, Suite 902
Toronto, ON M5S 1N5

RE: Upcoming BOG vacancies

Dear Jo-Ann,

We are looking forward to seeing you this year at our annual AGM. This year's AGM will be in Calgary on November 15, 2019. We have worked hard in collaboration with the FCC to avoid meeting conflicts and to maximize organizational resources.

This year we have two vacancies on our Board of Governors. Two of our long-serving board members; chiropractic member, Dr. David Millar (Saskatchewan) and public member, Trevor Paramchuk CPA (Alberta) are at the end of their third terms. As such they are not eligible for re-election. As always, the CCEB is committed to governance and organizational excellence and we are actively seeking eligible candidates to replace these positions.

The CCEB nominations committee is interested in your input. If you have chiropractic or public candidates that you feel would be a great addition to our board please contact your nominee and have them forward a letter of interest and a current CV for the attention of the Chair of the Nominations Committee, Dr. Elli Morton, at board@cceb.ca on or before April 26, 2019. Please find attached a job description related to the Governor role with the CCEB. Likewise, the Indeed job posting we are using to attract interested candidates for the public member role may be found [here](#).

Please note that the CCEB reimburses Governor expenses, as per our expense policy, and provides a courtesy per diem as a token of our gratitude and acknowledgement of their dedication.

The Nominations Committee has a rigorous review, interview and vetting process in order to ensure they put forward the most qualified and eligible candidates for election. Please respond on or before April 26, 2019. If you have questions or concerns please contact Gemma Beierback, CEO, at the CCEB office.

Regards,

A handwritten signature in black ink, appearing to read 'Gemma Beierback', with a stylized flourish extending to the right.

Gemma Beierback
Chief Executive Officer

Attachments:

Governor Job Description

cc: Mr. Joel Friedman
Director, Policy & Research

Ms. Rose Bustria
Administrative Assistant



Role:	Board Member (Governor)
Reports to:	CCEB Board Chair
Last updated:	April 2, 2019

About the CCEB:

The Canadian Chiropractic Examining Board (CCEB) is a national not-for-profit organization, incorporated in Canada. The members of the CCEB are the ten (10) provincial regulators (registrars) responsible for licensure of Chiropractors in their respective provinces. The CCEB administers three (3) examinations: Components A, B and C. These exams are delivered three (3) times per year at various centers across Canada and internationally. The CCEB is responsible for the development, delivery and administration of these exams. Our mission is to ensure fair and defensible evaluation of candidates, using psychometrically valid and reliable examinations.

More information about the history of CCEB and the examination process can be found at www.cceb.ca.

Role:

The CCEB has upcoming openings for both Chiropractic and Public Board members, with terms starting late this year.

As a member of the Board, a Governor acts in a position of trust and is responsible for the effective governance of the organization. Governors demonstrate a commitment to uphold the values of the CCEB: accuracy, defensibility, fairness and integrity. The CCEB has eight (8) members, six (6) Chiropractic members, duly licensed and in good standing in Canada, for a minimum five-year period, and two (2) public members.

Requirements:

1. Commitment to the purpose, strategic plan and policies of the CCEB. Understanding of the importance of the fiduciary obligations of the Governors of the organization.
2. Knowledge, skills, and experience in one or more areas:

- a. Board governance,
 - b. Law and/or policy
 - c. Healthcare and/or healthcare regulation
 - d. Finance,
 - e. High stake examination and/or education
 - f. Chiropractic
3. Ability to attend approximately 3-4 in-person meetings annually (2 days each), located in major centres throughout Canada. Travel is required.
 4. Ability to participate in additional commitments related to the work of the Board, included but not limited to:
 - a. Stakeholder meeting attendance
 - b. Conference attendance
 - c. Teleconference meetings
 - d. Committee meetings
 - e. Generating and presenting reports and other information
 5. Ability to serve a term of office up to three years with possibility for renewal upon review to a maximum of three terms (or nine years total).

Competencies:

- Integrity – you believe in doing what is right even if no one will notice, you pride yourself on being ethical and holding yourself and others accountable.
- Communication – you value clear and concise communication and pride yourself on being able to alter your tone and delivery to the audience. You are an active listener who understands effective group communication and decision-making.
- Leadership – you are a strong consistent leader, coach and mentor who can motivate people and create engaging and productive work environments. You provide constructive feedback and help guide organizational resources with prudence.
- Teamwork – you understand how to work collaboratively and provide support to the team. You believe we all succeed if we support each other and don't care who gets the credit. You have a keen ability to create consensus.

Additional Information:

Candidates for consideration may be subject to any of the following:

- Execution of the CCEB Confidentiality and Intellectual Property Agreement, Code of Conduct, and other such statements/disclosures as required by the CCEB.
- Proof of education/credentials: certificates, diplomas, degrees etc.;
- Criminal background check;

- Professional and personal references; and/or
- Any additional information verification requested by the CCEB.

Only applicants that can demonstrate they are free from conflict of interest will be considered. Such conflicts include, but are not limited to, being a member of faculty at a chiropractic College, president or senior staff officer of a Chiropractic regulatory body.

Please note that the CCEB reimburses Governor expenses, as per our expense policy, and provides a small courtesy per diem as a token of our gratitude and acknowledgement of their dedication.

From: Leslie Verville <Leslie.Verville@uoit.ca>

Date: March 19, 2019 at 1:41:08 PM EDT

To: "jpwillson@cco.on.ca" <jpwillson@cco.on.ca>, "cco.info@cco.on.ca" <cco.info@cco.on.ca>

Cc: "ldp.rhcc@sasktel.net" <ldp.rhcc@sasktel.net>, Carolina Cancelliere <Carolina.Cancelliere@uoit.ca>

Subject: CCGI - Stakeholder Report and Invoice

Dear Dr. Starmer and Ms. Wilson,

Please find attached our bi-annual stakeholder report (March 2019 report). You will see that it has been a busy year of transition, new projects and increasing engagement with our members. Our key priority over the next couple of years is to build CCGI's database of clinical practice guideline implementation tools such as online care pathways (we will be showcasing one of them at the WFC-ECU Congress in Berlin). We are also refreshing our website so that members can more easily access all CCGI tools and resources. Once we have our initial tools in place, as new evidence emerges, we will develop a system to update the tools. This is critical to demonstrate our commitment to excellent patient care and safety.

To be able to continue and improve our program, I ask that you contribute to the initiative (e.g., \$25 per member). Please see the invoice attached.

Thank you very much for your future commitment to the CCGI. Please do not hesitate to contact me or Carol if you have any questions, or require further information.

Yours sincerely,

Dr. David Peeace, DC

Chair, Guideline Steering Committee

Canadian Chiropractic Guideline Initiative (CCGI)

Dr. Carol Cancelliere, DC, PhD

CCGI Project Lead

CCRF Research Chair in Knowledge Translation

Faculty of Health Sciences

University of Ontario Institute of Technology

UOIT-CMCC Centre for Disability Prevention and Rehabilitation



Canadian Chiropractic Guideline Initiative

ADVANCING EXCELLENCE IN CHIROPRACTIC CARE

1199

2019 CANADIAN CHIROPRACTIC GUIDELINE INITIATIVE INVOICE

Please forward this form and your payment to the CCA office by April 30, 2019.

Canadian Chiropractic Association
186 Spadina Ave. Suite 6
Toronto, ON M5T 3B2

Note: We understand there are a few organizations that contribute based on fiscal year ends of August 1 and September 1. In these cases, the April deadline is not applicable.

ORGANIZATION: College of Chiropractors of Ontario

CONTACT: Ms. Jo-Ann Wilson

AMOUNT OF CONTRIBUTION FOR 2019 (\$50 per member if possible):

\$0 only for 2019

Please make cheques payable to the **Canadian Chiropractic Research Foundation** and include a note that designates it to the 2019 CCGI.

For more information, please contact Dr. David Peeace, at ldp.rhcc@sasktel.net or call 306-421-5559.

Thank you for supporting this important initiative. Your contribution will help to direct research that will significantly improve patient care outcomes.



Canadian Chiropractic Guideline Initiative

ADVANCING EXCELLENCE IN CHIROPRACTIC CARE

March
2019

1200



Canadian Chiropractic Guideline Initiative Bi-Annual Stakeholder Report

Enhancing the health of Canadians by fostering
excellence in chiropractic care



Dr. David Peeace, Chair, Guideline Steering Committee

For the benefit of patients and the public, the CCGI remains committed to developing and disseminating high-quality evidence to chiropractors and decision-makers. Aligning with the evidence and keeping our patients' best interests at the centre of everything we do will further integrate us into healthcare systems in the years to come. Only then could all Canadians access the valuable care we provide.



Dr. Carol Cancelliere, Project Lead CCRF Research Chair in Knowledge Translation in the Faculty of Health Sciences, UOIT

I am pleased to introduce a new team with expertise in chiropractic, developing guidelines and knowledge translation research and activities. We are focusing on disseminating evidence-based recommendations from existing high-quality guidelines. In order to do this, we are producing guideline summaries to start; from these we will create tools such as care pathways, exercise videos, and patient forms. Topics include soft-tissue injuries of the shoulder, concussion and persistent symptoms (adults and children), persistent headache associated

with neck pain, knee pain, etc. We continue to communicate with our stakeholders about the new material we post through our social media channels, newsletters, and presentations (CMCC, UQTR, AGMs).

We will continue to use the *integrated knowledge translation approach* for all research and activities. This means that we invite end users of our evidence-based tools – chiropractors, students, interns, residents, educators, patients – to be members of our research teams. This helps us ensure that our tools will be appropriate and useful to our target users. Our highly skilled CCGI team is providing training to those without research experience in critical appraisal of guidelines/studies and other methodologies. In this way, the chiropractic community can gain valuable skills while contributing to our important work. Many members have expressed interest so far and have been hard at work!

I had the privilege of travelling to Mumbai, India in January of this year. I was invited to speak at an international conference organized by World Spine Care and the MGM School of Physiotherapy. The theme was *Prevention, Early Detection and Management of Spine Disability: a Patient-centric Integrated Approach*. At the WFC EPIC in March, we will present one of our online care pathways during a workshop, and ask attendees to work through patient cases using the pathway. We will gather feedback from participants regarding the acceptability, appropriateness and feasibility of using the pathway, and modify it prior to further testing with chiropractors across Canada. We will use similar methods to produce other care pathways we have planned for the year (concussion, headache) prior to dissemination. You can also look forward to Dr. André Bussière's (former Project Lead) presentation on the management of lumbar spinal stenosis guideline at EPIC.

Please do not hesitate to contact David or myself if you require further information, or if you would like to join one of our upcoming projects. I hope to see many of you in Berlin!



CCGI Research Team

1202



Hainan Yu MBBS, MSc
Research Coordinator –
Guidelines



Heather Shearer DC, MSc, FCCS(C)
PhD student (Clinical Epidemiology)
Research Associate



Leslie Verville MHSc
Research Coordinator –
Knowledge Translation



Jessica Wong BSc, DC, MPH, FCCS(C)
PhD student (Epidemiology)
Research Associate



Gaelan Connell BHK, DC
MRSc (student)
Knowledge Broker



Anne Taylor-Vaisey
Research Associate,
Health Sciences Librarian



Poonam Cardoso BHSc, PMP
Finance and Administrative Officer



1203

Highlights

- Strategic priorities 2019 Page 1
- Clinical practice guideline adoption Page 3
- Public presentations Page 3
- Collaborative project with NBCA and the Tobique First Nation Page 4
- Development of patient-centered point-of-care tools for the assessment and management of soft-tissue shoulder injuries, persistent headaches associated with neck pain, and concussion and persistent symptoms Page 4
- Shoulder exercise videos Page 5
- Systematic review of non-pharmacological interventions on sleep characteristics among adults with musculoskeletal pain Page 5
- Social media Page 5
- Other highlights Page 6





CCGI Strategic Priorities 2019

Key objectives & events currently scheduled	Date expected
Strategy 1: Develop, adopt, adapt clinical practice guidelines	
New guideline: Non-surgical management of lumbar spinal stenosis <ul style="list-style-type: none"> Phase 1: evidence synthesis Phase 2: international Delphi consensus process 	Complete 2020
Proposal for new guideline: Management of adults with spinal disorders for disability prevention and rehabilitation <ul style="list-style-type: none"> Systematic review: effectiveness and safety of post-surgical rehabilitation interventions for improving disability and quality of life among adults with low back pain with or without radiculopathy treated with surgery 	Ongoing 2020
Critically review, adopt and summarize high-quality clinical practice guidelines: <ul style="list-style-type: none"> Soft-tissue shoulder injuries (Nov 2018) Osteoarthritis (Dec 2018) Concussion and persistent symptoms in adults (Jan 2019) Physical activity in pregnancy (critical appraisal in progress) Upcoming: knee injuries, concussion in children 	Bi-monthly
WHO Rehabilitation 2030 Action Plan: invited to join international Technical Working Group to develop evidence-based rehabilitation interventions for individuals with low back pain	2019
Guiding chiropractors to address lifestyle factors associated with musculoskeletal pain: <ul style="list-style-type: none"> Systematic review: effectiveness of non-pharmacological interventions on sleep characteristics among adults with musculoskeletal pain 	2020
Strategy 2: Engage in knowledge translation activities and research	
Develop patient-centered tools (e.g., care pathways, videos, handouts) for chiropractors to manage in adult populations: <ul style="list-style-type: none"> Soft-tissue shoulder injuries Persistent headaches associated with neck pain Concussion and persistent symptoms 	2019
Adapt CCGI low back pain tools for Tobique First Nation community, New Brunswick	2019
Integrated knowledge translation approach: Recruit and train chiropractors for CCGI activities and research	Ongoing



<p>Explore partners for CCGI resources to become available on online platforms (e.g., MRX, Vancouver)</p>	<p>Ongoing</p>
<p>Social Media and continuing education:</p> <ul style="list-style-type: none"> • Website improvements • Strategies to develop whiteboard videos, continuing education modules • YouTube exercise videos • Bi-weekly podcasts featuring evidence-based practice • Regular engagement on Facebook, Twitter, LinkedIn • CCGI Newsletter (bi-monthly) • Opinion leaders/best practice collaborators/student ambassador programs 	<p>Ongoing</p>
<p>Strategy 3: Engage Stakeholders</p>	
<p>National and provincial professional associations: Presentations at conferences, AGMs, bi-annual stakeholder reports</p>	<p>Ongoing</p>
<p>Educational institutions (CMCC, UQTR): Presentations and communication regarding EBP</p> <ul style="list-style-type: none"> • Osteoarthritis (CMCC; Jan 2019) • Concussion (CMCC; Mar 2019) 	<p>Ongoing</p>
<p>International Conferences:</p> <ul style="list-style-type: none"> • World Spine Care: Mumbai, India (Jan 2019) • World Federation of Chiropractic: Berlin, Germany (Mar 2019) • American Chiropractic Association: University of Pittsburgh (Nov 2019) 	<p>2019 2019 2019</p>
<p>Explore partnerships/funding opportunities:</p> <ul style="list-style-type: none"> • Eurospine (grant submitted Jan 2019) • European Chiropractic Union • Worker's Compensation Boards (e.g., Alberta WCB, WorkSafeBC, WSIB) 	<p>Ongoing</p>
<p>Strategy 4: Transform the culture of the profession</p>	
<p>Through strategies 1-3</p>	



Clinical practice guideline adoption

Chiropractors often report barriers to accessing and reading clinical practice guidelines (CPGs), such as time or difficulty appraising the quality of a guideline. We have begun to disseminate summaries of high-quality guidelines through our website. We develop summaries for CPGs that are relevant to chiropractors and pass critical appraisal using the AGREE II tool. The research team is training chiropractors to join us in critically appraising CPGs and participate in developing the summaries and other tools such as exercise videos. We have appraised and disseminated summaries for three CPGs to date - management of shoulder pain, osteoarthritis, and concussion and persistent symptoms. Look for them on our website by clicking on the body diagram www.chiroguidelines.org.

This is an ongoing CCGI initiative. Look for a new high-quality CPG summary bi-monthly.

Canadian Chiropractic Guideline Initiative (CCGI) Guideline Summary

Title of guideline	Guideline for Concussion/Mild Traumatic Brain Injury & Persistent Symptoms 3rd Edition
Author of guideline	Marshall S, et al.
Sponsor and Funder	Ontario Neurotrauma Foundation
Year of guideline publication	2018
Link to guideline	http://www.chiroguidelines.org/concussion/

Scope and purpose of guideline

- Objective: Diagnosis, assessment, and management of mild traumatic brain injury (mTBI)/concussion and persistent symptoms in adults.
- Target Population:
 - Adults (≥18 years) who have experienced concussion.
- Target Users: Healthcare professionals including primary care providers (family physicians, nurse practitioners), neurologists, physiatrists, psychiatrists, psychologists, occupational therapists, speech-language pathologists, physiotherapists, chiropractors, social workers, and counselors.
- Health Condition: mTBI/concussion
 - Acute neurophysiological event related to blunt impact or other mechanical energy applied to the head, neck or body (with transmitting forces to the brain), such as a sudden acceleration, deceleration or rotational forces.
 - Persistent symptoms (post-concussion symptoms): a variety of physical, cognitive, emotional and behavioural symptoms that may endure for weeks or months following a concussion.
 - Note: mTBI and concussion are used synonymously in this guideline. We will use the term concussion to mean both concussion and mTBI. At no time does the term concussion refer to moderate or severe TBI.

OVERVIEW OF TOPICS

A. CONCUSSION ASSESSMENT OF CONCUSSION	<ul style="list-style-type: none"> Role of PED FUMCS Comprehensive assessment
B. INITIAL MANAGEMENT OF CONCUSSION	<ul style="list-style-type: none"> Principles Overall approach (acute, subacute, persistent) Education and self-management
C. PERSISTENT SYMPTOMS AFTER CONCUSSION (>3 MONTHS)	<ul style="list-style-type: none"> General assessment General management
D. SPECIFIC ASSESSMENT & MANAGEMENT OF PERSISTENT SYMPTOMS AFTER CONCUSSION (>3 MONTHS)	<ul style="list-style-type: none"> Post-traumatic headache Sleep-wake disturbances Mental health disorders Cognitive difficulties Vestibular (balance/dizziness) and vision dysfunction Fatigue
E. RETURN TO ACTIVITY/WORK/SCHOOL	<ul style="list-style-type: none"> Assessment Management Return to post-secondary school
F. SPORT-RELATED CONCUSSION	<ul style="list-style-type: none"> Assessment Management Return to play
G. REFERRALS AND COLLABORATIONS	<ul style="list-style-type: none"> Red flags Beyond scope of practice Treatment goals not met

Public presentations

As we post clinical practice guidelines on our website, we continue to disseminate the information by holding public presentations for clinicians, students, educators, and other stakeholders. On January 11, 2019, CMCC invited faculty and students to attend a session by Dr. Carol Cancelliere and Dr. Jessica Wong about the assessment and management of osteoarthritis.

Dr. Carol Cancelliere and Dr. Scott Howitt presented the evidence-based recommendations regarding concussion at CMCC on March 4, 2019.

Concussion/MTBI and Persistent Symptoms: Care and Management

Ontario Neurotrauma Foundation
Fondation ontarienne de neurotraumatologie



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Collaborative project with the NBCA and Tobique First Nation

Indigenous communities are underserved with respect to healthcare services. Since 2014, the New Brunswick Chiropractors Association (NBCA) has established chiropractic care as part of the Neqotkuk Health Center to improve the musculoskeletal health of residents. Annually, 170 patients are managed by a visiting chiropractor; 62% of which present with low back pain (LBP) or other spinal disorders. Chiropractic services have been provided free of charge on a weekly/biweekly basis for residents. It is also necessary to provide residents with evidence-based written information and self-management strategies.



The adaptation and implementation of resources for indigenous communities within Canada is important to the CCGI. Therefore, the purpose of our study is to develop a toolkit of culturally appropriate self-management strategies for LBP with the Tobique First Nation. In this qualitative study, we will interview participants (patients with LBP and healthcare providers from the Neqotkuk Health Center) about their beliefs/attitudes regarding LBP management, perceived needs for information and self-management strategies, current management/practice patterns, and barriers/facilitators to implementing new knowledge. We will then adapt current CCGI LBP tools using this information, have participants test them out for a brief period, modify the tools further if required, and disseminate the final toolkit to the community.

Development of patient-centered point-of-care tools for the assessment and management of soft-tissue shoulder injuries, persistent headaches associated with neck pain, and concussion and persistent symptoms

Point-of-care tools are research and reference resources that clinicians can utilize immediately at the point of care with patients. They include care pathways derived from clinical practice guidelines, evidence summaries, and checklists.

We will use the integrated knowledge translation approach to develop our care pathways, test the pathways with chiropractors across Canada for key implementation outcomes, then begin to populate CCGI's new database of point-of-care tools once they are deemed acceptable, appropriate, and feasible by chiropractors.

Drs. Carol Cancelliere, Greg Stewart, and Silvano Mior will give a workshop at the World Federation of Chiropractic – European Chiropractic Union (ECU) Congress in Berlin, Germany. They will present the online care pathway for shoulder injuries, ask attendees to work through case studies using the care pathway, and then elicit feedback from attendees regarding how we can improve the tool for use in practice.





1208

Shoulder exercise videos

We have formed a panel consisting of chiropractors, educators, patients, and a physiotherapist to develop our new shoulder exercise video series. This series will be based on the recommendations from the 2015 OPTIMA systematic review, and additional input by our panel members. We plan to update all of our point-of-care tools as new high-quality systematic reviews and guidelines emerge.

The exercises will be relevant for soft-tissue disorders of the shoulder, which include grades I and II sprains or strains, tendinitis, bursitis and impingement syndrome affecting the gleno-humeral and acromio-clavicular joints. We plan to disseminate this new series through our website and YouTube by April 2019.

Systematic review of non-pharmacological interventions on sleep characteristics among adults with musculoskeletal pain

The CCGI team along with a group of CCGI-trained chiropractic volunteers are working together on this important topic. We know that a number of lifestyle factors, such as sleep quality, are associated with MSK pain.



Depending on the results of this review, we may be able to arm chiropractors with more tools to manage MSK conditions. Stay tuned...

Social Media

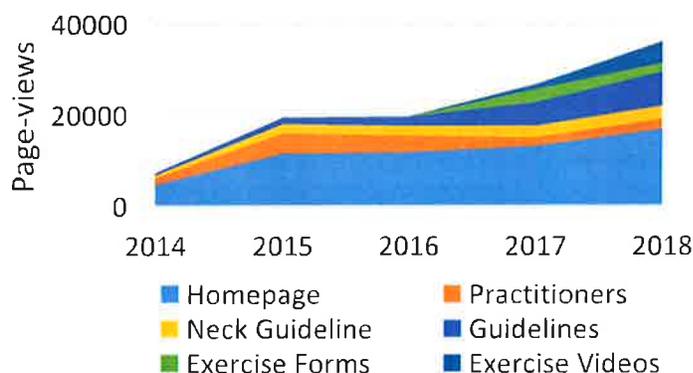
We connect with our members and knowledge users regularly through our YouTube channel (Canadian Chiropractic Guideline Initiative), Facebook and Twitter. We currently have over 2,000 social media followers!

Website

Visits to our website have increased from 65,000 in 2017 to over 85,000 in 2018.

We are making improvements to our website so that all of our resources – guidelines, point-of-care tools, podcasts, exercise videos, and handouts will be easily accessible.

Most Accessed CCGI Website Pages





1209

Podcasts accessed 6,500+ times

In just over a year's time, we have grown our podcast series to over 29 episodes featuring chiropractic researchers, clinicians, and evidence-based practice advocates.

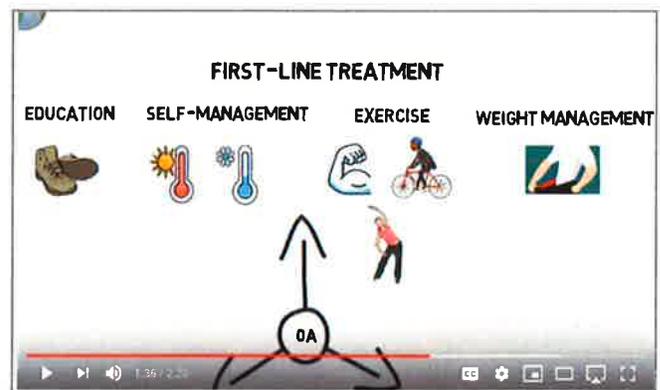
The central theme of every episode is the importance and application of clinical practice guidelines and best evidence. Our episodes can be streamed on our website or directly through iTunes.



Whiteboard videos

Whiteboard videos are just one way we are disseminating evidence-based practice to clinicians, patients, and other knowledge users. This is a fun and quick method to get the information out there. We plan to create new case-based educational modules in the near future.

Take a look at our most recent whiteboard video about the management of osteoarthritis from the National Institute for Health and Care Excellence (NICE) guideline development group. Our whiteboard videos can be found on our YouTube channel. With our upcoming website improvements, you will soon be able to access all of our resources in one place.



Other highlights

- As of November 2018, Manitoba Public Insurance is compensating chiropractors for prescribing CCGI exercises
- CCGI work is featured in the CADTH Report: "Access to and Availability of Non-Pharmacological Treatments for Chronic Non-Cancer Pain in Canada: An Environmental Scan".

Please remember to submit your nominations for the Guideline Steering Committee member by April 1, 2019

For more information about the CCGI and any of our initiatives, please feel free to contact Dr. Carol Cancelliere at Carolina.Cancelliere@uoit.ca



27-28 June 2019 | Vancouver, British Columbia

[Register Now](#)

For regulatory leaders looking for the chance to examine how global trends in professional and occupational regulation impact their own organizations, CLEAR's International Congress on Professional and Occupational Regulation offers an interactive and dynamic forum to explore the most salient issues for the international regulatory community. Unlike traditional conferences, CLEAR's International Congress employs a format of interactive education sessions and round table discussion groups to engage regulatory leaders in dialogue and active problem solving for regulatory authorities both locally and around the world.

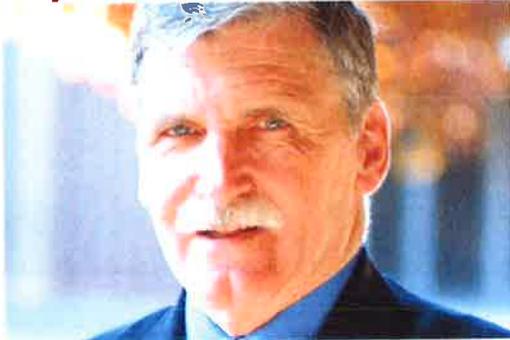
Presenting Sponsor |  **thentia**

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1211

Keynote Presenters



Lieutenant-General, the Honourable Romeo Dallaire (Ret'd)
Romeo Dallaire Child Soldiers Initiative

Opening Keynote sponsored by Thentia



Bob Rae

Current Canadian Special Envoy to Myanmar, former Leader of the Liberal Party of Canada, and former Premier of Ontario

View the Congress agenda [here](#). Additional information will be added as it becomes available.

Additionally, please take advantage of the below programs that will be preceding the International Congress.

Vancouver Regional Symposium - Cultural Awareness: Valuing Indigenous and Minority Populations in Professional Regulation

1212

and

Regulatory Research Day - At this time, This program is at its capacity. If you would like to be placed on a wait list, please email gblind@clearhq.org

Please refer to the links above for information and registration.

For questions regarding the program, please contact Kelly McKown King at kmckown@clearhq.org or (859) 654-0144.

Program Location

Wall

SHERATON VANCOUVER
WALL CENTRE



Sheraton Wall Centre | 1088 Burrard Street | Vancouver, BC

**Hotel Booking Information located [HERE](#)
Exhibitors & Sponsors**

CLEAR welcomes Exhibitors and Sponsors for the International Congress.

Council on Licensure, Enforcement & Regulation

CONGRESS

on Professional and Occupational Regulation

Sixth International Congress on Professional and Occupational Regulation June 27 – 28, 2019 | Vancouver

Thursday, June 27, 2019

9:00 – 9:15 a.m. *Welcome to the International Congress*

Michael Salvatori, CLEAR President

9:15 - 10:15 a.m. **Keynote Presentation – The New Leadership: A Humanistic Approach**

Lieutenant-General, the Honourable Romeo Dallaire (Ret'd)

Throughout his military career, Romeo Dallaire was lauded for his role in providing exemplary leadership during missions fraught with obstacles, most significantly as force commander of the UN mission in Rwanda during the genocide. He spearheaded critical reforms and professional development in the Canadian Forces, before going on to serve in the Senate. With the aim of encouraging pro-active leaders, Dallaire shares advice on regaining the initiative in the present while simultaneously anticipating the needs of the future; leading rather than reacting. His inspirational presentations encourage leaders to embrace new forms of communication with their team, giving them confidence to go beyond the perception of their own abilities. Professional longevity, a competitive edge, and personal fulfillment is awaiting those who put quality of life for themselves and their team at the forefront.

10:45 – 12 noon *Establishing Priorities, Challenges and Opportunities in Occupational Regulation (Discussion Groups)*

Roundtable Discussion Groups will provide attendees from a variety of professions and international jurisdictions with an opportunity to share challenges and best practices related to the most current and pressing issues in occupational and professional regulation.

12:00 – 1:30 p.m. Lunch

1:30 – 3:00 p.m. *Global Mobility and Entry to Practice Introductions*

Session One: Artificial Intelligence, Machine Learning, and Technology

Eric Fish, Senior Vice President, Legal Services, Federation of State Medical Boards

Technology and artificial intelligence will radically change the environment for regulated professions in the near future. These developments will not only impact the practice of professions directly, but also force regulatory boards to consider their role in addressing ancillary issues associated with the use of artificial intelligence such as confidentiality, the duty to warn, and conflicts of interest. The transformative power of technology may also be employed by regulators to assist in their duty to protect the public welfare. This session will help identify issues, trends and new regulatory models that may come before regulatory boards and offer a framework that can be utilized as regulators consider their own unique strategic planning issues and challenges presented by artificial intelligence.

Session Two: A New Professionalism for a Changing Workforce

Harry Cayton, International Advisor, Professional Standards Authority

Right-touch regulation (2015) says that regulators should ‘create a framework in which professionalism can flourish’. In this presentation Harry Cayton, who developed right-touch regulation at the Professional Standards Authority, will set out the principles of that approach to regulatory decision making. He will go on to explore the qualities of a modern profession and how we need to commit to more collaborative and less individualistic values if we are to be contemporary professionals.

Q&A

3:30 – 5:00 p.m. *Global Mobility and Entry to Practice Introduction*

Session Three: Global Mobility Strategies: Finding Commonality and Consistency

Jan Duke, Chief Advisor - Education, Policy & Research, New Zealand Social Workers Registration Board
Ginny Hanrahan, Chief Executive Officer, CORU – Regulating Health and Social Care Professionals
Mary Jo Monahan, Executive Director, Association of Social Work Boards

In this workshop, representatives from three continents will discuss their efforts to respond to the “challenges and opportunities created by increasingly mobile workforces,” one of the Congress themes.

Social work practice mobility refers to the physical and virtual mobility of social workers who elect to practice in multiple jurisdictions, physically or electronically. Increased physical movement of licensed social workers to other jurisdictions has led to the need for them to obtain license in addition to or in place of the jurisdiction of original licensure. Technological advancements have provided social workers with a means to practice social work electronically across countries and international lines and without the social worker’s physical presence in the jurisdiction where the client is located.

The Association of Social Work Boards Strategy to Address Social Work Practice Mobility identifies a process to “harmonize licensure eligibility criteria across all ASWB members boards so that equivalently licensed social workers can obtain licenses necessary to lawfully practice in other jurisdictions.” The Mobility Strategy aspires to maintain regulatory expertise and implement a commonsense approach to addressing social work practice mobility.

Discussion Groups

5:30 – 7:00 p.m.
International Congress Attendee Reception

Friday, June 28, 2019

1215

9:00 – 10:15 am. *Governance and Accountability in Professional Regulation*
Introductions

Session One: Embracing Leading Practices in Corporate Governance to Enhance Regulatory Performance

Elizabeth Watson, Founder, Watson Advisors

The term ‘corporate governance’ refers to the way organizations are managed, controlled and held to account. Over the last 15+ years, there has been tremendous focus on the role governing bodies play in leading and overseeing their organizations. Many elements of corporate governance practice have evolved during this time, as consensus builds on the ways in which governing bodies can be more effective in ensuring their organizations are successful in meeting their purpose and mandate.

In this session, we will explore how evolving corporate practices including board composition and succession planning, leadership evaluation and succession, enhanced meeting practices and intentional council/management dynamics, translate into better regulatory performance. We will share leading corporate governance practices, discuss how they are relevant to regulatory bodies, and invite you to consider how you might incorporate leading practice into your organization.

Session Two: Governance Reforms – Changes Across Systems

Iris Hentze, Policy Associate, Employment, Labor and Retirement Program, National Council of State Legislatures

Heidi Oetter, Registrar, College of Physicians and Surgeons of British Columbia

Marc Seale, Chief Executive Officer, The Health and Care Professions Council, United Kingdom

This panel will begin by exploring the origins of recent legislative regulatory reform reviews and initiatives across jurisdictions in the US, Canada, and the UK. Each panelist will then elaborate on specific examples of how regulators are reacting to these reform reviews and initiatives and what governance changes are occurring as a result of anticipated and unanticipated actions within each system.

Q&A

10:30 – 12:00 p.m. *Governance and Accountability in Professional Regulation*
Introduction

Session One: Continuing to Regulate in the Public Interest – Responding to Changing Public Expectations

Bradley Chisholm, Chief Officer, Strategy and Governance at BC College of Nursing Professionals

Jennifer McGuire, Assistant Deputy Minister of Environment and Climate Change, British Columbia

Erica Richler, Partner, Steinecke Maciura LeBlanc

Professional regulation is built upon a social contract. Society agrees to let the profession lead or be involved in the regulation of their profession, in return for the promise that they do so in the public interest. But as public expectations change, do we need to “reopen” this social contract, rethink how we regulate, to ensure we continue to maintain the public’s trust? This session will look at some specific examples of how regulators and government have responded or are being asked to respond to changing

public expectations. We will look at trends emerging from recent reports looking at the current and future state of professional regulation and we will also hear from a senior government leader about how the Ministry of Environment and Climate Change Strategy within the Government of British Columbia have responded to some of these critical shifts.

Discussion Groups

Following the presentation, attendees will break into roundtable discussion groups for focused discussion related to the key points from the morning presentations.

12:00 - 1:30 p.m. Lunch

1:30 – 3:00 p.m. *Striving for Continuing Competence*
Introductions

Session One: The Case of Dr. Bawa-Garba: Lessons Learned for Professional Regulation
Alan Clamp, Chief Executive, Professional Standards Authority

Dr. Bawa-Garba was working as a hospital registrar when a six-year-old boy was admitted to her care and within a few hours died from organ failure as a result of septic shock. She was convicted of Gross Negligence Manslaughter and suspended. On appeal from the General Medical Council, the suspension decision was changed to erasure. Dr. Bawa-Garba appealed through the courts and the suspension order was reinstated. As she prepares to return to work next year, this presentation sets out the lessons learned from the case and its wider implications for professional regulation in the UK and internationally.

Session Two: Mapping the Contours of Complaint Risk
Marie Bismark, Associate Professor, Melbourne School of Population and Global Health, University of Melbourne

A research partnership between the University of Melbourne and the Australian Health Practitioner Regulation Agency has analyzed six years of data on health, performance, and conduct concerns notified to national boards. This research has helped to identify areas of greatest risk to the public and has influenced regulatory policy in Australia and internationally.

Key questions that will be addressed in this presentation include: Who is at highest risk of being named in a complaint to a regulator? How does practice context influence complain risk? What dole to patients, peers, and employers play as sources of complaint? Would sharing information with other agencies improve our ability to predict (and prevent) future complaints?

Q&A

3:15 – 4:00 p.m. *Closing Keynote – Truth and Consequences: The Importance of Evidence in the Pursuit of Good Public Policy*

Bob Rae, Current Canadian Special Envoy to Myanmar, former Leader of the Liberal Party of Canada and former Premier of Ontario

In the current turmoil in so many parts of the world, it is critical that policy leaders remain focused on the importance of facts and evidence.

4:00 p.m. *Concluding Remarks*

**PROCEDURES FOR ATTENDING
EDUCATIONAL SESSIONS/PROFESSIONAL
DEVELOPMENT PROGRAMS**

**CCO Internal Policy: I-010
Executive Committee
Approved by Council: February 19, 2008
Re-affirmed: September 15, 2018**

INTENT

To provide clarification to council members on approved practices for attending educational sessions/professional development programs related to their duties and responsibilities as council members of CCO:

POLICIES

Council members often attend educational sessions/professional development programs related to their duties and responsibilities as council members of CCO.

Where a council member wishes to attend such a program, the following procedures shall be followed:

PROCEDURES**Written Request**

The council member shall make a written request to the registrar describing the program he/she wishes to attend and why this program is directly related to his/her duties and responsibilities as a council member of CCO.

The president and registrar have the discretion to determine whether an educational session/professional development program is directly related to the council member's duties and responsibilities as a council member of CCO.

Report to Council/Committees

Following attendance at an educational session/professional development program, the council member shall report to Council and/or any relevant committee(s), written or orally as appropriate, what was taught at the program.

Expenses

1219

Once approved, CCO shall reimburse the member for reasonable expenses in attending the educational session/professional development program consistent with CCO's budget.

ITEM 6.2.1

1220

ADVERTISING COMMITTEE

TERMS OF REFERENCE

1. The Advertising Committee is a non-statutory committee pursuant to the by-law in accordance with S. 94 (1)(i) of the *Health Professions Procedural Code*, Schedule 2 to the *Regulated Health Professions Act, 1991*.
2. The Committee is composed of two elected member, one public member, one alternate public member, and one non-Council member.
3. The Committee reports to the governing Council via the Executive Committee.
4. Areas of responsibility:
 - Develop, establish and maintain standards of advertising for chiropractors.
 - Advise CCO members of the Committee's procedures to determine if an advertisements falls within the advertising standard of practice. The advertisement is a proposed advertisement by a member sent to the Committee for approval prior to publication.
 - Encourage members to submit proposed advertisements to the Committee for review before publication.
 - Review proposed advertisements and provide feedback to members within a reasonable timeframe (approximately 10 business days).
 - Keep current with advertising/marketing trends in the contemporary environment.
5. Process for proposed advertisement by a member sent to the Committee for preapproval:
 - Member sends his/her proposed advertisement to CCO, which is forwarded to the Committee for review (preferably via e-mail).
 - Committee members review the advertisement and provide feedback to CCO staff (preferably via e-mail).
 - CCO staff aggregates the feedback and, on behalf of the chair, advises the member in writing (letter, facsimile and/or e-mail) within approximately 10 business days. The response includes the following information:

1221

- The advertisement complies or does not comply with the advertising standard of practice.
 - If the advertisement does not comply, why it does not comply and some suggestions on how it may be made to comply.
 - Approval of an advertisement by the Committee does not guarantee that a complaint will not come forward.
- If the member disagrees with the Committee's decision, the Committee will consider the member's comments, provided in writing, and take one the following actions:
 - advise the member that the Committee stands by its original decision;
 - advise the member that the Committee will revise its original decision; or
 - advise the member that the Committee will forward the member's letter to the Executive Committee for additional review/consideration.
6. The Committee will communicate to anyone who wishes to file an inquiry, complaint or report relating to a member's published advertisement to file this report in writing via mail or fax to the attention of the Inquiries, Complaints and Reports Committee.

POLICY P-004

Advertising Committee Protocol

Advertising Committee
Approved by Council: November 25, 1994
Amended: April 20, 2002, September 24, 2009, April 24, 2012

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

INTENT

To advise members of the Advertising Committee's procedure to determine if an advertisement falls within Standard of Practice S-016: Advertising.

The advertisement is a proposed advertisement by a member sent to the Committee for preapproval prior to publication.

DESCRIPTION OF POLICY

1. A member considering advertising is encouraged to forward his/her advertisements to CCO for review, prior to publication.
2. CCO forwards the advertisement to the Advertising Committee for review (via e-mail).
3. The members of the Advertising Committee review the advertisement and provide feedback to CCO (via e-mail).
4. CCO aggregates the feedback and, on behalf of the Committee Chair, advises the member in writing (letter, facsimile and/or e-mail) if the advertisement complies with the advertising standard of practice. CCO provides a response within approximately **10 business days**.
5. If the member disagrees with the Advertising Committee's decision, the committee will consider the member's comments, provided in writing, and take the following actions:
 - advise the member that the committee stands by its original decision;
 - advise the member that the committee will revise its original decision; or
 - advise the member that the committee will forward the member's letter to the Executive Committee for additional review and consideration.

STANDARD OF PRACTICE S-016

Advertising

Advertising Committee
Approved by Council: September 7, 1996
Amended: September 21, 2002, June 22, 2007, November 29, 2007,
September 24, 2009, February 28, 2017

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

INTENT

- To provide members with advertising guidelines to ensure all advertisements serve the public interest.
- To educate the public on what is available for their chiropractic care.
- To ensure advertisements are accurate, factual and contain information that is verifiable.
- To ensure, as much as possible, that the public has the information to make rational choices for their care.
- To assist the public in obtaining the services of members of their choice.
- To maintain a professional image.

Advertising Definition for the Purpose of Standard of Practice S-016: Advertising

Advertising is any message communicated outside a member's office through a public medium, including electronic media such as websites and social media, that can be seen or heard by the public at large with the intent of influencing a person's choice of service or service provider. This standard applies equally to members acting individually, as a group, or as a professional health corporation.

DESCRIPTION OF STANDARD

1

1. An advertisement must be:
 - (a) accurate, factual and contain information that is verifiable; and
 - (b) readily comprehensible by the persons to whom it is directed.

2. An advertisement may:

- (a) name a specific diagnostic or therapeutic procedure or modality but cannot claim superiority or endorse the exclusive use of such procedures, services, techniques, modalities or products. References to specific diagnostic or therapeutic procedures must comply with Standard of Practice S-001: Chiropractic Scope of Practice;
- (b) make reference to the member being a specialist, provided the member is recognized pursuant to CCO's policy as a specialist, and the specialty is disclosed. Refer to Policy P-029: Chiropractic Specialties, for the list of specialties currently recognized by CCO;
- (c) make reference to the member being affiliated with any professional association, society or body, other than CCO, only on a curriculum vitae, business stationery and recognized public displays;
- (d) allow an individual or organization to endorse a member provided:
 - (i) the individual or organization proposing the endorsement has sufficient expertise, according to CCO, relevant to the subject matter being endorsed; and
 - (ii) the member has been appropriately assessed as providing the subject matter being endorsed; and
- (e) offer an initial complimentary consultation¹.
- (f) include testimonials that refer only to the benefits of chiropractic and not to a particular member or office, with the exception of a member's website which may include testimonials that refer to a particular member or office, provided the testimonials are:
 - (i) accurate, verifiable, and recorded in the patient health record;
 - (ii) used only in accordance with the written consent of the patient;
 - (iii) not obtained using any undue pressure, duress, coercion or incentives; and
 - (iv) otherwise compliant and consistent with Standard of Practice S-016: Advertising, the chiropractic scope of practice, other CCO standards of practice, policies and guidelines, and privacy legislation.

2

3. Any advertisement with respect to a member's practice must not contain:
 - (a) anything false or misleading;
 - (b) a guaranteed success of care;
 - (c) any comparison to another member's or other health care provider's practice, qualifications or expertise;
 - (d) any expressed or implied endorsement or recommendation for the exclusive use of a product or brand of equipment used to provide services; and
 - (e) material that, having regard to all the circumstances, would reasonably be regarded as disgraceful, dishonourable or unprofessional.

4. A member may advertise his/her fee for chiropractic services provided:
 - (a) the advertisement contains accurate, complete and clear disclosure of what is and what is not included in the fee;
 - (b) there are no hidden fees/costs;
 - (c) the member does not bill a third-party payor for the complimentary portion of the diagnostic or treatment service;
 - (d) the advertisement expressly states the timeframe to be honoured for any complimentary or discounted diagnostic or treatment service;
 - (e) the advertisement does not limit the offer to a certain number of participants;
 - (f) no obligation is placed on the patient for follow-up appointments as a result of the complimentary or discounted diagnostic or treatment service; and
 - (g) the advertisement is presented in a professional manner that maintains the dignity of the profession.

5. A member advertising the exchange of products/services for proceeds/donations to a charity may do so as follows:
 - (a) the proceeds/donations are being collected for a registered charity, school or other organization that, in the opinion of the Advertising Committee, serves the public's interest ("charity");

- (b) the charity is disclosed in the advertisement;
 - (c) the member discloses the part of the proceeds/donations to be given to the designated charity and if he/she is taking any proceeds/donations to cover his/her expenses;
 - (d) the member may not bill any third-party payor for the diagnostic or treatment services provided in exchange for the charitable proceeds/donation; and
 - (e) the member providing diagnostic or treatment services in exchange for the charitable proceeds/donation must comply with all CCO standards of practice.
6. Public presentations or displays³ are permissible provided:
- (a) a member adheres to CCO's regulations and standards of practice (e.g., consent, record keeping);
 - (b) professional conduct is maintained at all times;
 - (c) material distributed complies with the advertising standard⁴;
 - (d) assessment(s) performed comply with CCO's Public Display Protocol (Policy P-016) and are for educational purposes;
 - (e) no controlled acts of diagnosis and/or adjustments are performed; and
 - (f) no coercion or pressure tactics are used⁵.
- 4 7. A communication by a member to a patient or prospective patient for the purposes of soliciting business shall be appropriate to the standards of the profession and shall be respectful of patient choice, and not involve undue pressure and not promote unnecessary products or services. A member must not contact or communicate with or allow any person to contact or communicate with potential patients via telemarketing or electronic methods.
8. A member must not advertise or permit advertising with respect to his/her practice in contravention of the regulations or standards of practice.

LEGISLATIVE CONTEXT

It is an act of professional misconduct to contravene or fail to maintain a standard of practice.

For additional information regarding billing procedures, please refer to Regulation R-008: Professional Misconduct (Business Practices section) and Guideline G-008: Business Practices.

¹ A consultation is a meeting to discuss how chiropractic may benefit the patient. A consultation does not include examination procedures, diagnostic tests (e.g., radiographs) or treatment services.

³ “Displays” include presentations or other visual material to members of the public, in a place normally frequented by the public, by a person or persons who are physically present when such material is disturbed or presented.

⁴ It is strongly recommended that material to be distributed be pre-approved by the Advertising Committee.

⁵ Voluntary appointments are permitted - i.e., if potential patients ask for the member’s business card or request an appointment.

Advertising Committee
Approved by Council: January 13, 1996
Amended and Approved by Council: September 21, 2002, June 22, 2007,
November 29, 2007, September 24, 2009, February 28, 2017

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

INTENT

The advertising guideline is designed to detail Standard of Practice S-016: Advertising, and to give members guidance when educating members of the public. Advertisements should help the public make informed choices regarding their health care. To assist members of the public in making knowledgeable choices, advertisements must be informative and maintain a professional image.

DESCRIPTION OF GUIDELINE

1. An advertisement must be:

(a) accurate, factual and contain information that is verifiable;

Providing the public with accurate, factual, objective and verifiable information to make an informed choice in health care is in the public's best interest. Subjective opinions may cause confusion and lack of trust.

(b) readily comprehensible by the persons to whom it is directed.

Advertisements should be readily understandable so the general public is not confused by the message.

2. An advertisement may:

(a) name a specific diagnostic or therapeutic procedure or modality but cannot claim superiority or endorse the exclusive use of such procedures, services, techniques, modalities or products. References to specific diagnostic or therapeutic procedures must comply with the Standard of Practice S-001: Chiropractic Scope of Practice;

Such references assist the public in finding a particular type of chiropractic care and allow an informed choice.

Members may advertise services (e.g., acupuncture, ultrasound, radiography), adjustive techniques, and other procedures within the public domain (e.g. orthotics, nutritional products). Members should understand exhaustive lists of everything possible may confuse the public and are not advised.

- (b) make reference to the member being a specialist, provided the member is recognized pursuant to CCO's policy as a specialist, and the specialty is disclosed. Refer to Policy P-029: Chiropractic Specialties, for the list of specialties currently recognized by CCO;

Members may only use terms such as "specialist" and "specializing in" in reference to the specialties recognized by CCO. A member cannot advertise a specialty in area(s) not recognized by CCO. A member may express an "interest in" or "focus on" an area of practice.

- (c) make reference to the member being affiliated with any professional association, society or body, other than CCO, only on curriculum vitae, business stationery and recognized public displays;

Advertising a member's affiliations in any other medium may confuse the public and may cause comparisons to other members, which is not permitted. In electronic media, a member may include professional associations other than CCO, only in the curriculum vitae/biography section of a website or social media home page.

- (d) allow an individual or organization to endorse a member, provided:

An unqualified endorsement from a source with little or no expertise is not in the public's best interest and undermines the public's trust.

- (i) the individual or organization proposing the endorsement has sufficient expertise, according to CCO, relevant to the subject matter being endorsed;
- (ii) the member has been appropriately assessed as providing the subject matter being endorsed;

2

- (e) offer an initial complimentary consultation.¹

Members may advertise complimentary/courtesy initial consultations. Members may not bill any third-party payors for complimentary/courtesy consultations.

- (f) include testimonials that refer only to the benefits of chiropractic and not to a particular member or office, with the exception of a member's website which may include testimonials that refer to a particular member or office, provided the testimonials are:

- (i) accurate, verifiable, and recorded in the patient health record;
- (ii) used only in accordance with the written consent of the patient, which may be withdrawn at any time;
- (iii) not obtained using any undue pressure, duress, coercion or incentives; and
- (iv) otherwise compliant and consistent with Standard of Practice S-016: Advertising, the chiropractic scope of practice, other CCO standards of practice, policies and guidelines and privacy legislation.

Testimonials that refer to the benefits of chiropractic and not to a particular member or office are permissible; however, members may continue to use specific testimonials on their websites.

Testimonials must be truthful and verifiable, and evidenced in the patient health record.

There must be documented patient consent related to a particular testimonial, documented in the patient health record.

Patients may only offer a testimonial under their own free will and not due to any coercion or compensation.

As with all advertising, use of testimonials must be consistent with the chiropractic scope of practice, as defined in the Chiropractic Act, 1991, and relevant legislation, standards of practice, policies and guidelines.

3. Any advertisement with respect to a member's practice must not contain:

- (a) anything false or misleading;

3

False or misleading statements undermine public trust in the profession and may result in a complaint to CCO by a colleague or a member of the public.

- (b) a guaranteed success of care;

Claims and guarantees of success are often not verifiable and may appear unprofessional. Members should not use expressions such as "will help" and "does relieve" which imply a guarantee. Members may use expressions such as "may be able to help" or "has been shown to relieve."

- (c) any comparison to another member's or other health care provider's practice, qualifications or expertise;

Comparison to any facet of another member's practice is unprofessional. The public and the profession are better served by positive and generic chiropractic facts.

Members should not use adjectives with comparatives (e.g., "more" or "better") in their advertising because they imply a comparison. Members may use words such as "safe" and "effective" to describe the chiropractic profession in general.

- (d) any expressed or implied endorsement or recommendation for the exclusive use of a product or brand of equipment used to provide services;

Exclusive endorsements of products suggest superiority and imply a comparison, which is not permitted.

- (e) material that, having regard to all the circumstances, would reasonably be regarded as disgraceful, dishonourable or unprofessional.

All advertisements must maintain professional integrity and serve the public's best interest.

It is an act of professional misconduct to engage in conduct or perform an act that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

4. A member may advertise his/her fee for chiropractic services provided:

- (a) the advertisement contains accurate, complete and clear disclosure of what is and what is not included in the fee;

The public is entitled to full disclosure of what is and what is not included in the advertised fee.

- (b) there are no hidden fees/costs;

The public is entitled to full disclosure of what is and what is not included in the advertised fee.

- (c) the member does not bill a third-party payor for the complimentary portion of the diagnostic or treatment service;

A member is not permitted to bill any third-party payor for complimentary diagnostic or treatment services as this practice is unethical and may be professional

misconduct.

- (d) the advertisement expressly states the timeframe to be honoured for any complimentary or discounted diagnostic or treatment service;

To ensure there is no confusion or misunderstanding, the advertisement must indicate the exact timeframe in which the complimentary or discounted diagnostic or treatment services apply.

- (e) the advertisement does not limit the offer to a certain number of participants;

Members of the public must all be given an equal opportunity to obtain the advertised complimentary or discounted diagnostic or treatment services. An advertisement that limits an offer to a certain number of participants may be misleading.

- (f) no obligation is placed on the patient for follow-up appointments as a result of the complimentary or discounted diagnostic or treatment service;

A member may not use an advertisement for complimentary or discounted diagnostic or treatment services to pressure or coerce a member of the public to return for follow-up appointments.

- (g) the advertisement is presented in a professional manner that maintains the dignity of the profession.

All advertisements must be presented in a professional manner, maintain professional integrity, and serve the public's best interest. Although discounted fees may be offered, online coupons, contests and giveaways are inappropriate.

- 5. A member advertising the exchange of products/services for proceeds/donations to a charity may do so as follows:

5

An advertisement that encourages philanthropy, if done professionally and ethically, serves the public's interest.

- (a) the proceeds/donations are being collected for a registered charity, school or other organization that, in the opinion of the Advertising Committee, serves the public's interest ("charity");

The charity or organization must serve the public interest.

- (b) the charity is disclosed in the advertisement;

The public is entitled to full disclosure regarding the charity or organization for which proceeds are being collected.

- (c) the member discloses the part of the proceeds/donations to be given to the designated charity and if he/she is taking any proceeds/donations to cover his/her expenses;

The public is entitled to full disclosure regarding how the proceeds will be divided.

- (d) the member may not bill any third-party payor for the diagnostic or treatment services provided in exchange for the charitable proceeds/donation;

A member is not permitted to bill any third-party payor for complimentary diagnostic or treatment services as this practice is unethical and may constitute an act of fraud.

- (e) the member providing diagnostic or treatment services in exchange for the charitable proceeds/donation must comply with all CCO standards of practice.

Members must comply with all CCO standards of practice. If the member is uncertain if the proposed advertisement is appropriate, he/she is encouraged to submit it to the Advertising Committee for review prior to publication. Turnaround time for a response is approximately 10 business days.

6. Public presentations or displays² are permissible provided:

The advertising standard permits public presentations for educational or informational purposes. Being intrusive to the public within a public place, harassing the public or using pressure tactics are unprofessional and undermines the public's trust.

6

- (a) member(s) adhere(s) to CCO's regulations and standards of practice (e.g., consent, record keeping);
- (b) professional conduct is maintained at all times;
- (c) material distributed complies with the advertising standard;⁴
- (d) assessment(s) performed comply with CCO's Public Display Protocol (Policy P-016) and are for educational purposes;

Assessment procedures, as listed in CCO's Public Display Protocol (Policy P-016), are permitted, provided the protocol is followed and consent is obtained.

- (e) no controlled acts of diagnosis and/or adjustments are performed;

Since a complete history and examination are inappropriate at a public display, making a diagnosis or performing an adjustment is not permitted. Adjustments at a public display may alarm the public when observing an adjustment procedure without a proper explanation.

- (f) no coercion or pressure tactics are used.¹

7. A communication by a member to a patient or prospective patient for the purposes of soliciting business shall be appropriate to the standards of the profession and shall be respectful of patient choice, and not involve undue pressure and not promote unnecessary products or services. A member must not contact or communicate with or allow any person to contact or communicate with potential patients via telemarketing or electronic methods.

Any communication to patients or prospective patients must be consistent with the advertising standard of practice, within the chiropractic scope of practice, professional and respectful of the public interest, and compliant with Canadian anti-spam legislation, no matter what the medium.

8. A member must advertise or permit advertising with respect to his/her practice only in compliance with the regulations or standards of practice; and

A member is responsible for all advertising that is directly or indirectly controlled by that member.

LEGISLATIVE CONTEXT

For additional information regarding billing procedures, please refer to Regulation R-008: Professional Misconduct (Business Practices section) and Guideline G-008: Business Practices.

¹ A consultation is a meeting to discuss how chiropractic may benefit the patient. A consultation does not include examination procedures, diagnostic tests (e.g., x-rays) or treatment services.

² “Displays” include presentations or other visual material to members of the public, in a place normally frequented by the public, by a person or persons who are physically present when such material is distributed or presented.

³ It is strongly recommended that material to be distributed be pre-approved by the Advertising Committee.

⁴ Voluntary appointments are permitted - i.e., potential patients ask for the member’s business card or request an appointment.

ITEM 6.2.5



COLLEGE OF CHIROPRACTORS OF ONTARIO

1236

MEMORANDUM

To: Chair, Quality Assurance Committee

From: Dr. Peter Amlinger, Chair, Advertising Committee

Date: April 30, 2019

Re: Development of Standards Related to Claims Related to Benefits from Chiropractic Care

The Advertising Committee is requesting that the Quality Assurance Committee review and consider the development of standards of practice addressing claims related to benefits from chiropractic care. Development of a standard would include consideration of the following:

- Types of conditions, diseases and disorders and standards of evidence related to claims that members may make related to the benefits from chiropractic care; and
- Standards of evidence, onus on the member to demonstrate this evidence and methods of communication for claims within the doctor/patient relationship and advertising to the public at large.

ITEM 6.3.1

Approved by Council: December 11, 2008
Amendments Approved by Council: April 26, 2017



PARTNERSHIP OF CARE

(Patients' Charter of Rights & Responsibilities)

1237

You and your chiropractor have an equal and vital role in the pursuit of your optimum health and well-being.

You have the right to expect your chiropractor to provide...

- ✓ ethical conduct of practice
- ✓ respectful, honest and clear communication in all aspects of consultation, consent, examination and care
- ✓ full disclosure of policies, procedures and fees
- ✓ relevant, safe and supportive patient-centred care
- ✓ accurate and comprehensive records
- ✓ a private, clean, accessible setting for receiving chiropractic care, that respects patient wishes
- ✓ accommodation and accessibility for disabilities and human rights, or alternative arrangements if accessibility is not possible
- ✓ an awareness of current health and well-being issues
- ✓ information about what chiropractic offers
- ✓ timely and necessary communication and/or referral to other health professionals
- ✓ timely transfer of records, upon request
- ✓ compliance with the College of Chiropractors of Ontario's (CCO) regulations, standards of practice, policies and guidelines (information posted on CCO's web site at www.cco.on.ca)
- ✓ privacy and confidentiality of your personal health information
- ✓ behaviour and clarity regarding dignified professional boundaries
- ✓ disclosure of real or perceived conflicts of interest
- ✓ a process for declining treatment and withdrawal of consent at any time

Your responsibilities to your chiropractor are to provide...

- ✓ honest, accurate and full disclosure of all pertinent health information
- ✓ constructive feedback (positive/negative) regarding all aspects of care
- ✓ a cooperative commitment to your treatment plan
- ✓ compliance with office policies, procedures and fees
- ✓ courtesy and respect for the office environment, staff and other patients
- ✓ up-to-date contact information

CCO is the governing body established by the provincial government to regulate chiropractors in Ontario. Every chiropractor practising in Ontario must be a registered member of CCO.

For more information, please visit www.cco.on.ca.

شراكة الرعاية (ميثاق حقوق ومسؤوليات المرضى)



أنت ومعالج العمود الفقري لديكما دور متساو وحيوي في السعي لتحقيق الصحة والرفاهية المثلى.

لديك الحق في توقع أن يقدم معالج العمود الفقري بما يلي...

- ✓ سلوكاً أخلاقياً للمهنة
- ✓ إبلاغاً محترماً وصادقاً وواضحاً بجميع جوانب التشاور والموافقة والفحص والرعاية
- ✓ إقصاحاً تاماً عن السياسات والإجراءات والرسوم
- ✓ رعاية ذات صلة ومأمونة ومساندة للمريض
- ✓ سجلات دقيقة وشاملة
- ✓ بيئة خاصة ونظيفة وسهلة الوصول لتلقي العلاج اليدوي، تُلبّي رغبات المريض
- ✓ التجهيز وإمكانية الوصول إلى الإعاقات وحقوق الإنسان أو ترتيبات بديلة إذا تعذر الوصول
- ✓ وعياً بالمسائل الحالية المتعلقة بالصحة والرعاية
- ✓ معلومات حول عروض العلاج اليدوي
- ✓ الإبلاغ اللازم في حينه و/ أو الإحالة إلى المهنيين الصحيين الآخرين
- ✓ نقل السجلات في الوقت المناسب، عند الطلب
- ✓ الامتثال للوائح كلية علاج العمود الفقري في أونتاريو (CCO)، ومعايير المهنة والسياسات والمبادئ التوجيهية (المعلومات المنشورة على موقع CCO الإلكتروني على www.cco.on.ca)
- ✓ خصوصية وسرية معلوماتك الصحية الشخصية
- ✓ السلوك والوضوح فيما يتعلق بالحدود المهنية المحترمة
- ✓ الإفصاح عن تضارب المصالح الحقيقي أو المتصور
- ✓ إجراء رفض العلاج وحجب الموافقة في أي وقت

مسؤولياتك تجاه معالج العمود الفقري هي توفير...

- ✓ إفصاح صادق ودقيق وتام عن جميع المعلومات الصحية ذات الصلة
- ✓ ردود فعل بناءة (إيجابية / سلبية) فيما يتعلق بجميع جوانب الرعاية
- ✓ التزام تعاوني بخطة العلاج الخاصة بك
- ✓ الامتثال لسياسات وإجراءات ورسوم العيادة
- ✓ احترام بيئة العيادة والعاملين والمرضى الآخرين
- ✓ معلومات اتصال حديثة

كلية علاج العمود الفقري في أونتاريو هي الهيئة الإدارية التي أنشأتها حكومة المقاطعة لتنظيم معالجي العمود الفقري في أونتاريو. يجب أن يكون كل معالج عمود فقري ممارس في أونتاريو عضواً مسجلاً في كلية علاج العمود الفقري.

لمزيد من المعلومات، يرجى زيارة الموقع www.cco.on.ca.



護理合夥關係 (患者的權利與責任)

1239

在您追求健康與康樂福祉的過程中，您本人及您的脊椎按摩師擔負著同等且重要的責任。

您有權期待您的脊椎按摩師…

- ✓ 表現出符合職業道德操守的行為
- ✓ 在諮詢、意見、檢查和護理等各方面進行恭敬有禮、誠實且明確的溝通
- ✓ 充分披露各項政策、程式和開銷費用
- ✓ 提供相關、安全、有效且以患者為中心的護理
- ✓ 提供準確且全面的記錄
- ✓ 尊重患者的意願，提供私密、乾淨且方便進出的環境，以供患者接受脊椎按摩治療
- ✓ 保護並保障殘疾和人權利益，或者，如果無法保證便利性，應提供替代性安排
- ✓ 認識到當前的健康與康樂福祉問題
- ✓ 提供脊椎按摩治療服務相關資訊
- ✓ 確保及時且必要的溝通，及/或轉介至其他保健專業人士
- ✓ 根據要求及時傳輸相關記錄
- ✓ 遵守安大略省脊醫學院（CCO）的各項規定、實踐標準、政策與指南（安大略省脊醫學院網站 www.cco.on.ca 可查閱相關資訊）
- ✓ 保護您個人健康資訊的隱私和保密性
- ✓ 表現出尊重職業界限的行為和明確態度
- ✓ 披露真實或可感知的利益衝突
- ✓ 提供隨時拒絕治療和撤回同意的流程

您本人對您的脊椎按摩師應承擔的責任包括…

- ✓ 誠實、準確且充分披露所有相關的健康資訊
- ✓ 提供與護理各方面相關且有建設性的回饋（正面/負面）
- ✓ 以合作的方式堅持您的治療計畫
- ✓ 遵守所提供的政策、程式和費用等要求
- ✓ 禮貌待人，尊重辦公室環境、員工和其他患者
- ✓ 提供最新的聯繫資訊

安大略省脊醫學院是由省政府建立的主管部門，負責監管安大略省的脊椎按摩師。安大略省的每一位脊椎按摩師均必須為安大略省脊醫學院的註冊成員。

如需瞭解更多資訊，請訪問 www.cco.on.ca。



COOPERAZIONE AL TRATTAMENTO *(Carta dei diritti e delle responsabilità dei pazienti)*

1240

Lei e il Suo chiropratico avete un ruolo di importanza parimenti vitale per l'ottenimento da parte Sua di una buona salute e benessere.

Lei ha il diritto di ricevere dal Suo chiropratico...

- ✓ una condotta professionale etica
- ✓ comunicazione rispettosa, onesta e chiara in tutti gli aspetti della consultazione, del consenso, dell'esame e del trattamento
- ✓ informazioni complete su norme, procedure e spese
- ✓ assistenza pertinente, sicura e di supporto, centrata sul paziente
- ✓ tenuta di una cartella medica precisa e completa
- ✓ un ambiente privato, pulito, accessibile per ricevere cure chiropratiche, che rispetti i desideri dei pazienti
- ✓ accessibilità per disabilità e diritti umani, o soluzioni alternative se l'accessibilità non è possibile
- ✓ consapevolezza dei problemi attuali di salute e benessere
- ✓ informazioni su ciò che offre la chiropratica
- ✓ comunicazioni necessarie tempestive e / o rinvio ad altri professionisti sanitari
- ✓ trasferimento tempestivo della cartella medica, su richiesta
- ✓ conformità con i regolamenti, le norme professionali, le politiche e le linee guida del College of Chiropractors of Ontario (CCO) - (informazioni pubblicate sul sito web del CCO all'indirizzo www.cco.on.ca)
- ✓ privacy e riservatezza delle Sue informazioni sanitarie personali
- ✓ educazione e chiarezza nel mantenere dei confini professionali dignitosi
- ✓ divulgazione di conflitti di interesse reali o presunti
- ✓ informazioni sulle modalità per rifiutare il trattamento e revocare il consenso in qualsiasi momento

Lei ha la responsabilità nei confronti del Suo chiropratico di fornire...

- ✓ comunicazione onesta, precisa e completa di tutte le informazioni pertinenti sulla Sua salute
- ✓ opinioni costruttive (positive o negative) su tutti gli aspetti dell'assistenza ricevuta
- ✓ impegno ad attenersi al Suo piano di trattamento
- ✓ conformità con le norme, le procedure e le spese dell'ufficio
- ✓ cortesia e rispetto per l'ambiente, il personale e gli altri pazienti dell'ufficio
- ✓ recapiti sempre aggiornati

Il CCO è l'organo governativo istituito dal governo provinciale per la regolamentazione dell'attività dei chiropratici in Ontario. Ogni chiropratico che esercita in Ontario deve essere un membro registrato del CCO.

Per maggiori informazioni, La preghiamo di visitare www.cco.on.ca.



PARCERIA DE CUIDADO

(Estatuto de Direitos e Responsabilidades do Paciente)

Você e o seu quiroprata têm um papel igual e vital na busca por saúde e bem-estar ideais.

Você tem o direito de esperar que o seu quiroprata forneça...

- ✓ prática conduzida de maneira ética.
- ✓ comunicação respeitosa, honesta e clara em todos os aspectos da consulta, do consentimento, do exame e do cuidado.
- ✓ total abertura sobre políticas, procedimentos e custos.
- ✓ cuidados centrados no paciente que sejam relevantes, seguros e de apoio.
- ✓ registros precisos e compreensivos.
- ✓ ambiente privado, limpo e acessível para receber os cuidados quiropráticos, respeitando as vontades do paciente.
- ✓ acomodação e acessibilidade para deficiências e direitos humanos, ou alguma solução alternativa se a acessibilidade não for possível.
- ✓ consciência de problemas de saúde e bem-estar.
- ✓ informações sobre o que a quiropraxia oferece.
- ✓ comunicação oportuna e necessária com outros profissionais de saúde ou o encaminhamento para eles.
- ✓ pronta transferência de histórico, quando requisitado.
- ✓ conformidade com os regulamentos, padrões de prática, políticas e diretrizes do Colégio de Quiropratas de Ontário (College of Chiropractors of Ontario, CCO) (informação publicada no site do CCO em www.cco.on.ca).
- ✓ privacidade e confidencialidade em relação às suas informações pessoais de saúde.
- ✓ comportamento adequado e clareza em relação aos limites pessoais de dignidade.
- ✓ abertura de conflitos de interesses reais ou percebidos.
- ✓ um processo de recusa do tratamento ou retirada do consentimento a qualquer momento.

As suas responsabilidades em relação ao seu quiroprata são de fornecer...

- ✓ abertura honesta, precisa e completa de todas as informações de saúde pertinentes.
- ✓ comentar construtivamente (posivo/negativo) em relação a todos os aspectos do cuidado.
- ✓ um compromisso cooperativo para com o seu plano de tratamento.
- ✓ cumprir com as políticas, procedimentos e custos do consultório.
- ✓ cortesia e respeito para com o ambiente do consultório, os seus funcionários e os outros pacientes.
- ✓ dar informações de contato atualizadas.

O CCO é o órgão dirigente estabelecido pelo governo provincial para regular quiropratas em Ontário. Todo quiroprata que atuar em Ontário precisa ser um membro registrado do CCO.

Para maiores informações, vá para www.cco.on.ca.



ASOCIACIÓN PARA ATENCIÓN MÉDICA

(Carta de derechos y responsabilidades de los pacientes)

1242

Usted y su quiropráctico juegan un papel igual e importantísimo en la búsqueda de su óptima salud y bienestar.

Usted tiene el derecho de esperar que su quiropráctico le brinde

- ✓ una conducta profesional ética,
- ✓ respetuosa, honesta y una comunicación clara respecto a todos los aspectos de la consulta, consentimiento, exámenes y cuidados,
- ✓ una información completa acerca de las políticas, procedimientos y tarifas
- ✓ atención relevante, segura y de apoyo centrada en el paciente
- ✓ registros precisos y completos
- ✓ un entorno privado, limpio y accesible para recibir atención quiropráctica, que respete los deseos de los pacientes
- ✓ alojamiento y accesibilidad para discapacitados y derechos humanos, o arreglos alternativos si la accesibilidad no es posible
- ✓ un conocimiento de los problemas actuales de salud y bienestar
- ✓ información sobre lo que ofrece la quiropráctica
- ✓ comunicación oportuna y necesaria y / o derivación a otros profesionales de la salud
- ✓ transferencia oportuna de registros, previa solicitud
- ✓ cumplimiento con los reglamentos, normas de práctica, políticas y pautas del Colegio de Quiroprácticos de Ontario (CCO) (información publicada en el sitio web de CCO en www.cco.on.ca)
- ✓ privacidad y confidencialidad de su información de salud personal
- ✓ comportamiento y claridad respecto a las fronteras profesionales dignas
- ✓ divulgación de conflictos de intereses reales o percibidos
- ✓ un proceso para rechazar el tratamiento y retirar el consentimiento en cualquier momento.

Sus responsabilidades para con el quiropráctico son proporcionar ...

- ✓ divulgación honesta, precisa y completa de toda la información de salud pertinente
- ✓ retroalimentación constructiva (positiva/negativa) con respecto a todos los aspectos del cuidado
- ✓ un compromiso cooperativo con su plan de tratamiento
- ✓ cumplimiento de las políticas, procedimientos y tarifas de la oficina
- ✓ cortesía y respeto por el entorno de la oficina, el personal y otros pacientes.
- ✓ información de contacto actualizada

CCO es el órgano de gobierno establecido por el gobierno provincial para regular los quiroprácticos en Ontario. Todo quiropráctico que practique en Ontario debe ser un miembro registrado de CCO.

Para obtener más información, visite www.cco.on.ca.



PAGTUTULUNGAN SA PANGANGALAGA

(Karta ng mga Karapatan at Responsibilidad ng mga Pasyente)

Ikaw at ang iyong chiropractor ay may pantay at mahalagang papel sa pagsisikap na makamit ang pinakamabuti mong kalusugan at kapakanan.

May karapatan kang umasa na magbibigay ang iyong chiropractor ng...

- ✓ etikal na pagsasagawa ng propesyon
- ✓ may paggalang, matapat at malinaw na komunikasyon sa lahat ng aspekto ng konsultasyon, pahintulot, eksaminasyon at pangangalaga
- ✓ lubusang paghahayag ng mga patakaran, proseso at bayarin
- ✓ nauugnay, ligtas at sumusuportang pangangalaga na nakatuon sa pasyente
- ✓ mga tumpak at komprehensibong record
- ✓ isang pribado at malinis na lugar para sa pagtanggap ng pangangalaga mula sa chiropractor, na gumagalang sa mga kahilingan ng pasyente
- ✓ kaginhawahan at accessibility para sa mga kapansanan at karapatang pantao, o mga kahaliling kaayusan kung hindi posible ang accessibility
- ✓ pagkakaroon ng kaalaman sa mga kasalukuyang isyu sa kalusugan at kapakanan
- ✓ impormasyon tungkol sa mga chiropractic na alok
- ✓ napapanahon at kinakailangang komunikasyon at/o referral sa ibang propesyonal sa kalusugan
- ✓ nasa oras na paglipat ng mga record, kapag hiniling
- ✓ pagsunod sa mga regulasyon, pamantayan sa pagsasagawa ng propesyon, patakaran at alituntunin ng College of Chiropractors of Ontario (CCO) (naka-post ang impormasyon sa web site ng CCO sa www.cco.on.ca)
- ✓ privacy at pagiging kumpidensyal ng iyong personal na impormasyon sa kalusugan
- ✓ paggawi at pagiging tiyak tungkol sa mararantal na pampropesyong hangganan
- ✓ paghahayag ng tunay o nahiwatigang mga pagkakasalungatan ng interes
- ✓ isang proseso para sa pagtanggap sa paggagamot at pagbawi ng pahintulot anumang oras

Ang iyong mga responsibilidad sa chiropractor mo ay ang magbigay ng...

- ✓ matapat, tumpak at lubusang paghahayag ng lahat ng may kaugnayang impormasyon sa kalusugan
- ✓ kapaki-pakinabang na feedback (positibo/negatibo) may kinalaman sa lahat ng aspekto ng pangangalaga
- ✓ kompromisong makikipagtulungan sa iyong plano ng paggagamot
- ✓ pagsunod sa mga patakaran, proseso at bayarin ng opisina
- ✓ paggalang at respeto sa kapaligiran ng opisina, sa staff at sa iba pang pasyente
- ✓ napapanahong impormasyon sa pakikipag-ugnayan

Ang CCO ay ang lupong tagapamahala na itinatag ng pamahalaan ng probinsya para pangasiwaan ang mga chiropractor sa Ontario. Ang bawat chiropractor na nagsasagawa ng propesyon sa Ontario ay dapat na rehistradong miyembro ng CCO.

Para sa higit pang impormasyon, bumisita sa www.cco.on.ca.



PARTENARIAT DE SOINS DE SANTÉ *(Charte des droits et responsabilités des patients)*

1244

Vous et votre chiropraticien jouez un rôle égal et vital dans la poursuite de votre santé optimale et de votre bien-être.

Vous avez le droit d'attendre de votre chiropraticien qu'il ou qu'elle...

- ✓ adopte une conduite professionnelle éthique
- ✓ communique de façon respectueuse, honnête et claire dans tous les aspects de la consultation, du consentement, de l'examen et des soins
- ✓ divulgue de façon complète les politiques, procédures et frais
- ✓ fournisse des soins pertinents, sécuritaires et axés sur le patient
- ✓ maintienne des dossiers précis et complets
- ✓ offre un lieu privé, propre et accessible pour recevoir des soins chiropratiques, qui respecte les souhaits du patient
- ✓ fournisse des ajustements et une accessibilité pour les personnes handicapées et les droits de la personne, ou des dispositions alternatives si l'accessibilité est impossible
- ✓ ait connaissance des problèmes actuels de santé et liés au bien-être
- ✓ fournisse des renseignements sur ses services de chiropractie
- ✓ offre une communication régulière et nécessaire et/ou un acheminement vers d'autres professionnels de la santé
- ✓ transfère les dossiers rapidement, sur demande
- ✓ se conforme aux règlements, normes de pratique, politiques et lignes directrices de l'Ordre des chiropraticiens de l'Ontario (OCO) (information affichée sur le site Web de l'OCO à l'adresse www.cco.on.ca)
- ✓ assure le respect de la confidentialité de vos renseignements personnels portant sur la santé
- ✓ démontre un comportement et une clarté concernant les barrières professionnelles respectant la dignité
- ✓ divulgue les conflits d'intérêts réels ou perçus
- ✓ offre un processus permettant de refuser le traitement et de retirer le consentement à tout moment

Vos responsabilités envers votre chiropraticien sont de...

- ✓ divulguer honnêtement, exactement et complètement tous les renseignements pertinents au sujet de votre santé
- ✓ fournir des commentaires constructifs (positifs/négatifs) concernant tous les aspects des soins
- ✓ d'accepter un engagement de coopération envers votre plan de traitement
- ✓ respecter les politiques, procédures et frais du bureau
- ✓ démontrer de la courtoisie et du respect envers l'environnement de bureau, le personnel et les autres patients
- ✓ mettre à jour vos coordonnées

L'OCO est l'organisme directeur mis en place par le gouvernement provincial pour réglementer les chiropraticiens en Ontario. Toutes les chiropraticiennes et tous les chiropraticiens exerçant en Ontario doivent être des membres inscrits de l'OCO.

Pour plus d'informations, veuillez visiter www.cco.on.ca.



ਦੇਖਭਾਲ ਦੀਸਾਂਝ

(ਮਰੀਜ਼ ਦੇ ਅਧਿਕਾਰਾਂ ਅਤੇ ਜ਼ਿੰਮੇਵਾਰੀਆਂ ਦਾ ਅਧਿਕਾਰ-ਪੱਤਰ)

1245

ਆਪਣੀ ਸਿਹਤ ਨੂੰ ਸਵਸਥ ਅਤੇ ਤੰਦਰੁਸਤ ਰੱਖਣ ਵਿੱਚ ਤੁਸੀਂ ਅਤੇ ਤੁਹਾਡਾ ਕਾਇਰੋਪਰੈਕਟਰ ਬਰਾਬਰ ਅਤੇ ਅਹਿਮ ਭੂਮਿਕਾ ਨਿਭਾਉਂਦੇ ਹੋ।

ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੇ ਕਾਇਰੋਪਰੈਕਟਰ ਕੋਲੋਂ ਹੇਠ ਲਿਖੀਆਂ ਚੀਜ਼ਾਂ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ...

- ✓ ਇਲਾਜ ਦਾ ਨੈਤਿਕ ਸੰਚਾਲਨ
- ✓ ਹਰ ਤਰ੍ਹਾਂ ਦੇ ਸਲਾਹ-ਮਸ਼ਵਰੇ, ਸਹਿਮਤੀ, ਜਾਂਚ ਅਤੇ ਦੇਖਭਾਲ ਲਈ ਸਨਮਾਨਪੂਰਨ, ਇਮਾਨਦਾਰ ਅਤੇ ਸਪਸ਼ਟ ਗੱਲਬਾਤ ਦੀ ਵਰਤੋਂ ਕਰਨਾ
- ✓ ਨੀਤੀਆਂ, ਪ੍ਰਕਿਰਿਆਵਾਂ ਅਤੇ ਫੀਸਾਂ ਬਾਰੇ ਪੂਰੀ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨਾ
- ✓ ਢੁੱਕਵੀਂ, ਸੁਰੱਖਿਅਤ ਅਤੇ ਸਹਾਇਕ ਮਰੀਜ਼-ਕੇਂਦਰਿਤ ਦੇਖਭਾਲ
- ✓ ਸਹੀ ਅਤੇ ਵਿਆਪਕ ਰਿਕਾਰਡ
- ✓ ਕਾਇਰੋਪਰੈਕਟਿਕ ਇਲਾਜ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਇੱਕ ਪ੍ਰਾਈਵੇਟ, ਸਾਫ਼, ਪਹੁੰਚਯੋਗ ਸਥਾਨ ਪ੍ਰਦਾਨ ਕਰਨਾ, ਜੋ ਮਰੀਜ਼ਾਂ ਦੀਆਂ ਇੱਛਾਵਾਂ ਦਾ ਸਤਿਕਾਰ ਕਰਦਾ ਹੈ
- ✓ ਅਪਾਹਜ ਮਰੀਜ਼ਾਂ ਲਈ ਰਿਹਾਇਸ਼ ਅਤੇ ਪਹੁੰਚਯੋਗਤਾ, ਅਤੇ ਮਨੁੱਖੀ ਅਧਿਕਾਰ, ਜਾਂ ਜੇ ਪਹੁੰਚਯੋਗਤਾ ਸੰਭਵ ਨਹੀਂ ਹੈ ਤਾਂ ਕੋਈ ਵਿਕਲਪਿਕ ਪ੍ਰਬੰਧ
- ✓ ਸਿਹਤ ਦੀ ਮੌਜੂਦਾ ਹਾਲਤ ਅਤੇ ਤੰਦਰੁਸਤੀ ਸੰਬੰਧੀ ਸਮੱਸਿਆਵਾਂ ਬਾਰੇ ਜਾਗਰੂਕਤਾ
- ✓ ਕਾਇਰੋਪਰੈਕਟਿਕ ਕੀ ਸੇਵਾਵਾਂ ਪ੍ਰਦਾਨ ਕਰਦੀ ਹੈ ਉਸ ਬਾਰੇ ਜਾਣਕਾਰੀ
- ✓ ਸਮੇਂ ਸਿਰ ਅਤੇ ਲੋੜੀਂਦਾ ਸੰਚਾਰ ਅਤੇ/ਜਾਂ ਦੂਜੇ ਸਿਹਤ ਪੇਸ਼ੇਵਰਾਂ ਕੋਲ ਜਾਣ ਦੀ ਸਲਾਹ ਦੇਣਾ
- ✓ ਬੇਨਤੀ ਕਰਨ 'ਤੇ ਰਿਕਾਰਡਾਂ ਨੂੰ ਸਮੇਂ ਸਿਰ ਟ੍ਰਾਂਸਫਰ ਕਰਨਾ
- ✓ ਕਾਲਜ ਆਫ ਕਾਇਰੋਪਰੈਕਟਰਸ ਆਫ ਓਨਟਾਰੀਓ (CCO) ਦੇ ਨਿਯਮਾਂ, ਇਲਾਜ ਦੀਆਂ ਮਿਆਰਾਂ, ਨੀਤੀਆਂ ਅਤੇ ਦਿਸ਼ਾ-ਨਿਰਦੇਸ਼ਾਂ ਦੀ ਪਾਲਣਾ ਕਰਨਾ (CCO ਦੀ ਵੈੱਬਸਾਈਟ www.cco.on.ca ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਪੇਸਟ ਕੀਤੀ ਗਈ ਹੈ)
- ✓ ਤੁਹਾਡੀ ਨਿੱਜੀ ਸਿਹਤ ਜਾਣਕਾਰੀ ਦੀ ਪਰਦੇਦਾਰੀ ਅਤੇ ਗੁਪਤਤਾ
- ✓ ਸਨਮਾਨਯੋਗ ਪੇਸ਼ੇਵਰ ਹੱਦਾਂ ਦੇ ਸੰਬੰਧ ਵਿੱਚ ਵਤੀਰਾ ਅਤੇ ਸਪਸ਼ਟਤਾ
- ✓ ਅਸਲੀ ਜਾਂ ਪਛਾਣੇ ਗਏ ਹਿੱਤਾਂ ਦੇ ਟਕਰਾਅ ਬਾਰੇ ਸਪਸ਼ਟੀਕਰਨ
- ✓ ਇਲਾਜ ਕਰਵਾਉਣ ਤੋਂ ਇਨਕਾਰ ਕਰਨ ਲਈ ਕਾਰਵਾਈ ਅਤੇ ਕਿਸੇ ਵੀ ਸਮੇਂ ਸਹਿਮਤੀ ਵਾਪਸ ਲੈਣਾ

ਤੁਹਾਡੀ ਜ਼ਿੰਮੇਵਾਰੀ ਹੈ ਕਿ ਤੁਸੀਂ ਆਪਣੇ ਕਾਇਰੋਪਰੈਕਟਰ ਨੂੰ ਹੇਠ ਲਿਖੀਆਂ ਚੀਜ਼ਾਂ ਪ੍ਰਦਾਨ ਕਰੋ...

- ✓ ਆਪਣੀ ਸਿਹਤ ਸੰਬੰਧੀ ਸਾਰੀ ਜਾਣਕਾਰੀ ਨੂੰ ਇਮਾਨਦਾਰੀ, ਸਟੀਕਤਾ ਅਤੇ ਪੂਰੀ ਤਰ੍ਹਾਂ ਦੱਸਣਾ
- ✓ ਦੇਖਭਾਲ ਦੇ ਸਾਰੇ ਪਹਿਲੂਆਂ ਦੇ ਸੰਬੰਧ ਵਿੱਚ ਉਪਯੋਗੀ ਫੀਡਬੈਕ (ਸਕਾਰਾਤਮਕ/ਨਕਾਰਾਤਮਕ) ਦੇਣਾ
- ✓ ਆਪਣੇ ਇਲਾਜ ਦੌਰਾਨ ਲਈ ਸਹਿਕਾਰੀ ਵਚਨਬੱਧਤਾ ਪ੍ਰਦਾਨ ਕਰਨਾ
- ✓ ਦਫ਼ਤਰ ਦੀਆਂ ਨੀਤੀਆਂ, ਪ੍ਰਕਿਰਿਆਵਾਂ ਅਤੇ ਫੀਸਾਂ ਦੀ ਪਾਲਣਾ ਕਰਨਾ
- ✓ ਦਫ਼ਤਰ ਦੇ ਮਾਹੌਲ, ਸਟਾਫ਼ ਅਤੇ ਹੋਰ ਮਰੀਜ਼ਾਂ ਦਾ ਆਦਰ ਅਤੇ ਸਤਿਕਾਰ ਕਰਨਾ
- ✓ ਬਿਲਕੁਲ ਨਵੀਂ ਸੰਪਰਕ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨਾ

CCO ਇੱਕ ਸਰਕਾਰੀ ਸੰਸਥਾ ਹੈ ਜਿਸ ਨੂੰ ਓਨਟਾਰੀਓ ਵਿੱਚ ਮੌਜੂਦਾ ਕਾਇਰੋਪਰੈਕਟਰਾਂ ਨੂੰ ਨਿਯੰਤ੍ਰਿਤ ਕਰਨ ਲਈ ਸੂਬੇ ਦੀ ਸਰਕਾਰ ਦੁਆਰਾ ਸਥਾਪਤ ਕੀਤਾ ਗਿਆ ਹੈ। ਓਨਟਾਰੀਓ ਵਿੱਚ ਇਲਾਜ ਪ੍ਰਦਾਨ ਕਰਨ ਵਾਲੇ ਹਰ ਕਾਇਰੋਪਰੈਕਟਰ ਲਈ ਜ਼ਰੂਰੀ ਹੈ ਕਿ ਉਹ CCO ਦਾ ਰਜਿਸਟਰਡ ਮੈਂਬਰ ਹੋਵੇ।

ਹੋਰ ਜਾਣਕਾਰੀ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ www.cco.on.ca 'ਤੇ ਜਾਓ।

STANDARD OF PRACTICE S-001

Chiropractic Scope of Practice

Quality Assurance Committee
Approved by Council: February 8, 2011
S-001 replaces S-010 and S-015, which were are
revoked on February 8, 2011
Amended: April 24, 2018

1279

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

INTENT

To provide guidance to members and the public about CCO's expectations concerning members as providers of chiropractic services to patients and as responders to general health-related questions from patients.

CCO recognizes that:

- One of the underlying principles of the *Regulated Health Professions Act, 1991 (RHPA)* is to permit the public to exercise freedom of choice of health professional within a range of safe options;
- Members are required to practise within the chiropractic scope of practice set out in the *Chiropractic Act, 1991*, in providing patient-centred care;
- Members use a variety of diagnostic and therapeutic procedures in providing chiropractic care to patients; and
- Members are primary health professionals who are frequently asked general health-related questions by patients, some of which relate to acts outside the chiropractic scope of practice (such as medication, surgery, and vaccination).

Definitions

For the purpose of this standard:

"controlled act" means any diagnostic or therapeutic procedure listed in section 27(2) of the *RHPA* that is authorized only to certain regulated health professionals in providing patient care

"public domain" means any diagnostic or therapeutic procedure other than those listed in section 27(2) of the *RHPA* that any regulated health professional may utilize in the course of providing patient care

DESCRIPTION OF STANDARD

Practising Within the Chiropractic Scope of Practice

All activities and services performed by members must relate to the chiropractic scope of practice and authorized acts as set out in the *Chiropractic Act, 1991*, as follows:

Chiropractic Scope of Practice

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

- (a) dysfunctions or disorders arising from the structures or functions of the spine and the effects of those dysfunctions or disorders on the nervous system; and
- (b) dysfunctions or disorders arising from the structures or functions of the joints.

Authorized Acts

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

1. Communicating a diagnosis identifying, as the cause of a person's symptoms,
2. **2**
 - i. A disorder arising from the structures or functions of the spine and their effects on the nervous system, or
 - ii. A disorder arising from the structures or functions of the joints of the extremities.
2. Moving the joints of the spine beyond a person's usual physiological range of motion using a fast, low amplitude thrust.
3. Putting a finger beyond the anal verge for the purpose of manipulating the tailbone.

Expectations of a Chiropractic Visit

CCO regulates the full range of chiropractic approaches and a member shall always practise within the chiropractic scope of practice. As such, a member shall perform the following, which is to be clearly and legibly reflected in the patient health record:

- a consultation related to the patient's presenting condition and/or goals;
- an assessment of chiropractic conditions related to the spine, nervous system and joints; and
- a diagnosis or clinical impression related to the chiropractic scope of practice, consistent with Standard of Practice S-008: Communicating a Diagnosis;
- recommendations for care, including possible referral to an appropriate health care provider if necessary; and
- obtaining of informed consent, consistent with Standard of Practice S-013: Consent

On each patient visit (as outlined and defined in G-013: Chiropractic Assessments), the member shall allow sufficient time to:

- provide relevant, safe, supportive and patient-centred quality care within the chiropractic scope of practice, and related to the patient's condition and goals;
- conduct outcome measures, assessment and reassessment of progress related to the patient's presenting condition and goals, as required (as outlined and defined in G-013: Chiropractic Assessments); and
- document legible and accurate, individualized and personalized notes capturing the unique aspects of that particular patient encounter (as outlined and defined in G-013: Chiropractic Assessments)

Diagnostic and Therapeutic Procedures

A member shall take reasonable steps to ensure that any proposed diagnostic or therapeutic procedure to be used for the benefit of a patient relates to the chiropractic scope of practice.

For a diagnostic or therapeutic procedure to be acceptable for clinical purposes, it must be taught in the core curriculum, post-graduate curriculum or continuing education division of an accredited educational institution.

In order to perform a diagnostic or therapeutic procedure, a member shall:

- achieve, maintain and be able to demonstrate clinical competency (e.g., examination, certification, or proof of training) in the diagnostic or therapeutic procedure; or
- be fulfilling the requirements to achieve clinical competency and have informed the patient that they are fulfilling the requirements to achieve clinical competency.

A member shall obtain the patient's consent to the use of the diagnostic or therapeutic procedure, consistent with Standard of Practice S-013: Consent, that is:

- fully informed;
- voluntarily given;
- related to the patient's condition and circumstances;
- not obtained through fraud or misrepresentation; and
- evidenced in a written form signed by the patient or otherwise documented in the patient health record.

- 4 If a proposed diagnostic or therapeutic procedure does not relate to the chiropractic scope of practice, a member should not use the diagnostic or therapeutic procedures in their professional capacity.

In providing patient care, a member may use adjunctive diagnostic and therapeutic procedures that are in the public domain. This includes, but is not limited to, providing nutritional counselling, prescribing orthotics, giving advice on lifestyle and exercise, providing therapeutic modalities, and other therapies.

A member is reminded that CCO has specifically prohibited the use of some diagnostic and therapeutic procedures including, but not limited to, dark field microscopy, hyperbaric oxygen therapy, pelvic and prostate examinations, and vega testing.

Responding to General Health-Related Questions

A member is restricted from treating or advising outside the chiropractic scope of practice by section 30 of the *RHPA* as follows:

Treatment, etc., where risk of harm

30 (1) No person, other than a member treating or advising within the scope of practice of his or her profession, shall treat or advise a person with respect to his or her health in circumstances in which it is reasonably foreseeable that serious bodily harm may result from the treatment or advice or from an omission from them. (specific, limited exemptions are referenced in section 30 of the *RHPA*)

Offences

- 40 (1) Every person who contravenes subsection ... 30 (1) is guilty of an offence and on conviction is liable,
- (a) for a first offence, to a fine of not more than \$25,000, or to imprisonment for a term of not more than one year, or both; and
 - (b) for a second or subsequent offence, to a fine of not more than \$50,000, or to imprisonment for a term of not more than one year, or both.

In responding to general health-related questions by patients that relate to controlled acts outside the chiropractic scope of practice (such as prescribing a drug as defined in the *Drug and Pharmacies Regulation Act, 1990*, performing surgery and administering vaccinations), a member shall:

- advise the patient that the performance of the act is outside the chiropractic scope of practice and the patient should consult with a health professional who has the act within his/her scope of practice;
- respond in a professional, accurate and balanced manner in the context of providing primary health care to the patient consistent with the chiropractic scope of practice; and
- encourage the patient to be an active participant in his/her own health care which allows the patient to make fully informed decisions concerning his/her health care.

Implications of Failure to Comply

A member is reminded that he/she may be the subject of an inquiry, complaint or report concerning the provision of chiropractic services or discussions related to general health-related questions from patients. The Inquiries, Complaints and Reports Committee (ICRC), composed of elected (chiropractor), appointed (public) and non-council (chiropractor) committee members will review any inquiry, complaint or report to determine the member's compliance with all relevant standards of practice including Standard of Practice S-001: Scope of Practice. In exercising its discretion, the ICRC may consider if:

- the diagnostic or therapeutic procedure related to the chiropractic scope of practice for the benefit of the patient;
- the member achieved, maintained and can demonstrate clinical competency in the diagnostic or therapeutic procedure; and
- the discussions with the patient relating to general health-related questions were consistent with this standard of practice.

LEGISLATIVE CONTEXT

In addition to the legislative provisions outlined above, members are reminded that the following are acts of professional misconduct under Ontario Regulation 852/93 (Professional Misconduct):

2. Contravening a standard of practice of the profession or failing to maintain the standard of practice expected of members of the profession.
12. Failing to reveal the nature of a remedy or treatment used by the member following a patient's request to do so.
- 6 13. Failing to advise a patient to consult with another health professional when the member knows or ought to know that,
 - the patient's condition is beyond the scope of practice and competence for the member;
 - the patient requires the care of another health professional;
 - or
 - the patient would be appropriately treated by another health professional.
14. Providing a diagnostic or therapeutic service that is not necessary.

**GUIDELINE
G-008**

Business Practices

ITEM 6.4.3

1285

Quality Assurance Committee
Approved by Council: November 29, 2007
Amended: February 26, 2013, April 26, 2017,
November 29, 2018

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

INTENT

To advise members of acceptable business practices in a clinical practice, including but not limited to: the disclosure of fees to the patient for the delivery of care and services, unit billing, billing arrangements as they relate to care or a plan of care delivered to the patient; and the billing of third-party payors.

OBJECTIVES

- To clarify for members the sections of the Professional Misconduct Regulation 852/93 concerning Business Practices.
- To ensure members provide accurate, complete information to patients regarding fees, unit billing, billing arrangements, including block fees and/or payment plans, as they relate to the delivery of care.
- To ensure members clearly communicate to patients their right to choose and/or refuse billing arrangements, block fees and/or payment plans and their right to opt out of such arrangements or plans at any time during care.
- To ensure members understand, comply with and communicate with patients about the policies and procedures for billing third-party payors.

DESCRIPTION OF GUIDELINE

Fees

Fees for chiropractic care must reflect the examination and care that is recommended, provided and documented in the patient health record.

When creating and implementing fees for service in clinical practice, members must adhere to the following conditions:

- fees must be for care that is diagnostically or therapeutically necessary;
- fees must be fair and reasonable;

- billing practices, as they relate to patient care, must be disclosed to patients in advance of any care. This includes, but is not limited to:
 - o the nature of the care or plan of care to be provided,
 - o who is delivering the care,
 - o if any care is to be delegated, assigned or referred
 - o the use of any adjunctive therapies and/or services,
 - o the sale of any products, and/or
 - o practices relating to billing third-party payors (see section on "Billing Third Party Payors");
- an account for professional services must be itemized, if:
 - o requested to do so by the patient or a person or agency who is to pay, in whole or in part, for the services, or
 - o if the account includes a fee for a product or device or a service other than care;
- a re-assessment, as set out in Standard of Practice S-002: Record Keeping, must:
 - o be conducted when clinically necessary and, in any event, no later than each 24th visit; and
 - o be sufficiently comprehensive for the member to:
 - evaluate the patient's current condition;
 - assess the effectiveness of the member's chiropractic care;
 - discuss with the patient, the patient's goals and expectations for his/her ongoing care; and
 - affirm or revise the member's plan of management for the patient.

Fees for Service as Provided

A member charging and collecting a fee for the service as provided must comply with the conditions as set out above.

2 Unit Billing

Unit billing refers to charging and invoicing a patient for each component of the service performed at a single visit, as opposed to charging and invoicing the patient for the whole visit. A member engaging in unit billing shall:

- comply with CCO regulations, standards of practice, policies and guidelines relating to business and billing practices; and
- ensure that the unit billing is fair and reasonable and be aware that charging a fee excessive to the service performed may constitute professional misconduct.

Billing Arrangements¹

A billing arrangement, which includes a block fee and/or payment plan (“billing arrangement”) is any fee arrangement where the patient is charged for multiple services and/or treatments at any time other than when the services and/or treatments are provided.

A member offering a billing arrangement must comply with the requirements of Regulation R-008: Professional Misconduct:

- i. the patient is given the option of paying for each service as it is provided,
- ii. a unit cost per service is specified,
- iii. the member agrees to refund to the patient the unspent portion of the block fee, calculated by reference to the number of services provided multiplied by the unit cost per service.

In offering a billing arrangement, a member must:

- consider the appropriateness of offering a billing arrangement to reflect that the plan of care, the objectives and planned outcomes of care, patient goals and requests, and patient comfort;
- discuss with the patient the appropriateness of a billing arrangement, including but not limited to, the nature of the treatment plan, the health care goals and objectives for the patient, the patient's comfort in agreement to a billing arrangement, the value and outcomes of the billing arrangement, and any billing or reimbursement from insurance companies or third party payors that would be affected by a billing arrangement;
- ensure that the patient is comfortable with and understands all aspects of the billing arrangement, including the right of the patient to pay for each services as it is provide and the right to opt out of the billing arrangement at any time and receive a refund for the unspent portion of the billing arrangement, calculated by reference to the number of services provided multiplied by the unit cost per service;
- not subject a patient to any undue pressure or duress to agree to a billing arrangement, or opt out of a billing arrangement;
- refrain from using any language that is or could be perceived as coercive or which suggests that without agreeing to a billing arrangement, services will be limited or reduced, or that quality of care provided may suffer;

- ensure there are protections for the patient to receive a refund for any unused portion of the billing arrangement in case of bankruptcy, death, dissolution of practice and other incidences which may interrupt a course of care; and
- respect a patient request to pay for each service as it is provided.

A member charging a billing arrangement must ensure that there is a signed, written agreement between the member and the patient, which includes the following provisions in which the member has:

- given the patient the option to pay for each service on a "pay per visit" basis;
- disclosed to the patient the regular unit cost per service and the unit cost per service established by the billing arrangement if the fees differ; and
- fully inform the patient of his/her right to opt out of a billing arrangement at any time during care, and the patient's right to a refund of any unspent portion of the billing arrangement, calculated by reference to the number of services provided multiplied by the billing arrangement unit cost per service.

A member shall not subject the patient to any undue pressure and/or duress when offering a billing arrangement.

Repayment of Unused Portion of Billing Arrangement

- A patient may choose to opt out of a billing arrangement at any time during care, even if an agreement has been previously signed.
 - A member shall not subject the patient to any undue pressure and/or duress when the patient chooses to opt out of a billing arrangement.
- 4
- A member must fully refund to the patient any unused portion of the billing arrangement calculated by multiplying the number of services provided by the established unit cost per service of the billing arrangement.
 - If a patient opts out of the billing arrangement, a member may not charge a patient any additional fees for any treatments or services that were discounted or complimentary as part of the billing arrangement. A refund must reference the unit cost per service, which may be complimentary or discounted, of the billing arrangement.

Example of Calculation of Refund of Unused Portion of Billing Arrangement

Service	Fee for Service	Billing Arrangement Fee
Chiropractic Treatment	20 treatments at \$50 per treatment = \$1000	20 treatments at \$45 per treatment = \$900
2 Re-evaluations	2 re-evaluations at \$75 per re-evaluation = \$150	2 re-evaluations at \$0 per re-evaluation = \$0
Cervical Traction	\$150	\$0
Radiographs	\$100	\$0
Total Cost	\$1400	\$900

In this example, a patient under the billing arrangement pays \$900 up front, and opts out of the billing arrangement after receiving 10 chiropractic treatments, 2 re-evaluations, cervical traction and radiographs.

Total amount of billing arrangement (\$900)

Services Received:

- Billing arrangement unit cost per service (\$45) x number of services received (10) = \$450
- 2 Re-evaluations, cervical traction and radiographs = \$0

Total Refund = \$900 (total amount of billing arrangement) - \$450 (spent portion of billing arrangement) = \$450 (unused portion of billing arrangement)

Billing Third-Party Payors

A member may not bill any third-party payor in excess of his/her usual regular fee billed to an uninsured patient for similar services.

The practice of having one fee for a patient and a different fee for a third-party payor, or various fees for different third-party payors (e.g., dependent upon the amount of coverage) is not permitted. There is an exemption to this restriction when a fee has been negotiated with a third-party payor such as the Workplace Safety and Insurance Board (WSIB), the Financial Services Commission of Ontario (FSCO) or a similar organization.

A member should have a discussion with a patient of the member's involvement with billing third-party payors to ensure the patient is fully aware of their own responsibilities regarding reimbursement from any third-party payor.

LEGISLATIVE CONTEXT

Regulation R-008: Professional Misconduct

1. The following are acts of professional misconduct for the purposes of clause 51(1)(c) of the Health Professions Procedural Code:

The Practice of the Profession and the Care of and Relationship with Patients

1. Contravening a standard of practice of the profession or failing to maintain the standard of practice expected of members of the profession.
11. Breaching an agreement with a patient relating to professional services for the patient or fees for such services
14. Providing a diagnostic or therapeutic service that is not necessary.

Business Practices

23. Submitting an account or charge for services the member knows is false or misleading.
24. Failing to disclose to a patient the fee for a service before the service is provided, including a fee not payable by the patient.
25. Charging a block fee unless,
 - i. the patient is given the option of paying for each service as it is provided,
 - ii a unit cost per service is specified,
 - iii. the member agrees to refund to the patient the unspent portion of the block fee, calculated by reference to the number of services provided.

-
26. Failing to itemize an account for professional services,
- i. if requested to do so by the patient or person or agency who is to pay, in whole or in part, for the services, or
 - ii. if the account includes a fee for a product or device or a service other than a treatment multiplied by the unit cost per service.²⁷
27. Selling any debt owed to the member for professional services. This does not include the use of credit cards to pay for professional services.

Miscellaneous Matters

28. Contravening the Act, the *Regulated Health Professions Act, 1991* or the regulations under either of those Acts.
29. Contravening a federal, provincial or territorial law, a municipal by-law or a by-law or rule of a hospital within the meaning of the *Public Hospitals Act*, if the contravention is relevant to the member's suitability to practise.
33. Engaging in conduct or performing an act that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, or unprofessional.

¹ A block fee is any fee where the patient is charged for multiple services and/or treatments at any time other than when the services and/or treatments are provided.

MENU ▾

British Columbia

Chiropractic treatment for children to face 'rigorous' review in B.C.

College says it wants analysis of scientific evidence for therapies involving patients of all ages



Bethany Lindsay - CBC News

Posted: March 05, 2019



The College of Chiropractors of B.C. is beginning a process to review the evidence for chiropractic treatment of patients of all ages, including children. (Shutterstock/Dmitry Naumov)

Read Comments 

The body that regulates chiropractors in B.C. is promising a thorough review of the scientific evidence about chiropractic treatments for children.

The move comes after the College of Chiropractors of B.C. received a complaint from a health-care professional about a chiropractor advertising therapies for kids, according to interim college registrar Richard Simpson.

ADVERTISEMENT



"There is a significant body of evidence concerning the benefits of chiropractic treatment for patients of all ages. Still, the CCBC is committed to evidence-informed practice, best practices and standards in marketing," Simpson wrote in an email.

"As such, the board has decided to proceed with a rigorous review and evaluation of research and evidence concerning this issue and other topics."

- **Halifax chiropractor gives up licence, admits to professional incompetence**

He added that the college is interested in establishing a review of the evidence for chiropractic therapies involving patients of all ages.

"The college has received a number of documents from citizens and registrants purporting to be acceptable evidence for one form of treatment or another. It is my view, even as a layperson, that most, if not all, of the documents would not meet the test of acceptable evidence," Simpson wrote.

1295

These reviews have not yet begun, and the college has not settled on a process for analyzing the current evidence. Simpson said it's possible the reviews will be part of a national process, which the college believes is "in the best interests of the profession."

'Zero evidence' supporting treatment of babies

The news comes as some chiropractors in other parts of the country are facing scrutiny over their treatment of babies, [including newborns](#).

In an interview with CBC, Bernie Garrett, a UBC nursing professor who studies deception in health care, described the college's proposed review of chiropractic treatment for children as "excellent news."

- **SECOND OPINION | Chiropractic critics being monitored by Ontario's College of Chiropractors**

"There's practically zero evidence of any benefits, particularly in infants," Garrett said. "If you ask any pediatrician or pediatrics society as well, they'll confirm that there is no indication for chiropractic in infants or in children, unless there's obviously some [spinal] issues."

According to a [position paper from the Canadian Pediatric Society](#), there have been no satisfactory studies of chiropractic treatments for back pain in children. Some studies have suggested that chiropractic manipulation of the neck can provide short-term relief of neck pain in children, but its efficacy hasn't been compared to other therapies, the paper says.

Garrett said he'd like to see chiropractic for infants banned in B.C., as well as strict guidelines for treatment of other children.

67 chiropractors under investigation

The college has already barred chiropractors from claiming to treat a long list of childhood conditions as part of its new efficacy claims policy. That policy, which came into effect last October, forbids chiropractors from making unscientific and unsupported claims about treating everything from Alzheimer's disease and cancer to autism, ear infections and ADHD.

1296

- **50 B.C. chiropractors refuse to remove misleading claims from websites, face possible discipline**

All practitioners were given until Nov. 1 to bring their advertising in line with the new policy or face investigation and potential discipline.

To date, 67 chiropractors have been investigated for possible violations of the policy, and 53 have consented to reprimands, agreed to pay fines and signed undertakings promising to follow the rules from now on. Another 13 have hired lawyers, and one has yet to respond.

1297

"Overall, I am satisfied that the vast majority of B.C.'s 1,200-plus chiropractors understand the importance of a clear, focused efficacy claims policy. For the handful of registrants who may not be in compliance, the college has been quick to identify them, communicated directly with them to discuss the issue, and forwarded concerns to the inquiry committee for consideration," Simpson said.

He said all the violations of policy were identified by the college, which has developed a scanning program that sweeps websites and social media for keywords. The college plans to continue updating the policy as it reviews scientific evidence about treatments.

Vancouver chiropractor Avtar Jassal resigned his position as vice-chair of the college board after he created a video in which he falsely suggested smoothies are more effective than vaccination at preventing the flu. (Facebook)

Unproven claims by B.C. chiropractors became a public issue last year, after CBC reported on a Facebook video created by then-vice-chair of the college board, Avtar Jassal. In the video, he falsely claimed that smoothies are more effective than vaccination at preventing influenza.

- **Vancouver chiropractor resigns from college board over anti-vaccine video**

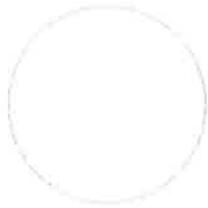
1298

That video violated the college's policy on immunization, which forbids chiropractors from providing any advice on vaccination issues. The video was removed from Facebook and Jassal resigned from the board following CBC's reporting.

On Monday, the college revealed that Jassal agreed to a reprimand and a fine last summer after an investigation by an independent inspector.

Is there more to this story? Reach the reporter by email at bethany.lindsay@cbc.ca

ABOUT THE AUTHOR



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Bethany Lindsay has more than a decade of experience in B.C. journalism, with a focus on the courts, health and social justice issues. She has also reported on human rights and crimes against humanity in Cambodia. Questions or news tips? Get in touch at bethany.lindsay@cbc.ca or on Twitter through [@bethanylindsay](https://twitter.com/bethanylindsay).

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POSITION STATEMENT

Chiropractic care for children: Controversies and issues

Posted: Feb 1 2002 | **Reaffirmed:** Feb 28 2018

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Paediatr Child Health 2002;7(2):85-9

The demand for alternative and complementary therapies is increasing. This patient-led trend creates new challenges for physicians because parents may already be integrating or considering the use of alternative therapies in the treatment of their children. Therefore, it is vital that physicians are knowledgeable about the various types and the most commonly used treatments of this kind. The present paper discusses chiropractic care for children, reviews the current literature and provides a practical approach for the physician whose paediatric patient is already using or is interested in using chiropractic.

General background

A history of chiropractic

Although spinal manipulation has been used as a treatment since the times of ancient Greece, chiropractic is a relatively recent discipline that was established in 1895. It evolved from 'energetic' healing traditions that were current at that time in an eclectic American medical practice. This practice evolved in an era when patients were seeking a drugless alternative to potentially toxic conventional drugs [1]. DD Palmer, an American magnetic healer, believed that diseases are often caused by subluxations of the vertebrae, which, in turn, lead to an interruption of nervous impulses; and that the correction of these subluxations allows the body to heal itself. This is still a central tenet of chiropractic.

In 1997, the Association of Chiropractic Colleges, representing 16 North American chiropractic colleges, reached a consensus that stated:

Chiropractic is concerned with the preservation and restoration of health, and focuses particular attention on the subluxation. A subluxation is a complex of functional and or pathological articular changes that compromise neural integrity and may influence organ system function and general health [2].

In North America, chiropractic is the most established discipline considered to be alternative by practitioners of conventional medicine [3]. Chiropractors in the United States have become the third largest group of health care professionals (after physicians and dentists) who have primary contact with patients [4]. Approximately 5000 chiropractors and 56,000 physicians are licensed in Canada (personal communication, Canadian Medical Association [Betty Green, Southam Group, November 9, 2000]) [5]. In the United States, there are 70,000 chiropractors and 778,000 physicians [6]. Every year, there are over 4000 chiropractic graduates from 30 educational institutions, and with increasing enrolment, the number of American chiropractors is projected to rise to 145,000 by 2015 [7].

Chiropractic philosophy

During the evolution of chiropractic, different schools of thought and practice have emerged. There is a continuing debate both within and outside the chiropractic profession about whether chiropractic should be considered to be a nonsurgical musculoskeletal discipline or a broadly based alternative to conventional medicine [8]. Chiropractors agree, however, that the primary purpose of chiropractic is to improve health by adjusting the spine and using other natural means to stimulate the body's innate recuperative power by way of the nervous system [9]. They also believe that a musculoskeletal problem must be identified before treatment is provided [10].

One framework that helps to clarify the disparate chiropractic philosophies has been proposed by Biggs et al [11]. The conservative chiropractic philosophy emphasizes the scientific validation of chiropractic concepts and methods. In general, chiropractors who adhere to this philosophy have a narrow scope of practice that is restricted to treating musculoskeletal conditions. They are in the minority. In the 1997 Canadian survey conducted by Biggs et al [11], only 19% of respondents held the conservative viewpoint. The liberal philosophy accepts the perspective that chiropractic is not limited to treating only musculoskeletal conditions but encompasses a broad range of practices. The Biggs et al survey [11] found that 22% of respondents shared this viewpoint. However, a 59% majority were moderates (ie, they positioned themselves between the two poles). Irrespective of a particular philosophy, 74% of chiropractors believed that they should not be limited to treating only musculoskeletal conditions. A recent survey of chiropractors in the United States confirmed that most respondents considered chiropractic to be a complete system of healing rather than therapeutic techniques [12]. Biggs et al [11] also revealed that there was no uniform distribution of opinions across Canada. For example, Quebec had the highest proportion of chiropractors espousing a liberal philosophy, whereas Saskatchewan had the most conservative practitioners, with the practitioners in the other provinces situated between the two philosophies.

Chiropractic and its use in children

Chiropractic use in Canadian adults is strongly correlated with place of residence [13]. For provinces in which adult chiropractic is used frequently, treatment of children younger than 18 years of age is also more common. The exception is Quebec, where chiropractic is not used as often as in the western provinces, but the treatment of children younger than age 18 years is more common than in any other region [13][14].

A cross-sectional survey of 1200 Canadian chiropractors revealed that almost all respondents treated patients younger than 18 years of age [14]. Forty-five per cent of respondents indicated that they had received formal postgraduate paediatric chiropractic training via seminars or courses. Seventy-one per cent of chiropractors stated that they had received informal training in the care of children through reading journals, attending conferences or personal communication with colleagues. Most respondents desired more training.

A Boston study [15] of chiropractic care used by children found that it is often inconsistent with recommended medical guidelines. Chiropractors may give advice on diet, immunizations and general health, and may also sell herbal remedies and homeopathic preparations [12][15][16].

Physicians may assume that patients use chiropractic mainly for musculoskeletal problems and that treatment for other conditions is rare. However, a recent survey of chiropractors in the United States, Canada and Australia found that 10% of the chief complaints presented to a chiropractor were nonmusculoskeletal in nature [16]. The American Chiropractic Association quotes similar figures [17]. In children, chiropractic is also commonly used as primary or adjunctive therapy for nonmusculoskeletal conditions such as colic, enuresis, asthma, recurrent otitis media, cancer and illness prevention [14][18][19]. According to a study done in Alberta [10] on chiropractors' beliefs, most respondents believed that they should play a role – albeit a role secondary to physicians – in the treatment of nonmusculoskeletal health problems in children. A Canada-wide survey [14] of chiropractic care of children younger than age 18 years found that, overall, musculoskeletal conditions accounted for 40% of visits, prevention 24%, headaches 7%, otitis media 5% and various other conditions 23%. Prevention accounted for a large proportion of visits for children younger than age four years, with treatment for musculoskeletal conditions increasing with age. Chiropractors in Quebec were the most likely to provide preventive care and those in Atlantic Canada were the least likely to do so. Spinal manipulation was, by far, the most common form of therapy provided, followed by exercises, soft tissue treatment, and postural and nutritional counselling.

Controversies

Scientific evidence

Physicians question whether chiropractic is effective in treating the variety of conditions for which it is used. Koes et al [20], after conducting a review of systematic randomized clinical trials and taking into account methodological rigour, found insufficient evidence to prove that spinal manipulation is useful for treating either acute or chronic low back pain. Other studies, however, suggest that manipulation may be effective for acute low back pain in adults, but its effectiveness has not been proven in patients with chronic symptoms [21]-[23]. No studies have been published on chiropractic treatment of back pain in a paediatric population.

Systematic reviews of the literature and expert panels suggest that cervical manipulation or mobilization may provide some short term relief for certain individuals with subacute or chronic neck pain [24][25]. However, neither the efficacy of manipulation relative to that of other therapies nor the cost effectiveness has been established for these types of problems [4][26]. The evidence to support manipulation for conditions such as migraine is even less compelling [26]. Once again, there are no specific, well-documented data for the paediatric age group.

One of the few studies to be published in the medical literature on chiropractic therapy in children was conducted by Balon et al [27] and involved children with stable asthma who were treated with active or simulated chiropractic as an adjunct to medical therapy. The researchers did not find any improvement in the symptoms of asthma, pulmonary function tests or quality of life between the two groups. The authors state that "In children with mild or moderate asthma the addition of chiropractic spinal manipulation to usual medical care provided no benefit" [27]. A recent review of randomized trials of manual therapy for asthma in both adults and children confirmed that there is insufficient evidence to support the use of manual therapy in asthma [28].

Some chiropractors do not believe that controlled clinical trials are the best way to validate their methods [11]. Anecdotal evidence may be thought to be sufficient proof of efficacy. As well, the amount of research conducted in chiropractic institutions is small compared with medical establishments [29]. Poorly designed trials and the lack of reproducibility pose other problems [30]. To address some of these issues, agencies that promote chiropractic care research have been established and include the Consortial Center for Chiropractic Research (established in 1998 in the United States), the Canadian Chiropractic Association (CCA) and the Canadian Memorial Chiropractic College [26], <<http://www.cmcc.ca/> (<http://www.cmcc.ca/>)>).

Another concern identified by physicians is the wide variety of paediatric conditions treated by chiropractic. Colic is one such example. Although a self-limiting condition, colic causes a lot of distress for parents who may seek the help of a chiropractor to treat their infant. In a recent study [31] on the treatment of colic by using chiropractic, the authors conducted a randomized controlled trial that compared drug therapy (dicyclomine hydrochloride) with spinal manipulation and found improvement with manipulation. Unfortunately, despite adhering to a sound methodology, the two study groups could not be compared because treatment was not blind, and the chiropractor-treated group had more interactions between chiropractors and the parents and baby during the treatment sessions [30]. A collaborative study performed by paediatricians and a chiropractor of 86 infants in a randomized, blinded and placebo controlled trial of colic treated by spinal manipulation found that chiropractic manipulation was no more effective than placebo [32].

The ability to adequately define and, subsequently, to evaluate improvement in several paediatric illnesses is problematic for physicians and even more problematic for chiropractors who do not have equivalent training in medical diagnosis [33].

Chiropractors and immunizations

Chiropractors may also give advice on immunizations. A survey [34] of attitudes toward vaccination among American chiropractors found that one-third of 117 respondents (36% response rate) believed that there was no scientific proof that immunization prevents disease, that immunization has not

substantially changed the incidence of any major infectious disease and that immunizations cause more disease than they prevent. The official policy of the American Chiropractic Association states that "...the use of vaccines is not without risk..." and, therefore, it supports the conscience clause in compulsory vaccination laws [35]. The CCA is more in line with the prevailing medical opinion, and states:

The CCA accepts vaccination as a cost-effective and clinically efficient public health preventive procedure for certain viral and microbial diseases, as demonstrated by the scientific community. [36]

However, not all chiropractors agree, and some may be influenced by the free distribution of chiropractic newsletters that sometimes present erroneous antivaccination information. A complete discussion on chiropractic and immunization can be found in a recent article in Pediatrics [29].

The safety of chiropractic in paediatrics

In adults, after chiropractic manipulation, minor complications, such as mild pain or discomfort, slight headache or fatigue, are quite common, but are usually transient [21][37]. However, several reports have been published on major neurological complications in adults resulting from cervical manipulation. These complications consist primarily of vertebrobasilar accidents that occur, particularly after cervical rotation to the upper neck is performed [38]-[40]. The published incidence is low; estimates place the risk of injuries due to cervical manipulation in the order of one to four cases per million cervical manipulations [39][41]. These figures are considered to be conservative [38][42][43]. Part of the reason may be the understandable reluctance of therapists involved in neck manipulations to report adverse effects and the lack of awareness of vertebrobasilar accidents manifesting as other neurological symptoms such as acute neck pain [44][45]. A recent Canadian study [5] reviewed malpractice claims for stroke following chiropractic manipulation in adults, and concluded that the risk is only one in 5.85 million manipulations. However, the use of malpractice claims is unlikely to lead to an accurate estimate of the risk of stroke [26].

The Canadian Stroke Consortium is collecting detailed information on cases of dissection of the cervical arteries, which is the most common cause of stroke in patients aged 45 years or younger [44][45]. About 25% of all traumatic dissections were associated with neck manipulation [45]. None of the patients were younger than 18 years of age. Another recent study that was conducted in Ontario and involved adults younger than 45 years of age (no lower age limit is mentioned), found that patients with vertebrobasilar ischemia are five times more likely than control subjects to have visited a chiropractor within a week of the event [46]. Unfortunately, the practitioner cannot reliably assess the risk for any particular patient undergoing manipulation either by using clinical risk factors or by premanipulative positional testing [24][46][47]. In children, there has been one case report of vertebrobasilar occlusion in a seven-year-old following gymnastics and repeated chiropractic manipulations of the cervical spine [48]. Because chiropractors treat headache and neck pain in children and youth, a history of neck manipulation should be ascertained in any paediatric patient presenting with signs of stroke.

Reports of other paediatric complications are few [49][50]. Of greater concern is the possibility that chiropractors may attempt to treat acute paediatric conditions, leading to a delay in appropriate medical therapy or, less commonly, the refusal of families to seek conventional treatment [15][51].

Chiropractic: Issues for the physician

Some chiropractors actively promote themselves as primary health care providers and encourage spinal manipulation as a way to maintain wellness [9][52]. They may advise that birth is a traumatic event for the spine and may be a primary cause of illness in children, and, therefore, recommend chiropractic realignment for the newborn infant [35]. Paediatric treatment may be offered initially without cost, when parents visit a chiropractor for themselves. Although parents use alternative medicine for a variety of reasons, they may consult a chiropractor because of word of mouth referrals, fear of side effects of conventional treatments, willingness to try anything to help their child and the presence of a chronic illness [18][19][53].

Although families may use chiropractic for their children, many will not spontaneously disclose this information to their physician. In a study [18] conducted in a Montreal, Quebec paediatric outpatient department, less than 50% of parents told their doctor about using alternative therapies, and similar results have been described in other paediatric populations [53][54]. This reluctance to disclose information may be due, in part, to the parents' expectation of a negative reaction from their doctor. The basis for obtaining and maintaining good communication is a nonjudgmental attitude on the part of the physician. Parents will often welcome the opportunity to share their opinions with their physician, provided that the dialogue is conducted in a respectful manner.

The physician should routinely ask families about complementary and alternative therapies or products that their child may be using. When the parents disclose that they have been taking the child to a chiropractor, one should inquire whether neck manipulations or forceful thrusts have been used, and if herbal or homeopathic preparations have been given. It is important to know the conditions for which the parent has used chiropractic for the child, the frequency of visits and the motivation for seeking chiropractic care. The parents' and, if age-appropriate, the child's opinion about the perceived benefit of the treatment should be sought.

All questions arising about the risks and benefits of immunization must always be discussed. If it is established that a chiropractor has negatively influenced a decision, it can then be pointed out that the CCA accepts and endorses vaccination [36].

On occasion, while receiving chiropractic care, a child's conventional medical treatment may become disrupted, either from the parent's own desire or based on the advice of a chiropractor. In this situation, a full inquiry into parental motives for this decision needs to be undertaken, their concerns addressed and appropriate information given about the child's condition.

Parents may at times request radiographic examinations that are suggested by their chiropractor. This issue is very contentious. For example, the College of Alberta Radiologists in 1998 passed a resolution that no longer endorsed x-rays for children that were prescribed by a chiropractor [55]. Parents should be made aware that there is a lack of substantiated evidence for the theory of subluxated vertebrae as the causality for illness in children, and x-rays taken for this purpose expose the child to unnecessary radiation [56].

Conclusions

Chiropractic treatment for children and adolescents is not uncommon. Open and honest discussions with families using or planning to use chiropractic for their children will, hopefully, bring about a rational use of this treatment in selected musculoskeletal conditions for which there is proof of efficacy, and enable parents to make informed choices about this form of therapy. Further, well-designed studies are needed to evaluate the chiropractic belief that musculoskeletal dysfunctions can be located and treated in children with nonmusculoskeletal conditions [10]. Ideally, collaborative evidence-based research into chiropractic care for diverse paediatric conditions should define those patients best suited for chiropractic therapy.

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Disclaimer: The recommendations in this position statement do not indicate an exclusive course of treatment or procedure to be followed. Variations, taking into account individual circumstances, may be appropriate. Internet addresses are current at time of publication.

Last updated: **May 8 2018**

Tuesday, March 5, 2019 - 14:11 [News Staff](#)



Nurse Says there is Practically Zero Evidence for Chiropractic - Especially in Infants

In what has to be one of the most ridiculous anti-chiropractic and ignorant statements uttered since Wilk v. AMA, a **nurse at the University of British Columbia** stated in regards to chiropractic that:

"There's practically zero evidence of any benefits, particularly in infants"

The false statements were made in another chiropractic hit piece written by "journalist" Bethany Lindsay in CBC News. Lindsay has become well known for her disdain and ignorance of chiropractic leaving a trail of misinformation in her articles.

Garrett, a nurse who teaches at the University of British Columbia, went on to state that **". . . he'd like to see chiropractic for infants banned in B.C., as well as strict guidelines for treatment of other children."**

Garrett fashions himself as an "expert" in alternative health care deception. [CLICK HERE to see how the school even promotes him as a media expert on their website.](#)

The article by Lindsay reviews the current status of the Witch Hunt going on in Canada against chiropractors who practice in a salutogenic model.

[CLICK HERE for the history of attacks in Canada](#)

Some chiropractic regulatory boards in Canada have redefined evidence informed practice in such a way that virtually all chiropractic care beyond cracking backs for stuck joints is off limits. In fact, were the same guidelines applied to the medical profession, all health care would come to a grinding halt. That's how ridiculous this is.

1313

According to the story 67 chiropractors have been brought under investigation following a "sweep" of websites **using a scanning program that sweeps websites and social media for keywords** the Board doesn't like.

Hello, George Orwell?

53 of the chiropractors caught up in the "sweep" ". . . **have consented to reprimands, agreed to pay fines and signed undertakings promising to follow the rules from now on**" according to Lindsay.

The good news is that another 13 have hired lawyers. One has yet to respond.

The events in Canada mirror what has already taken place in the United Kingdom and Australia and is part of a movement that includes organizations such as the American Chiropractic Association in the United States where leaders have called for the "**elimination**" of chiropractors who manage vertebral subluxation while they push for expansion of chiropractic scope to include drugs, injections and primary health care.

[Unfortunately, many chiropractic schools and organizations that align with conservative chiropractic have endorsed the ACA's agenda, CLICK HERE for more on that story.](#)

The chiropractors, organizations and schools supporting these moves have made unlikely allies of the media.

None of it is based on the scientific evidence or the standards of care that actually support the management of vertebral subluxation in a salutogenic model.

One has to wonder how much of an expert Garrett is when he can't seem to find what is readily available to anyone.





ITEM 7.3

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Manitoba

Lawsuit alleges Manitoba physicians college broke agreement to 'refrain from criticisms' of chiropractors



Chiropractors association, College of Physicians and Surgeons had 2003 agreement to work together, suit says

Holly Caruk · CBC News · Posted: Apr 11, 2019 5:00 AM CT | Last Updated: April 11



The Manitoba Chiropractors Association is suing the College of Physicians and Surgeons of Manitoba over comments made about spinal procedures. Those comments violate an agreement made 16 years ago, the association alleges. (Shutterstock)

1315

Manitoba's chiropractors are suing the regulatory body of the province's doctors over comments about a spinal procedure — comments the association says are offside, inaccurate and violate a longstanding agreement to work together.

The Manitoba Chiropractors Association filed a statement of claim with the province's Court of Queen's Bench last week against the College of Physicians and Surgeons of Manitoba.

The suit hinges on an agreement made between the two organizations in March 2003, following previous defamation suits in 1997 and 1998.

"The agreement of 2003 accepted the legitimacy of the practice of chiropractic and agreed never again to take a contrary position," the association claims in its suit.

The agreement requires the two organizations "to enter into co-educational activities and to refrain from criticisms by each institution of the other," according to the statement of claim.

The association says a 2016 letter, written by College of Physicians and Surgeons registrar Dr. Anna Ziomek to the Manitoba Health Professions Advisory Council — which advises the health minister on the regulation of Manitoba's health professions — violates that agreement.

Ziomek's comments to the council sought to challenge the legitimacy of chiropractic care, the association's suit says.

Comments 'entirely offside'

A portion of Ziomek's letter is quoted in the suit.

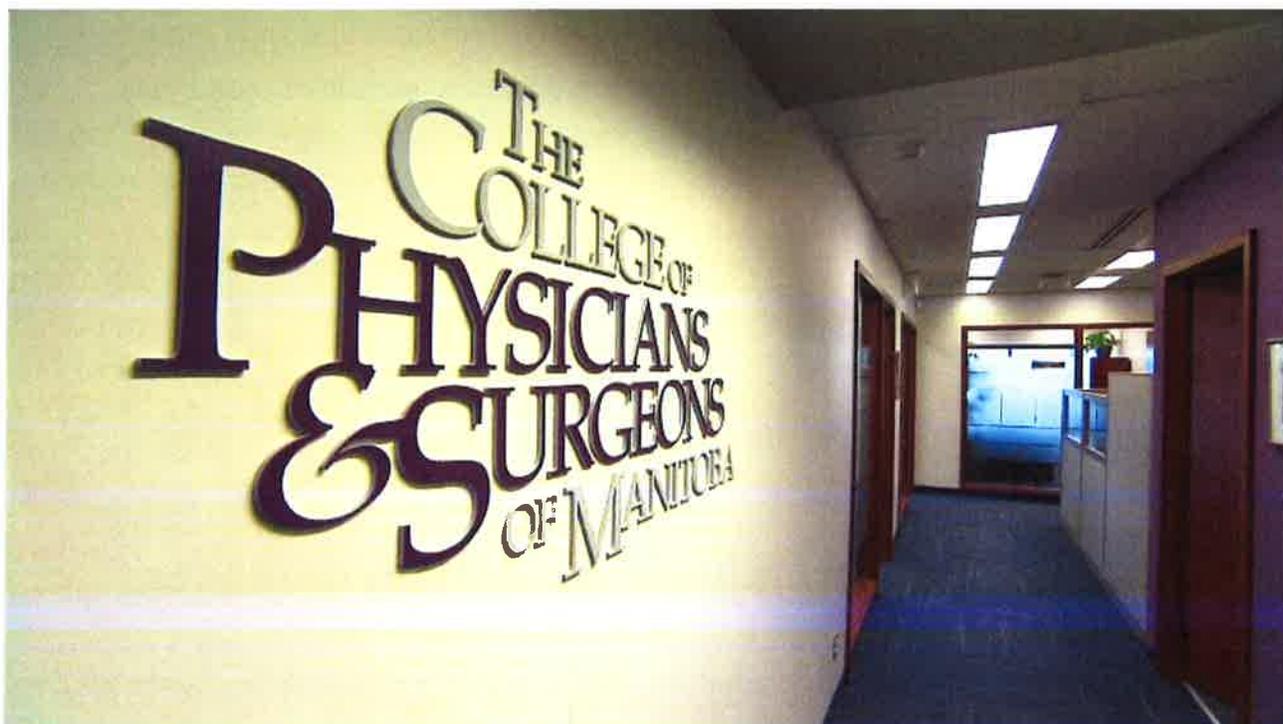
In it, she raises concerns about a chiropractic treatment. The portion of the letter quoted in the suit doesn't specify which treatment Ziomek was referring to.

The college told CBC News it could not comment on the lawsuit, but indicated the letter was in relation to a report on high-neck manipulation prepared for the province's health minister.

- **Chiropractic neck manipulations risk to public, says report**

"The resulting clinical conditions [from the treatment] can be quite serious and life threatening," the portion of the letter quoted in the lawsuit says.

Ziomek lists a variety of adverse effects from the treatment, including tearing of arteries which can lead to strokes, "as well as lesser adverse effects such as tiredness, dizziness, nausea, ringing in the ears, etc."



The college wouldn't comment on the lawsuit because it is before the courts, but said the agreement between it and the Manitoba Chiropractors Association is confidential. (CBC)

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The suit also quotes part of the letter that expresses the college's reservations about an association proposal that would see spinal manipulation procedures reserved for chiropractors.

"The [college] believes the onus should be on the Chiropractors Association to demonstrate scientifically the safety and efficacy of this particular treatment," the letter said, according to the statement of claim.

"The onus should be on the chiropractors to approach all procedures with the same scientific rigor as is required for medical treatments ... in order to ensure patient safety, especially when the consequences of the risks are so profound and include quadriplegia and death," the letter is quoted as saying.

- **CBC INVESTIGATES** **Manitoba chiropractors need proactive oversight over members, says health lawyer**

The suit calls those comments "entirely offside" and "both inaccurate and more fundamentally, a complete violation and repudiation and retraction of the [2003] agreement."

The statement of claim said chiropractic practice is legislated by the province and is "scientifically accepted and established."

None of the allegations in the lawsuit have been proven in court.

Suit asks for enforcement of agreement, damages

The statement of claim said that when the association became aware of the letter, a meeting was held with Ziomek in October 2018 — nearly two years after the letter was written.

The association says Ziomek took issue with the fact the letter was made public, because it was intended to be confidential, but that she refused to withdraw the remarks.

It's asking the court to force the college to comply with the agreement, and to award financial damages.

The college said the memorandum of understanding between the two groups is confidential. However, the suit includes [a joint statement from the college and the association](#), which outlines the objectives of a liaison committee between the two organizations.

The two groups have [been at odds with each other](#) over regulation and oversight, as well as some recent claims by chiropractors that the practice can treat autism, Alzheimer's disease, and some forms of cancer.

- **CBC INVESTIGATES [Publicly funded chiropractic care should have strict limits, leaked report says](#)**

The two professional bodies have agreed "to establish a collaborative, co-educational relationship for the betterment of both professions and their patients," according to the chiropractors association, which said it wouldn't comment further while the matter is before the courts.

The 2003 agreement, it alleges in its suit, required the liaison committee to meet once a year to discuss issues of concern, with an objective of furthering education between the groups.

The suit claims that an agreement to work on continued education between the two bodies "has become entirely ignored" by the college.

- *Have a story idea or tip? Email holly.caruk@cbc.ca.*

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Manitoba Chiropractors Association lawsuit:

To print the document, click the "Original Document" link to open the original PDF. At this time it is not possible to print the document with annotations.

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A professor at UQTR multiplies the anti-vaccine remarks



PHOTOMONTAGE THE PRESS



[Philippe Mercure](#)

The Press

As New York City tries to stem a measles epidemic and Canada's public health authorities say they want to take action against the anti-vaccine movement, a professor of biochemistry at the Université du Québec à Trois-Rivières, Christian Linard, multiplies the remarks against the vaccination on his personal Facebook page. A situation denounced by several stakeholders.

"Irresponsible" publications

Vaccination is linked to autism. It has already been used to sterilize populations in Africa. It represents an operation "irreversible, dangerous and not studied". While the World Health Organization views mistrust of vaccines as one of the top 10

threats this year, a professor at the University of Quebec in Trois-Rivières has been making negative comments about vaccination on his personal Facebook page.

Between March 14 and April 11, Christian Linard, Professor of Clinical Biochemistry attached to the Department of Chiropractic, published or shared 17 comments or studies that address the issue of the alleged dangers of vaccines, question their effectiveness or advocate free choice of the population in the face of vaccination. No positive comments about the vaccines were relayed during this period. In fact, *La Presse* found none in all of Linard's Facebook publications.

These publications raise the concern of immunology experts consulted by *La Presse*.

"It's irresponsible of him to relay only the articles that show that the vaccines are terrible. We know that vaccines save lives, it's indisputable," said Dr. Brian Ward, professor in the Department of Medicine and Vaccine Expert at McGill University. Dr. Ward believes "unacceptable" that Christian Linard is a professor at a Quebec university.

"He must lose his job," he says.

"This is a position that is neither nuanced nor balanced," also denounces Caroline Quach, pediatrician and microbiologist-infectiologist CHU Sainte-Justine and Professor at the University of Montreal, after reading the publications of Christian Linard on Facebook.

"Like any position that shows only one side of the coin, it's problematic - especially when people have a posture like a teaching position," says Dr. Quach.

"We have a responsibility to the community for the messages we receive."

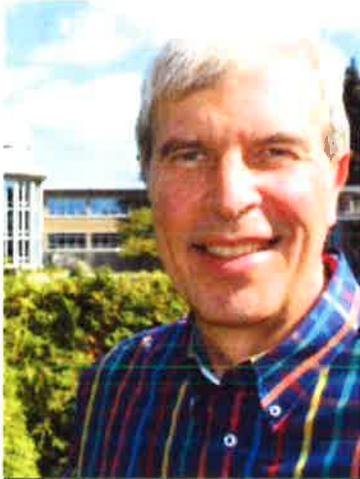
- Dr. Caroline Quach, pediatrician and microbiologist-infectiologist

Around the world, mistrust of vaccines causes headaches for public health authorities. The World Health Organization (WHO) reports that measles cases have increased by 30% worldwide since 2016, including in several countries where the disease was eradicated or was in the process of being eradicated. Several factors are involved, but the "false information" circulating on vaccines is being blamed by WHO.

New York City is currently fighting a measles epidemic. Yesterday, in *La Presse*, Canada's Chief Public Health Officer, Dr. Theresa Tam, affirmed her desire to act "quickly and better" to respond to anti-vaccine groups.

Christian Linard, however, defends himself to be "anti-vaccines".

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Christian Linard, professor of clinical biochemistry
PHOTO FROM THE UQTR WEBSITE

"What I'm trying to do is turn people on so they think. And, as a precautionary principle, say: you have to be careful. "

- Christian Linard

It does not give credibility to WHO's warnings that misinformation about vaccines puts people at risk.

"If you look at the heads of the WHO, those on the board, many come from the pharmaceutical industry," he says. Christian Linard also said he doubted that the recent measles outbreaks were due to a drop in vaccination, saying instead that they were due to a deficient vitamin A diet. "I am studying this," he said. he.

Legitimate questions

Brian Ward of McGill University agrees that it is

legitimate to raise scientific questions about vaccination.

"I agree that everything is not white or black. There are gray regions. There are real important questions that need to be answered," he says.

Professor Linard relays in particular on his Facebook page studies on what are called the "non-specific effects" of vaccines. This new field of study seems to show that vaccines are more complex than previously thought and that they can influence, positively or negatively, how the body defends itself against other diseases or pathogens for which the vaccine was not designed (see other tab).

Brian Ward, however, denounces the fact that Christian Linard reports only the negative effects noted by these studies, without ever mentioning the positive effects - nor, especially, the immense benefits of vaccines in general.

"When we talk about vaccination, it's a lot, a lot more white than black. "

- Dr. Brian Ward

Dr. Caroline Quach recalls that the decision to be vaccinated must go beyond individual considerations.

"The problem is that people look at everything from an individual point of view - what is good for my child, regardless of the rest of the population," she says.

Sterilization of women?

Dr. Ward is particularly concerned that Professor Linard is relaying on Facebook a thesis that the World Health Organization (WHO) has attempted to sterilize 2.3 million women in Kenya under the guise of a vaccination campaign against tetanus.



screenshots taken from Christian Linard's Facebook page, anti-vaccine professor UQTR
SCREENSHOT

"Vaccines and crimes against humanity! Vaccinate to eliminate some populations = Eugenics," wrote Christian Linard on Facebook on March 14th.

WHO and UNICEF have vigorously denied these rumors by Kenyan Catholic organizations, which have also been dismantled by many fact-finders.

"That's when the gentleman falls into ridicule," said Dr. Ward.

"When we start saying that vaccines are an effort to sterilize or control populations, we really fall into the dark. "

- Dr. Brian Ward

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"There is eugenics in many African countries, it has been demonstrated. It was published and it was not contradicted. So I'm suspicious. I say to myself: one can vaccinate me, but one can very well put a product in this vaccine which will harm me, "reiterated Professor Linard at *La Presse* .

"Academic Freedom"

La Presse told Christian Linard about Facebook, the University of Quebec at Trois-Rivières said it did not intend to act.

"In communication policy, according to the principle of academic freedom, one does not study the personal or professional accounts of professors. That means that what teachers publish on their Facebook, Instagram or other account is their responsibility, "says Yvon Laplante, Director of Communications at UQTR.

Jean-Marie Lafortune, president of the Quebec Federation of University Teachers, confirms that there are few tools to intervene in this type of situation. However, he believes that Christian Linard holds "a statement that does not reflect the responsibility of scientists in society."

"Academic freedom is the ability to say truths that can offend economic, political, religious or other powers, but that must be based on an honest search for the truth," he says. He believes that by posting his title of professor at UQTR on his personal Facebook page, Christian Linard "maintains the confusion of the genres".

"He claims to be a science, a university institution, and it's supposedly from the top of that that we should believe it," says Mr. Lafortune. We are also dealing with someone who is very close to the point. If a professor of art history tells us that the budget does not look good, we can take it lightly. But here, it sows even more confusion, because this person is from sciences that have yet demonstrated the relevance of vaccination. "

Christian Linard's allegations under the microscope

On his Facebook page and in an interview with *La Presse* , Professor UQTR Christian Linard relayed many theories and studies that question the safety and effectiveness of vaccines. The point on some of them.

Links between vaccines and autism

This old controversy stems from the infamous study by researcher Andrew Wakefield, published in *The Lancet* in 1998, which linked autism to the MMR (rubella-measles-mumps) vaccine. The rest of the story is known: it was discovered that the study contained errors and that the researcher was in a conflict of interest, and the publication was withdrawn.

Christian Linard relays another study that claims to establish an association between vaccines and autism. The study is signed by Gayle DeLong, a finance professor who has previously been associated with the SafeMinds anti-vaccine group. "It's purely correlation [unlike a cause-and-effect relationship] and statistical analysis does not even work," says microbiologist-infectiologist Caroline Quach, who reviewed the study.



Professor Christian Linard multiplies anti-vaccine pronouncements on his personal Facebook page.

SCREENSHOT

Many other studies have concluded that there is no link between vaccines and autism. In 2018, a large meta-analysis of 10 studies with more than 1.25 million children confirmed this lack of linkage.

Eradication of infectious diseases

In an interview with *La Presse* , Christian Linard says that it is not thanks to vaccines that several infectious diseases like polio or measles have been virtually eradicated in Western countries.

"It's not vaccines that have reduced infectious diseases. The incidence of major illnesses decreased well before the emergence of vaccines. Why ? Because of sanitary measures.

[...] In some cases, vaccination has even led to an increase in incidence for a certain period of time, "he told *La Presse* .

"Hygiene, nutrition and modern medicine have clearly helped to reduce the incidence and severity of many infectious diseases. But denying that vaccines played a major role is Trumpian logic at its worst. "

- *Dr. Brian Ward of McGill University*

"If today a child with measles coughs near you and you have not been vaccinated, you will get measles and it will be very serious - 30% of hospitalization rates in North America at home. adults, and it's even higher in children. And it does not matter if your home is clean or you have taken your vitamins, "continues ^{Dr.} Ward.

Increase in mortality

Christian Linard also relays on Facebook and mentioned in an interview studies that show an increase in infant mortality after vaccination in developing countries, including a study conducted in Guinea-Bissau after the administration of the diphtheria-tetanus vaccine. whooping cough

This serious study touches on the so-called "non-specific effects" of vaccines. New discoveries tend to show that a vaccine has effects that go beyond the disease for which it was designed. By modifying our immune system, the vaccine would affect our protection, positively or negatively, against other viruses and pathogens. The mechanisms of these effects are still poorly understood.

It should be noted that the majority of studies on these non-specific effects have been conducted in developing countries, where people's immune systems are much more in demand. The pioneer in this field is Peter Aaby, a Danish researcher working in Guinea-Bissau.

"Considering the enormous effect that some vaccines have had in developing countries, I find it sad to see people in rich countries developing mistrust of all vaccines," Aaby said in a statement. e-mail exchange with *La Presse* . That said, I find it even more sad that public health authorities have developed a religious belief that all vaccines are safe, as this evidence does not exist. "

"Vaccinated people have a huge advantage over unvaccinated people," says ^{Dr.} Brian Ward of McGill, who is following this work closely. Are vaccination schedules ideal? Can we eliminate these subtle effects with a different schedule? These studies are in progress. "



Twitter

The list: -1: list; the box: 219: box; tpl: html.tpl: file
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Manual therapy for the pediatric population: a systematic review



Carol Parnell Prevost¹, Brian Gleberzon², Beth Carleo¹, Kristian Anderson³, Morgan Cark¹ and Katherine A. Pohlman^{4*} 

Abstract

Background: This systematic review evaluates the use of manual therapy for clinical conditions in the pediatric population, assesses the methodological quality of the studies found, and synthesizes findings based on health condition. We also assessed the reporting of adverse events within the included studies and compared our conclusions to those of the UK Update report.

Methods: Six databases were searched using the following inclusion criteria: children under the age of 18 years old; treatment using manual therapy; any type of healthcare profession; published between 2001 and March 31, 2018; and English. Case reports were excluded from our study. Reference tracking was performed on six published relevant systematic reviews to find any missed article. Each study that met the inclusion criteria was screened by two authors to: (i) determine its suitability for inclusion, (ii) extract data, and (iii) assess quality of study.

Results: Of the 3563 articles identified, 165 full articles were screened, and 50 studies met the inclusion criteria. Twenty-six articles were included in prior reviews with 24 new studies identified. Eighteen studies were judged to be of high quality. Conditions evaluated were: attention deficit hyperactivity disorder (ADHD), autism, asthma, cerebral palsy, clubfoot, constipation, cranial asymmetry, cuboid syndrome, headache, infantile colic, low back pain, obstructive apnea, otitis media, pediatric dysfunctional voiding, pediatric nocturnal enuresis, postural asymmetry, preterm infants, pulled elbow, suboptimal infant breastfeeding, scoliosis, suboptimal infant breastfeeding, temporomandibular dysfunction, torticollis, and upper cervical dysfunction. Musculoskeletal conditions, including low back pain and headache, were evaluated in seven studies. Twenty studies reported adverse events, which were transient and mild to moderate in severity.

Conclusions: Fifty studies investigated the clinical effects of manual therapies for a wide variety of pediatric conditions. Moderate-positive overall assessment was found for 3 conditions: low back pain, pulled elbow, and premature infants. Inconclusive unfavorable outcomes were found for 2 conditions: scoliosis (OMT) and torticollis (MT). All other condition's overall assessments were either inconclusive favorable or unclear. Adverse events were uncommonly reported. More robust clinical trials in this area of healthcare are needed.

Trial registration: PROSPERA registration number: CRD42018091835

Keywords: Pediatric, Manual therapy, Chiropractic, Osteopathic, Systematic review

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Background

Parents consult complementary and alternative medicine (CAM) providers for a wide variety of pediatric conditions [1, 2]. In addition to botanical medicines and supplements, some seek manual therapy including soft tissue therapy, mobilization and high velocity low amplitude manipulations directed to the spine and peripheral joints. The United States (US) Department of Health and Human Services conducts a population-based survey and creates the National Health Interview Statistics (NHIS) reports on the use of CAM with children ages 4–17 every 5 years with results published in 2007 and 2012. Overall, approximately 12% of children used a CAM modality the previous year [1, 2].

Manual therapy is a CAM therapy regulated for use among many professions (e.g., doctor of osteopathy, medical doctors and physical therapists), but doctors of chiropractic (DCs) are the most likely profession to use manual therapy on a regular basis [3]. According to a recent job analysis of the overall DC profession, 17.1% of chiropractic patients are 17 years of age or less; this increases to 38.7% among DCs who have specialized in pediatrics [3, 4]. Ndetan et al. conducted a sub-analysis of the 2007 NHIS data for chiropractic and/or osteopathic manipulation use and found that 3.3% of US children had received chiropractic or osteopathic manipulation the previous year [5]. Most commonly, children were between 12 and 18 years of age and received care for back or neck pain.

Concerns regarding manual therapy, specifically manipulation [6], have led to complications identified in the literature. However, no prospective population-based active surveillance have been conducted [7]. Serious events are rare, but may be related to high-velocity extension and rotational spinal manipulation [8]. The serious events identified in mostly retrospective studies commonly occurred with patients that had preexisting underlying pathology, which emphasizes the need for a thorough history and physical examination so that abnormal findings are identified prior to manual therapy in a child [7–9].

Six systematic reviews have previously been conducted to evaluate the use of manual therapy for pediatric health conditions [9–14]. These reviews ranged in manual therapy definitions from high-velocity variable amplitude to profession-specific manipulative therapy. Nonetheless, all reviews concluded that this is a paucity of evidence for the effectiveness of manual therapy for conditions within the pediatric population, especially for musculoskeletal conditions. The purpose of this systematic review was to evaluate the use of manual therapy for clinical conditions in the pediatric population, assess the methodological quality of the studies found, and synthesize findings based on health condition. We also assessed the reporting and incidence of adverse events within the included studies. Additionally, we compared conclusions to Clar et al.'s UK Update manuscript [10].

Methods

This study was registered at the PROSPERA - Center for Reviews and Dissemination, University of York, York, U.K. on March 28, 2018. Details of the protocol for this systematic review were registered on PROSPERO and can be accessed at https://www.crd.york.ac.uk/prospero/display_record.php?RecordID=91835.

Search strategy

A comprehensive search of the literature was performed by three independent librarians at three different educational institutions. The databases stated in Table 1 were searched for English manuscripts published between 2001 through March 31, 2018. Data mining and reference tracking of the six previously published systematic reviews were performed for relevant papers. No condition terms were included to keep the search as broad as possible. The list of search terms and keywords used in the search are included in Table 1.

Eligibility criteria

Studies were eligible for inclusion if they were full text reports of RCTs (no abstracts). Feasibility studies without outcome measures were not included in this review. For observational studies, the Agency for Healthcare Research and Quality's (AHRQ) *Assessing Risk of Bias and Confounding in Observational Studies of Interventions or Exposures* was utilized to determine study type with non-comparative (case report or case series without pre and post measurements) and cross-sectional studies excluded [15]. Additional eligibility criteria were that a study

Table 1 Databases searched: PubMed, Cochrane Library, Medline complete, CINAHL complete, ScienceDirect, McCoy Press, Index to Chiropractic Literature, and National Guideline Clearinghouse

Chiropractic	AND	pediatric*
Chiropractic	AND	child*
Chiropractic	AND	adolescent*
Manipulation, chiropractic (MeSH heading)	AND	(pediatric*, child*, adolescent*)
Manipulation, orthopedic (MeSH heading)	AND	(pediatric*, child*, adolescent*)
Manipulation, osteopathic (MeSH heading)	AND	(pediatric*, child*, adolescent*)
Osteopath*	AND	(pediatric*, child*, adolescent*)
Orthopedic manipulation	AND	(pediatric*, child*, adolescent*)
Orthoped*	AND	(pediatric*, child*, adolescent*)
Pediatric manual therapy	AND	(pediatric*, child*, adolescent*)
Ped MT	AND	(pediatric*, child*, adolescent*)
Spinal manipulative therapy	AND	(pediatric*, child*, adolescent*)
SMT	AND	(pediatric*, child*, adolescent*)

had to include children under the age of 18 who were treated with manual therapy (definitions and abbreviations shown in Table 2) of any type from any health care professional for any condition.

Study selection, data extraction, & summary assessment

Two independent reviewers evaluated the studies identified by the searches for potential inclusion in our study. They applied the inclusion/exclusion criteria to the studies identified by first screening the abstracts and then the full text of any studies appearing to fulfill the inclusion criteria. Any discrepancies as to whether or not to include a study was resolved by a third independent evaluator. Data extraction was conducted by an independent reviewer using an *a priori* designed data extraction form with a second reviewer validating the findings.

An overall result summary assessment was determined for each study based on their results as either: “improvement” (manual therapy appeared to be effective in the intervention group), “no improvement” (manual therapy did not appear to be effective in the intervention group), or “no difference” (results appeared to be the same in the intervention group as compared to a different intervention, sham intervention or control group).

Quality assessment-individual studies

The quality assessment process was conducted by an independent reviewer and validated by a second randomly assigned reviewer. Disagreements for each criterion were settled through discussion with a third reviewer. Two

different assessment tools were utilized to assess the quality of the RCTs and observational studies included in this review. The Cochrane Risk of Bias tool, consisting of 7 domains, was used to assess the risk of bias of the RCTs [16]. The domains were:

- adequate sequence generation,
- allocation concealment,
- patient blinding,
- assessor blinding,
- addressing of incomplete data,
- selective outcome reporting, and
- other sources of bias.

The tool used to assess observational studies was the same used to evaluate the observational study design [15]. This AHRQ tool consists of 9 domains:

- inclusion/exclusion criteria variances across groups (cohort studies only),
- recruitment strategies for groups (cohort studies only),
- appropriate, selection of comparison groups (cohort studies only),
- blinding outcome assessor to intervention,
- use of valid and reliable outcome tools,
- length of follow-up variances across study groups,
- missing important primary outcomes,
- missing harms or adverse events, and
- account of any confounding variables.

Table 2 Abbreviations and definitions used for this study

SMT (Spinal Manipulative Therapy)	A procedure involving an high velocity, low amplitude (HVLA) thrust beyond the passive range of motion into the para-physiological space, but within the limits of anatomic integrity [71] ^{p10} , [72] ^{p142-143} , [73]. It is a bimanual motor skill involving various levels of interlimb coordination and postural control combined with a timely weight transfer and is characterized by a HVLA thrust that typically results in joint cavitation [74]. SMT is highly adaptive and context-dependent, meaning the amount of force delivered to the patient must take into account clinically relevant pathologies as well as anthropomorphic differences between the doctor and patient [73]. The safe delivery of SMT requires consideration with respect to preload, speed of force production, peak amplitude of force delivered, duration of impulse/thrust delivered, doctor position, patient positioning, and line of drive (direction of thrust) [71, 74].
Mobilization	A low velocity, low amplitude (LVA) oscillation procedure, within the active or passive ranges of motion [71] ^{p18} , [72] ^{p142} .
OMT (Osteopathic Manipulative Therapy)	Involves physical manipulation of various tissues and parts of the body that includes soft tissue massage and stretch, strain-counter-strain, articulation, high velocity thrust, gentle low amplitude mobilizations and neuromuscular techniques [49] ^{p1-2} . In some instances OMT is better classified as a mobilization [71] ^{p18} .
CST (Cranial-Sacral Therapy)	A group of manual procedures directed to the sutures of the skull designed to enhance the functioning of the membranes, tissues, fluids, and bones surrounding or associated with the brain and spinal cord. It is postulated that low-force pressure can influence the vitality of the Cranial Rhythmic Impulse created by the flow of cerebrospinal fluid as it moves from the ventricles of the skull to the sacrum within the spinal cord [71] ^{p123-136} .
CMT (Chiropractic Manipulative Therapy)	Synonymous with SMT, but performed by a doctor of chiropractic.
VOMT (Visceral Osteopathic Manipulation)	A manual therapy directed to various organs of the body to aid in smooth muscle function, influence somatic biomechanics and body fluid mechanics [49] ^{p251-252} .
Instrument-assisted manipulation	The use of any number of different types of hand held instruments used to provide a manipulation-type force.
MT (Manual Therapy)	Any of the above.

We omitted the following questions from the AHRQ assessment for the following reasons. Questions 4 (Does the study fail to account for important variations in the execution of the study from the proposed protocol?) and 12 (Any attempt to balance the allocation between the groups or match groups (e.g., through stratification, matching, propensity scores)?) as these were not relevant for our body of literature. Question 8 (In cases of high loss to follow-up (or differential loss to follow-up)), was the impact assessed (e.g., through sensitivity analysis or other adjustment method?) as our included studies did not have this level of statistical analysis involved. And question 11 (Are results believable taking study limitations into consideration?) as we felt this question was too subjective [15, 17].

The study's overall quality score was then determined to be: low quality study if the score was between 0 and 33.3%, medium quality, if the score was between 33.4 and 66.6%, and high quality if the score was above 66.6%.

Quality assessment-overall conditions

We employed the same criteria to summarize the overall strength of evidence for the studies by conditions to be consistent with the UK Update/Clar et al. report [10], which used an adapted version from the US Preventive Services Task Force. This report, along with Clar et al. reports, summarized the overall strength/quality of evidence as: "high-quality positive/negative", "medium-quality positive/negative", or "inconclusive evidence favorable/non-favorable/unclear" [10]. The overall evidence grading system used allows the evidence to be grouped into three categories based upon its strength: high quality evidence, moderate quality evidence, or inconclusive evidence. The definitions of these three categories are listed below:

High quality evidence

The evidence comes from at least 2 RCTs and is considered high quality due to low risk of bias. As a result, the conclusion is unlikely to be affected by future studies.

Moderate quality evidence

The evidence comes from at least 1 high-quality RCT (with sufficient statistical validity) OR at least 2 higher-quality RCTs (with some inconsistency) OR at least 2 consistent lower-quality RCTs.

Low quality (inconclusive) evidence

The available evidence is insufficient to determine effectiveness. If all papers showed improvement they are classified as "Favorable". If all papers failed to show improvement they are classified as "Unfavorable". If all papers showed a mix of improvement, lack of improvement, or no difference they are classified as "Unclear". Note that observational studies cannot be rated higher than "Inconclusive (unclear)", as observational studies are not designed to show effectiveness.

Results

Search results

As shown in Fig. 1, the initial database searches generated a total of 3563 records (2440 after deduplication). Of which, 166 full articles were assessed in detail. One hundred sixteen of the articles were excluded. Of the 50 included articles, 32 were RCTs and 18 were observational studies. Table 3 provides a summary of the studies along with the details, sample sizes, quality, results of the study and an overall summary. This table also compares the overall summary from Clar et al.'s UK Update study [10]. These studies are then summarized by study design (RCT and observational) in Table 4 and 5, respectively, with the individual quality assessment criteria outlined.

Overall, we found 23 studies that used OMT (7 of which specifically used cranial therapies and 1 VOMT); 17 studies used CMT/SMT (including one using Toftness technique, one using an upper cervical technique, one using a neuroimpulse instrument, and one using cranial therapy with CMT), 10 studies used mobilizations (1 also using CST).

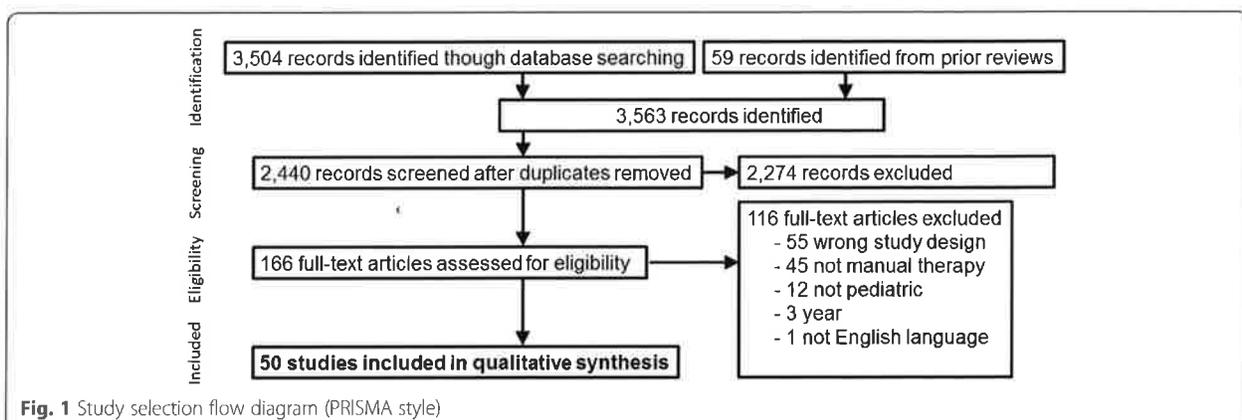


Fig. 1 Study selection flow diagram (PRISMA style)

Table 3 Overall summary in comparison with the UK Update report

Clinical condition	UK update (1) summary	Studies in current review	Intervention	Citations	Quality	Sample size	Results of study	Current study overall summary
Gastrointestinal Conditions								
Constipation	Not evaluated	1 OBS	OMT	Tarsuslu, 2009 [18]	Medium	13	No difference	Inconclusive (unclear)
Infantile Colic	Inconclusive/ favorable	3 RCT 1 OBS	CMT	Miller, 2012 [19] Wiberg, 2010 [20] Browning, 2008 [21] Olafsdottir, 2001 [22]	High Low High High	104 749 43 86	Improvement No improvement No difference No difference	Inconclusive (unclear)
Infantile Colic	Inconclusive/ favorable	1 RCT	OMT/CST	Hayden, 2006 [23]	Medium	28	Improvement	Inconclusive (favorable)
Pediatric dysfunctional voiding	Inconclusive/ favorable	1 RCT	OMT	Nemett, 2008 [24]	Medium	21	Improvement	Inconclusive (favorable)
Pediatric nocturnal enuresis	Inconclusive/ favorable	1 OBS	CMT	van Poecke, 2009 [25]	Medium	33	Improvement	Inconclusive (unclear)
Suboptimal infant breastfeeding	Not evaluated	2 OBS	CMT/CST	Miller, 2009 [26] Vallone, 2004 [27]	Medium Low	114 25	Improvement Improvement	Inconclusive (favorable)
Musculoskeletal Conditions								
Clubfoot	Not evaluated	1 RCT	MT	Nilgun, 2011 [28]	Low	29	Improvement	Inconclusive (favorable)
Cuboid Syndrome	Not evaluated	1 OBS	MT	Jennings, 2005 [29]	Medium	2	Improvement	Inconclusive (unclear)
Headache	Not evaluated for pediatrics	1 OBS	OMT	Przekop, 2016 [30]	Medium	83	Improvement	Inconclusive (unclear)
Headache	Not evaluated for pediatrics	1 RCT	MT	Borusiak, 2010 [31]	Medium	52	No difference	Inconclusive (unclear)
Headache	Not evaluated for pediatrics	1 OBS	CMT	Marchand, 2009 [32]	Low	13	Improvement	Inconclusive (unclear)
Low Back Pain	Not evaluated	1 RCT 1 OBS	CMT	Evans, 2018 [33] Hayden J, 2003 [36]	High Medium	185 54	Improvement Improvement	Moderate (favorable)
Low back pain	Not evaluated	1 OBS 1 RCT	MT	Walston, 2016 [34] Selhorst, 2015 [35]	Medium Medium	3 35	Improvement No difference	Inconclusive (unclear)
Pulled (Nursemaid's) Elbow	Not evaluated	2 RCT	MT	Garcia-Mata, 2014 [37] Bek, 2009 [38]	Medium Medium	115 66	Improvement Improvement	Moderate (favorable)
Temporomandibular Joint Dysfunction	Not evaluated for pediatrics	1 RCT	OMT	Monaco, 2008 [39]	Low	28	Improvement	Inconclusive (favorable)
Respiratory Conditions								
Asthma	Not evaluated for pediatrics	1 RCT	OMT	Guiney, 2005 [40]	Medium	140	Improvement	Inconclusive (favorable)
Asthma	Not evaluated for pediatrics	1 RCT	CMT	Bronfort, 2001 [41]	High	34	No improvement	Inconclusive (unclear)
Obstructive apnea	Not evaluated	1 RCT	OMT	Vandenplas, 2008 [42]	Medium	34	Improvement	Inconclusive (favorable)
Otitis Media	Inconclusive/ unclear	3 RCT 1 OBS	OMT	Steele, 2014 [43] Wahl, 2008 [44] Degenhardt, 2006 [45] Mills, 2003 [47]	Medium High Medium High	34 90 8 57	Improvement No difference Improvement Improvement	Inconclusive (favorable)
Otitis Media	Not evaluated	1 OBS	CMT	Zhang, 2004 [46]	Medium	22	Improvement	Inconclusive (unclear)

Table 3 Overall summary in comparison with the UK Update report (Continued)

Clinical condition	UK update (1) summary	Studies in current review	Intervention	Citations	Quality	Sample size	Results of study	Current study overall summary	
Special Needs									
ADHD	Inconclusive/ unclear	1 RCT	OMT	Accorsi, 2014 [48]	High	28	Improvement	Inconclusive (favorable)	
Autism	Not evaluated	1 OBS	VOMT	Bramati-Castellarian, 2016 [49]	Medium	49	Improvement	Inconclusive (unclear)	
Cerebral Palsy	Not evaluated	1 RCT	CMT	Khorshid, 2006 [50]	Low	14	Improvement	Inconclusive (favorable)	
	Inconclusive/ unclear	3 RCT	OMT	Wyatt, 2011 [51]	High	142	No improvement	Inconclusive (unclear)	
				Duncan, 2008 [53]	High	55	Improvement		
Preterm infants	Inconclusive/ unclear	4 RCT	OMT/CST	Duncan, 2004 [52]	Low	50	Improvement	Inconclusive/unclear for general movement Moderate (favorable) length of stay and hospital costs	
				Raith, 2015 [54]	High	30	No difference		
				Cerretelli, 2015 [55]	High	695	Improvement		
				Pizzolorusso, 2014 [56]	High	110	Improvement		
Structural Conditions	Cranial asymmetry	1 RCT	MT/CST	Cabrera-Martos, 2016 [58]	High	46	Improvement	Inconclusive (favorable)	
				Lessard, 2011 [59]	Medium	12	Improvement		
	Postural Asymmetry	Not evaluated	1 RCT	OMT/CST	Phillippi, 2006 [60]	High	32	Improvement	Inconclusive (favorable)
	Scoliosis	Not evaluated	1 RCT 3 OBS	CMT	Byun, 2016 [61]	Medium	5	Improvement	Inconclusive (unclear)
					Rowe, 2006 [62]	High	6	No difference	
					Morningstar, 2004 [63]	Low	6	Improvement	
					Lantz, 2001 [64]	Medium	42	No improvement	
	Scoliosis	Not evaluated	1 RCT	OMT	Hasler, 2010 [65]	High	20	No improvement	Inconclusive (unfavorable)
	Torticollis	Not evaluated	1 RCT	MT	Haugen, 2011 [66]	Medium	32	No difference	Inconclusive (unfavorable)
	Upper cervical dysfunction	Not evaluated	1 OBS	MT	Saedt, 2017 [67]	High	307	Improvement	Inconclusive (unclear)

Pediatric clinical conditions

1. Gastrointestinal/urinary conditions

Table 6 provides a summary of the 10 studies that investigated the clinical effects of manual therapy for conditions categorized as “gastrointestinal/urinary conditions”. One of the studies investigated the use of manual therapy for constipation [18], five for infantile colic [19–23], one for children with dysfunctional voiding [24], one for pediatric nocturnal enuresis [25], and two studies for suboptimal infant breastfeeding [26, 27].

1.1. Constipation

One study was found that investigated the use of OMT for constipation [18].

Tarsuslu et al. conducted a medium quality, interrupted time-series with a comparison group that investigated the potential effects of OMT on constipation in 13 children ages 2–16 with cerebral palsy. The children were put into one of two groups with no description of how this allocation happened. The first group received OMT alone and the second group received OMT in addition to medical treatment. Both groups showed significant changes from all baseline measures at 3 months. The baseline measures included defecation frequency, gross motor function, and functional independence measure. Group 1 showed significantly favorable changes in defecation frequency and constipation scale at 6 months. Group 2 showed significantly favorable changes from baseline measures at 6 months. The researchers suggest advanced additional studies should be conducted. There was no mention of adverse events made in this study [18].

Overall Summary:

Inconclusive (unclear) for use of OMT in treating constipation.

1.2. Infantile colic

Four of the five studies investigated the use of CMT in treating infantile colic; three of these studies were high quality RCTs [19, 21, 22] and one low quality retrospective investigation of the clinical records [20]. One medium quality prospective RCT investigated the use of OMT cranial therapy [23].

A high quality parent-blinded RCT, authored by Miller et al., showed favorable results in treating 104 colicky infants less than 8 weeks of age with CMT. This study had two objectives; the first was to determine the efficacy in treating colic with CMT and the second was to determine if parental reporting bias contributes to the success of the treatment. The infants were randomized into 3 groups:

infant treated-parent aware; infant treated-parent unaware; and infant not treated-parent unaware. The outcomes were determined by a decrease in crying time, as assessed by a parent questionnaire and a 24 h crying diary. The study found there was a greater decrease in crying time in the infants treated with CMT, either parent aware or unaware, compared to infants who were not treated, concluding that parents did not appear to contribute to the observed treatment effects in the study. Adverse event was reported in one patient in the control (non-treatment) group that reported increased crying [19].

Wiberg et al. conducted a low quality interrupted time series without a comparison group observational study that looked at 749 clinical records of infants 0–3 years of age who fulfilled the study’s definition of excessive crying. This study investigated if the outcome of excessively crying infants treated with CMT was associated with or partially associated with age in the natural decline in crying with age in infants. The outcomes were determined by the parents recording crying in the infants as “improved”, “uncertain”, or “non-recovery”. These researchers concluded that there was no apparent link between the clinical effect of chiropractic treatment and improvement in the crying patterns. Limitation of the study was that it was pragmatic, thus not standardized on management or CMT technique. There was no mention of adverse events in this study [20].

Browning and Miller conducted a high quality parent-blind RCT involving 43 infants less than 8 weeks of age that presented with infantile colic. The study objective was to compare two intervention groups in the treatment of infantile colic. One intervention group received CMT and the other occipital-sacral decompression. The outcomes were determined by the change in mean daily hours of crying as recorded in a crying diary by a parent. Although the mean hours of daily crying were statistically significantly reduced in both study groups, there were no statistically significant differences between them. The researchers noted that although all participants’ symptoms improved prior to the normal remission age of colic, the natural course of remission could not be ruled out. There was no mention of adverse events made in this study [21].

Olafsdottir et al. conducted the third high quality RCT that set out to evaluate the effect of CMT on infantile colic. This study included 86 colicky infants (46 receiving CMT, 40 in control group) at 3–9 weeks of age. The outcome was determined by the parents recording the hours of infant crying per 24 h period in a crying diary. The results showed no statistically significant improvement in the infants in either group. There was no mention of adverse events made in this study [22].

Another medium quality prospective, open-controlled RCT that investigated the impact of cranial osteopathy

Table 4 Quality rating of randomized controlled trials

Author/year	Condition sample size (n)	Results summary	Intervention	Selection bias: random	Selection bias: allocation	Performance bias: blinding of personnel and participants	Detection bias: blinding of outcome assessment	Attrition bias: incomplete outcome data	Reporting bias: selective reporting	Other bias: anything else, ideally pre-specified	Overall quality rating
Gastrointestinal/Urinary											
Miller J, et al. 2012 [19]	Infantile Colic (n = 104)	Improvement	CMT	L computer generated permuted blocks	L sealed in sequentially numbered opaque envelopes	L envelopes revealed to treating provider before treatment, 1 of 3 groups parents knew infants were being treated	U-PY two of three groups of parents blinded to treatment, data extractor blinded to treatment	H per protocol analysis conducted	L all outcomes reported	U-PN "parent diagnosis", selective nature of diary	High
Browning M & Miller J, 2008 [21]	Infantile Colic (n = 43)	No difference	CMT	L computer generated	H not stated	L blinding of both parents and patients	L independent observer blinded to treatment	L all outcomes reported	L all outcomes reported	H strict inclusion criteria, small study size, inexperienced interns	High
Hayden C & Mullinger B, 2006 [23]	Infantile Colic (n = 28)	Improvement	OMT/CST	L random number table	U-PY random table number utilized but not discussed	H patients and providers not blinded	H outcome assessors unblinded	H 2 withdrew and not included in analysis	L all outcomes reported	U-PN small study size, lack of standardized treatment	Medium
Olafsdottir E, et al. 2001 [22]	Infantile Colic (n = 86)	No difference	CMT	H "randomized" not described	U-PY "sealed" envelopes	L parents and providers blinded	L outcome assessor blinded	L intention to treat analysis	L all outcomes reported	U-PY small sample size	High
Musculoskeletal											
Nemett D, et al. 2008 [24]	Pediatric Dysfunctional Voiding (n = 21)	Improvement	OMT	U-PY stated "randomized assigned" with no further description	H nothing stated	H nothing stated	H on y primary outcome assessor blinded	H per protocol analysis conducted	L all expected outcomes reported, secondary outcome not initially evaluated in control group per protocol	L study appears free of other sources of bias	Medium
Nilgun B, et al. 2011 [28]	Idiopathic Clubfoot (n = 29)	Improvement	MT	H randomized by travel and physical abilities	H not concealed	H parents, patients, therapists not blinded	H outcome assessor not blinded	L all outcomes reported	L all outcomes reported	H pilot study only	Low
Borusiak P, et al. 2010 [31]	Cervicogenic HA (n = 52)	No difference	MT	L computer generated	L sequentially numbered identical opaque envelopes	L parents, patients and pediatrician blinded	U-PY pre-established analysis plan not described	H per protocol analysis conducted	L all outcomes reported	H small sample size, clinical effect of sham, observational bias	Medium
Evans R, et al. 2018 [33]	Subacute and Chronic LBP (n = 185)	Improvement	CMT	L computerized dynamic allocation	L sealed in sequentially numbered	H patients and providers not blinded	L outcome assessor blinded	L all outcomes reported	L all outcomes reported	L study appears free of other sources of bias	High

Table 4 Quality rating of randomized controlled trials (Continued)

Author/year	Condition sample size (n)	Results summary	Intervention	Selection bias: random	Selection bias: allocation	Performance bias: blinding of personnel and participants	Detection bias: blinding of outcome assessment	Attrition bias: incomplete outcome data	Reporting bias: selective reporting	Other bias: anything else, ideally pre-specified	Overall quality rating
				(rank-order minimization) system	opaque envelopes						
Selhorst M & Selhorst B, 2015 [35]	Mechanical LBP (n = 35)	No difference	MT	H not described	H not described	U-PY blinding of patients, exercise therapist, no blinding of manual therapist	L all outcomes patient self-report blinded	H per protocol analysis conducted	L all outcomes reported	L study appear to be free of other sources of bias	Medium
Garcia-Mata S & Hidalgo-Ovejero A, 2014 [37]	Pulled Elbow (n = 115)	Improvement	MT	H not described	H not described	H parents, patients, therapists not blinded	H outcome assessors not blinded	L all expected outcomes reported	L all outcomes reported	L study appear to be free of other sources of bias	Medium
Bek B, et al. 2009 [38]	Pulled Elbow (n = 66)	Improvement	MT	H not described	H not described	H no blinding	H outcome assessors not blinded	L intention to treat analysis	L all outcomes reported	L study appears free of other source of bias	Medium
Monaco A, et al. 2008 [39]	Non-Specific Temporomandibular Disorder (n = 28)	Improvement	OMT	H not described	H not described	H patients and providers not blinded	H outcome assessor not blinded	H follow up of participants were not discussed	U-PN sample response for each outcome not provided	U-PN small study size	Low
Respiratory											
Guiney P, et al. 2005 [40]	Asthma (n = 140)	Improvement	OMT	U-PY not well described "randomization based on a 2:1 ratio"	H not described	H provider not blinded	H outcome assessor not blinded	L all patients accounted for	L all outcomes reported	L study appears free of other sources of bias	Medium
Bronfort G et al. 2001 [41]	Asthma (n = 34)	No improvement	CMT	L computer generated	L sealed in opaque envelopes	L blinding of both parents and patients	L outcome assessor blinded	L all patients accounted for	L all outcomes reported	L study appears free of other sources of bias	High
Vandenplas YDE, et al. 2008 [42]	Obstructive Apnea (n = 34)	Improvement	OMT	H not described	H not described	L patients blinded	L outcome assessors blinded	H per protocol analysis, 6 participants dropped out and not included in analysis	L all outcomes reported	U-PN small study size, imbalance in sizes of control to study	Medium
Steele D, et al. 2014 [43]	Otitis Media (n = 34)	Improvement	OMT	L study used "Research Randomizer"	U-PY randomized tables generated with unique number assignment	H providers not blinded, parents blinded but in treatment room	L outcome assessors blinded	L all patients accounted for	L all outcomes reported	H small sample size, pilot study	Medium
Wahl R, et al. 2008 [44]	Otitis Media (n = 90)	No difference	OMT	L randomization in blocks of 8 using random number table	L 2 by2 factorial design	L patients, parents, providers blinded	L outcome assessor blinded	L all patients accounted for	L all outcomes reported	U-PN unequal distribution of risk factors in treatment group	High

Table 4 Quality rating of randomized controlled trials (Continued)

Author/year	Condition sample size (n)	Results summary	Intervention	Selection bias: random	Selection bias: allocation	Performance bias: blinding of personnel and participants	Detection bias: blinding of outcome assessment	Attrition bias: incomplete outcome data	Reporting bias: selective reporting	Other bias: anything else, ideally pre-specified	Overall quality rating
Mills M, et al, 2003 [47]	Acute Otitis Media (n = 57)	Improvement	OMT	L computer generated	L independent nurse monitored and disclosed by phone	H parents and provider not blinded	L outcome assessor blinded	H per protocol analysis, 19 dropped out and not included in analysis	L all outcomes reported	L study appears free of other sources of bias	High
Special Needs											
Accorsi A, et al, 2014 [48]	Attention-Deficit/Hyperactivity Disorder (n = 28)	Improvement	OMT	L permuted-block ratio 1:1 using R statistical program	U-PN allocation was concealed but not described	U-PY patients/providers not blinded but were blinded as to outcomes	L outcome assessors blinded	L all patients accounted for	U-PN adverse events were being collected but not reported	U-PN sample size not justified	High
Khorshid KA, et al, 2006 [50]	Autism (n = 14)	Improvement	CMT	H not described	H not described	H patients and providers not blinded	H outcome assessors not blinded	U-PN enrollment number not discussed	L all outcomes reported	U-PN sample size not justified	Low
Wyatt K, et al, 2011 [51]	Cerebral Palsy (n = 142)	No improvement	OMT	L telephone based randomization by independent statistician at remote site	L allocation provided by independent statistician at remote site	H parents and patients not blinded	L outcome assessors blinded	L all patients accounted for	L all outcomes reported	U-PN sample size not justified	High
Duncan B, et al, 2008 [53]	Cerebral Palsy (n = 55)	Improvement	OMT	L draw technique using stratification	L blinding of concealment	H parents, patients, providers not blinded	L outcome assessors blinded	H per protocol analysis conducted	L all outcomes reported	L study appears free of other sources of bias	High
Duncan B, et al, 2004 [52]	Cerebral Palsy (n = 50)	Improvement	OMT	H not described	H not described	H not described	H outcome assessors not discussed	H per protocol analysis conducted	L all outcomes reported	L study appears free of other sources of bias	Low
Raith W, et al, 2016 [54]	Prematurity (n = 30)	No difference	OMT/CST	L randomized using block design with block size 6	L sequentially sealed opaque envelopes	L parents and providers blinded	L outcome assessors blinded	L all patients accounted for	L all outcomes reported	L study appears free of other sources of bias	High
Cerritelli F, et al, 2015 [55]	Prematurity (n = 695)	Improvement	OMT/CST	L randomized using block design with block size 10	L performed in coordinating center	U-PN providers not blinded	L NICU staff blinded	H per protocol analysis performed	L all outcomes reported	L study appears free of other sources of bias	High
Pizzolorusso G, et al, 2014 [56]	Prematurity (n = 110)	Improvement	OMT/CST	L computer generated permuted block	L randomized by IT consultant	U-PN providers not blinded	L outcome assessors blinded	L all patients accounted for	L all outcomes reported	L study appears free of other sources of bias	High
Cerritelli F, et al, 2013 [57]	Prematurity (n = 110)	Improvement	OMT/CST	L computer generated permuted block	L random allocation by independent consultant	H parents, patients, providers not blinded	L outcome assessor blinded	H per protocol analysis conducted	L all outcomes reported	L study appears free of other sources of bias	High

Table 4 Quality rating of randomized controlled trials (*Continued*)

Author/year	Condition sample size (n)	Results summary	Intervention	Selection bias: random	Selection bias: allocation	Performance bias: blinding of personnel and participants	Detection bias: blinding of outcome assessment	Attrition bias: incomplete outcome data	Reporting bias: selective reporting	Other bias: anything else, ideally pre-specified	Overall quality rating
Structural											
Cabrera-Martos I, et al. 2016 [58]	Cranial Asymmetry (nonsynostotic plagiocephaly) (n = 46)	Improvement	MT/CST	L randomized number generator in blocks of 4	L sealed envelope	H patients and providers not blinded	L outcome assessors blinded	L all outcomes accounted for	L all outcomes reported	L study appears free of other sources of bias	High
Philippi H, et al. 2006 [60]	Postural Asymmetry (n = 32)	Improvement	OMT/CST	L block randomization	L sealed in sequentially numbered envelopes	L parents, patients, provider blinded	L outcome assessor blinded	L all outcomes accounted for	L all outcomes reported	L study appears free of other sources of bias	High
Hasler C, et al. 2010 [65]	Scoliosis (n = 20)	No improvement	OMT	L block randomization	U-PY consealed envelopes	H patients and provider not blinded	L outcome assessor blinded	L all outcomes accounted for	L all outcomes reported	U-PN small sample size	High
Rowe DE, et al. 2006 [62]	Scoliosis (n = 6)	No difference	CMT	L computer generated	L independent personnel provided allocation assignment via e-mail	L patients and provider blinded	L outcome assessors blinded	L all outcomes accounted for	L all outcomes reported	U-PN small sample size	High
Haugen E, et al. 2011 [66]	Torticollis (n = 32)	No difference	MT	H not described	U-PY sealed envelope	U-PN patients blinded, providers not blinded	L outcome assessor blinded	U-PN patient description and enrollment not discussed	H not all outcomes reported	U-PN sample size not justified	Medium

Legend: H-High risk of bias; L-Low risk of bias; NA-Not applicable; U-Unclear; PN-Probably No (high risk of bias); PY-Probably Yes (low risk of bias). Interventions: CMT Chiropractic Manipulative Therapy, CST Craniosacral Therapy, MT Manual Therapy, OMT Osteopathic Manipulative Therapy.

Table 5 Quality rating of observational studies

Author/year	Study design type	Condition sample size (n)	Result summary	Intervention	Include/exclude	Recruitment strategy	Comparison selection	Blinded outcome assessor(s)	Valid, reliable measures	Length of follow-up	Missing outcomes	Missing harms/adverse events	Missing confounding variables	Overall quality rating
Gastrointestinal/Urinary														
Tarsuslu T, et al. 2009 [18]	Interrupted time series (with comparison group)	Constipation and Cerebral Palsy (n = 13)	No difference	OMT	L does not vary	H not described	H not described	H not blinded	U-PN property measurements not fully evaluated for children	L consistent	L all outcomes discussed	H adverse events not reported	U-PN dietary	Medium
Wiberg K & Wiberg J, 2010 [20]	Interrupted time series (without a comparison group)	Infantile colic (n = 749)	No improvement	CMT	NA	NA	NA	H not blinded	U-PN property measurements not fully evaluated for children	H not discussed	L all outcomes discussed	H adverse events not reported	U-PN co-interventions missing	Low
van Poecke A & Cunliffe C, 2009 [25]	Before-after	Nocturnal Enuresis (n = 33)	Improvement	CMT	NA	NA	NA	H not blinded	U-PN property measurements not fully evaluated for children	L consistent	L all outcomes discussed	H adverse events not reported	U-PN dietary	Medium
Miller J, et al., 2009 [26]	Before-after	Suboptimal Infant Breastfeeding (n = 114)	Improvement	CMT	NA	NA	NA	H not blinded	U-PN property measurements not fully evaluated for children	H not discussed	L all outcomes discussed	L adverse events reported	L confounding variables accounted for	Medium
Vallone S, 2004 [27]	Before-after	Suboptimal Infant Breastfeeding (n = 25)	Improvement	CMT/CST	NA	NA	NA	H not blinded	U-PN property measurements not fully evaluated for children	H not discussed	U-PN different outcomes for participants	H adverse events not reported	H no confounding variables included	Low
Musculoskeletal														
Jennings J & Davies G, 2005 [29]	Interrupted time series (without comparison group)	Cuboid Syndrome (n = 2)	Improvement	MT	NA	NA	NA	H not blinded	U-PN property measurements not fully evaluated for children	U-PY not different but not specified	L all outcomes discussed	H adverse events not reported	U-PN variables that may influence outcome discussed but no adjustment to outcome taken into account	Medium
Przekop P, et al. 2016 [30]	Before-after	Chronic tension-type headache (n = 83)	Improvement	OMT	NA	NA	NA	H not blinded	U-PN property measurements not fully evaluated for children	L consistent	L all outcomes discussed	H adverse events not reported	L confounding variables accounted for	Medium
Marchand A, et al. 2009 [32]	Before-after	Benign infant headache (n = 13)	Improvement	CMT	NA	NA	NA	H not blinded	U-PN property measurements not fully evaluated for children	H not discussed	L all outcomes discussed	H adverse events not reported	H medication not accounted for	Low

Table 5 Quality rating of observational studies (Continued)

Author/year	Study design type	Condition sample size (n)	Result summary	Intervention	Include/exclude	Recruitment strategy	Comparison selection	Blinded outcome assessor(s)	Valid, reliable measures	Length of follow-up	Missing outcomes	Missing harms/adverse events	Missing confounding variables	Overall quality rating
Walston Z & Yake D, 2016 [34]	Interrupted time series (without comparison)	Mechanical Low Back Pain (n = 3)	Improvement	MT	NA	NA	NA	H not blinded	U-PN property measurements not fully evaluated for children	H not consistent	L all outcomes discussed	L adverse events reported	U-PN information not consistently collected	Medium
Hayden J, et al. 2003 [36]	Before-after	Mechanical Low Back Pain (n = 54)	Improvement	CMT	NA	NA	NA	H not blinded	U-PN property measurements not fully evaluated for children	L consistent	U-PN not all cases collected	H adverse events not reported	U-PY retrospective data, information not consistently collected	Medium
Respiratory														
Degenhardt B & Kuchera M, 2006 [45]	Before-after	Otitis media (n = 8)	Improvement	OMT/CST	NA	NA	NA	H not blinded	U-PN property measurements not fully evaluated for children	L consistent	L all outcomes discussed	H adverse events not reported	U-PN natural course of OM diagnosis, differences in AOM and OM, dietary considerations	Medium
Zhang JQ & Snyder BJ, 2004 [46]	Before-after	Otitis media (n = 22)	Improvement	CMT	NA	NA	NA	H not blinded	U-PN property measurements not fully evaluated for children	H not discussed	L all outcomes discussed	L adverse events reported	H several confounding variables missing	Medium
Special Needs														
Bramati-Castellarin I, et al. 2016 [49]	Interrupted time series (without comparison)	Autism (n = 49)	Improvement	VOMT	NA	NA	NA	H not blinded	U-PN property measurements not fully evaluated for children	L follow up consistent	L all outcomes discussed	H adverse events not reported	U-PY not all confounding variables known	Medium
Structural														
Lessard S, et al. 2011 [59]	Before-after	Cranial asymmetry (nonsynostotic plagiocephaly) (n = 12)	Improvement	OMT	NA	NA	NA	L blinded	U-PN property measurements not fully evaluated for children	L follow-up consistent	L all outcomes discussed	H adverse events not reported	U-PN natural course	Medium
Byun S & Han D, 2016 [61]	Before-after	Scoliosis (n = 5)	Improvement	CMT	NA	NA	NA	H not blinded	L Cobb angle	L follow-up consistent	L all outcomes discussed	H adverse events not discussed	H confounding variables not accounted for, no mention of natural course	Medium
Momingstar M, et al. 2004 [63]	Before-after	Scoliosis (n = 6)	Improvement	CMT	NA	NA	NA	H not blinded	L Cobb angle	H length of follow-up similar but some patients had received prior	L all outcomes discussed	H adverse events not reported	H confounding variables not accounted for, no mention of natural course	Low

Table 5 Quality rating of observational studies (Continued)

Author/year	Study design type	Condition sample size (n)	Result summary	Intervention	Include/exclude	Recruitment strategy	Comparison selection	Blinded outcome assessor(s)	Valid, reliable measl.res	Length of follow-up	Missing outcomes	Missing harms/adverse events	Missing confounding variables	Overall quality rating
Lantz C & Chen J, 2001 [64]	Before-after	Scoliosis (n = 42)	No improvement	CMT	NA	NA	NA	L blinded	L Cobb angle	H follow-up not consistent	L all outcomes discussed	H adverse events not reported	H confounding variables missing, no mention of natural course	Medium
Saedt E, et al 2018 [67]	Before-after	Upper cervical dysfunction (n = 307)	Improvement	MT	NA	NA	NA	L blinded	U-PN property measurements not fully evaluated for children	L follow-up consistent	L all outcomes discussed	L adverse events discussed	U-PY not all confounding variables known	High

Legend: H-High risk of bias; L-Low risk of bias; NA-Not applicable; U-Unclear; PN-Probably No (high risk of bias); PY-Probably Yes (low risk of bias)
Interventions: CMT Chiropractic Manipulative Therapy, CST Craniosacral Therapy, MT Manual Therapy, OMT Osteopathic Manipulative Therapy

Table 6 Data extraction for the gastrointestinal/urinary studies

Condition	Author/year	Study objective	Study design Sample size Intervention	Patient description/ condition	Primary/ main outcome(s)	Main results/ conclusions	Adverse events
Constipation	Tarsuslu T, et al, 2009 [18]	Investigate potential effects of osteopathic treatment on constipation in children with cerebral palsy.	Interrupted Time Series (with comparison group) <i>n</i> = 13 OMT	Children with CP, ages 2–16, with constipation	Defecation frequency, gross motor function classification system, Modified Ashworth scale, functional independence measure for children, constipation assessment scale, visual analog scale	Both groups showed significant changes from all baseline measures at 3 mos.	There was no mention of adverse events made in this study.
Infantile Colic	Miller JE, et al, 2012 [19]	Two-fold: 1. Determine efficacy of chiropractic manipulation therapy for infants with colic; and 2. Parental reporting bias.	RCT <i>n</i> = 104 CMT	Infants < 8 weeks, diagnosed with colic	Decreased crying (as assessed by parent questionnaire and 24 h crying diary)	1. Greater decrease in crying in colicky infants treated with CMT compared to infants who were not treated. 2. Unlikely that observed treatment effect is due to bias on part of reporting parent.	One patient in the control group noted increased crying.
	Wiberg K & Wiberg J, 2010 [20]	Investigate if the outcome of excessively crying infants treated with chiropractic manipulation is associated with age.	Interrupted Time Series (without comparison group) <i>n</i> = 749 CMT	Healthy, thriving infants, ages 0–3 months, who fit diagnostic criteria of infantile colic	Parent report of crying: classified as “improved”, “uncertain recovery”, “non recovered”	No apparent link between clinical effect of chiropractic treatment and a natural crying pattern was found, Slightly older age was found to be linked to crying infants with clinical improvement	There was no mention of adverse events made in this study.
	Browning M & Miller J, 2008 [21]	To compare chiropractic manual therapy and occipital-sacral decompression in the treatment of infant colic.	RCT <i>n</i> = 43 CMT	Infants < 8 weeks, who cried more than 3 h a day for at least 4 of the previous 7 days	Change in group mean daily hours of crying (recorded in crying diary)	Mean hours of crying were significantly reduced in both groups. Both treatments appear to offer benefits to infants with colic. There was no difference between two treatment approaches.	There was no mention of adverse events made in this study.
	Olafsdottir E, et al. 2001 [22]	To evaluate chiropractic spinal manipulation management on infantile colic.	RCT <i>n</i> = 86 CMT	Infants ages 3–9 weeks, diagnosed with infantile colic	24 h diary of infant's crying (crying diary) completed by parent; Parent report of effect after last visit (8–14 days later)	No difference between groups with either outcome.	There was no mention of adverse events made in this study.
	Hayden C & Mullinger B, 2006 [23]	To determine the impact of cranial osteopathy on infantile colic.	RCT <i>n</i> = 28 OMT/CST	Infants 1–12 weeks, with signs of infantile colic that included; 90 min/ 24 h. of inconsolable crying on 5 out of 7 days and additional	Parents record of time spent crying and sleeping in a 24-h diary	No between group comparisons done. While both groups, demonstrated decreases, only the OMT/CST	There was no mention of adverse events made in this study.

Table 6 Data extraction for the gastrointestinal/urinary studies (Continued)

Condition	Author/year	Study objective	Study design Sample size Intervention	Patient description/ condition	Primary/ main outcome(s)	Main results/ conclusions	Adverse events
				clinical signs such as borborygmi, knees drawn up to chest, fists clenched, backward bending of head or trunk		group had significant reduction for time spent crying and sleeping.	
Pediatric dysfunctional voiding	Nemett D, et al. 2008 [24]	To determine whether manual physical therapy-osteopathic approach added to standard treatment improves dysfunctional voiding more effectively than standard treatment alone.	RCT n = 21 OMT	Children ages 4–11, diagnosed with dysfunctional voiding and symptoms of daytime incontinence and/or vesicoureteral reflux	Improved dysfunctional voiding symptoms; 1. improved or resolved vesicoureteral reflux 2. elimination of post-void urine residuals	Results suggest that manual physical therapy-osteopathic approach treatment can improve short-term outcomes in children with dysfunctional voiding, beyond improvements observed with standard treatments.	There was no mention of adverse events made in this study.
Nocturnal Enuresis	van Poecke A & Cunliffe C, 2009 [25]	To evaluate the effect of chiropractic treatment on the wet night frequency of patients with nocturnal enuresis.	Before-After n = 33 CMT	Children ages 3–18, diagnosis of nocturnal enuresis	Diary of wet night frequency, diurnal urinary output	66.6% resolution rate within 1 year, indication for possible effectiveness of chiropractic treatment (Neuroimpulse instrument) in patients with primary nocturnal enuresis.	There was no mention of adverse events made in this study.
Suboptimal infant breastfeeding	Miller J, et al. 2009 [26]	To determine the effect of chiropractic manipulative therapy on infants who had difficulty breastfeeding.	Before-After n = 114 CMT	Infants ages 2 days - 12 weeks diagnosed by medical provider with feeding difficulties	Mother's report of exclusivity of breastfeeding, rating of improving and infant weight gain	Exclusively of breastfeeding was accomplished in 78%.	No negative side effects were reported.
	Vallone S, 2004 [27]	To investigate problems interfering with successful breastfeeding and to see if proper lactation management can increase the bonding experience.	Before-After n = 25 CMT/CST	Infants ages 5 days - 12 weeks, referred by other healthcare providers as having difficulty breastfeeding	Improvement in ability to latch and ability to breastfeed	> 80% of infants experienced improvement in latch and ability to breastfeed	There was no mention of adverse events made in this study.

on infantile colic in 28 infants was conducted by Hayden et al. These researchers found a reduction in crying times (63%), improved sleeping (11%), and a need for less parental attention. Due to the favorable findings of this study, the researchers suggested that a larger scale study is warranted. There was no mention of adverse events made in this study [23].

Overall Summary:

Inconclusive (unclear) for CMT in treating infantile colic.

Inconclusive (favorable) for OMT/CST in treating infantile colic.

1.3. Pediatric dysfunctional voiding

A medium quality RCT sought to determine whether OMT in addition to standard treatment improved dysfunctional voiding in 21 children diagnosed with pediatric dysfunctional voiding. Improvements in short-term outcomes in children with dysfunctional voiding were reported beyond improvements observed with standard treatment. No mention of adverse events were reported in this study [24].

Overall Summary:

Inconclusive (favorable) evidence for use of OMT plus standard treatment to improve dysfunctional voiding.

1.4. Pediatric nocturnal enuresis

A medium quality before-after retrospective record review of 33 consecutive patients over a three-year period found somewhat favorable results using CMT, specifically utilizing the Neuroimpulse protocol. The children were between the ages 3–18 with primary nocturnal enuresis. The frequency of wet nights was abstracted from the records at 3, 6, 9 and 12 months after the commencement of treatment. The records found 22 patients showed complete resolution of primary nocturnal enuresis during the 12 months after commencement of chiropractic care. The resolution rate was 66.6% within 1 year with the mean number of treatments in the responder's group being 2.05 ± 1.33 . There was no mention of adverse events made in this study [25].

Overall Summary:

Inconclusive (unclear) evidence for use of CMT to improve nocturnal enuresis.

1.5. Suboptimal infant breastfeeding (SIB)

Two case series with pre and post measurements investigated the use of CMT on infants with SIB [26, 27].

A medium quality before-after case series investigated the effect of CMT on 114 infants with SIB, 112 classified with an ineffective suck (grades 0–2) and 2 having

excessive suck (grade 4) as objectively determined with a suck grading chart. The results of this study showed favorable improvement in all the infants after four treatments (78% were able to exclusively breastfeed). Outcomes included the mother's report of improved weight gain and a specific list of historical data and clinical examination findings including improvements in suck reflex grading. No negative side effects were reported [26].

A low quality before-after case series of 25 infants with SIB set out to determine if proper lactation might increase the bonding experience between mother and infant following CMT/CST. This study reported improvement in the ability to latch after the infants received CMT (which included craniosacral treatment). The study's authors posited CMT/CST in the early stages of neurological imprinting appear to safely and effectively address the craniocervical dysfunction and help restore natural efficient sucking patterns for infants who are unable to latch. There was no mention of adverse events made in this study [27].

Overall Summary:

Inconclusive (favorable) evidence for use of CMT/CST for children with SIB.

2. Musculoskeletal conditions

Table 7 summaries the 12 studies that investigated the clinical effects of manual therapy for conditions categorized as "musculoskeletal conditions". One of these investigated the use of manual therapy on clubfoot [28] and one on cuboid syndrome [29]. Three of these studies investigated the use of manual therapy for headaches [30–32], four for low back pain [33–36], two investigated pulled elbow [37, 38], and one study for temporomandibular (TMD) dysfunction [39].

2.1. Clubfoot

One study was found that investigated the use of MT on patients with clubfoot [28].

A low quality RCT conducted by Nilgun et al. investigated the effectiveness of intensive physical therapy (including mobilization technique) as an adjunct to Ponseti technique in 29 children (average age 15–12 months) with idiopathic clubfoot. Using the Dimeglio classification system they reported a statistically significant improvement in the group that received both MT and the Ponseti technique combined. The study group received the intervention once per day, 5 days a week for 1 month. There is no mention of adverse events made in this study [28].

Overall Summary:

Inconclusive (favorable) evidence for the use of MT combined with Ponseti technique in children with clubfoot.

Table 7 Data extraction for the musculoskeletal studies

Condition	Author/ year	Study objective	Study design sample size intervention	Patient description/ condition	Primary/main outcome(s)	Main results/conclusions	Adverse events
Clubfoot	Nilgun B, et al. 2011 [28]	To determine efficacy of physical therapy, including manual mobilization, as adjunct to Ponseti technique in idiopathic clubfoot.	RCT n = 29 MT	Children ages 3 and under, Dimeglio Score of 17 or under with idiopathic clubfoot	Improvements in passive ranges of motion for plantar flexion, inversion, eversion, rear foot varus angle and forefoot adduction angle and decrease in Dimeglio Score	Treatment procured a statistically significant improvements in ranges of motion, Dimeglio Score and decrease of rear foot varus angle in the study group.	There is no mention of adverse events made in this study.
Cuboid Syndrome	Jennings J & Davies D, 2005 [29]	Describe the examination and treatment of the cuboid syndrome following lateral ankle sprain.	Interrupted Time Series (with comparison group) n = 2 MT	7 patients age range 15–36 (2 pediatric patients can be isolated), with cuboid syndrome	Visual Analog Scale: Pre- and post-treatment	All patients had substantial resolution of symptoms following cuboid manipulation.	There is no mention of adverse events made in this study.
Headache	Przekop P, et al. 2016 [30]	Evaluate and compare a multimodal with pharmacologic treatment for the prevention of chronic tension type headaches (CTTH) in adolescents.	Before-After n = 83 OMT	Children ages 13–18, diagnosec with CTTH	5 main effects: headache frequency, pain intensity, general health, pain restriction and number of tender points	Both approaches showed significant improvements across all 5 main effects outcomes, but multimodal treatments produced more favorable results in headache frequency, general health, and number of tender points.	There is no mention of adverse events made in this study.
	Borusiak P, et al. 2010 [31]	To investigate the efficacy of spinal manipulative therapy in adolescents with recurrent headache.	RCT n = 52 MT	Adolescents ages 7–15, with cervicogenic headache	Assessment of; percentage of days with headache, total duration of headache, days with school absence due to headache, consumption of analgesics, and intensity of headache	No difference in any outcome measure between placebo and cervical spine manipulation.	No serious or moderate adverse events were noted. Minor adverse events occurred in both groups that included; hot skin in 15 patients (treatment group 6, placebo 9), dizziness in 11 patients (treatment group 7, placebo 4). There was reported transitory increase in headache intensity and frequency being reported for up to 4 days (treatment group 8, placebo 6).

Table 7 Data extraction for the musculoskeletal studies (Continued)

Condition	Author/ year	Study objective	Study design sample size intervention	Patient description/ condition	Primary/main outcome(s)	Main results/conclusions	Adverse events
	Marchand A, et al. 2009 [32]	To conduct a retrospective file search of infants presenting with probable benign infantile headache at a chiropractic teaching clinic.	Before-After n = 13 CMT	Children ages 2 days - 8.5 months, with benign infant headache	Reduction in behavioral findings recorded verbatim by parents such as; grabbing holding face, ineffective latching, grimacing and positional discomfort, rapping head against floor, photophobia, and anorexia.	All 13 consecutive cases had favorable results based on parent report of outcomes.	There is no mention of adverse events made in this study.
Low Back Pain	Evans R, et al. 2018 [33]	To compare 12 weeks of chiropractic manipulative therapy combined with exercise therapy to exercise therapy alone in the treatment of chronic lower back pain in children.	RCT n = 185 CMT	Children ages 12–18, with chronic lower back pain	Primary outcome - self-reported level of low back pain (11 box numerical rating scale), Secondary outcomes - patient-rated disability (18 item Roland-Morris Disability questionnaire), quality of life (23 item PedsQL), improvement (9-point scale), frequency of medication use for low back pain (days/week), patient satisfaction with care (7-point scale)	Chiropractic manipulative therapy plus exercise resulted in larger reduction in primary outcome of pain severity over the course of 1 year.	Side effects were similar in both groups, mild and self-limiting and occurred at a frequency comparable to adult population.
	Walston Z & Yake D, 2016 [34]	To illustrate the feasibility and safety of lumbar manipulation as an adjunct to exercise for treatment of adolescent population with mechanical low back pain.	Interrupted Time Series (without comparison group) n = 3 MT	Adolescents ages 13–15, with mechanical low back pain	Pain measured on numerical pain rating scale and disability (Oswestry) for each patient	All outcome showed improvements (0/10 on numeric scale and 0% in the Oswestry disability index) for each patient.	No adverse reactions were reported or observed with any episode of manipulation.
	Selhorst M & Selhorst B, 2015 [35]	To assess efficacy of lumbar manipulation in addition to a 4-week physical therapy exercise program.	RCT n = 35 MT	Adolescents ages 13–17, with mechanical low back pain of < 90 days	Patient Specific Functional Scale, pain (11-point Numerical Pain Rating Scale), and Global Rating of Chance scales	No difference between groups for Patient Specific Functional Scale, pain, or Global Rating of Chance scales. All patients improved.	Two patients in both the sham and manipulation group had an adverse reaction at 1 week. No patients in either groups reported adverse reactions at either 4 weeks or 6 months. They concluded that no additional risk of having an adverse reaction were noted in this study.
	Hayden J, et al. 2003 [36]	To describe chiropractic management, outcomes, and factors associated	Before-After n = 54 CMT	Children ages 4–18, with acute mechanical low	Subjective assessment of improvement on a 5-point rating scale (Pediatric Visual	Over a course of 4–6 weeks of chiropractic management, 55–62%	Complications from chiropractic patient management were

Table 7 Data extraction for the musculoskeletal studies (*Continued*)

Condition	Author/ year	Study objective	Study design sample size intervention	Patient description/ condition	Primary/main outcome(s)	Main results/conclus ons	Adverse events
		with outcomes for low back pain in childhood.		back pain	Analog Scale)	of patients had improvement that met the study's stringent criteria and 82–87% had much improvement.	collected with none noted throughout the study data collection period.
Pulled Elbow	García-Mata S & Hidalgo-Ovejero A, 2014 [37]	To determine the relative efficacy of two pulled elbow reduction maneuvers, hyper pronation and supination-flexion.	RCT n = 115 MT	Children ages 1–5, with pulled elbow	Reduction of pulled elbow verified by observing active flexion and extension	Both maneuvers were effective with a higher first-attempt success rate with hyper pronation.	There is no mention of adverse events collected in this study.
	Bek D, et al. 2009 [38]	To compare the reduction efficiency of hyper pronation to supination-flexion maneuvers for a pulled elbow.	RCT n = 66 MT	Children ages 1–5, with pulled elbow	Reduction of pulled elbow indicated by child using the arm	Final reduction rates similar. Hyper pronation maneuver was more successful on the first attempt.	There is no mention of adverse events collected in this study.
Temporomandibular Disorder	Monaco A et al. 2008 [39]	To evaluate the effects of osteopathic manipulative therapy on mandibular kinematics in patients with temporomandibular dysfunction.	RCT n = 28 OMT	Children average age 12, diagnosed with TMD	Objective measures pre- and post-treatment using kinesiographic tracings to assess mandibular movement	Osteopathic manipulation made significant improvements in maximal mouth opening and in maximal mouth opening velocity.	There is no mention of adverse events made in this study.

2.2. Cuboid syndrome

One study was found that investigated the use of MT on patients with cuboid syndrome [29].

A medium quality interrupted time-series without a comparison group described the proper examination, evaluation, and treatment of cuboid syndrome with manual manipulation following lateral ankle sprains in 7 patients aged 15–36 of which 2 children met our inclusion (ages 15 and 16). Using visual analog scales pre and post treatment Jennings et al. reported patients' subjective pain at rest, during palpation, during midtarsal mobility testing, with gait, and with single-leg hop. Both children were diagnosed with this condition and received a cuboid manipulation. They each required only one treatment and were able to return to competitive activity with one treatment without injury recurrence. There is no mention of adverse events made in this study [29].

Overall Summary:

Inconclusive (unclear) evidence for MT in patients with cuboid syndrome.

2.3. Headache

Three studies investigated the use of manual therapy on pediatric headaches. One medium quality before-after study investigated the use of OMT on chronic tension-type headaches in adolescents [30]. One medium quality RCT that was stopped early (before recruitment goal based on interim analysis) evaluated the clinical effectiveness of MT [31]. One low quality retrospective case series with pre and post measurements looked at the CMT [32].

Przekop et al. conducted a medium quality before-after observational study that compared multimodal (OMT) and pharmacologic effects on chronic tension-type headaches (CTTH). This study included 83 patients, (67 females and 16 males), between the ages of 13 and 18. Outcome measures included: headache frequency, pain intensity, general health, pain restriction and the number of tender points as found by the provider. They reported that both multimodal and pharmacologic treatments were effective for CTTH; however, results from multimodal treatment produced more favorable results in headache frequency, general health and in the number of tender points elicited. There was no mention of adverse events in this study [30].

Borusiak et al. conducted a medium quality RCT comparing the use of cervical MT to a sham MT in 56 children with cervicogenic headaches. Of these, data sets of 52 children were analyzed (mean age 11.6 years). Outcomes included: percentage of days with a headache, total duration of headache in hours, percentage of days

missing school, percentage of days with necessity of analgesic medication, and intensity of headache based on a 10-point numerical analog scale. No significant difference was reported for any outcome measure. They did note that baseline and follow-up frequency of days with headache was reduced in both groups however, the differences were not significant. Minor adverse events occurred in both groups with no serious or moderate adverse events reported [31].

Marchand et al. conducted a low quality before-after case series that investigated the effects CMT for 13 infants (aged 2 days to 8.5 months) with probable benign infant headache. Outcome measures were changes noted in behavioral findings as reported verbatim by parents including: less grabbing or holding of the face, improved latching, less grimacing and positional discomfort, less rapping of the head against the floor and less photophobia and anorexia. They reported that all of the patients responded favorably to CMT and that a therapeutic trial is warranted. There is no mention of any adverse events in this article [32].

Overall Summary:

Inconclusive (unclear) for the use of OMT for chronic tension-type headaches in adolescents, for the use of MT for cervicogenic HA, and for the use of CMT for benign infant headache.

2.4. Low back pain (LBP)

Four studies investigated the use of manual therapy for LBP in the pediatric population. Two studies looked at the use of CMT; one high quality RCT, the other a medium quality before-after study [33, 36]. The other two looked at the use of MT; a medium quality interrupted time-series, the other a medium quality RCT [34, 35].

Evans et al. presented a high quality RCT with a comparison group between CMT with exercise against solely focusing on exercise therapy. The patients included a range of ages between 12 and 18 years, concluding with 185 total patients. They concluded that adolescents showed that by adding CMT with exercise therapy, resulted in a larger reduction in the primary outcome (visual analog scale) of pain severity over the course of 1 year. The study reported minor self-limiting adverse events that were about equal frequency in both groups [33].

Walston and Yake conducted a medium quality interrupted time-series without a comparison group of 3 patients (age range 13 through 15). They showed feasibility and safety of lumbar manipulation with exercise in the adolescent population with LBP. Patient centered outcomes used included: subjective pain measured on a numeric pain rating scale and the use

of Oswestry disability index. All outcomes showed improvement for all patients with no adverse reactions to manipulation [34].

The medium quality RCT of 35 patients (age range 13–17, mean 14.9 years) with mechanical LBP of less than 90 days, was conducted to evaluate the clinical effects of MT in addition to an exercise program. Eighteen children received MT and 17 received a sham manipulation, which consisted of the child lying on their side and a therapist passively flexing both hips until slight lumbar flexion. Patient centered outcomes utilized included, Patient Specific Functional Scale and Numerical Pain Rating Scale. Global Rating of Change scales was used to evaluate perceived improvement. Both groups of patients reported improvements in LBP. The authors reported that there was no additional risk for lumbar manipulation, as both groups reported the same number of adverse events [35].

Hayden et al. conducted a medium quality before-after cohort study without a control group that investigated the effectiveness of CMT for LBP for 54 patients ranging in age between 4 and 18 years. They reported that the majority of the patients responded favorably and there were no reported adverse events. The researchers were quick to point out that a causal relationship between CMT and improvements in pediatric LBP could not be established due to both the small study size and the observational design of the study itself. Complications from chiropractic patient management were collected with none noted throughout the study data collection period [36].

Overall Summary:

Moderate (positive) evidence for the use of CMT for adolescent LBP.

Inconclusive (unclear) evidence for the use of MT for pediatric mechanical LBP.

2.5. Pulled (nurse's) elbow

Two RCTs met our inclusion criteria and investigated the effectiveness of two MT maneuvers for the reduction of pulled elbow. It is important to point out that both of these studies compared two different types of manipulation and both show favorable results on pulled elbow [37, 38].

A medium quality RCT of 115 patients (mean age 2.3 years old) was conducted by Garcia-Mata et al. and sought to determine which procedure was the most effective to reduce a pulled elbow. There were 65 patients allocated to the hyper pronation group and 50 in the supination-flexion group. The hyper pronation group was found to be more efficient on reduction at the first attempt. There is no mention of adverse events made in this study [37].

A medium quality RCT compared the efficiency of hyper pronation and supination flexion maneuvers in the reduction of pulled elbow on 66 children (34 hyper pronation-flexion and 32 supination-flexion) with an average age of 28 months. Successful reduction was considered by the observation of the child being able to use the arm after the reduction. Although the authors concluded that final reduction rates were similar in both groups they found that the hyper pronation maneuver was more efficient on the first attempt. There is no mention of adverse events made in this study [38].

Overall Summary:

Moderate (positive) evidence for use of CMT/CST for children with SIB.

2.6. Temporomandibular dysfunction (TMD)

One study was found that investigated the use of OMT for TMD dysfunction [39].

A low quality RCT conducted by Monaco et al. evaluated the effects of OMT on mandibular kinematics in 28 children diagnosed with non-specific temporomandibular disorders. Kinesiographic tracings using K71 measured mandibular incisor-point movement in three dimensions was the only outcome assessed. The results of this study showed a significant statistical improvement in the maximal mouth opening velocity in the study group. It was reported that the use of OMT improved non-specific TMD. There is no mention of adverse events made in this study [39].

Overall Summary:

Inconclusive (favorable) evidence for OMT in pediatric TMD.

3. Respiratory and eyes, ears, nose, and throat (EENT) conditions

Table 8 summarizes the eight studies that investigated respiratory, EENT conditions. In total, there were two studies that investigated children with asthma [40, 41], one study that investigated children with obstructive apnea [42], and five studies investigated children with otitis media [43–47].

3.1. Asthma

Two studies were identified that investigated the use of manual therapy for the treatment of pediatric asthma. One study was a medium quality and investigated OMT [40]. The other study was a high quality pilot RCT and investigated CMT [41].

Guiney et al. conducted a medium quality RCT and reported favorable results with the use of OMT in 140 patients (90 treatment group, 50 control group), ages 5–17

Table 8 Data extraction for respiratory studies

Condition	Author/year	Study objective	Study design sample size intervention	Patient description/ condition	Primary/main outcome(s)	Main results/conclusions	Adverse events
Asthma	Guiney P, et al. 2005 [40]	To demonstrate the therapeutic relevance of osteopathic manipulation in the pediatric asthma population.	RCT n = 140 OMT	Children ages 5–17, diagnosed with asthma by guidelines from NIH	Peak Expiratory Flow Rates	There was statistically significant improvement of 7 L per minute to 9 L per minute for peak expiratory flow rates in the treatment group.	There was no mention of adverse events made in this study.
	Bronfort G, et al. 2001 [41]	To determine if chiropractic manipulative therapy in addition to optimal medical management resulted in clinically important changes in asthma-related outcomes.	RCT n = 34 CMT	Children ages 6–17, with persistent asthma	Pulmonary function tests, diary recording peak expiratory flow and inhaler use, questionnaires assessing quality of life, asthma severity and improvement	Little to no change in pulmonary function tests at 12 weeks and no change in patient, parent/guardian or pulmonologist rated improvement	There was no mention of adverse events made in this study.
Obstructive Apnea	Vandenplas Y, et al. 2008 [42]	To evaluate if osteopathy can influence the incidence of obstructive apnea during sleep in infants.	RCT n = 34 OMT	Infants aged 1.5–4 months, with obstructive apnea as determined by a polysomnographic test	Decrease in the number of obstructive apneas as measured by polysomnography.	Infants aged 1.5–4 months, with obstructive apnea as determined by polysomnographic	There was no mention of adverse events made in this study.
Otitis Media	Steele D, et al. 2014 [43]	To evaluate the efficacy of an osteopathic manipulative treatment protocol on middle ear effusion resolution following acute otitis media.	RCT n = 52 OMT	Infant ages 6–24 months, with acute otitis media and abnormal tomogram	Tympanometer and acoustic reflectometer	Both tympanometer data and acoustic reflectometer analysis demonstrated significantly improvement in middle ear effusion at visit 3 in the standard care plus osteopathic treatment group.	There were no serious adverse events reported during the study.
	Wahl R, et al. 2008 [44]	To assess the efficacy of Echinacea and osteopathic manipulative treatment for preventing acute otitis media.	RCT n = 90 OMT	Children aged 12–60 months, with recurrent otitis media	Reduction in future episodes of OM	No interaction was found between Echinacea and osteopathic manipulation. Echinacea was associated with a borderline increased risk of having at least one episode of acute otitis media during 6-month follow-up compared to placebo. Osteopathic manipulation did not significantly affect risk compared to sham.	*One subject withdrew from the study following an adverse effect (vomiting after taking the Echinacea placebo). One additional subject reported adverse effects (vomiting and non-urticarial rash 2 days after starting Echinacea for a viral upper respiratory illness) but did not withdraw. Neither adverse effect was considered to have been caused by the study medication.

Table 8 Data extraction for respiratory studies (*Continued*)

Condition	Author/year	Study objective	Study design sample size intervention	Patient description/ condition	Primary/main outcome(s)	Main results/conclusions	Adverse events
	Degenhardt B & Kuchera M, 2006 [45]	Does osteopathic manipulation decrease the recurrence of otitis media?	Before-After <i>n</i> = 8 OMT/CST	Infants ages 7–35 months, with recurrent otitis media	Decreased incidence of acute otitis media	5 participants had no recurrence after 1 year follow-up. 1 participant had 1 recurrence. 2 participants had a short-term of no recurrence only.	There is no mention of adverse events made in this study.
	Zhang J & Snyder B, 2004 [46]	To study the effect of Toftness chiropractic adjustment for acute otitis media.	Before-After <i>n</i> = 22 CMT	Children ages 9 months –9 years, with acute otitis media	Tympanic Membrane visualization via otoscopic exam and oral temperature	After Toftness chiropractic adjustment, red and bulging tympanic membrane returned to normal in 95% of children. A decrease in average oral temperature was noted.	"During the study protocol, no side effects or deterioration of clinical presentations were found among 21 children with otitis media."
	Mills M, et al. 2003 [47]	To evaluate the effect of usual care and osteopathic manipulation for children with acute otitis media.	RCT <i>n</i> = 57 OMT	Children ages 6 months - 6 years, with recurrent otitis media	Decreased frequency of acute otitis media, antibiotic use, surgical interventions, and improved tympanometric and audiometric performance	Intervention group had fewer episodes of acute otitis media, fewer surgical procedures and an increased frequency of more normal tympanogram readings.	There were no adverse events reported during the study.

with asthma. The primary outcome was improved peak expiratory flow rates. Their results show a statistically significant improvement from 7 L/min to 9 L/min for peak expiratory flow rates. No mention of adverse events was noted in this study [40].

Bronfort et al. conducted a high quality pilot RCT that investigated if CMT in addition to medical management would result in clinically important changes in asthma-related outcomes. This study included an observation component, but no actual data was available to include in this review. Their study included 34 children aged 6–17 years of age with persistent asthma. The main outcomes were determined by pulmonary technicians at baseline and at 12 weeks. They looked at diaries of recording peak expiratory flow and inhaler use, questionnaires assessing quality of life, asthma severity, and improvements. They found little to no change in pulmonary function tests at 12 weeks and no change in patient or pulmonologist rated improvement with the use of CMT. However, Bronfort et al. did report improvement in patient-centered outcomes such as quality of life, even 1 year after the last treatment. No mention of adverse events was noted in this study [41].

Overall Summary:

Inconclusive (favorable) for OMT in treating asthma.

Inconclusive (unclear) for CMT in treating asthma.

3.2. Obstructive apnea

One study was found that investigated the use of OMT on obstructive apnea [42].

A medium quality pilot RCT by Vandenplas et al. sought to investigate if OMT can influence the incidence of obstructive apnea during sleep in infants. This study of 34 infants, ages 1.5–4 months diagnosed with obstructive apnea showed a significant decrease in the number of observed apnea episodes in the OMT group compared to the control group. The main outcome measured was a decrease in the incidence of apnea with the suggestion for additional research. No mention of adverse events was noted in this study [42].

Overall Summary:

Inconclusive (favorable) evidence for OMT in treating obstructive apnea.

3.3. Otitis media

Five studies investigated the clinical effectiveness of manual therapy on otitis media that met our inclusion criteria. Four of the studies investigated the use of OMT. Of these, two were of high quality and two were of medium quality [43–45, 47]. One medium quality study looked at the use of CMT (specifically Toftness

technique) for acute otitis media [46]. All but one of the OMT studies showed favorable results on the use of MT for acute otitis media.

Steele et al. conducted a medium quality prospective, pilot RCT (stopped before it reached its recruitment goal of 80 patients) that evaluated 52 infants ages 6–24 months with acute otitis media and abnormal tomograms. The primary outcome was measured with a tympanometer and an acoustic reflectometer. They determined there was faster resolution in middle ear effusion in 2 weeks with what they described as “standardized OMT”. There were no serious adverse events reported during this study [43].

A high quality RCT evaluated the use of *Echinacea purpurea* and OMT on 90 (84 completed the study) infants aged 12–60 months with recurrent otitis media. The main outcome of the study was a reduction in the incidence of recurrent otitis media. As reported in monthly telephone interviews and at the 3- and 6-month visits, there was no statistically significant difference in reporting of any side effects between placebo and treatment groups for either echinacea or OMT. One participant withdrew from the study following adverse events (vomiting after taking the echinacea placebo). One additional participant reported adverse events (vomiting and non-urticarial rash 2 days after starting echinacea for a viral upper respiratory illness) but did not withdraw [44].

A medium quality before-after cohort, practice based study evaluated 8 infants ages 7–35 months with recurrent acute otitis media was undertaken by Degenhardt et al. The main outcome was a decreased incidence of otitis media. The results of this study were that 5 of the 8 children had no recurrence after 1 year follow up, one had 1 recurrence, and 2 of the 8 children had a short period of no recurrence after receiving OMT. In the method section of this study, the OMT used met the description of craniosacral therapy (CST). It is also important to note that all participants in this study were also under concurrent medical care. No mention of adverse events was noted in this study [45].

A medium quality study before-after case series investigated 22 children ages 9 months to 9 years with acute otitis media showed favorable results utilizing Toftness chiropractic technique, a type of low force technique chiropractic system. The primary outcome measures utilized in the study was otoscopic visualization and oral temperature. The researchers of this study state that otitis media may benefit from Toftness CMT and that the data justified a clinical trial be undertaken. During the study, no side effects or deterioration of clinical presentations were noted among the pediatric participants [46].

A second high quality RCT investigated the use of OMT for 57 children with acute otitis media. In this study, Mills et al. grouped 25 participants into the treatment group that received OMT in addition to routine pediatric care and 32 subjects in the control group who received only routine pediatric care. The average age was 26 months in the treatment group and 20 months in the control group. Decreased symptoms and improved tympanogram scores were only reported in the OMT group. The researchers stated there were no adverse events reported during the study [47].

Overall Summary:

Inconclusive (favorable) evidence for OMT in treating acute otitis media.

Inconclusive (unclear) evidence for CMT (Toftness technique) in treating acute otitis media.

4. Special needs

Table 9 summarizes the ten studies investigating the use of manual therapy for pediatric conditions categorized as special needs that met our inclusion criteria. One study investigated OMT on children with Attention Deficit Hyperactive Disorder (ADHD) [48], two studies investigated the use of manual therapy for autistic children [49, 50], (one used VOMT and the other used CMT). Three studies investigated the use of OMT on children with cerebral palsy [51–53] and four of the studies investigated the use of OMT on premature infants [54–57].

4.1. Attention deficit hyperactive disorder (ADHD)

One study was found that investigated the use of OMT on patients with ADHD [48].

Accorsi et al. conducted a high quality RCT evaluating the efficacy of OMT in the treatment of 28 children ages 5 to 15 years old with ADIID. One half of the participants ($n = 14$) were placed in a treatment group, which received OMT plus conventional treatment, and one half of participants ($n = 14$) were placed in the control group, receiving conventional therapy alone. The outcome measures were better accuracy and rapidity scores on the Biancardi-Stroppa Modified Cancellation test, a test that is used to measure visual-spatial attention. Accorsi et al. reported the children in the intervention group demonstrated statistically significant improvement in selective and sustained attentive performances, as measured using the Biancardi-Stroppa Modified Cancellation Test. These findings prompted the researchers to recommend a larger study be undertaken. There is no mention of adverse events in this study [48].

Overall Summary:

Inconclusive (favorable) evidence for OMT in treating ADHD in children.

4.2. Autism

Two studies were found that investigated the use of manual therapy on patients with autism. One looked at the use of visceral osteopathic manual therapy (VOMT) the other CMT [49, 50].

A medium quality interrupted time-series without comparison was conducted by Bramati-Casterllarian et al. They investigated the influence of VOMT on behavior and GI symptoms on children with autism. Their study included 49 autistic children ages 3 1/2 to 8 years of age with GI symptoms and impaired social interactions and communication. The primary outcome measure they utilized was parental completion of the Modified Autism Research Institute survey and secretin assessment to assess the GI signs and symptoms. Overall significant symptomatic improvement for social behaviors and communication, as well as improvement in digestive issues such as vomiting and poor appetite, were reported. They concluded VOMT could have a significant improvement in quality of life and well-being for children suffering from both autism and GI signs and symptoms. There was no mention of adverse events made in this study [49].

A low quality RCT without a control group intended to identify the differences in efficacy between Upper Cervical CMT and Full Spine (Diversified) CMT in 14 autistic children. The clinical effects of the autistic children were evaluated using the Autism Treatment Evaluation Checklist, a questionnaire that assessed the children's development and progress that is answered by the parents. Although autistic children in both groups demonstrated improvements in their autistic behaviours, the ATEC score for the upper cervical group was 32% versus 19% for the full spine group. The authors concluded autistic children receiving Upper Cervical CMT experienced better improvement in their autistic behaviors compared to autistic children receiving Diversified CMT. There is no mention of adverse events in this study [50].

Overall Summary:

Inconclusive (unclear) evidence for VOMT in treating autism.

Inconclusive (favorable) evidence for CMT in treating autism.

4.3. Cerebral palsy

Three RCT's were found that met our criteria investigated the use of OMT on children with cerebral palsy [51–53].

Table 9 Data extraction for the special needs studies

Condition	Author/year	Study objective	Study design sample size intervention	Patient description/ condition	Primary/main outcome(s)	Main results/conclusions	Adverse events
ADHD	Accorsi A, et al. 2014 [48]	To evaluate efficacy of osteopathic manipulative treatment of children with ADHD.	RCT n = 28 OMT	Children ages 5–15, with primary diagnosis of ADHD	Biancardi-Stroppa Modified Bell Cancellation Test, accuracy and rapidity scores	Osteopathic manipulative treatment was positively associated with changes in the Biancardi-Stroppa Test accuracy and rapidity scores.	There was no mention of adverse events made in this study.
Autism	Bramati-Castellarin I, et al. 2016 [49]	Investigate the influence of visceral osteopathic technique on the behaviour and GI symptoms of children with autism,	Interrupted Time Series (without control group) n = 49 VOMT	Autistic children ages 3 1/2–8, with GI symptoms, impaired social interactions and communication	Parental completion of the Modified Autism Research Institute outcomes survey form (9 S.O.S. questionnaires) and secretin assessment used to assess GI signs and symptoms	Significant improvements reported in “social behavior and communication” and “digestive signs” subscale of the questionnaire and in vomiting and poor appetite comparing before and after VOMT.	“There was no mention of adverse events made in this study.”
	Khorshid K, et al. 2006 [50]	Identify the differences in efficacy between upper cervical and full spine adjustment in autistic children	RCT n = 14 CMT	Children diagnosed with autism	ATEC average scores and parental observations	Clinical improvements observed through parental observations and through a decrease in the ATEC scores in both groups. Upper cervical group had improved ATEC average scores of 32%. Full spine group had improved ATEC scores of 19%.	Clinical deterioration was shown in one of the children of the full spine group, but only marginal in one child of the upper cervical group.
Cerebral Palsy	Wyatt K, et al. 2011 [51]	Evaluate the general health and wellbeing effect of cranial osteopathy on cerebral palsy children.	RCT n = 142 Cranial Osteopathy	Children with CP, ages 5–12	Gross Motor Function Measure - (GMFMM-66) Quality of life Child Health Questionnaire- (CHQ) PF50	No statistical change in GMFMM-66 or CHQ. PF50 Parents (unblinded) reported better global health.	No serious adverse events were reported.
	Duncan B, et al. 2004 [52]	Evaluate effectiveness of osteopathic manipulation or acupuncture as a supplemental therapies for children with spastic cerebral palsy.	RCT n = 50 OMT	Children with spastic CP, ages 20 months - 12 years	Parent reporting of changes observed (open-ended questions)	96% reported improvements. Most frequent seen in use of arms and legs (61 and 68%) and more restful sleep (39 and 68%) in osteopathic and acupuncture respectively. Additional improvements also noted in mood and bowel functions.	There was no mention of adverse events made in this study.
	Duncan B, et al. 2008 [53]	Evaluate effectiveness of osteopathic manipulation (cranial field, myofascial release or both) vs. acupuncture in spastic cerebral palsy patients.	RCT n = 55 OMT/ Acupuncture	Children with CP, ages 20 months - 12 years	11 outcomes used: Primary- GMFCS, GMFM total percent, PEDI mobility, PEDI self-care, WeeFIM mobility, WeeFIM self-care; Secondary- DO rating of spasticity, MAS biceps, MAS hamstring, parent/guardian rating of arched back, parent/guardian rating of startle reflex	Osteopathic manipulation was associated with improvements in 2 of 11 outcomes; GMFM total percent and WeeFIM Mobility. Acupuncture was not associated with improvements in any of the outcomes variables.	There was no mention of adverse events made in this study.

Table 9 Data extraction for the special needs studies (Continued)

Condition	Author/year	Study objective	Study design sample size intervention	Patient description/ condition	Primary/main outcome(s)	Main results/conclusions	Adverse events
Prematurity	Raith W, et al. 2016 [54]	Investigate neurological short term effects of craniosacral therapy on general movements in preterm infants.	RCT n = 30 OMT/CST	Preterm infants ages 25–33 weeks, free from medical complications in NICU	Primary outcome: General movement assessment tool, Secondary outcomes: General movement optimality score	No difference in the general movement could be observed between the groups, No change in general movement optimality score was noted.	There was no mention of adverse events made in this study.
	Cerretelli F, et al. 2015 [55]	Investigate whether osteopathic manipulation reduces the length of hospital stay, costs, and weight gain for preterms.	RCT n = 695 OMT/CST	Preterm infants ages 29–37 weeks, without congenital complications in NICU	1. Reducing length of hospital stay 2. Weight gain and hospital savings	Osteopathic treatment reduced days hospital (3.9 days) and reduced costs by 1250.65€ per newborn per length of stay. No change in weight gain was noted.	There were no complications associated to the intervention.
	Pizzolorusso G, et al. 2014 [56]	Investigate whether osteopathic manipulation reduces length of hospital stay, what effect the timing of introduction of osteopathic treatment may have on the outcome and hospital costs in preterm infants.	RCT n = 110 OMT/CST	Preterm infants ages 32–37 weeks, free from medical complications in NICU	1. Reducing length of hospital stay and impact on length of stay of timing of introduction of osteopathic manipulation 2. Reducing hospital cost	Sooner osteopathic manipulation introduced, shorter length of stay. There is a positive association of osteopathic manipulation with overall reduction in cost of care.	There were no complications associated to the intervention.
	Cerretelli F, et al. 2013 [57]	Determine effectiveness of osteopathic manipulative therapy in reducing the length of hospital stay, hospital costs and weight gain in preterm infants.	RCT n = 110 OMT/CST	Preterm infants ages >28 and <38 weeks, free from medical complications in NICU	1. Decreased length of hospital stay 2. Improved weight gain and reduced NICU costs	Osteopathic manipulation reduced length of stay and hospital costs but not effect weight gain.	No serious adverse events were reported.

A high quality pragmatic RCT evaluated the effect of OMT using cranial therapy on the general health and well-being of 142 children ages 5–12 with cerebral palsy. In this study, Wyatt et al. placed 71 children in treatment group, who received 6 OMT sessions over 6 months and 71 children in a control group, which they referred to as “waiting list”. Primary outcome measures included: Gross Motor Function Measure 66 (GMFMM-66) and Quality of Life Child Health Questionnaire (CHQ) PF50. Secondary outcomes measures used in this study included: Parental Assessment of Global Health and Sleep at 6 months, Pain and Sleep Questionnaire at 10 weeks and 6 months, CHQ PF50 at 10 weeks and the Quality of Life Short Form-36. This trial showed no statistically significant evidence that OMT led to sustained improvement in motor function, pain, sleep, quality of life of the subjects or in the quality of life of their caretakers. No serious adverse events were reported and none of the children withdrew from the study due to side effects of the treatment [51].

Duncan et al. conducted a high quality assessor blinded wait-list controlled pilot RCT that investigated the effectiveness of OMT (cranial therapy), myofascial release or both versus acupuncture on 55 cases of children ages 20 months to 12 years with moderate to severe spastic cerebral palsy. Participants were grouped into one of three groups: OMT (which included osteopathy, myofascial release or both) ($n = 15$), acupuncture ($n = 19$) and wait-list control (non-therapeutic attention) ($n = 22$). The six primary outcome measures were: Gross Motor Functional Classification, Gross Motor Measurement Total percentage, Pediatric Evaluation of Disability Inventory mobility and self-care, and Functional Independent Measure for Children mobility and self-care. Duncan et al. reported that OMT resulted in an improvement in the child's gross motor function as indicated by the outcome measures in children with moderate to severe spastic cerebral palsy. There was no mention of adverse events in this study [53].

A low quality RCT evaluated the effectiveness of OMT, acupuncture or both for 50 children aged 11 months to 2 years with spastic cerebral palsy. Participants were grouped into four groups: OMT ($n = 23$), acupuncture ($n = 19$), both OMT and acupuncture ($n = 8$) and wait-list control ($n = 19$). Multiple outcome variables were used to determine if these interventions would decrease muscle tone, improve function and quality of life. Evaluation in this study included parental interviews to assess perceptions and changes observed. Only 2 of 17 parents reported positive gains while their child was in a wait-list control period, but all 17 parents reported gains while in the treatment phase of the study. Improvement was claimed by 96% (48 of 50) of the parents while their child was receiving treatments, but the gains varied. The most frequent gains were seen in improvement

in the use of arms or legs (61 and 68%) and more restful sleep (39 and 68%) in the OMT and the acupuncture groups, respectively. Improvement in mood and improved bowel function were also very common benefits noted by the parents in both groups. There is no mention of adverse events in this study [52].

Overall Summary:

Inconclusive (unclear) evidence for OMT in treating children with cerebral palsy.

4.4. Prematurity

Four high quality RCTs were found, that investigated the use of OMT on various clinical outcomes of children born preterm [54–57].

A high quality RCT was conducted by Raith et al. on 30 preterm infants between 25 and 33 weeks in the neonatal intensive care unit, free from medical complications, with OMT/CST. The aim was to investigate neurological short term effects of craniosacral therapy on general movement in preterm infants. The primary outcome utilized was improvement in general movement assessment tool. Secondary outcomes included improvement in general movement optimality score. They found no differences between the control or study group for all outcome measures and at all time points. There was no mention of adverse events made in this study [54].

Cerretelli et al. conducted a high quality RCT in 2015 that investigated the effectiveness of OMT/CST on length of hospital stay, hospitalization costs, and weight gain in 695 preterm infants' ages 29–37 weeks. (Study group, $n = 352$; control group, $n = 343$) The primary objective was in determining the effect of OMT/CST in reducing the length of the hospital stay. Secondary objectives evaluated the effect on weight gain and NICU cost savings. They found a reduction in days in hospital (3.9 days) and associated cost savings, but no significant change in weight gain after OMT/CST compared to the control group. Similar to the Pizzolorusso et al. 2014 study, the description of the intervention listed as “manipulation” met the characteristics of cranial/craniosacral therapy. No complications were associated with the intervention [55].

Pizzolorusso et al. investigated whether OMT (cranial sacral) reduced the length of the hospital stay in 110 preterm infants ages 32–37 weeks in a high quality RCT. Fifty-five infants were placed in the study group who received routine pediatric care and OMT/CST and compared to 55 infants in the control group who received routine pediatric care only. The primary objective of the study was to determine the effect of OMT/CST on reducing the length of stay and what effect the timing of introduction OMT/CST may have

on the outcome. The secondary objective was to estimate the potential savings in terms of hospital costs. Pizzolorusso et al. reported that length of stay and neonatal intensive care unit costs were improved after introduction of OMT. It was also concluded that the earlier the OMT/CST had the shorter the hospital stay. No adverse events were recorded in this study [56].

Lastly, Cerretelli et al. conducted another high quality RCT that sought to determine the clinical effects of OMT in 110 preterm infants ages range 29–37 weeks. The treatment group had 55 assigned to receive OMT/CST plus routine pediatric care. They were compared to 55 infants in the control group who received only routine pediatric care. The primary outcome measure was to determine the effectiveness of OMT/CST in reducing the length of the hospital stay. Secondary objectives included determining the effect of OMT/CST on weight gain and in reducing NICU costs. The results of this study show that OMT reduced the length of stay (–5.9 days) and NICU costs, but did not impact weight gain. They suggested that further studies based on multi-center design are required to confirm these results. No adverse or side effects were shown in either group [57].

Overall Summary:

Moderate (favorable) evidence for OMT/CST in reducing length of stay and hospital costs for preterm infants.

Inconclusive (unclear) evidence for OMT/CST in improving general movement in preterm infants.

5. Structural conditions

Table 10 provides a summary of ten studies that were categorized as “structural” conditions. Two studies assessed changes to cranial asymmetry [58, 59], one evaluated postural asymmetry [60], five studies investigated scoliosis [61–65], one study evaluated torticollis [66], and one study evaluated upper cervical dysfunction [67].

5.1. Cranial asymmetry (non-synostotic plagiocephaly)

Two studies investigated the use of manual therapy on cranial asymmetry.

One high quality RCT evaluated the use of MT/CST [58], the other a medium quality before-after observational study looked at OMT [59].

Cabrera-Martos conducted a high quality RCT that evaluated the effects of CST in infants with severe nonsynostotic plagiocephaly. Forty-six children meeting eligibility were randomized into control and study groups. Twenty-three children allocated to the control group received standard treatment which included

positional changes and the use of an orthotic helmet. The study group included 23 infants who received CST in addition to standard treatment to evaluate treatment duration and motor development. The primary outcome utilized was the Alberta Infant Motor Scale at baseline and at discharge of the patients. The results of the study showed that CST added to usual treatment for severe nonsynostotic plagiocephaly resulted in significant improvement in asymmetry, less treatment duration, and improved motor behavior. There were no adverse events seen during the treatment period [58].

One medium quality pilot before-after study reported favorable results utilizing OMT (the most frequently used techniques used in the study were described as “cranial” work) on 12 infants with cranial asymmetry. Twelve infants with cranial asymmetries received four OMT treatments over 2 weeks. Anthropometric, plagiocephalometric, and qualitative measures were administered pre-intervention, during the third treatment and 2 weeks after the fourth treatment. The study group showed a significant decrease in cranial vault asymmetry, skull base asymmetry, and trans-cranial vault asymmetry. The researchers concluded that OMT contributes to improvements in cranial asymmetries in infants younger than 6.5 months presenting with nonsynostotic occipital plagiocephaly characteristics. There was no mention of adverse events in this study [59].

Overall Summary:

Inconclusive (favorable) evidence for both OMT and MT/CST in treating cranial asymmetry in children.

5.2. Postural asymmetry

One high quality RCT reported improved infant postural asymmetry utilizing OMT/CST on 32 infants, (18 males, 14 females) with gestational age of at least 36 weeks. Infants were assigned to intervention ($n = 16$) or sham ($n = 16$) groups. Outcomes were measured using a standardized video-based asymmetry scale from baseline to final visit. In the control group, the mean improvement was 1.2 points. In the treatment group, the mean improvement was 5.9 points. The researchers concluded that OMT/CST in the first months of life is beneficial for infants with idiopathic asymmetry. At least two of the seven vegetative symptoms aggravated for 2 days after the intervention in six patients of the control group and in four patients of the treatment group. No other adverse events were described [60].

Overall Summary:

Inconclusive (favorable) evidence for OMT/CST in treating postural asymmetry in children.

Table 10 Data extraction for structural studies

Condition	Author/year	Study objective	Study design sample size intervention	Patient description/ condition	Primary/main outcome(s)	Main results/conclusions	Adverse events
Cranial Asymmetry	Cabrera-Martos I, et al. 2016 [58]	Evaluate the effects of manual therapy as an adjuvant option on treatment duration and motor development in infants with severe nonsynostotic plagiocephaly.	RCT n = 46 MT/CST	Infants ages 4–8 months, with severe nonsynostotic plagiocephaly	Treatment duration and motor development assessed with Alberta Infant Motor Scale	Treatment duration was significantly reduced in manual therapy group (109.84 +/- 14.45) compared to the control group (148.65 +/- 11.53) days. Asymmetry after the treatment was minimal Type 0 or Type 1. Motor behaviour was normal in all the infants after treatment.	Study reported no adverse effects were seen during the treatment period.
	Lessard S, et al. 2011 [59]	Does osteopathic manipulation alter cranial asymmetry in infants.	Before-After n = 12 OMT	Infants ages < 6.5 months, diagnosed with nonsynostotic plagiocephaly	Anthropometric changes	Osteopathic treatment led to improvements in cranial asymmetry.	There is no mention of adverse events made in this study.
Postural Asymmetry	Philippi H, et al. 2006 [60]	To assess the therapeutic efficacy of osteopathic manipulation in infants with postural asymmetry.	RCT n = 32 OMT/CST	Infant ages 6–12 weeks, with postural asymmetry	Video-based measurements	Significant improvement in postural asymmetry (mean 5.9 points) observed with osteopathic manipulation.	"At least two of the seven vegetative symptoms aggravated for 2 days after the interventions in six patients of the control group and in four patients of the treatment group. Otherwise no adverse effects were seen."
Scoliosis	Byun S & Han D, 2016 [61]	Examine whether chiropractic techniques would reduce the curvature of idiopathic scoliosis.	Before-After n = 5 CMT	Children ages 10–13, with Cobb angles > 10 degrees	Reduction in Cobb angle	No significant difference in Cobb angle was noted after the 4th week of chiropractic manipulation.	There is no mention of adverse events made in this study.
	Hasler C, et al. 2010 [65]	Test to see if osteopathy alters trunk morphology, to unload the concave side of the scoliosis to halt curve progression.	RCT n = 20 OMT	Post-pubertal females ages 12–18, with Cobb angles 20–40	Trunk morphology, spine flexibility and scoliometer measurements	Repeat measurements revealed no therapeutic effect on rib hump, lumbar prominence, plumb line, sagittal profile and global flexibility.	"No intervention-related side effects or complications were noted"

Table 10 Data extraction for structural studies (Continued)

Condition	Author/year	Study objective	Study design sample size intervention	Patient description/ condition	Primary/main outcome(s)	Main results/conclusions	Adverse events
	Rowe D, et al. 2006 [62]	To conduct a pilot (feasibility) study and explore issues of patient safety, patient recruitment and compliance, treatment standardization, sham treatment refinement, interprofessional cooperation, quality assurance, and outcome measure selection.	RCT n = 6 CMT	Children ages 10–16, with Cobb angles 20–40 degrees	Reduction in Cobb angle	Feasible to recruit AIS patients for a randomized clinical trial to compare chiropractic care and standard medical treatment.	CMT delivered on 52 visits resulted in two benign reactions one with moderate pain lasting 24 h; the other produced mild pain lasting 6 h.
	Morningstar M, et al. 2004 [63]	Evaluate of scoliosis treatment using a combination of manipulative and rehabilitative therapy.	Before-After n = 19 (6 pediatrics) CMT	Scoliotic patients aged 15–65 (6 patients 18 and uncer- identified in Table 3 of study)	Reduction in Cobb angle	Reduction in Cobb angles in all patients.	There is no mention of adverse events made in this study.
	Lantz C & Chen J, 2001 [64]	Effect of chiropractic manipulation on small scoliotic curves in younger subjects.	Before-After n = 42 CMT	Children aged 6–17, with Cobb angles 6–25	Reduction in Cobb angle	No overall reduction in Cobb angle after 6.5–28.5 months of care.	There is no mention of adverse events made in this study.
Torticollis	Haugen E, 2011 [66]	Evaluate measurement methods and examine short-time effect of manual therapy in addition to physiotherapy in infants with torticollis.	RCT n = 32 MT	Infant aged 3–6 months, diagnosed with torticollis	Primary outcome: Videoclip recordings, Secondary outcomes: 12 parameters of body function, activity, participation	No significant difference in primary outcome. Found non-significant tendency to greater improvement in lateral flexion and head righting in intervention group.	There is no mention of adverse events made in this study.
Upper Cervical Dysfunction	Saedt E, et al. 2018 [67]	To gain insight into the patient characteristics and reasons for seeking care in infants with indications of upper cervical dysfunction referred for manual therapy.	Before-After n = 295 MT	Infants aged < 27 weeks, with positional preference, restless, abnormal head position, excessive crying	Improved flexion-rotation test and lateral flexion tests Parental perception of treatment effects Pre- and post treatment self-reported questionnaires	Flexion- rotation test decreased from 78.8 to 6.8%. Lateral flexion test decreased from 91.5% to 6.2%. All parents perceived positive treatment effects.	No serious adverse events were reported during this study.

5.3. Scoliosis

Five studies looked at the use of manual therapy in the treatment of scoliosis. Four looked at the use of CMT [61–64]. Of these, one was a high quality RCT, three before-after, two medium and one of low quality. The fifth study was a high quality RCT that looked at the use of OMT [65].

A medium quality before-after observational study by Byun and Han examined whether chiropractic techniques would reduce the curve of adolescent idiopathic scoliosis in 5 healthy children with an average age of 11.8 years with Cobb angles greater than 10 degrees (average 11.2 degrees). The primary outcome was the change in the Cobb angle that was measured after 4 and at 8 weeks of treatment. The results of this study were that the Cobb angle was noticeably decreased after 4 weeks, but no further reduction in Cobb angle was noted after 8 weeks, except in one male. They concluded that chiropractic techniques effectively reduced the Cobb angle in adolescent idiopathic scoliosis after 4 weeks. There was no mention of adverse events made in this study [61].

Rowe et al. conducted a high quality pilot RCT that investigated the clinical effects of CMT on children with scoliosis. This was a feasibility study whose purpose was to explore issues of safety, patient recruitment, patient compliance, treatment standardization, sham treatment refinement, inter-professional cooperation, quality assurance, and outcome measure selection. The primary outcome measured was the Cobb angle. Secondary outcome was the Scoliosis Quality of Life Index (SQLI). The researchers reported improved Cobb angles in 5 of the 6 patients that received CMT and an improved SQLI in 1 of the 6. Due to the small sample size, no conclusions could be made regarding effectiveness. Regarding adverse events, CMT delivered on 52 visits resulted in two benign reactions; 1 with moderate pain lasting 24 h, the other produced mild pain lasting 6 h [62].

Morningstar et al. conducted a low quality before-after case series that reviewed the clinical files of 22 patients, 6 of whom were 18 years or younger, who received a combination of CMT and rehabilitative therapy. The authors found reductions in Cobb angle (average 17 degree reduction) in all the patients, including the patients under the age of 18 years. No mention of any adverse events was noted in this study [63].

Lantz et al. conducted a medium quality before-after case series of 42 children, 16 males, 26 females, with scoliotic curves ranging from 4 to 22 degrees, ages 6–17 years, to determine the clinical effects of full spine CMT, use of heel lifts, and lifestyle counseling on the progression of the curves. Participants were treated for between 6.5 to 28.5 months. The main outcome was a reduction

in scoliotic curvature. The authors reported no overall improvement in scoliotic curves using CMT. No mention of adverse events was made in this study [64].

Hasler et al. conducted a high quality prospective RCT that sought to determine if OMT altered trunk morphology to unload the concave side of the scoliosis in order to halt curve progression. The study included 20 pre-pubertal women with curves that ranged from 20 to 40 degrees. The primary outcomes was trunk morphology and spine flexibility. The authors concluded that there was no evidence to support the use of OMT in the treatment of mild idiopathic scoliosis. No intervention-related side effects or complications were noted [65].

Overall Summary:

Inconclusive (unclear) evidence for use of CMT in childhood scoliosis.

Inconclusive (unfavorable) evidence for use of OMT in childhood scoliosis.

5.4. Torticollis

One medium quality pilot RCT investigated whether MT improved torticollis in 32 patients between the ages of 3–6 months. There were 15 infants in the study group who received MT plus physiotherapy (PT) and 16 infants in the control group who received child physiotherapy alone. The study did not describe the type of MT provided. The primary outcome measured was evaluating the torticollis symptoms via videotape footage of the child using a 4-point scale in which the child was rated as “much better”, “better”, “no significant change” or “worse”. Secondary outcomes included 12 measurement parameters that involved body function, activity, and participation corresponding to the International Classification of Function The study reported no significant improvement in the MT and PT group in the primary outcome, but improvement in two of the secondary outcome measures of improved passive and active lateral flexion of the neck. No mention of adverse events were noted in this study [66].

Overall Summary:

Inconclusive (unfavorable) evidence for MT for torticollis.

5.5. Upper cervical dysfunction

A high quality before-after observational study by Saedt et al. sought to gain insight into the patient characteristics and reasons for seeking care in infants with upper cervical dysfunction (UCD). A group of 295 infants (mean age of 11.2 weeks) with positional preference, restlessness, abnormal head position and excessive crying were treated with mobilization. The primary outcomes

were assessed with pre- and post-treatment self-reported questionnaires used to assess diagnostics, treatment procedures, outcomes, and harms from parents and manual therapists. The questionnaires consisted of two sections: one collected at baseline; the other posttreatment by both the parents and the manual therapists. The researchers concluded that the majority of infants with upper cervical dysfunction showed positional preference of the head and reduced the active and passive mobility of the upper cervical spine. After gentle upper cervical mobilization techniques, active and passive cervical mobility increased. They also reported that the parents reported a reduction in symptoms. No serious adverse events were reported during this study [67].

Overall Summary:

Inconclusive (unclear) evidence for the use of MT in infants with upper cervical dysfunction.

Discussion

This review identified 50 RCTs and observational original studies that evaluate manual therapy for pediatric conditions, which updates several previously published systematic reviews. Of particular importance, our review included studies investigating the effects of manual therapy on musculoskeletal conditions, including pediatric low back pain and headache. Other conditions not previously reported in some previous systematic reviews include: constipation, suboptimal infant breastfeeding, clubfoot, cuboid syndrome, headache, pulled (nurse's) elbow, asthma, obstructive apnea, autism, cranial asymmetry, postural asymmetry, scoliosis, torticollis, and upper cervical dysfunction.

Of the 50 studies, 32 were RCTs (18 high-quality, 10 medium-quality, and 4 low-quality). The remaining 18 studies were observational (1 high-quality, 13 medium-quality, and 4 low-quality). Observational studies were further broken down by study design (13-before-after, 4 interrupted time-series without comparison group, and 1 interrupted times-series with comparison group). Thirty-six studies reported 'favorable' results, five showed 'no improvement', and nine showed 'no difference' between study groups. In five of the nine 'no difference' studies, 'favorable' results were noted in both groups, of which two of these studies had MT in both groups.

Pediatric conditions assessed as 'moderate-favorable' were:

- Low Back Pain (using CMT);
- Pulled (or Nurse's) Elbow (using MT); and
- Preterm Infants (using OMT/CST to reduce days and costs in hospital).

Pediatric conditions assessed to be 'inconclusive-favorable' were:

- ADHD (using OMT);
- Autism (using CMT);
- Asthma (using OMT);
- Clubfoot (using MT);
- Cranial Asymmetry (using MT/CST);
- Dysfunctional Voiding (using OMT);
- Infantile Colic (using OMT/CST);
- Obstructive Apnea (using OMT);
- Otitis Media (using OMT);
- Postural Asymmetry (using OMT/CST);
- Suboptimal Infant Breastfeeding (using CMT/CST); and
- Temporomandibular Joint Dysfunction (using OMT).

Pediatric conditions assessed to be 'inconclusive-unclear' were:

- Asthma (using CMT);
- Autism (using VOMT);
- Cerebral Palsy (using OMT);
- Constipation (using OMT);
- Cranial Asymmetry (using OMT);
- Cuboid Syndrome (using MT);
- Headache (using CMT, OMT, and MT);
- Infantile Colic (using CMT);
- Low Back Pain (using MT);
- Otitis Media (using CMT);
- Nocturnal Enuresis (using CMT);
- Preterm Infants (using OMT/CST for general movement);
- Scoliosis (using CMT); and
- Upper Cervical Dysfunction (using MT).

Pediatric conditions assessed to be 'inconclusive-unfavorable' were:

- Scoliosis (using OMT) and
- Torticollis (using MT).

Our findings had a few notable updates from prior systematic reviews, especially the UK Update, of which "inconclusive-unclear" or "inconclusive-favorable" was the outcome for all conditions [10]. The UK Update was unable to review any musculoskeletal conditions because no studies were available at that time [10]. Evans et al. published the first high-quality RCT on adolescent low back pain, which allowed for this review to report a "moderate-positive" evidence for low back pain using CMT [33]. Another musculoskeletal condition that has an ongoing study is headaches (ClinicalTrials.gov Identifier: NCT02684916); we anticipate the results of this study will allow for better practitioner guidance because of the high rigor described in the protocol. Pulled (Nurse's) elbow using MT was also not in the UK Update, and was found to have a "moderate-positive" result in this study [37, 38].

Additional evidence ratings changed in a positive direction in our study from the UK Update for preterm infants (reducing length of stay and hospital costs) using OMT/CST. Three new high-quality RCT's not previously identified by the UK Update were identified showing favorable results, which accounted for this modification [55–57]. We were able to change the evidence ratings from “inconclusive-unclear” to “inconclusive-favorable” for two additional conditions: otitis media, based on data gathered from two medium quality RCT's [43, 45], reporting favorable results and for ADHD, based on the results of a high quality RCT showing favorable results [48].

We amended the evidence from “inconclusive-favorable” to “inconclusive-unclear” for infantile colic and pediatric enuresis using CMT. Regarding the change for infantile colic, our study included four studies, the most recent of which is a high-quality with improved outcomes [19]. However, the remaining studies showed either “no improvement” or “no difference” [20–22]. Our evidence rating is similar to the recent 2018 systematic review and meta-analysis of infantile colic and manual therapy conducted by Carnes et al. [68]. Carnes et al. concluded that while small benefits were found for the overall outcome, the benefit of manual therapy for infantile colic is still unclear [68]. For pediatric enuresis, our search identified only one observational study showing favorable results; however, this level of evidence was not enough to substantiate a “favorable” rating [25]. The UK Update conclusion was based off the Huang et al. systematic review, which included clinical trials that did not meet our eligibility criteria for manual therapy and year of publication [69].

Similar to the previous systematic review on this topic, and despite using only recent literature, this review continued to find serious methodological limitations within the included studies. Our most common methodological concern was the lack of standardization of the intervention, which varied across the professions and even between studies within the same profession. Many studies failed to adequately describe the methods used by the practitioner; most of the studies also failed to describe the number of treatments the patients received and over what duration of time. In addition, the provider's experience, training, and type of intervention used in the same study varied considerably. Another notable methodological concern was small sample size, which was not accounted for in the quality assessment. Finally, many studies failed to report on the incidence of adverse events.

Adverse events were addressed in only 20 of the 50 included studies reviewed. No lasting or significant adverse events were reported for children receiving any form of MT. Two previous systematic reviews have been published regarding the incidence of adverse events associated with pediatric spinal manipulation [7]. These reviews

report that adverse events are rare, but that the true incidence is unknown as they have not been evaluated prospectively. The current “Best Practices for Chiropractic Care of Children: A Consensus Update” report states that the best way to minimize adverse events is by conducting a thorough history and examination, as the majority of adverse event cases in the literature are often due to underlying pre-existing pathology that was not diagnosed [9]. Our review is in agreement with previous studies in recommending that prospective-population-based studies should be conducted to identify the true incidence of serious adverse events due to MT in the pediatric population. Such a clinical trial is currently ongoing (ClinicalTrials.gov Identifier: NCT02268331).

Additionally the “Best Practice” report states that manual procedures should be modified when treating children to take into account the differences in patient size, structural development and flexibility of the joints [9]. Modifications should include using gentler, lighter biomechanical forces proportioned to the size and structural development of the child. Both Triano et al. and Todd et al. [8, 70]. have posited that healthcare providers using SMT are able to modulate the amount of forces used. We agree this ability to modulate for pediatric, geriatric, and other special populations ought to be included in undergraduate training programs or during continuing education workshops for field practitioners.

Limitations

Aside from using rigorous methodology in this systematic review and conducting a comprehensive search, it is possible that our search failed to identify every relevant study, especially considering the restriction of the search to English-language studies. Our knowledge of unpublished trials have influenced our conclusions; unpublished trials may be more likely to produce negative or equivocal results. Although the independent reviewers performed this review, and in spite of utilizing systematic strategies for assessing the quality of the included studies, there is still room for subjective interpretation. While we deliberately chose widely accepted recommendations for assessing quality and determining bias, our adaptation of some recommendations to better fit our study design may have impacted our conclusions. Also, each reviewer has varying degrees of familiarity with the assessment tools *a priori*, which could influence the inter-reviewer reliability of the primary quality and bias assessments. Finally, all six reviewers are chiropractors; this expertise, as well, may be considered a source of bias.

Conclusions

Favorable, albeit inconclusive, results were reported in 36 of the 50 studies we assessed that used different types of

manual therapies for pediatric conditions. Compared to previous reviews of the literature, we found a number of clinical trials investigating the effects of manual therapies on pediatric musculoskeletal conditions. Twenty-four studies included information on adverse events that were all transient and mild to moderate in nature. Clearly more research investigating the clinical effectiveness of manual therapies for pediatric conditions, along with the incidence of adverse events, is required in order to allow practitioners and parents to make better informed choices with respect to care planning for children with pediatric conditions.

Abbreviations

ADHD: Attention deficit hyperactivity disorder; AHRQ: Agency for Healthcare Research and Quality; CAM: Complementary and alternative medicine; CMT: Chiropractic manipulative therapy; CST: Cranial-sacral therapy; EENT: Eyes, ears, nose, and throat; HHS: Department of Health and Human Services; HVL: High velocity, low amplitude; LBP: Low back pain; MT: Manual therapy; NHIS: National Health Interview Statistics; OMT: Osteopathic manual therapy; RCT: Randomized controlled trial; SMT: Spinal manipulation therapy; TMD: Temporomandibular dysfunction; UK: United Kingdom; US: United States; VOMT: Visceral osteopathic manipulation

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Subject: FW: FW: Vitalism and chiropractic

From: Jo-Ann Willson
Sent: Monday, March 11, 2019 10:14 AM
To: Rose Bustria <RBustria@cco.on.ca>
Subject: FW: FW: Vitalism and chiropractic

Council – FYI.

Jo-Ann Willson, B.Sc., M.S.W., LL.B.
Registrar & General Counsel

From: Dave Starmer [<mailto:drstarmer@gmail.com>]
Sent: Monday, March 11, 2019 10:11 AM
To: Jo-Ann Willson <jpwillson@cco.on.ca>
Subject: Re: FW: Vitalism and chiropractic

Hi Jo-Ann,

I have no objection to this link being shared in the FYI section of a package and council members can review it if they are interested.

Dave.

On Mon, Mar 11, 2019 at 9:57 AM Jo-Ann Willson <jpwillson@cco.on.ca> wrote:

I have received this. The President is responsible for setting the agenda. Please advise if you want it included on the Exec or Council agenda. Thank you.

Jo-Ann Willson, B.Sc., M.S.W., LL.B.

Registrar & General Counsel

From: Gilles LaMarche [<mailto:gilles.lamarche@life.edu>]
Sent: Monday, March 11, 2019 8:39 AM
To: Jo-Ann Willson <jpwillson@cco.on.ca>
Subject: Vitalism and chiropractic

Good morning Jo-Ann – hope all is well. Dr. Rob Scott, president of Life University posted this video last week.

<https://www.facebook.com/TodaysChiropracticLeadership/videos/851826325171006/UzpfSTY1ODAlNjMxOToxMDE1NzU1MjM1NzQ3NjMyMA/>

He is a DC, who also has a PhD in physiology, and his explanation of vitalism in this video is excellent. It is brilliant and simple to understand. He is a former CCO registrant who understands what is going on. This video is in the public interest, and I thought it would be a good idea for council to view it. Those of us who have lived this paradigm for decades are not crazy, and personally I am alive because of that is the paradigm I chose to live.

G

Dr. Gilles A. LaMarche

1363

Vice President of University Advancement

Life University

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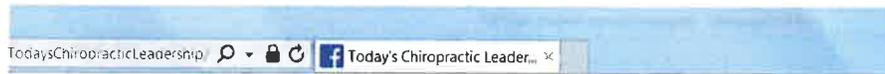
gilles.lamarche@life.edu

LIFE
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--

Dr. David J. Starmer

drstarmer@gmail.com



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Today's Chiropractic Leadership
March 9 at 8:28 AM ·

Life University president, Dr. Rob Scott, shares his frustration with a view of chiropractic "that is being driven by a very small, narrow, politically focused segment of the profession...based upon misinformation, innuendo, and a frank bias."

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ITEM 7.7

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Chiropractic & Manual Therapies 1365

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Debate | Open Access

Chiropractic, one big unhappy family: better together or apart?

Charlotte Leboeuf-Yde, Stanley I. Innes, Kenneth J. Young, Gregory Neil Kawchuk and Jan Hartvigsen

Chiropractic & Manual Therapies 2019 27:4
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Abstract

Background

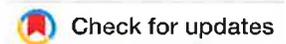
The chiropractic profession has a long history of internal conflict. Today, the division is between the ‘evidence-friendly’ faction that focuses on musculoskeletal problems based on a contemporary and evidence-based paradigm, and the ‘traditional’ group that subscribes to concepts such as ‘subluxation’ and the spine as the centre of good health. This difference is becoming increasingly obvious and problematic from both within and outside of the profession in light of the general acceptance of evidence-based practice as the basis for health care.

Because this is an issue with many factors to consider, we decided to illustrate it with an analogy. We aimed to examine the chiropractic profession from the

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perspective of an unhappy marriage by defining key elements in happy and unhappy marriages and by identifying factors that may determine why couples stay together or spilt up.

Main body

We argue here that the situation within the chiropractic profession corresponds very much to that of an unhappy couple that stays together for reasons that are unconnected with love or even mutual respect. We also contend that the profession could be conceptualised as existing on a spectrum with the 'evidence-friendly' and the 'traditional' groups inhabiting the end points, with the majority of chiropractors in the middle. This middle group does not appear to be greatly concerned with either faction and seems comfortable taking an approach of

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‘you never know who and what will respond to spinal manipulation’. We believe that this ‘silent majority’ makes it possible for groups of chiropractors to practice outside the logical framework of today’s scientific concepts.

Conclusion

There is a need to pause and consider if the many reasons for disharmony within the chiropractic profession are, in fact, irreconcilable. It is time to openly debate the issue of a professional split by engaging in formal and courageous discussions. This item should be prioritised on the agendas of national associations, conferences, teaching institutions, and licensing/registration as well as accreditation bodies. However, for this to happen, the middle group of chiropractors will have to become engaged

and consider the benefits and risks of
respectively staying together or breaking
up.

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Keywords ▼

Background ▼

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ITEM 7.8

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Chiropractic Board announces interim policy on spinal manipulation

14 Mar 2019

The Chiropractic Board of Australia (the Board) has set an interim policy on spinal manipulation for infants and young children while an independent review of the practice is carried out by Safer Care Victoria.

The Board is committed to ensuring the public has access to, and receives, safe, ethical and competent care from registered chiropractors.

The Board awaits with keen interest the outcome of an independent expert review of the current best evidence for the efficacy of spinal manipulation to treat childhood illnesses or health concerns in infants and young children.

The review outcomes will be used to inform future policy on the regulation of spinal manipulation for infants and young children for public protection.

The *Interim Policy – Spinal manipulation for infants and young children* is to protect the public until the outcomes of the expert review are known, and a final policy is developed on the issue.

The interim policy clearly outlines **our expectation that chiropractors not use spinal manipulation to treat children under two years of age**, pending the recommendations arising from the review.

The Board expects chiropractors to comply with the interim policy, in addition to following the guidance provided in the [Statement on paediatric care](https://www.chiropracticboard.gov.au/Codes-guidelines/FAO/Position-statements/Paediatric-care.aspx) (https://www.chiropracticboard.gov.au/Codes-guidelines/FAO/Position-statements/Paediatric-care.aspx) (2017) and the [Code of conduct for chiropractors](https://www.chiropracticboard.gov.au/Codes-guidelines/Code-of-conduct.aspx) (https://www.chiropracticboard.gov.au/Codes-guidelines/Code-of-conduct.aspx) (2014).

The interim policy is available as a position statement under [Codes and guidelines](https://www.chiropracticboard.gov.au/Codes-guidelines.aspx) (https://www.chiropracticboard.gov.au/Codes-guidelines.aspx) on the Board's website.

For more information

- Read the [interim policy](https://www.chiropracticboard.gov.au/documents/default.aspx?record=WD19%2f27998&dbid=AP&chksum=E%2f6wDiXxS%2bwjvXirLDCw%3d%3d) (https://www.chiropracticboard.gov.au/documents/default.aspx?record=WD19%2f27998&dbid=AP&chksum=E%2f6wDiXxS%2bwjvXirLDCw%3d%3d).
- Lodge an [online enquiry form](https://www.ahpra.gov.au/About-AHPRA/Contact-Us/Make-an-Enquiry.aspx) (https://www.ahpra.gov.au/About-AHPRA/Contact-Us/Make-an-Enquiry.aspx).
- For registration enquiries: 1300 419 495 (within Australia) +61 3 9275 9009 (overseas callers).
- For media enquiries: (03) 8708 9200.

Position statement

20 June 2017

Statement on paediatric care

The Chiropractic Board of Australia

The role of the Chiropractic Board of Australia (the Board) is to protect the public consistent with the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law).

In regulating the profession, the Board is responsible for registering practitioners, setting the professional standards and investigating concerns about chiropractors.¹ The Board aims to make sure the public has access to safe and competent services from members of the profession. It does this through its work in the National Registration and Accreditation Scheme (the National Scheme) in partnership with the Australian Health Practitioner Regulation Agency (AHPRA).

The National Scheme has patient safety at its heart, and all health practitioners have a duty to make safe and effective patient care their primary concern.

Codes and guidelines

The Board's Code of conduct for chiropractors (the Code) and Chiropractic guidelines for advertising of regulated health services are published on its website at www.chiropracticboard.gov.au. These documents, and the Board's other codes and guidelines, outline the Board's guiding principles and expectations of practitioners to deliver effective healthcare in an ethical framework.

The Code of conduct for chiropractors helps guide practitioners' professional judgement, and assists the Board in setting and maintaining expectations of good practice.

Section 1.1 states: 'If professional conduct varies significantly from this Code, health practitioners should be prepared to explain and justify their decisions and actions, and serious or repeated failure to meet this Code may have consequences for registration.'

Section 3.7 of the *Code of conduct for chiropractors* outlines the Board's expectations on caring for children and young people, including that good chiropractic practice involves 'placing the interests and wellbeing of the child or young person first.'

The *Code of conduct for chiropractors* requires practitioners to practice in an evidence-based and patient-centred manner so that they provide the best healthcare for their patients. Evidence-based practice involves a practitioner considering available evidence, including research and other sources of information, in addition to their clinical experience and the patient's values during their clinical decision-making process.

Healthcare decisions made in the context of evidence-based practice must be adequately underpinned by proper informed consent. As set out in section 3.5 of the Code, the informed consent process includes a full and honest disclosure of the evidence supporting any proposed care.

¹ Except in New South Wales, which has a co-regulatory model.

Whilst lower forms of evidence may be adequate to support a well-constructed and controlled trial of clinical care for some conditions, clinical experience alone is rarely adequate to support clinical decision-making that is contrary to current evidence and/or best-practice approaches. Patient consent does not end a practitioner's responsibilities to provide ethical and professional care consistent with the standards and expectations of the Board.

Chiropractic Board of Australia's position on paediatric care

Chiropractors receive extensive university education and training, including about caring for children. Parents typically seek chiropractic services for their children for musculoskeletal disorders. In caring for children chiropractors may provide a range of treatment modalities including manipulation, dietary and ergonomic advice, exercise, counseling and other manual therapies such as massage.

Best-practice approaches to providing chiropractic care to children are published in peer reviewed literature. This evidence should be used to guide clinical practice and ensure chiropractors provide safe care. Current research indicates that the incidence of serious adverse events, either directly from manual therapy or indirectly by delayed or mis-diagnosis, is rare but does occur. The Board considers that more research is required to better understand this.

The Board expects practitioners to make sure their clinical practice is consistent with current evidence and/or best-practice approaches. Practitioners should critically evaluate their strengths and weaknesses and use continuing professional development (CPD) and other educational tools to ensure their knowledge and skills are appropriate for their work.

The Board expects practitioners to:

- discuss their proposed management plan with the patient's parent and/or guardian
- inform the parent and/or guardian about the quality of the acceptable evidence and explain the basis for the proposed treatment
- provide patients (or parent and/or guardian) with information about the risks and benefits of the proposed treatment and the risks of receiving no treatment
- understand that children have significant anatomical, physiological, developmental and psychological differences and needs from adults and that their healthcare management requires specific skills and expertise; including informed consent, examination, diagnosis, referral of 'red flags'² and contraindications to care
- modify all care and treatment (including technique and force) to suit the age, presentation and development of the patient
- promptly refer patients to the care of other registered health practitioners when they have conditions or symptoms outside a chiropractor's scope of practice, for example 'red flags', and
- communicate effectively with other health practitioners involved with the care of the patient such as the patient's general practitioner or paediatrician.

When practitioners do not have the clinical skills and knowledge to appropriately assess and/or manage a paediatric patient, the Board expects them to refer the patient to another healthcare practitioner who has the appropriate skills, or to co-manage the patient with them.

This should happen immediately when there are serious conditions that require urgent referral present, such as 'red flags'. In all cases, the patients' best interests must be the priority.

² The presence of possible serious pathology that requires urgent medical referral

If anyone has a concern about a chiropractor

As the national regulation and registration body governing the chiropractic profession, the Board would be very concerned about any practitioner who is not practising chiropractic safely and within the limits of their competency, training and expertise.

Complaints or concerns about registered chiropractors can be brought to the attention of the Board through AHPRA. Anyone seeking details about the management of complaints or concerns (referred to under the National Law as 'notifications') or if anyone wants to raise a concern or make a complaint about the, advertising, health, conduct or performance of a chiropractor they can do so by going to the AHPRA website, see the *Complaints or concerns* section of www.ahpra.gov.au.

All complaints or concerns received will be assessed by the Board and be dealt with according to the disciplinary processes and provisions defined in the National Law.

For more information

- Visit www.chiropracticboard.gov.au under *Contact us* to lodge an online enquiry form.
- For registration enquiries: 1300 419 495 (within Australia) +61 3 8708 9001 (overseas callers).
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Home » Breaking News » President of Tokyo College of Chiropractic Issues Statement on Australian Ban of Infants

President of Tokyo College of Chiropractic Issues Statement on Australian Ban of Infants

Friday, March 15, 2019 - 15:14
NEWS ANALYSIS



Chiropractors Trained to be Competent and Capable in Care to the Very Young

Phillip Ebrall is a leading world authority on chiropractic education, having lead two program renewals with RMIT University and assisted the establishment of new education programs in Japan, South Korea and Malaysia, and Australia's first chiropractic program outside a capital city to serve regional Australians.

Phillip Ebrall, PhD, PhD (Cand)
President, Tokyo College of Chiropractic
Professor of Chiropractic

The advice of the Chiropractic Board of Australia is both precipitous and indecisive, being ignorant of the evidence strongly supportive of chiropractic care for children under two.

It appears to be an example of a regulatory body collapsing to political pressure led by the members of the medical profession now holding elected positions in governments and Ministerial advisors throughout Australia.

This planned political infiltration for the purpose of subverting chiropractic has been reported by chiropractic historians such as Rome and Painter and is documented in the papers of The Wilk Trial as The Iowa Plan, having originated by the Iowa Medical Society.

The Iowa Plan is summed up in the plaintiffs' 132-page aid to the court, submitted June 25, 1987, in the Wilk case. The Iowa Plan's section "What Medicine Should Do About The Chiropractic Menace" includes a Part G titled "Undertake a positive program of 'containment'" to ensure chiropractic as a profession will 'wither on the vine' and the chiropractic menace will die a natural but somewhat undramatic death. The Iowa Plan states that such actions taken by the medical profession should be persistent and behind-the-scenes whenever possible. Any professional chiropractic body that dismisses The Iowa Plan as a 'conspiracy theory' is negligent in their duty of care to its members and the profession.

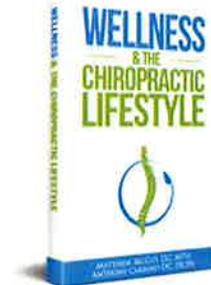
Any professional chiropractic body that dismisses The Iowa Plan as a 'conspiracy theory' is negligent in their professional duty of care to its members.

BLOGS

- [Chiropractic Care of Infants - Sherman College Issues Statement](#)
- [New Research on Rheumatoid Arthritis, Spinal Pain & Chiropractic](#)
- [Foundation for Vertebral Subluxation Responds to Australian Infant Ban](#)
- [Chiropractic Expert Says Australian Board's Infant Ban Further Evidence of a "Coup d'état" of the Profession's Identity](#)
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CHIROFUTURES MALPRACTICE INSURANCE PROGRAM

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This decision of the CBA meets the evidential basis for an element of the US-AMA's Iowa plan which is being enacted by a global cabal, recently in Indonesia and South Korea, and for a long time, Australia.

The use by the CBA of the vague term 'manipulation' demonstrates its isolation from real-world chiropractic practice where conventional chiropractors 'adjust' within an evidence-based clinical framework and rarely, if ever, manipulate children. The notion that chiropractors 'manipulate' babies is a deliberate myth of political medicine with nefarious intent.

All five programs of chiropractic education that I have for 30 years successfully and repeatedly led through accreditation, specifically teach the contraindications to chiropractic management of the young. Management includes a broad spectrum of personalised care from adjustment to nutrition, activity, soft-tissue treatment, and self-care.

The literature clearly establishes birth trauma as an event, however low its prevalence, and chiropractors are trained to be competent and capable in the provision of integrated support based around highly specific and expressly gentle care to the very young, with supportive care to the mother.

The type of chiropractic care shown in the relevant video clip represents standard practice within medicine in Germany. There is substantial evidence of this and as with chiropractic, absolutely no evidence of harm. To the contrary, there is much evidence of efficacy and safety of conservative chiropractic care of children.

For Australian authorities to target only the chiropractic profession in this matter is blatant discrimination and most ill-informed. Chiropractors will continue to care for infants and families in their safe, conservative and well-documented manner, as will physiotherapists, osteopaths, practitioners of Traditional Chinese Medicine and Philippines Healing, and medical practitioners, in their less evidence-based manner.

The real issues overlooked in this matter are the absence of evidence of harm by chiropractors, and the absence of evidence supportive of clinical management by medicine and other disciplines."

Phillip Ebrall
Tokyo, 15 March 2019



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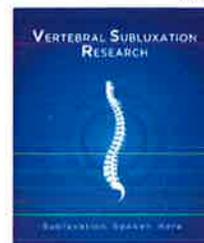
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WEDNESDAY, FEBRUARY 27, 2019

Health-care overhaul called 'biggest in 50 years'

Tories unveil plan to amalgamate 20 agencies in effort to make patient care more seamless

THERESA BOYLE
HEALTH REPORTER

What has been described as the “biggest change” in Ontario’s health system since medicare was created half a century ago could dramatically impact how patients receive care and workers deliver it, health-care leaders say.

The massive transformation unveiled by Health Minister Christine Elliott on Tuesday is aimed at making the health

system easier for patients to navigate.

The weak links in the current system are the transfer points between various sectors, including hospitals, primary care, home care, long-term care and mental health. Most complaints come from patients who fall between the cracks of those sectors, particularly after being discharged from hospital.

The plan for the reformed system will see those sectors come together under

the oversight authority of a single super-agency known as Ontario Health, Elliott told a news conference. Employees from the various sectors will work together in teams, silos will be eliminated and patients will ultimately be able to move through the health system “seamlessly,” she said.

Twenty existing agencies will be absorbed into Ontario Health, including 14 Local Health Integration Networks, Cancer Care Ontario and eHealth. None of these agencies will disappear overnight as the rollout of the new system is expected to take years, senior bureaucrats explained in a technical briefing.

Elliott said the health system of the future will see fewer patients treated in hospital hallways, more seniors get care in their homes, less bumpy discharges from hospital and fewer unnecessary trips to emergency departments.

A major emphasis will be placed on improving digital health so that patients will have easier access to primary care providers, such as family doctors and nurse practitioners, the minister said.

HEALTH continued on A7

Inside: 'Transformation' to take years. A7

Former deputy minister questions 'radical change'

HEALTH from A1

Patients will be able to make appointments online, have "virtual" appointments and get computer access to their own health records.

Former deputy health minister Dr. Bob Bell described the overhaul as "the biggest change since we started medicare in this country 50 years ago" and questioned why such "radical change" is necessary.

Until now, the biggest changes Ontario's health system has seen were the merging and closing of hospitals by the Health Services Restructuring Commission more than 20 years ago and the elimination of community care access centres two years ago, he noted.

The Progressive Conservatives ran in last year's provincial election on a health platform that promised to end hallway

medicine, improve mental health and addiction services and create new long-term-care beds.

"You don't need this kind of radical change to achieve those goals. This requires a huge leap of faith and is based upon some untested hypotheses."

He said other provinces that have made such changes have not fared that well and questioned why Ontario would want to mess with world-class agencies such as Cancer Care Ontario.

He said he is especially concerned about the effect on home-care patients.

Bell said he was pleased to hear the minister assure patients they will still be able to access services with their "OHIP card rather than their credit card."

There will be a reduction in "back office" positions as a re-

sult of the changes, said several health-care leaders who spoke on condition of anonymity because they were not authorized to give interviews. Services such as human resources and communications will be centralized, but because the transformation is to roll out slowly, positions can be eliminated through attrition, they said.

Sue VanderBent, CEO of Home Care Ontario, said one of the biggest problems in the sector right now is that home-care workers such as visiting nurses do not have real-time access to patient records. So hospitals, primary care providers and home-care providers are not on the same page when it comes to caring for patients, she said.

It's not unusual for a family doctor to change a prescription after a patient has been discharged from hospital, VanderBent said. It can then take up to

two days for a home-care worker to learn of the change.

In the interim, the patient can get worse and be rushed to the emergency department by panicked loved ones, she said, noting such journeys put unnecessary stress on patients, families and the health system, and contribute to overcrowding.

"Technology will be a huge enabler in terms of being able to deliver better care," VanderBent said.

Kevin Smith, president of the University Health Network, said he welcomes the focus on eradicating hallway medicine. He estimated that 20 patients were being cared for in the corridors of the emergency departments at Toronto Western and Toronto General hospitals on Tuesday.

"My hope is that we allow providers the tools that they need to provide outstanding care in a

system that is not struggling to operate with hospitals that are at over 110 per cent occupancy every day," he said.

It will take money to ensure the transformation rolls out smoothly, Smith said.

"The elephant in the room is money," he said, noting hospital inflation alone stands at 3 per cent annually.

"In order to protect patients, we need to see some investment that will allow us to preserve front-line staff and the teams that will allow that staff to become integrated."

Doris Grinspun, CEO of the Registered Nurses' Association of Ontario, said care co-ordinators who now work for Local Health Integration Networks — which are to be scrapped — will likely see some changes to their jobs. She said she expects about 4,500 of them to be transferred to primary-care settings.

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Massage therapist Mark Donlevy faces 14th sexual assault charge

CBC/Radio-Canada 14 hrs ago



© CBC Mark Donlevy has been charged with sexual assault for the 14th time, for an alleged incident dating back to 2012.

Former Saskatoon massage therapist Mark Donlevy has been charged with sexual assault for the 14th time.

Donlevy, 50, was convicted in November in relation to an alleged 2004 sexual assault and sentenced to three years in prison. He has since appealed the conviction.

Saskatoon police announced on Wednesday that a now-48-year-old woman made a report in December.

A news release alleges the woman was assaulted after talking with Donlevy on a dating site and meeting up in June 2012.

The Saskatoon Police Service encourages anyone who believes they may have been the victim of a sexual assault, regardless of when it happened, to call them at 306-975-8300 or file a report in person as SPS headquarters.

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Getting away with pharmacy fraud is 'no problem' in Ontario

Marco Chown Oved - Investigative Reporter, Carolyn Jarvis - Global News 3 hrs ago



© Provided by Toronto Star Newspapers Limited Ayman Mikhael pleaded guilty to Ontario's biggest pharmacy fraud in the last five years. In July 2015, he admitted to overbilling ODB for \$2.5 million between 2009 and 2011.

"I'm the cleaner," says the man wearing a ball cap and sunglasses to mask his identity.

"I help them to clean up the books ... fix the papers," he says. "Make it look nice, like a proper pharmacy."

We'll call the cleaner "Ivan." He agreed to share details of the murky world of pharmacy fraud — a scam that costs the public millions of dollars every year, but no one knows exactly how much.

Ivan is the man pharmacists call when they have been flagged for overbilling the Ontario Drug Benefit Program (ODB), sometimes for

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hundreds of thousands or even millions of dollars. He comes in and creates a paper trail to hide the fraud and get pharmacists off.

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The pharmacists are "scared, afraid," when they first call, he says. "The possibility exists that they're going to jail. It's fraud."

But Ivan, who has a long and well documented history in the health-care field, "knows the system really well." Ministry of Health auditors look for drugs a pharmacy has billed for but never had in stock. Ivan creates fake transfers from other pharmacies to make those drugs appear in the inventory.

Ivan claims to have helped disguise fraud at more than 100 Ontario pharmacies over the last five years. He says it's easy to hide the evidence, and coaches pharmacists on how to fool the auditors.

"You say, 'Oh, I forgot about this. ... We never scanned it, we never entered it. ... We transferred that medication two months ago from (another) pharmacy and it was never put in the system.' "

Sometimes the auditors give notice that they are going to inspect a pharmacy and Ivan comes and fixes the books ahead of time.

"Three hours," is all he needs, he says, chuckling. "No problem."

The ODB pays for medications for Ontario's most vulnerable: children, the elderly and those on social assistance. When a qualified patient fills a prescription, they either don't pay anything, or pay a few dollars and ODB covers the rest.

The program costs the province more than \$5.4 billion a year.

Pharmacists bill the province every two weeks for medication dispensed to ODB patients and are paid shortly afterwards.

Dishonest pharmacists overbill by tacking drugs they never dispensed onto their bills, so they are reimbursed for more drugs than they sold. Untold millions of dollars earmarked for the sick and needy end up in their pockets instead.

A Toronto Star/Global News investigation has found a system that struggles to catch fraud and hold those responsible to account.

The investigation reveals:

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Very few pharmacists get caught. Of the more than 16,000 pharmacists in Ontario, only 39 were disciplined by the College of Pharmacists for unsubstantiated ODB billing between 2013 and 2017, according to an analysis of college records. This number includes pharmacists disciplined for poor record keeping.

When pharmacists are caught, they are rarely charged. During those same five years, only seven pharmacists were charged with criminal offences, and four others with lesser provincial offences.

Pharmacists charged with ODB fraud aren't getting convicted. The investigation found only two pharmacists convicted of criminal offences for overbilling during this time period, and three more convicted of provincial offences.

Even when a pharmacist is caught, it doesn't prevent the overbilling from continuing, either at the same pharmacy or another one owned by the same person.

The Ministry of Health recouped almost \$40 million in overbilled payments in the last five years. Statistics obtained from a freedom of information request show that once identified, virtually all overbilled amounts are recovered.

This excellent recovery rate is because, most of the time, overbilled amounts are simply “clawed back” from the next payment to the pharmacy. The recovery occurs almost immediately, often years before pharmacists face criminal charges or disciplinary proceedings.

But while the auditors are good at recouping what they have found, there's evidence to show they're missing millions more. Ontario's auditor general identified \$4 million of unrecovered overpayments made in 2016/2017 simply by flagging suspicious paperwork — drugs dispensed to dead patients, or birth control pills prescribed to men, for example.

And when it comes to holding pharmacists accountable — even when they admit to overbilling — the system is set up to fail.

In June 2017, Eiman Amin stood in the second-floor hearing room at the college of pharmacists and admitted that she overbilled the ODB for nearly \$1 million. She was not charged criminally, nor did she lose her pharmacist's licence.

Despite having overbilled for “huge quantities of drugs and products” and attempting “to mislead ministry inspectors,” the only punishment

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she received was from the college, which suspended her license for 16 months and gave her a \$5,000 fine. The government recouped its money after Amin remortgaged her house and sold land in Sudan.

Amin ran the Noor Drug Mart on Eglinton Ave. in Mississauga for more than a decade before a ministry audit found she had overbilled \$907,039.85 between 2010 and 2012.

In their report, inspectors wrote that the pharmacy had more than doubled its ODB reimbursements by overbilling.

Amin provided fake invoices that overstated her wholesale drug purchases by 726 per cent, according to college disciplinary documents. When confronted, Amin asked for a "favour" and requested they be disregarded.

Amin did not respond to interview requests made through messages left with her children and a detailed letter delivered to her home.

She explained her actions to the college by saying her husband did not have a full-time job and she was the family's sole provider, responsible for her four children, who she claimed were all living at home at the time of the overbilling.

Citing Amin's "remorse" and her "difficult personal circumstances, including multiple stressors in her personal life relating to emotional, health and financial issues," the college decided a licence suspension was appropriate.

She was permitted to return to work as a pharmacist in August 2018.

Anyone who fills a prescription has their information entered into a pharmacy's computer. In fraud cases, pharmacists typically use this information to repeatedly fill phantom prescriptions and bill the government.

"So if you came into the pharmacy once, they have your Ontario health card," said Ivan the cleaner. "They have that information in the system, and then they can bill that anytime they want.

"There's so many pharmacies and then there's a system (that) is not that great, and it's not red-flagging," he said. "If you're not doing the crazy amounts, you're not going to get caught."

It's simply too tempting to tack a few extra drugs onto your bi-weekly bill, especially typical products likely to go unnoticed.

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"It's the smaller, mundane products that equal up to a lot over a given period of time," said Det.-Sgt. Ted Schendera, who heads the Ontario Provincial Police health fraud investigation unit. "Smaller products are easier to hide."

Boxes of Contour diabetes test strips, for example, cost \$85 each. Many pharmacies bill for hundreds of boxes each month. A dozen boxes added into each bill adds up to tens of thousands of dollars in fraud a year — and that's just one product. With multiple products, illicit profits can soar into the millions.

After massive frauds involving blood glucose test strips were exposed in the early 2010s, the province changed its reimbursement policy, limiting how many strips ODB will cover.

OPP investigators often discovered that not only were the test strips never dispensed, they were never bought by the pharmacy, said Schendera.

"Most of the cases, they're not ordering the items," he said. "They never existed."

Because audits take so long to complete, it makes it difficult for police to make arrests. After an audit, pharmacists have been known to quickly sell their businesses and even "skip the country," said Schendera.

These fraudster pharmacists often sell their pharmacies at a premium because the overbilling makes them look more profitable than they actually are.

Said Attalla is one of the few pharmacists in Ontario to be criminally charged with fraud.

Attalla has owned 18 pharmacies across the GTA and Golden Horseshoe over the last 20 years. He admitted to professional misconduct at the college, but the prosecution of his criminal case fell apart after audit reports were ruled inadmissible and the charges were withdrawn in 2016.

In 2012, Attalla was charged for overbilling more than \$355,000 over two years at Rathburn Pharmacy in Mississauga.

After his criminal proceeding, Attalla was brought before the college, where he admitted to professional misconduct relating to more than \$406,000 in overbilling at Rathburn and at Supercare Pharmacy,

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located in Toronto's Jane and Finch neighbourhood. His pharmacist's licence was suspended for 30 months, he was ordered to sell his pharmacies, and fined \$20,000.

Shortly afterwards, Attalla's life and businesses began to unravel. Three of his pharmacies declared bankruptcy and were seized in 2016. The next year, Attalla stopped paying the mortgage on his 10,000-sq.-ft. Mississauga mansion, which was seized by creditors and sold. Seven months later, he declared personal bankruptcy, listing \$1.8 million in debts.

"Yes, I was accused and I was proved innocent by the court, which is a higher level of legal system in Canada, right?" Attalla told reporters from the Star and Global News at his new, smaller Mississauga home.

He also said he only admitted fault at the college because he ran out of money to defend himself.

The amount overbilled was clawed back from later payments to his pharmacy, said Attalla, although the ministry would not confirm this.

Attalla said he took responsibility at the college hearing for failure to properly oversee his pharmacies' billings, not for the overbilling itself.

"Because I was the owner, I took the responsibility," he said. "But I wasn't working in the pharmacy. I hired people to work for me.

"The documentation is a thing which unfortunately wasn't actually very well maintained in the pharmacy," he said. "I wasn't able to (find) every single document they asked for.

"If you read (the decision) very carefully, you see most of (it) is about documentation, not intention to do anything."

In criminal court, Attalla said, the Crown "didn't prove what he accused: that I sold drugs on paper that I never bought. He didn't prove that. He couldn't prove that ... If you say I billed government for certain drugs that I never bought, then prove it. Prove it.

"They never proved it."

Attalla's lawyer, Howard Rubel, declined to discuss his case specifically, but said the Crown often has difficulty proving pharmacy fraud.

"The state of the evidence in many of these cases is rather poor," said Rubel. "(The ODB) is not set up as a forensic system, so when they try

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to use it as a forensic system to create proof that can be used in a criminal court, often that proof just doesn't meet the test."

That's why many cases don't even lead to charges, let alone convictions, Rubel said.

"If they don't have admissible proof of who entered the prescription, who filled the prescription, who entered the information into the pharmacy's database ... it's not even going to make its way into a criminal court."

Some criminal investigations result in provincial charges under the Ontario Drug Benefit Act. But although such charges could technically lead to up to a year in jail, they generally result in little more than a fine, Rubel said.

"Provincial offences? It's gonna be the same as a speeding ticket," he said.

Joseph Salek's name is emblazoned on the pedestrian bridge over Bayview Ave. at the Canadian National Institute for the Blind, where commuters see it every day.

Salek contributed enough money toward the footbridge's renovation in 2014 that his name, alongside another donor's, was erected on it in large white letters.

Only months before, Salek had quietly resigned from the Ontario College of Pharmacists and surrendered his licence after allegations that he overbilled the ODB for \$202,386.83 in 2009-10.

Shortly after the bridge was unveiled, Salek pleaded guilty to a breach of the Ontario Drug Benefit Act — a non-criminal offence — for the overbilling and was fined \$30,000. He was never charged criminally.

In an agreed statement of facts filed at Newmarket court, Salek said he was not in charge of billing at the Richmond Hill Medical Pharmacy, where the overbilling took place, although he admitted that he "received the monies."

The manager at the pharmacy was also disciplined by the college, which acknowledged "there is no evidence that (the manager) directly benefited," from the overbilling.

Salek did not respond to requests for an interview. Contacted by phone, his wife, Susan, said, "He is not available."

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His lawyer, Jody Berkes, said Salek paid back the province for the entire overbilling and also paid the fine.

Before resigning, Salek owned three pharmacies, all of which he sold to another pharmacist, Magdy Salama, for a combined \$12.2 million.

The college later found Salama had also overbilled. In his case, it was for \$762,000.

But Salama was nowhere to be found. All three pharmacies would close and Salama's pharmacist licence was revoked in absentia in 2018.

Ontario's auditor general has called out the ODB on four occasions for having too few inspectors. Hiring more inspections was an AG recommendation in 1996, in 2001, in 2007 and again in 2017.

"There are 4,200 pharmacies; they only inspect about six per cent a year," said current auditor general Bonnie Lysyk in an interview. "There's more money to be recovered."

In 2005-06, the Ministry of Health employed three inspectors and recovered just over \$1 million in overbilled payments. By 2016-17, there were 10 inspectors who recovered \$10.3 million.

"Governments don't like to increase staff because they're trying to save money. But at the same point, perhaps that will end up recouping more money into the public purse," said Lysyk.

Her team didn't inspect pharmacies but still found \$3.9 million in inappropriate payments by combing through ODB billings and looking for obvious problems. They found \$910,000 in drugs billed for dead people and \$922,000 in drugs billed for people who didn't need them, such as birth control for men.

"We ran analytics that identified situations that, had they inspected, they likely would've been able to recover more money," she said.

Beyond money, Lysyk says the inspection regime needs to be strengthened to speed up cases where fraud has occurred.

Three different bodies — the Ministry of Health, the OPP and the Ontario College of Pharmacists — are tasked with catching pharmacy fraud. But instead of three times the oversight, the system is clunky and drags out the process over years, sometimes topping a decade. That's because those agencies work consecutively, not simultaneously.

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The OPP’s health fraud investigation unit does not proactively investigate pharmacies, but waits for cases to be referred to it from the ministry.

“We can only investigate what’s referred to us,” Schendera said.

Not a single pharmacist was referred for criminal investigation between 2013 and 2015, prompting the OPP to approach the ministry.

That move resulted in 13 referrals in 2016-17. But of those, eight were too old to pursue because the pharmacy had been sold or the records were lost, Schendera said.

Ayman Mikhael pleaded guilty to Ontario’s biggest pharmacy fraud in the last five years. In July 2015, he admitted to overbilling ODB for \$2.5 million between 2009 and 2011.

When Mikhael was cut off from billing the ODB, he was able to transfer patient files to another pharmacy that he co-owned with his wife, Safaa Eskander, where the overbilling continued.

As the owner/operator of Wilson Medical Centre pharmacy in Hamilton, Mikhael was audited in late 2011 and found to have been billing for medications he had never purchased.

The ministry passed the file to the OPP, which charged Mikhael with fraud in February 2014. The next year, he pleaded guilty and was sentenced to two years less a day in jail for what the judge called a “massive fraud” that was “well-planned (and) deliberate.”

In sentencing Mikhael, Judge Maria Speyer said he “deliberately abused his position of trust as a pharmacist.”

In an interview, Mikhael said his life was unravelling while the fraud took place.

“I was having bad debts and I had major depression and it was all snowballing,” he said. “It was just lots of things happening. Bad bookkeeping. Bad supervision. Relying on other people to do the job.”

Speyer noted there was no evidence presented that Mikhael was “living a lavish lifestyle.”

During the time he was defrauding the government, land registry documents show he purchased a \$1.1-million mansion near the Mississauga waterfront. After extensive renovations, the opulent

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residence, which features an indoor swimming pool and movie theatre, was sold for \$4.65 million — while Mikhael was in jail.

Mikhael's pharmacist's licence was revoked in 2017, following his release from jail.

"I had to sell the house. I had to sell the business, everything," he told reporters at his doorstep. "I paid more back than I gained."

When Wilson Pharmacy's ODB billing privileges were revoked shortly after auditors first uncovered Mikhael's fraud in 2011, its patient files were moved to another pharmacy that he co-owned with his wife, Safaa Eskander. More overbilling took place there.

In July 2012, the ministry audited the second pharmacy, MT Cross, and identified \$162,000 in overbilling, involving many of the same patient names and drugs Mikhael had admitted to falsely billing.

"I don't deny anything," said Eskander, reached by phone.

She declined to comment further, saying, "I am not answering any questions."

Neither Mikhael nor Eskander were criminally charged for the overbilling at MT Cross.

Eskander admitted to professional misconduct at the college in 2017 and her licence was suspended for 14 months. The ODB overbilling was clawed back by the ministry.

Ivan the cleaner estimates that only two or three per cent of the pharmacists who commit fraud — "the sloppy ones" — are caught.

That's one reason to open up dispensing records to a wider group of health care professionals, said Kelly Grindrod, a pharmacy professor at the University of Waterloo.

"In other provinces, for example, every time a medication is dispensed through a pharmacy, a record is created," Grindrod said. "And if a physician was to look at the list of medications that had been dispensed for their patient, they could see some of these things."

With more scrutiny on which medications are being dispensed to patients, we wouldn't need to rely on a tiny number of inspections to catch pharmacy fraud.

"Ontario doesn't have this," Grindrod said. "We should have had this a long time ago. We don't."

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With files from Robert Cribb, Toronto Star, Chelsea Lecce and Ryan Moore, Ryerson School of Journalism, Jigar Patel, Seneca College, Megan Robinson and Leslie Whyte, Global News, and Sarah Bholra, Centennial College.

Marco Chown Oved is a Toronto-based investigative reporter. Follow him on Twitter: @marcooved

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THE CANADIAN PRESS 

Regulator won't pursue complaints about doctor's advocacy work

Paola Loriggio 15 mins ago

TORONTO - A Toronto doctor says Ontario's medical regulator has decided not to investigate dozens of complaints made about her push for stricter gun laws.

Dr. Najma Ahmed, a trauma surgeon who treated victims of a fatal mass shooting in Toronto last summer, says the College of Physicians and Surgeons of Ontario told her of its decision Tuesday.

Ahmed is a founding member of Canadian Doctors for Protection from Guns, a group calling for a national ban on private ownership of handguns and assault rifles.

The group has said it considers gun control a public health issue and stressed that physicians have a duty to speak out on policies that affect people's safety and well-being.

"Physician advocacy remains an important function that doctors fulfil on behalf of the public," Ahmed said in a statement issued late Tuesday.

Another group, the Canadian Coalition for Firearm Rights, had urged its supporters to file official complaints to the college about Ahmed's advocacy work.

The coalition argues doctors are not experts on firearms policy and should not be taking political positions.

The organization said Wednesday it understood the college's decision as saying the complaints were not deemed without foundation, but simply that it was not the appropriate forum to hear them.

"Concerning whether we believe that complaints to the CPSO was the correct course of action, the doctors have demonstrably spread misinformation and we fear that Canadians believed it without question because they are doctors," the coalition said in a statement.

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"We believe that lodging complaints with the licensing body was a reasonable course of action."

Those who filed complaints have 30 days to appeal the college's decision. The coalition said it would be up to individual complainants to decide whether to seek an appeal.

In a statement Wednesday, the doctors' group said it is pleased by the college's decision not to pursue the more than 70 complaints made about Ahmed.

"Dr. Ahmed wishes to sincerely thank Canadians for the hundreds of letters, emails, calls, and demonstrations of support and solidarity she has received in recent days," it said. "The CPSO decision is affirmation that advocacy for public health is an integral responsibility of physicians."

The college said it could not confirm the details of its decision given the appeal period. Its registrar, Nancy Whitmore, has previously said the complaints process is generally intended to focus on clinical care or professional behaviour rather than political issues.

A gun control law, Bill C-71, is making its way through the Senate, and Ahmed was among those who testified before the committee examining the bill.

The proposed legislation includes changes to the Firearms Act and Criminal Code, such as considering events more than five years in the past when judging applicants' eligibility for gun licences and requiring a buyer's licence be verified in the sale of non-restricted firearms.

The bill does not include an outright ban on private ownership.

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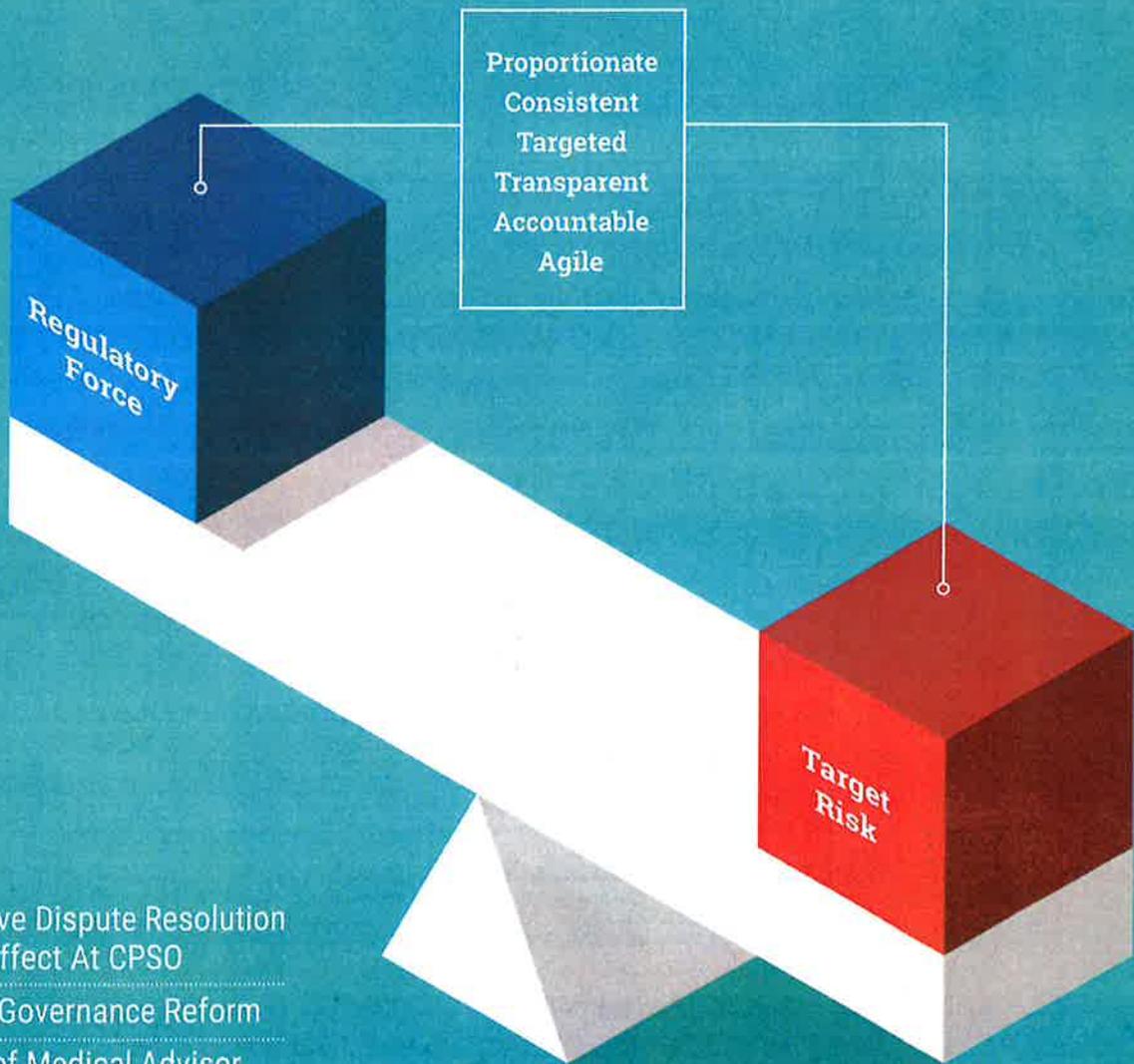
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Striving for Balance

College adopts **Right Touch Regulation** approach



'Right-touch regulation is based on a proper evaluation of risk, is proportionate and outcome focused; it creates a framework in which professionalism can flourish and organisations can be excellent' – *The Professional Standards Authority*

It's another busy night at a hospital emergency department, and two physicians end up exchanging fiery words with each other in front of patients and other colleagues.

While the behaviour is not professional and certainly does not reflect well on either physician, it could be argued that this is not a matter in which the College needs to be directly involved. In fact, it may be the type of matter that is most effectively managed at the hospital level.

If the antagonism between the two physicians is ongoing and escalates to the point where patients are placed in harm's way and the hospital is unable to manage the situation, then a solid argument could be made for regulatory intervention.

This approach is an example of right touch regulation, which has been adopted by a number of regulatory bodies across the world. Because the regulator is usually furthest removed from the harm it is trying to prevent, ▶

6 Principles of Right Touch Regulation

1. **Proportionate**
Regulators should only intervene when necessary. Remedies should be appropriate to the risk posed.
2. **Consistent**
Rules and standards must be joined up and implemented fairly.
3. **Targeted**
Regulation should be focused on the problem, and minimize side effects.
4. **Transparent**
Regulators should be open, and keep regulations simple and user friendly.
5. **Accountable**
Regulators must be able to justify decisions, and be subject to public scrutiny.
6. **Agile**
Regulation must look forward and be able to adapt to anticipate change.

Source: Professional Standards Authority

proponents of the framework suggest it is a very dull instrument for promoting behaviour change. Right touch regulation should see regulators only intervene when necessary and remedies should be appropriate to the risk posed.

It is an evidence-based framework that has found favour with this College.

“We need to change our mindset and work to identify how much regulatory force is actually needed to achieve a desired effect,” said Dr. Nancy Whitmore, College Registrar and CEO.

“We can’t target everything with the same amount of energy. The matters with the greatest urgency in terms of public safety must be our biggest priority,” she said.

Originating with the Professional Standards Authority (PSA) in the United Kingdom, right touch regulation ensures that the level of regulation is proportionate to the level of risk to the public. A frequently used analogy is finding the right balance on a set of scales. “When

weighing something on balancing scales, nothing happens until you reach the desired weight, at which point the scales tip over,” states a paper authored by the PSA. “Once they have tipped any further, weight added to the other side is ineffectual. So the right amount of regulation is exactly that which is needed for the desired effect,” stated the paper. “Too little is ineffective; too much is a waste of effort.

It is a concept that underlies our new approach to investigations, which is to triage complaints on the basis of risk of harm to the public and to consider managing lower risk complaints through an alternative dispute resolution process (See page 12).

The framework recognizes that there is no such thing as “zero risk” and that all decisions about what and how to regulate will involve a trade-off between different risks and competing benefits.

Dr. Whitmore says that a key role for regulators in right touch regulation is to provide clinicians who may

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Dr. Nancy Whitmore,
Registrar/CEO

“We can't target everything with the same amount of energy. The matters with the greatest urgency in terms of public safety must be our biggest priority.”

be vulnerable to potentially harmful situations with the knowledge to contribute to their prevention.

In a recent presentation to hospital presidents and chiefs of staff, Dr. Whitmore said the College is developing new tools that will increase our proactive engagement with physicians at all stages of their careers and help create conditions most favorable to ensuring their success.

A right touch regulation framework that includes accessible tools to help physicians self-manage the course of their careers is fundamental to modernizing medical regulation. It also allows us to be more transparent about our expectations, said Dr. Whitmore.

“Applying the right touch principles sets the stage for what medical regulation should be in the 21st century,” said Dr. Whitmore. ^{MD}

Elements at the core of Right Touch Regulation

► Identify the problem before the solution

The problem must be properly described and fully understood before a solution is found.

► Quantify and qualify risks

Quantifying risks means gauging the likelihood of harm occurring and its severity. Qualifying risks means looking closely at the nature of the harm, and understanding how and why it occurs.

► Get as close to the problem as possible

Understand the context in which the problem arises and the tools available to address the harm.

► Focus on the outcome

The outcome should be both tangible and measurable, and it must be directed towards the reduction of harm

► Use regulation only when necessary

Once a problem has been fully considered, serious thought must be given as to whether regulation is the best tool to address it.

► Keep it simple

If one cannot explain the purpose of a particular regulation, it will not work.

► Check for unintended consequences

Regulating to remove one risk without a proper analysis of the consequences may create new risks.

► Review and respond to change

Regulation strategy needs to be flexible enough to respond to new evidence that calls for change.

Source: Professional Standards Authority



Council puts forward recommendations for governance structural change

An overview of the discussions and decisions made at the December Council meeting.

PHOTOS: CLAUDIA HUNG

Council adopted several recommendations to modernize the governance structure of the College. We will present the government with the following recommendations:

- Composition: a 50/50 public member/physician member board.
- A smaller board: 12-16 members, to be determined by each regulatory college.
- Each college should have flexibility to determine whether an executive committee is required (the number of board members is a determining factor).
- Separation between statutory com-

mittees and the board (no overlap in membership)

- A competency-based board model, whereby members, together, have desired attributes and competencies.
- Selection process: Hybrid model (some competency based appointments, some elected positions for professional members).
- Equal reimbursement for public and physician members of the board.

Council also approved by-law amendments to facilitate opening up the College president and vice-president positions to public members of the Council.

We provide more detail on page 25. ▶▶

1400

Helping Shape Governance Reform



Council has put forward several recommendations that, if adopted, will significantly change the governance structure of this College.

Over the last several years, there has been an increasing call to modernize the oversight of regulatory bodies around the world. The recommendations put forward by Council are intended to ensure the College has a role in helping shape governance reform.

There appears to be a universal understanding that change is necessary, said Dr. Peeter Poldre, the College's new President, noting that the legislation which governs health-care professionals is more than 25 years old. And while it is ultimately up to the government

to decide how it will proceed, the College's extensive experience can help inform the government's decisions, he said.

"I think a real danger exists if we stand on the sidelines and simply watch changes unfold without providing our input or participation. It is much better that we are involved earlier, when we can proactively influence the process of change," he said.

The College of Nurses of Ontario (CNO) has been leading the charge on governance reform, and while the CPSO and the CNO share a similar vision in many respects, there is one significant difference. The CPSO's plan for reform envisions a board which retains some elected positions of professional members.

Council has given itself a timeline of three years to put a new model fully in place. The College is recommending the following changes:

➤ **Smaller Boards**
(12-16 members)
Smaller-sized groups are believed to be able to communicate more effectively and reach decisions more efficiently than larger ones. The current size of Council is 33.

➤ **Board Composition**
(50/50 public member/physician member board)
Literature suggests that councils that regulate health professions have, as a minimum, an equal number of public and professional members, to ensure that purely professional concerns are not thought to dominate their work. Currently, there are 14 public members and 19 physician members.

➤ **Separation between Board and Statutory Committees**
Council has previously advocated for this separation, believing that the adoption of an entirely independent adjudication process promotes public confidence and clarity of roles. A separation also allows the board to focus on strategy and oversight.

Continued on next page...

...continued

➤ Diversity

Research suggests that board member diversity is associated with better-performing organizations because diversity expands views on issues, options and solutions.

Council identified the importance of having the following represented:

- Physicians with diverse clinical experience
- Geographical diversity
- Diversity of perspective/opinion
- Diversity of age and career stage

➤ Board

Recruitment

(Hybrid model)

The CPSO believes that a hybrid model (election and appointments) encourages physician engagement, while appointments based on competencies ensure that the board is comprised of a diverse group of people with a wide range of expertise, skills, knowledge and perspectives.

➤ Board

Competencies

Desirable competencies of board members include both specific skills and characteristics of board members. Characteristics include qualities such as being well-informed, strategic, energized and engaged. Skills include competencies in areas such as governance and organizational effectiveness, policy development, regulation and the public interest and specific fields (e.g., communications, finance, human resources, law, etc.).

➤ Equal

Remuneration

Board members will sit at the table because they have the expertise and competencies for effective regulatory governance. They will also carry a similar workload. Given this situation, it makes sense to pay all members equally. ^{MD}

Council Award

2019 Council Award Recipients

Congratulations to the following four physicians who have been chosen by the Council Award Committee to receive the 2019 Award:

Dr. Marie Gear, Teeswater

Dr. Michelle Hladunewich, Toronto

Dr. Rayfel Schneider, Toronto

Dr. Mark Spiller, Kirkland Lake

[47] In my view, the motion judge erred in concluding that any duty of care automatically expired when Mr. Williams arrived home. Assuming that such a duty existed, it is an issue for the jury to determine if and when the duty ended.

(3) *Other issues*

[48] In the alternative, the respondents assert that if they owed a duty of care, this court should determine whether it is negated by other, broader policy considerations and, if it is not, whether their actions met the standard of care. I would decline to consider these issues on appeal.

[49] The issue of whether a duty of care is negated by policy considerations is best dealt with after the duty has been found to exist. That way any consideration of countervailing policy arguments can be undertaken with the benefit of an evidentiary record supporting the finding of a duty of care. Similarly, an analysis of whether the duty of care has been met should be considered after the precise nature of the duty has been established.

E. *Disposition*

[50] I would: (i) allow the appeal and set aside the motion judge's order; (ii) remit the cases to the Superior Court for trial; (iii) order the respondents to pay the appellants their costs of the appeal in the agreed upon, all-inclusive sum of \$4,000; and (iv) remit the costs of the motion below to the trial judge.

Appeal allowed.

**College of Physicians and Surgeons of Ontario v.
Peirovy**

2018 ONCA 420

*Court of Appeal for Ontario, Rouleau, Benotto and L.B. Roberts J.J.A.
May 3, 2018*

Administrative law — Appeals — Standard of review — Divisional Court allowing college's appeal from penalty imposed by Discipline Committee for doctor's sexual abuse of patients — Divisional Court recognizing that standard of review was reasonableness but failing to properly apply that standard as it incorrectly substituted its own assessments of evidence and penalty for those of Discipline Committee — Penalty imposed by Discipline Committee not manifestly unfit.

Professions — Physicians and surgeons — Discipline Committee finding that doctor sexually abused four female patients and engaged in inappropriate conduct with fifth — Committee unable to find that doctor's

conduct was sexually motivated — Committee basing finding of liability on fact that doctor's actions violated sexual integrity of patients and were of sexual nature when viewed objectively — Committee imposing penalty of six-month suspension and restrictions on return to practice — Committee also requiring doctor to undergo individualized training and to pay victims' therapy costs — Penalty not manifestly unfit — Divisional Court failing to show deference to committee's decision when it allowed college's appeal.

The Discipline Committee of the College of Physicians and Surgeons found that the appellant doctor was guilty of professional misconduct involving the sexual abuse of four female patients and inappropriate conduct with a fifth. He unnecessarily touched the breasts of four patients while ostensibly using a stethoscope to examine their lungs, and asked a fifth patient for a date. The Discipline Committee was unable to find as a fact that the appellant's conduct was sexually motivated, but based its finding of liability on the fact that the touching in question was objectively a violation of the patients' sexual integrity. At the penalty stage of the proceedings, the committee heard expert evidence that the appellant's risk of re-offending was low, that he had worked hard to understand his inappropriate behaviour and that he was sincere in his desire that it not happen again. With the benefit of expert evidence, the committee concluded that the appellant's behaviour was in part due to serious deficits in his communication skills and his awkward, unskilled and non-empathic manner with female patients. The committee suspended the appellant's licence for six months, ordered him to submit to a reprimand and to pay the victims' therapy costs and the costs of the proceedings, and placed a number of restrictions on him when he returned to practice, such as requiring that his contacts with female patients be supervised and that a sign be posted in the waiting room and examination rooms advising patients of that restriction. The Divisional Court allowed the college's appeal from the penalty, holding that the Discipline Committee made inconsistent findings of fact that warranted intervention and that the penalty was manifestly unfit. The court remitted the penalty decision to the Discipline Committee for reconsideration. The appellant appealed.

Held, the appeal should be allowed.

Per Rouleau J.A. (L.B. Roberts J.A. concurring): The Divisional Court correctly identified the standard of review applicable to the Discipline Committee's decision as reasonableness, but it failed to apply that deferential standard and instead erroneously re-weighed the evidence and substituted its own view of what might constitute an appropriate penalty in the absence of any reversible error made by the Discipline Committee. The Discipline Committee did not make inconsistent findings of fact that warranted intervention. The Divisional Court's position that it was unreasonable for the Discipline Committee to rule at the sentencing phase that the appellant did not understand his conduct to be sexual abuse after having found that an objective observer would have considered that it constituted a violation of the patients' sexual integrity reflected a misunderstanding of the nuanced findings made by the committee and misconstrued the objective test. The objective test that led to the committee's finding of sexual abuse turned on the perspective of a reasonable observer, and did not go so far as to attribute subjective sexual motivation to the appellant.

The Divisional Court also erred in concluding that the penalty was manifestly unfit. The penalty fit comfortably within the range of penalties imposed in other similar or more serious cases of sexual abuse of patients. The Discipline Committee did not erroneously assume that revocation of registration is reserved for egregious conduct or offenders with a high risk to re-offend. The Divisional Court erred in

finding that the penalties imposed by numerous other discipline committees over the course of more than a decade were wrong and that the Discipline Committee erred in referring to them as precedents. The Divisional Court effectively acknowledged that the penalty imposed was consistent with the range of penalties established in the existing authorities. Consistency in sentencing is as important in professional bodies as in the criminal courts. The Divisional Court should not have simply declared that the penalties imposed in the cases making up the well-established range, of which it was not seized, were wrong. Legislative amendments in 2017 which made revocation mandatory in cases where touching of a sexual nature occurs on the patient's genitals, anus, breasts or buttocks did not retroactively validate the Divisional Court's erroneous application of the deferential standard of review to the Discipline Committee's 2016 decision on penalty for offences occurring in 2009 and 2010.

Per Benotto J.A. (dissenting): The Divisional Court did not err in concluding that the Discipline Committee made inconsistent findings of fact and that the penalty was manifestly unfit. The Discipline Committee contradicted its own factual findings from the liability phase during the penalty phase. Having rejected the submission that the appellant's blatant sexual abuse could be explained by misunderstanding, the Discipline Committee accepted the opposite in its penalty decision. The committee's finding regarding the impact of the appellant's awkwardness, lack of skill and unawareness was without foundation. While the penalty was within the range of penalties imposed in past Discipline Committee decisions involving sexual abuse, reasonableness is not a static concept and ranges are not set in stone. What was once reasonable may no longer accord with the modern conscience. The Discipline Committee imposed a penalty that failed to fulfill its mandate to protect the public, maintain public confidence in the medical profession's ability to self-regulate, and eradicate the sexual abuse of patients by members. The short suspension imposed in this case was clearly inadequate to deter others and to contribute meaningfully to the eradication of sexual abuse in the medical profession. The fact that the penalty was in line with past cases did not insulate the Discipline Committee's penalty decision from appellate interference.

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Protecting Patients Act, 2017, S.O. 2017, c. 11

Regulated Health Professions Act, 1991, S.O. 1991, c. 18, Sch. 1, ss. 1.1, 38(1) [as am.], 51 [as am.], (1) [as am.], (4.2), (5) [as am.]

Authorities referred to

The Final Report of the Task Force on Sexual Abuse of Patients, An Independent Task Force Commissioned by The College of Physicians and Surgeons of Ontario (November 25, 1991) (Chair: Marilou McPhedran)

APPEAL from the order of the Divisional Court (Molloy, Dambrot and Ramsay JJ.), [2017] O.J. No. 194, 2017 ONSC 136 (Div. Ct.) reversing a decision of the Ontario College of Physicians and Surgeons Discipline Committee, [2016] O.C.P.S.D. No. 14, 2015 ONCPSD 30.

W. Niels F. Ortved, David M. Porter and Jordan Katz, for appellant.

Elisabeth Widner and Ruth Ainsworth, for respondent.

ROULEAU J.A. (L.B. ROBERTS J.A. concurring): —

A. Overview

[1] This appeal concerns the proper application of the standard of review applicable to the decision of a professional disciplinary administrative tribunal by an appellate court.

[2] The appellant, Dr. Javad Peirovy, was found guilty of professional misconduct by the Discipline Committee of the College of Physicians and Surgeons (the “Discipline Committee”). He appeals from the order of the Divisional Court, which overturned the penalty imposed on him by the Discipline Committee and

remitted the penalty decision to the Discipline Committee for reconsideration.

[3] Dr. Peirovy's misconduct involved the sexual abuse of four female patients and inappropriate conduct with respect to a fifth at a walk-in family medicine clinic in 2009 and 2010. The Discipline Committee imposed a penalty consisting of a six-month suspension and restrictions on his return to practice. These included supervision during all encounters with female patients and the posting of a sign publicizing this requirement for a minimum of 12 months. The penalty also included a requirement that Dr. Peirovy undergo individualized training. It was also ordered that he pay the victim's therapy costs, and \$35,680 in costs of the proceedings. The College of Physicians and Surgeons of Ontario (the "College") appealed from the penalty decision on the basis, *inter alia*, that it was unreasonable in that the Discipline Committee made inconsistent findings of fact and the penalty imposed was manifestly unfit.

[4] The Divisional Court allowed the College's appeal. While acknowledging that the Discipline Committee's decision on penalty was subject to deference, the Divisional Court determined that the penalty imposed was unreasonable on the bases submitted by the College.

[5] Dr. Peirovy was granted leave to appeal the Divisional Court's decision. He submits that it should be set aside, and the Discipline Committee's penalty be reinstated.

[6] For the reasons that follow, I agree that the appeal should be allowed, and the Discipline Committee's penalty be restored. Dr. Peirovy's behaviour was reprehensible. However, the Discipline Committee is the expert tribunal created by the legislature to assess allegations of misconduct in the medical profession and to determine the penalty appropriately tailored to the circumstances of each case. As I will explain, the Discipline Committee's decision on penalty contained no inconsistent findings of fact nor was the penalty imposed manifestly unfit. While the Divisional Court properly identified reasonableness as the standard of review, it failed to correctly apply that deferential standard to the Discipline Committee's findings of fact and determination of penalty. Instead, the Divisional Court erroneously re-weighed the evidence and substituted its own view of what might constitute an appropriate penalty in the absence of any reversible error made by the Discipline Committee.

B. *Decision Below — Liability*

[7] In the liability phase of the hearing, the Discipline Committee heard from the various complainants and Dr. Peirovy. The allegations included claims that while examining patients with

a stethoscope, he cupped patients' breasts, touched patients' nipples, placed his stethoscope directly on patients' nipples and in one instance "tweaked" or squeezed a patient's nipple.

[8] Dr. Peirovy testified in his defence and denied that he had conducted the examinations in an inappropriate manner. He explained his touching as the result of his practice of examining lungs by placing his stethoscope under the patients' clothes. He acknowledged that he may have occasionally and inadvertently touched a patient's breast.

[9] The Discipline Committee also heard conflicting evidence from experts as to the appropriateness of the manner in which Dr. Peirovy examined the complainants.

[10] The College's expert, Dr. Howard J. Goldstein, maintained that Dr. Peirovy's decisions to conduct lung examinations of three of the patients was clinically appropriate. Regarding a fourth patient, the expert characterized the decision to conduct a physical examination as "not unreasonable". He agreed that it was appropriate for Dr. Peirovy to place the stethoscope directly on the patient's bare skin, corresponding to the various areas of the lung. He acknowledged that it was possible during such an examination that a physician's hand might come in contact with the skin.

[11] However, the College's expert opined that in all four of those cases, there was no medical necessity for Dr. Peirovy's placement of the stethoscope or his fingers on the nipples of the patients or his hand on their breasts during the examinations. He opined that there would be no benefit or medical necessity to place the stethoscope in that manner because the density of the breast tissue would influence the quality of the breath sounds one was listening for. In his view, the breasts of a female patient, being private and sensitive areas, particularly the nipples, "would be sort of generally excluded as part of a routine lung examination". He noted that "[b]esides the fact that in my opinion it is medically unnecessary . . . touching the nipple with either the stethoscope or the hand may be misinterpreted by the patient". He did agree during cross-examination that some of the authoritative textbooks provide for the placement of the stethoscope near or on the nipple of patients for the purposes of examining the right middle lobe of the lung and that it was possible to hear breath sounds through breast tissue.

[12] In the opinion of Dr. Peirovy's expert, Dr. Wayne Weston, the manner in which all four of those examinations were conducted in the setting of a very busy clinic was clinically appropriate. He opined that given the limited amount of space when trying to examine important areas of the lung under a bra with a stethoscope, it would be difficult to always avoid touching and almost inevitable that the hand or fingers holding the stethoscope

would touch the breast or maybe even the nipple of the patient. He was of the view that it was necessary to auscultate the lung on locations over the breast tissue because otherwise a physician would be missing important parts of the lungs, such as, for example, the right middle lobe. Dr. Weston's report states that auscultating near the nipple and listening longer than expected by the patient could be misinterpreted as sexual contact unless the physician has provided a prior explanation.

[13] The Discipline Committee accepted the evidence of the four complainants as to the inappropriateness of the touching, finding that their description of what had occurred was inconsistent with a misunderstanding. The Discipline Committee therefore rejected Dr. Peirovy's evidence to the effect that there had been no inappropriate touching, or that it was inadvertent or misunderstood by those four women.

[14] The Discipline Committee also accepted the opinion of the College's expert. It concluded that the manner in which four of the examinations were conducted was medically unnecessary and inappropriate.

[15] The Discipline Committee concluded that the allegations had been made out, that the touching was deliberate and that there was no consent from the patients or clinical reason for Dr. Peirovy to have touched them in that manner.

[16] When considering whether the inappropriate touching constituted sexual abuse, the Discipline Committee explained [at para. 91] that it need not find that Dr. Peirovy's touching of the breasts and nipples of the complainants was sexually motivated. It adopted the objective approach articulated by the Supreme Court of Canada in *R. v. Chase*, [1987] 2 S.C.R. 293, [1987] S.C.J. No. 57, as follows:

In its deliberations on whether or not Dr. Peirovy's actions were of a sexual nature, the Committee took guidance from the Supreme Court of Canada in the case of *R. v. Chase* [1987], 2 SCR 293. Sexual assault is an assault that is committed in circumstances of a sexual nature, such that the sexual integrity of the victim is violated. The Court concluded that the test to be applied is an objective one, stating "viewed in light of all the circumstances, is the sexual or carnal context of the assault visible to the reasonable observer". Sexual motivation on the part of the perpetrator is one factor to be considered but *the absence of sexual motivation, or in situations where the offender's motivation is unknown, would not preclude a finding that the behaviour in question is sexual in nature.* This is exemplified in a criminal case, *R. v. KBV* [1993], 2 SCR 857, where the accused was convicted of sexual assault for grabbing the genitals of his 3-year-old son, despite the obvious absence of sexual motivation.

(Emphasis added)

[17] Using this approach, the Discipline Committee noted that it need only be satisfied that when viewed objectively, the actions

in question were of a sexual nature. As the Discipline Committee observed [at para. 92],

The female breast is private and sensitive both physiologically and emotionally. Female patients have a right to expect that physicians will understand and respect their privacy when examinations of this nature are being conducted. A violation of the sexual integrity of a patient, including the deliberate touching of a patient's breast without her consent and for no proper medical reason, constitutes sexual abuse.

[18] For these reasons, the Discipline Committee concluded that, even in the absence of a finding as to Dr. Peirovy's motivation, a finding of sexual abuse could be made where the touching in question was objectively a violation of a patient's sexual integrity.

[19] As a result, the Discipline Committee found as a fact that an objective observer would conclude that Dr. Peirovy's conduct constituted violations of the sexual integrity of the complainants, regardless of his motivation, given his deliberate touching of the complainants' private and sensitive areas without their consent and for no necessary medical reason.

[20] The Discipline Committee therefore found Dr. Peirovy guilty of sexual abuse in relation to the four patients. In each case, the abusive conduct consisted of medically unnecessary touching of the breast or nipples of the patients during medically required chest examinations conducted using a stethoscope.

[21] The Discipline Committee also found that Dr. Peirovy had asked a fifth patient on a date immediately following his medical examination of her during which her breasts were exposed. While not found to be sexual abuse, that conduct, as well as the four sexual abuse incidents, constituted disgraceful, dishonourable and unprofessional conduct.

[22] The Discipline Committee was also informed that Dr. Peirovy had pleaded guilty to simple assault of two of the complainants in relation to these same incidents. These convictions, for which Dr. Peirovy received a conditional discharge, were considered relevant to his suitability to practice. The Discipline Committee also considered these convictions to be professional misconduct.

C. Decision Below — Penalty

[23] Several months later, the Discipline Committee held a separate hearing on penalty during which it heard evidence from two experts: Dr. Rootenberg, a forensic psychiatrist, who specializes in the assessment and treatment of persons who have committed sexual and other offences, including their risk of re-offending; and Dr. Martin, an educational consultant in the Office of Post-Graduate Medicine at the University of Toronto with a Ph.D. in curriculum teaching and learning, who specializes in assisting

physicians with patient communications, boundary awareness and maintenance and remediation training, and has provided remedial training to over 100 physicians on referral from the College. Their qualification as experts in these areas was not challenged.

[24] The Discipline Committee accepted the expert evidence of Dr. Rootenberg that Dr. Peirovy did not meet the diagnostic criteria for psychopathology or sexual deviance, which, he testified, is relevant with respect to relapse and prevention. Dr. Rootenberg's opinion was based on numerous sources, including assessment interviews he conducted with Dr. Peirovy, assessment interviews conducted by a forensic psychologist and forensic social worker, and information obtained from collateral sources including the managers of the two medical clinics where Dr. Peirovy currently practices. Dr. Rootenberg also drew from the Discipline Committee's liability decision, and the evidence given, and exhibits filed at the liability hearing.

[25] The Discipline Committee also accepted the expert evidence that the risk of Dr. Peirovy re-offending by committing further sexual transgressions in the future was low. In Dr. Rootenberg's view, Dr. Peirovy had worked hard to understand his inappropriate behaviour, was very embarrassed and ashamed of what he had done and was sincere in his desire that this not happen again.

[26] Dr. Martin's expert evidence was relevant to the issues of remediation and risk management that the Discipline Committee was required to consider in determining the appropriate penalty. She highlighted deficits in Dr. Peirovy's interactive skills with patients that give rise to the same risk factors of misunderstanding by patients outlined by the experts who testified at the liability hearing. The Discipline Committee agreed with Dr. Martin's assessment of Dr. Peirovy which it summarized as follows [at para. 174]:

Dr. D's [Dr. Martin's] assessment of Dr. Peirovy indicated that, in her opinion, he had deficits in a number of areas. These included his interviewing skills, his manner (which was described as awkward and clumsy), his verbal communication, his awareness of issues pertaining to patient consent, his sensitivity to how his patients were perceiving him, and how his behaviour was affecting his patients. Dr. D [Dr. Martin] stated that Dr. Peirovy was largely unaware of his professional responsibilities in maintaining appropriate boundaries in the doctor/patient relationship.

[27] The Discipline Committee also accepted Dr. Martin's opinion that Dr. Peirovy had made good progress in remedying the deficits identified. She had worked with him from August 2013 to June 2015. Dr. Martin reported that there had been "huge professional maturation". No concerns had been expressed by the practice monitor. Although the Discipline Committee acknowledged the substantial progress, it nonetheless felt further remediation work was needed as he had not yet taken full responsibility for his actions.

[28] With the benefit of the expert evidence, the Discipline Committee was able to conclude that some of the antecedents to Dr. Peirovy's sexual misconduct were due to [at para. 195] "serious deficits in his communication skills, his sensitivity to the extent of his patients' vulnerability, and his understanding of boundaries and consent". Although the Discipline Committee acknowledged that those deficits "in no way diminish or excuse the fact that he repeatedly subjected several patients to abusive experiences", the Discipline Committee found as a fact that "Dr. Peirovy's awkward, unskilled, and non-empathic manner with his female patients was a factor in understanding his abusive behaviour".

[29] The assessment of the Discipline Committee, however, was that a full understanding of Dr. Peirovy's motivations remained unclear. The expert evidence effectively ruled out psychopathology or sexual deviance, which the Discipline Committee found lessened the risk of re-offence. However, while no finding of sexual motivation was made, a degree of prurient interest in the patients could not be completely excluded.

[30] The Discipline Committee then explained that the fact that four patients had been subjected to sexual abuse in fairly close succession was an aggravating factor. Based on the expert evidence, it declined however to infer that this was indicative of [at para. 197] "predatory intent or uncontrollable deviant urges on Dr. Peirovy's part". It is at this point that the Discipline Committee posited another possible inference that could explain why there were four patients abused in close succession [at para. 198]:

Another possible inference is that this pattern reflects a physician who was genuinely and completely unaware of the ways in which his behaviour in relation to his patients was, in fact, abusive.

[31] It is this quote that the Divisional Court cites as demonstrating that the Discipline Committee made an unreasonable finding that contradicted the findings it made at the liability stage.

[32] The Discipline Committee ultimately suspended Dr. Peirovy's licence for six months. He was ordered to submit to a reprimand and required to pay \$64,240 for the victims' therapy costs and \$35,680 in costs of the proceedings. He was also ordered to continue undergoing individualized instruction with Dr. Martin focused on consent, boundaries and doctor-patient communications, and to complete a clinical education program focused on physical examinations.

[33] A number of restrictions were also imposed on Dr. Peirovy's return to practice. He was prohibited from engaging in any encounter with female patients except under the supervision of a practice monitor approved by the College. He was also required

to post a sign in the waiting room and examination rooms at each of his practice locations advising patients of this restriction. The practice monitor condition could be reconsidered on an application to the Committee after a minimum of one year following his return to practice. Dr. Peirovy was also required to tell patients how to access the Discipline Committee's decision if requested, and to submit to unannounced inspections of his practice locations and patient charts by the College in order to ensure compliance.

D. *Issues*

[34] Dr. Peirovy raises two issues:

- (1) did the Divisional Court err in concluding that the Discipline Committee made inconsistent findings of fact warranting intervention; and
- (2) did the Divisional Court err in determining that the penalty imposed by the Discipline Committee was manifestly unfit?

[35] I will deal with both of these issues in turn.

E. *Analysis*

[36] To frame my analysis of the issues on appeal, it is important to set out the standard of review that the Divisional Court was required but failed to properly apply to the penalty decision of the Discipline Committee.

[37] When it acts as a reviewing court of an administrative tribunal, the Divisional Court must not interfere if the decision is reasonable, that is, “[i]f any of the reasons that are sufficient to support the conclusion are tenable in the sense that they can stand up to a somewhat probing examination”: *Law Society of New Brunswick v. Ryan*, [2003] 1 S.C.R. 247, [2003] S.C.J. No. 17, 2003 SCC 20, at para. 55; and *Groia v. Law Society of Upper Canada* (2016), 131 O.R. (3d) 1, [2016] O.J. No. 3094, 2016 ONCA 471, at para. 81.

[38] To overturn a penalty, the Discipline Committee must have made an error in principle or the penalty must be clearly unfit: *Reid v. College of Chiropractors of Ontario*, [2016] O.J. No. 3080, 2016 ONSC 1041 (Div. Ct.), at para. 99. A penalty will be clearly unfit where the decision does not fall within “a range of possible, acceptable outcomes which are defensible in respect of the facts and law”: *Dunsmuir v. New Brunswick*, [2008] 1 S.C.R. 190, [2008] S.C.J. No. 9, 2008 SCC 9, at para. 47.

[39] Where, as here, there is a statutory appeal from a decision of a specialized administrative tribunal, the appropriate standards of

review are the ones that apply on judicial review, not those that normally apply on appeal: *Mouvement laïque québécois v. Saguenay (City)*, [2015] 2 S.C.R. 3, [2015] S.C.J. No. 16, 2015 SCC 16, at para. 29. The question this court must answer is whether the Divisional Court chose the appropriate standard of review and applied it correctly. This requires the court to step into the lower court's shoes and focus on the administrative decision: *Agraira v. Canada (Minister of Public Safety and Emergency Preparedness)*, [2013] 2 S.C.R. 559, [2013] S.C.J. No. 36, 2013 SCC 36, at para. 46.

[40] The Divisional Court correctly selected and articulated the reasonableness standard of review. However, as I will explain in the following paragraphs, the Divisional Court failed to properly apply the reasonableness standard. Instead, it incorrectly substituted its own assessments of the evidence and penalty for those of the Discipline Committee.

(1) *Did the Divisional Court err in concluding that the Discipline Committee made inconsistent findings of fact warranting intervention?*

[41] The Divisional Court found the Discipline Committee's penalty decision to be unreasonable because it was based on inconsistent findings of fact.

[42] Specifically, it rejected the Discipline Committee's suggestion that Dr. Peirovy's unawareness as to how his behaviour was abusive could possibly explain the abuse of four patients. According to the Divisional Court, there was [at para. 32]

no line of analysis that could reasonably lead the tribunal to conclude that [Dr. Peirovy's] awkward, unskilled and non-empathic manner was a factor in understanding his abusive behaviour or that it could reasonably infer that he was genuinely and completely unaware of the ways in which his behaviour in relation to his patients was in fact abusive.

[43] This "possible inference" of unawareness drawn by the Discipline Committee was, in the Divisional Court's view, inconsistent with the finding of fact that there were several offences. More importantly, the inference was considered inconsistent with the Discipline Committee's finding at the liability stage that Dr. Peirovy had touched the complainants in a way that an objective observer would find to be sexual and which the complainants described as "blatantly sexual".

[44] There are several problems with the Divisional Court's concern. First, the Discipline Committee's finding is well supported by the testimony of the experts, some of which I have summarized above. This includes the College's expert at the liability hearing, who testified that touching a female patient's

nipple with either the hand or the stethoscope during a lung examination should be avoided because it is medically unnecessary and could be misinterpreted. In addition, the finding is supported by the Discipline Committee's assessment of Dr. Peirovy's testimony. Finally, the Discipline Committee did not, as the Divisional Court suggests, find that Dr. Peirovy's awkward, unskilled and non-empathic manner was the only cause; it simply opined that it was a factor.

[45] The Discipline Committee specifically considered the significance of the number of incidents. It rejected the inference that Dr. Peirovy had a predatory intent or uncontrollable deviant urges on the basis of the entire record and Dr. Rootenberg's evidence. This finding was open to the Discipline Committee, as was the inference that this improves the prognosis and lessens the risk of re-offence. It was also open to the Discipline Committee to suggest that the number of incidents, including one that occurred after Dr. Peirovy was informed of a complaint against him, might be explained by his lack of insight as to the abusive nature of his conduct.

[46] It is to be recalled that Dr. Peirovy's culpability was based on the finding of objectively sexual misconduct. The paramount principle animating the penalty proceedings was, as the Discipline Committee recognized, the protection of the public. In essence, the questions the Discipline Committee had to answer were, first, the appropriate sanction for the misconduct; and second, whether it was safe to allow Dr. Peirovy to continue to practise and, if so, subject to what conditions.

[47] The Divisional Court advanced a second basis for rejecting the Discipline Committee's suggestion that the several counts of sexual abuse could possibly be explained by Dr. Peirovy's genuine and complete unawareness of the ways in which his behaviour was abusive. In the Divisional Court's view, such an inference is inconsistent with Dr. Peirovy having been found guilty of criminal assault on two of the complainants.

[48] This basis is also flawed. The Discipline Committee's possible inference is not inconsistent with a finding of guilt for simple assault. Simple assault contemplates an unwanted touching. The Discipline Committee found that Dr. Peirovy deliberately touched the complainants in areas that were medically unjustified and that the complainants had not consented to the touching. This is sufficient to support the simple assault convictions. Such inferences are not inconsistent with the finding that Dr. Peirovy lacked understanding with respect to appropriate boundaries, patient consent and sensitivity to how patients were perceiving him. Clearly, there was touching by Dr. Peirovy in a manner

that had not been consented to. A sexual motivation need not be proven to support a conviction for simple assault.

[49] The Divisional Court then expressed [at para. 34] the view that Dr. Peirovy's motivation "can have been nothing but sexual". It stated that the Discipline Committee had made such a finding in the liability phase of the hearing and then contradicted itself in its sentencing reasons. The Divisional Court explained that it would be unreasonable for the Discipline Committee to rule at the sentencing phase that Dr. Peirovy did not understand his conduct to be sexual abuse after having found that an objective observer would have considered that it constituted a violation of the patients' sexual integrity.

[50] The difficulty with the Divisional Court's position is that it reflects a misunderstanding of the nuanced findings made by the Discipline Committee and misconstrues the objective test articulated in *Chase*. The objective test that led to the Discipline Committee's finding of sexual abuse turned on the perspective of a reasonable observer and did not go so far as to attribute subjective sexual motivation to Dr. Peirovy. As set out earlier, the Discipline Committee was not able to make any clear finding as to the presence or absence of sexual motivation in Dr. Peirovy's conduct. It was not required to do so in the circumstances of this case, where it found that the sexual integrity of the patients had been violated because private and sensitive areas of the body had been touched without the patients' consent and without medical necessity. Nevertheless, in fashioning the appropriate penalty, the Discipline Committee was careful to note that a degree of prurient interest could not be completely ruled out. This made clear that it took this possibility into account in designing the penalty imposed.

[51] It may well be that conclusions and inferences different from those reached and made by the Discipline Committee are possible, but the standard of reasonableness is satisfied so long as the explanation given for the conclusion is reasonable even if it "is not one that the reviewing court finds compelling": *Ryan*, at para. 55; and *Groia*, at para. 81. Deference requires respectful attention to the tribunal's reasoning process: *Stewart v. Elk Valley Coal Corp.*, [2017] 1 S.C.R. 591, [2017] S.C.J. No. 30, 2017 SCC 30, at para. 27.

[52] This court's role is to determine whether the reviewing court chose and applied the correct standard of review: *Agraira*, at paras. 45-47. If that was not the case, we must assess the administrative body's decision in light of the correct standard of review, namely, reasonableness: *Dr. Q. v. College of Physicians & Surgeons of British Columbia*, [2003] 1 S.C.R. 226, [2003] S.C.J.

No. 18, 2003 SCC 19, at para. 43; and *Board of Regents of Victoria University v. GE Canada Real Estate Equity*, [2016] O.J. No. 4493, 2016 ONCA 646, at para. 84.

[53] Here, the Divisional Court chose the correct standard of review. However, in my view, the Divisional Court not only erred in its understanding of the evidence and of the reasons of the Discipline Committee, it effectively sought to retry the case in a manner inconsistent with the proper application of the standard of review. This is contrary to the Supreme Court's holding in *Dunsmuir*, at para. 48, that a reviewing court must do more than simply cite the correct standard of review. It must apply it and refrain from substituting its own view for that of the tribunal. The reviewing court must resist the temptation to "place itself in the position of the decision-maker of first instance and compare the decision it would have made against the decision actually made at first instance", as this approach is prone to undue conclusions of unreasonableness: *Ottawa (City) Police Services v. Ottawa (City) Police Services*, [2016] O.J. No. 4331, 2016 ONCA 627, 352 O.A.C. 310, at para. 66.

[54] There were no inconsistent findings of fact warranting intervention by the Divisional Court. It subjected the reasons of the Discipline Committee to excessive scrutiny, rejecting the reasonable, available findings made by the Discipline Committee and arriving at different factual findings based on its improper reassessment of the evidence *de novo*.

(2) *Did the Divisional Court err in concluding that the penalty imposed by the Discipline Committee was manifestly unfit?*

[55] The Divisional Court's second basis for allowing the appeal is that the Discipline Committee imposed an unfit penalty. As I will explain, the Divisional Court's analysis is flawed. First, it misunderstood the Discipline Committee's reasons and misapplied the reasonableness standard of review. As the Divisional Court properly stated [at para. 25], "[a] penalty decision of such a tribunal is at the heart of its discretion and is due great deference". Nevertheless, the Divisional Court in effect simply substituted its view of what might constitute an appropriate penalty and did not defer to the Discipline Committee's decision as was required. Furthermore, the penalty imposed was not manifestly unfit but represented the Discipline Committee's careful consideration of all relevant factors and was within the range of reasonable outcomes.

[56] To be overturned by a reviewing court, the Discipline Committee must have made an error in principle or the penalty must be "clearly unfit": *Reid*, at para. 99. The Supreme Court

recently considered the meaning of similar phrases in the criminal context in *R. v. Lacasse*, [2015] 3 S.C.R. 1089, [2015] 3 S.C.R. 1089, 2015 SCC 64, noting that courts have used a variety of expressions to describe a sentence that reaches this threshold, including [at para. 52] “demonstrably unfit”, “clearly unreasonable”, “clearly or manifestly excessive”, “clearly excessive or inadequate” or representing a “substantial and marked departure”. Wagner J. observed, at para. 52, that “[a]ll these expressions reflect the very high threshold that applies to appellate courts when determining whether they should intervene after reviewing the fitness of a sentence”. He concluded, at para. 53, that a sentence will be demonstrably unfit if it constitutes an unreasonable departure from the principle of proportionality.

[57] A similarly high threshold applies in the administrative context. To be clearly unfit, the penalty must fall outside of the range of reasonableness. A reasonable penalty will be “guided by proportionality and an assessment of the range of appropriate penalties dependent upon the facts of each case, [and] guided by penalties imposed in other cases”: *Reid*, at para. 100.

[58] The Discipline Committee considered a number of its previous decisions involving the sexual abuse of patients. The factual scenarios in those cases are, like the present case, disturbing. However, they show that the penalty imposed on Dr. Peirovy is in line with those that have been imposed in Ontario. In fact, a six-month suspension has been imposed for sexual misconduct more egregious than the misconduct at issue here: see *Lee (Re)*, [2009] O.C.P.S.D. No. 10; *Rakem (Re)*, [2014] O.C.P.S.D. No. 22, 2014 ONCPSD 25. Only one decision in which a doctor’s licence was revoked was submitted to the Discipline Committee. *Minnes (Re)*, [2015] O.C.P.S.D. No. 3, 2015 ONCPSD 3 involved a physician’s attempted sexual assault of a 17-year-old female counsellor, a non-patient, at a summer camp where he was camp physician. The Discipline Committee noted that the horrific circumstances of the attempted sexual assault required no penalty short of revocation in that case, which bore little similarity to the present one.

[59] The penalty imposed by the Discipline Committee was carefully tailored to the circumstances of this case and fit comfortably within the range of penalties imposed in other similar or more serious cases of sexual abuse of patients. It was based on forensic psychiatric evidence accepted by the Discipline Committee as well as the evidence it heard during the liability phase. It also took into account the progress shown by Dr. Peirovy in addressing some of the concerns. Further, following the lodging of

the complaints, Dr. Peirovy had practised with supervision for about five years without any incident.

[60] The Divisional Court relies on four errors allegedly made by the Discipline Committee to justify its interference with the penalty imposed. I will address each of them in turn.

(a) *Did the Discipline Committee fetter its discretion with respect to the penalty of revocation?*

[61] The first basis advanced by the Divisional Court is that the Discipline Committee improperly fettered its discretion by proceeding on the basis that [at para. 36] “revocation of registration is reserved for egregious conduct or offenders with a high risk to re-offend”.

[62] Had the Discipline Committee proceeded on this basis, it may well have erred, even on the reasonableness standard of review. This is not, however, an accurate or reasonable interpretation of what the Discipline Committee said or intended. In the relevant portion of the reasons, the Discipline Committee was discussing two of the several principles of sentencing: maintaining public confidence in the integrity of the profession and protection of the public.

[63] The Discipline Committee explained that protection of the public is generally taken as the paramount principle of sentencing. It is then that the Discipline Committee stated [at para. 193]:

Although the two principles are not identical, and there will be cases where the egregious nature of the misconduct itself will demand revocation even where the risk of re-offence is low, a well-informed public would be expected to maintain confidence in a self-regulating process which results in the public being protected from abusive physicians.

[64] In this passage, the Discipline Committee was quite properly pointing out that revocation is sometimes “demanded” by egregious conduct alone. As it indicated in other parts of its reasons, however, it is tasked with arriving at a fair and just penalty that addresses all of the sentencing principles. Those principles include the paramount consideration of protection of the public, as well as maintenance of public confidence in the reputation and integrity of the profession, effective self-governance, general deterrence, specific deterrence and the potential for the member’s rehabilitation. Proportionality is also an important consideration.

[65] The Discipline Committee’s reasons as a whole make clear that it did not erroneously assume that revocation was available only in a narrowly constrained set of circumstances. Rather, it concluded that the suspension and practice restrictions imposed struck the most appropriate balance between the variety of sentencing principles at play in this case.

(b) *Was the suspension imposed by the Discipline Committee unreasonably short?*

[66] The second concern raised by the Divisional Court is that the six-month suspension imposed by the Discipline Committee was too short. The Divisional Court explained [at para. 37] that the suspension was “clearly inadequate to deter others and to contribute meaningfully to the eradication of sexual abuse in the profession”. The Divisional Court opined [at para. 39] that on the facts of this case, it “would expect the Committee to be debating whether to revoke the member’s registration or impose a suspension measured in years, as opposed to months”.

[67] I disagree. The penalty imposed was serious and within the range of reasonable outcomes. In my view, the Divisional Court improperly substituted its own view for the Discipline Committee’s determination, as a statutorily mandated, specialized tribunal, of what is required to respond to the legislature’s goal of eradicating the sexual abuse of patients.

[68] A court examining the reasonableness of a disciplinary tribunal’s decision on penalty is concerned with “whether the decision falls within a range of possible, acceptable outcomes which are defensible in respect of the facts and law”: *Dunsmuir*, at para. 47. The Divisional Court ought not, therefore, to have effectively substituted its view of the appropriate penalty for that of the Discipline Committee. As explained by the Supreme Court of Canada in *Dr. Q*, at para. 31:

A statutory purpose that requires a tribunal to select from a range of remedial choices or administrative responses, is concerned with the protection of the public, engages policy issues, or involves the balancing of multiple sets of interests or considerations will demand greater deference from a reviewing court.

(Citations omitted)

See, also, *Association des courtiers et agents immobiliers du Québec v. Proprio Direct inc.*, [2008] 2 S.C.R. 195, [2008] S.C.J. No. 32, 2008 SCC 32, at paras. 17-21; and *Ryan*, at para. 51.

[69] It is undeniable that the conduct exhibited by Dr. Peirovy in this case is to be roundly condemned. This is the approach followed by the Discipline Committee in this case. The penalty imposed was serious. It followed a lengthy period during which Dr. Peirovy was required to practise under supervision and with restrictions. The Discipline Committee did not accept the four-month suspension proposed by Dr. Peirovy but imposed six months, in keeping with the range of similar and in some cases more serious instances of sexual abuse.

[70] Further, as already highlighted, the penalty imposed did not consist solely of a suspension. It contained other restrictions, including supervision during all interactions with female patients and the posting of a sign advising patients of this restriction on Dr. Peirovy's practice. The penalty provides that these restrictions will continue for a minimum of one year after Dr. Peirovy has served his suspension. Dr. Peirovy will also have to continue individualized instruction and pay significant sums for costs incurred in the prosecution and for therapy undergone by the complainants.

[71] Although not coming to a final determination on the issue of Dr. Peirovy's motivation for his conduct, it is implicit that the Discipline Committee was confident that his behaviour could be corrected, even if a prurient interest could not be completely ruled out. In fact, the Discipline Committee found that it was possible for Dr. Peirovy to continue to practise safely. This conclusion did not depart from the range of reasonable outcomes in the circumstances, considering the evidence of the experts and the numerous mitigating factors. Those included the progress made by Dr. Peirovy since the last incident, his engagement in the rehabilitation process, the lack of deviant urges, his embarrassment and shame for his actions and the effectiveness of the practice monitor condition.

[72] The legislature gave the Discipline Committee the task of fashioning penalties that will favour the goal of eradicating sexual abuse of patients while taking into account and balancing other relevant factors. Unlike criminal sentences, which are determined by the courts pursuant to the *Criminal Code*, R.S.C. 1985, c. C-46, self-regulated professions are mandated to make these determinations.

[73] Deference is owed to discipline committees because they are tribunals composed of members of the profession and of the public with the expertise to assess "the level of threat to the public and . . . the . . . profession posed by certain forms of behaviour". Therefore, they are in a better position than the courts to determine appropriate penalties for professional misconduct: see *Ryan*, at para. 33; and *Law Society of Upper Canada v. Abbott* (2017), 139 O.R. (3d) 290, [2017] O.J. No. 3311, 2017 ONCA 525, at paras. 12-15, 52 and 54, leave to appeal to S.C.C. refused [2017] S.C.C.A. No. 355; *Richardson v. Law Society of New Brunswick*, [2011] N.B.J. No. 461, 2011 NBCA 108, 381 N.B.R. (2d) 391, at para. 4.

[74] As this court has said in the past, "[t]he issue of the appropriate penalty for infractions within a profession or industry is one that is uniquely within the experience, expertise and

discretion of the relevant disciplinary tribunal and is therefore subject to a high degree of deference”: *Stetler v. Agriculture, Food and Rural Affairs Appeal Tribunal* (2005), 76 O.R. (3d) 321, [2005] O.J. No. 2817 (C.A.), at para. 108.

[75] In *Abbott*, this court also highlighted, at para. 13, two additional reasons why professional disciplinary bodies are entitled to deference from a reviewing court. First, the committee has the benefit of hearing live testimony directly from witnesses and consequently has a more comprehensive understanding of the evidence. Second, determining an appropriate penalty is a question of mixed fact and law, which does not lend itself to the extrication of a pure question of law. In *Ryan*, the Supreme Court observed, at para. 41:

The question of what sanction Mr. Ryan should face as a result of his misconduct is a question of mixed fact and law since it involves the application of general principles of the Act to specific circumstances. The Court of Appeal impugned the weight that the Committee assigned to particular mitigating evidence and also disapproved of the Committee’s selection of factually similar cases. These are fact-intensive elements within the question of mixed fact and law. They do not involve easily extracted and discretely framed questions of law. The Committee’s decision on sanction is not one that will determine future cases except insofar as it is a useful case for comparison. The decision is intricately bound to many factual findings and inferences about the misconduct of Mr. Ryan and the interests of the public and the profession.

[76] A reviewing court that fails to show due deference effectively usurps the administrative body’s statutory role. The concept of deference is rooted in part in respect for the legislature’s decision to create and delegate powers to administrative bodies: *Dunsmuir*, at para. 48. The Divisional Court’s decision did not respect the legislature’s choice to delegate the determination of the appropriate penalty to the Discipline Committee: *Dunsmuir*, at para. 49. Reasonable penalties should not be overturned when deference is due. Otherwise, nothing prevents reviewing courts from arbitrarily intervening in every administrative decision and undermining the disciplinary scheme created by the legislature. This would also have the effect of introducing uncertainty in the finality of disciplinary penalties.

(c) *Did the Discipline Committee incorrectly treat public confidence as a “shifting standard”?*

[77] The third error the Divisional Court purported to identify is that the Discipline Committee incorrectly viewed public confidence in the medical profession to be a “shifting standard”.

[78] In my view, the Divisional Court’s concern with the Discipline Committee’s reference to public confidence is unclear and, in any event, misplaced. The relevant quotation from the

Discipline Committee's reasons is as follows [at para. 192]: "The Committee accepted that the maintenance of public confidence is a shifting standard." This statement appears to simply be an acceptance by the Discipline Committee of a submission made by the College. The Discipline Committee was properly observing that what needs to be done to maintain the public's confidence must constantly be reassessed in light of considerations such as changes in society and in the practise of medicine. This is a reasonable observation. It neither constitutes a palpable and overriding error nor an error in principle. Moreover, it is in keeping with the Divisional Court's concern that the Discipline Committee's penalties remain current with public standards and expectations.

(d) *Do the prior decisions considered by the Discipline Committee constitute "a litany of clearly unfit penalties"?*

[79] The final basis advanced by the Divisional Court for interfering is that all the penalties imposed in similar cases were, in the Divisional Court's view, "a litany of clearly unfit penalties". In other words, it considered that the penalties imposed by numerous other discipline committees over the course of more than a decade were wrong and that the Discipline Committee erred in referring to these as precedents.

[80] By this statement the Divisional Court was, in effect, acknowledging that the penalty imposed was consistent with the range of penalties established in the existing authorities. Although the Discipline Committee was not bound by its previous decisions, it is well settled that consistency in sentencing is as important in professional bodies as in the criminal courts, and that consideration should be given to disciplinary penalties imposed in similar cases: see *Stevens and Law Society of Upper Canada (Re)* (1979), 55 O.R. (2d) 405, [1979] O.J. No. 4546 (Div. Ct.), at p. 411 O.R.; *Law Society of Upper Canada v. Neinstein*, [2008] O.J. No. 3731, 241 O.A.C. 199 (Div. Ct.), at para. 15.

[81] The Divisional Court should not have simply declared that the penalties imposed in the cases making up the well-established range, of which it was not seized, were wrong. The penalties imposed in those cases were not appealed and, in some cases, were the result of joint submissions by the College and the offender: *Le (Re)*, [2010] O.C.P.S.D. No. 10; *Marks (Re)*, [2012] O.C.P.S.D. No. 19, 2012 ONCPSD 13; *Rakem (Re)*. The Divisional Court should not have opined, long after the fact, that penalties in a whole series of cases, which were "intricately bound" to their own factual contexts, were incorrect.

[82] In its submissions before this court, the respondent suggests that we should interpret the Divisional Court's decision as appropriately declaring that a change to the penalty range was required. In other words, the Divisional Court viewed the penalty range that has existed for over a decade to be too low. Therefore, even if we were to accept that the prior cases cited by Dr. Peirovy were properly decided, under current circumstances, the range that these reflected was no longer appropriate. In support of this submission, the respondent points to the College's Revised Draft Sexual Abuse Principles prepared in 2015 and the legislature's 2017 amendment, the *Protecting Patients Act, 2017*, S.O. 2017, c. 11, to the governing statute, the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18. The 2017 amendment made revocation mandatory for sexual abuse of the nature committed in this case.

[83] I disagree. First, this is not what the Divisional Court said. More importantly, the Divisional Court had neither the mandate nor the evidentiary basis to intervene, let alone change, the penalty range for an entire category of behaviour. This is not to suggest that penalty ranges cannot change. The Discipline Committee was in the best position to assess whether a deviation from the range of penalties previously imposed for similar misconduct or a wholesale change was required. However, in the circumstances of this case, changing the penalty range was effectively an arbitrary exercise. The Divisional Court's conclusion that the penalty imposed in this and similar cases was [at para. 38] "inadequate to protect the public and vindicate the integrity of the profession" was not grounded in the jurisprudence of the Discipline Committee.

[84] The court's conclusion was also made in the absence of a proper and sufficient record showing that the Discipline Committee was not properly carrying out its mandate and that its approach was failing or manifestly out of step with contemporary social values. As already explained, specialized tribunals like the Discipline Committee have been given the mandate to design appropriate penalties for professional misconduct. They have been consistently recognized as being in the best position to assess the level of threat posed to the public by certain forms of behaviour: *Mussani v. College of Physicians and Surgeons of Ontario* (2004), 74 O.R. (3d) 1, [2004] O.J. No. 5176 (C.A.), at para. 113; *Ryan*, at para. 33.

[85] As for whether the time had come for change, the Discipline Committee noted that the College had prepared Revised Draft Sexual Abuse Principles in 2015 which proposed more severe penalties. The Discipline Committee was aware of and would therefore have taken account of the increasing concern for

sexual abuse by physicians. This concern is not new. Since at least 1991, when a taskforce on the sexual abuse of patients submitted its report, it has been recognized that sexual abuse tarnishes public trust in the entire profession. The legislative response to that taskforce report came in 1993 with the introduction of a zero tolerance/mandatory revocation scheme for specified sexual acts between health professionals and their patients.

[86] In 2017, after the decision under appeal, the legislature responded to the College's 2015 Draft Sexual Abuse Principles. It determined that penalties for sexual abuse should be increased by expanding the application of mandatory revocation. That penalty is now mandatory in cases where touching of a sexual nature occurs on the patient's genitals, anus, breasts or buttocks. Dr. Peirovy's conduct would likely be covered by this definition. The amendments further require the discipline committees to make interim orders suspending a member's certificate of registration immediately upon making a finding of sexual abuse that would attract a mandatory revocation.

[87] These 2017 legislative amendments do not retroactively validate the Divisional Court's erroneous application of the deferential standard of review to the Discipline Committee's 2016 decision on penalty for offences occurring in 2009 and 2010. A penalty must reflect the context in which the misconduct occurred: *Law Society of Upper Canada v. Neinstein* (2007), 85 O.R. (3d) 446, [2007] O.J. No. 958 (Div. Ct.), at para. 104, rev'd on other grounds (2010), 99 O.R. (3d) 1, [2010] O.J. No. 1046, 2010 ONCA 193. In accordance with the proper administration of justice and procedural fairness, Dr. Peirovy's case had to be adjudicated based on the law in force at the time. Any legislative change that followed is irrelevant.

[88] In fact, to some extent, the legislative response serves to further highlight the differing institutional roles at play in this case. The legislature is responsible for setting the framework under which the Discipline Committee operates. The application of the framework is left in the hands of the Discipline Committee, and deference is owed to the way in which the Discipline Committee discharges its duties within the scope of that mandate. The fact that the legislature chose to modify the parameters under which the Committee operates in 2017 does not render decisions made under the previous regime unreasonable.

[89] As already noted, the suspension imposed was serious, accompanied by other restrictions, and lasted for a longer term than requested by Dr. Peirovy. Furthermore, the range of penalties imposed in the cases reviewed by the Committee show that

the penalty received by Dr. Peirovy was in keeping (and exceeding in some instances) those imposed in Ontario and across Canada.

[90] The Divisional Court panel clearly felt that the penalties being imposed on medical practitioners by discipline committees for sexual abuse had not been severe enough for many years and should be increased. However, in the absence of reviewable error by the Discipline Committee or the imposition of a penalty outside the range of possible, acceptable and defensible outcomes open to it on the evidence, the Divisional Court could not and should not have interfered to substitute its own opinion for that of the expert panel charged with the duty of determining the appropriate penalty.

[91] No reversible error has been identified in the Discipline Committee's decision on penalty. The Discipline Committee correctly stated and applied the established principles it was required to consider at the penalty phase. It was aware of the range of the penalties that it could impose, which included revocation of Dr. Peirovy's licence to practise, as urged by the respondent. Acknowledging that it was not bound by previous decisions, the Discipline Committee properly looked to them for assistance in establishing the range of possible acceptable and defensible outcomes that were open to it on the evidence.

[92] Most importantly, the Discipline Committee was manifestly concerned with the paramount principle of the protection of the public. It accepted Dr. Rootenberg's evidence that Dr. Peirovy posed a low risk of recidivism. Risk is to be assessed in light of the conditions that can be imposed in order to mitigate that risk for the purposes of sentencing: see *R. v. Proulx*, [2000] 1 S.C.R. 61, [2000] S.C.J. No. 6, 2000 SCC 5, at para. 72; *R. v. Esmonde*, [2002] O.J. No. 2544, 161 O.A.C. 40 (C.A.), at para. 11. In this case, in addition to the suspension imposed, the Discipline Committee imposed conditions on Dr. Peirovy's return to practice to address the particular nature of his risk to the public. Overall, the Discipline Committee crafted a careful penalty that reflected the principle of the protection of the public, while balancing the other principles that it was required to consider, including proportionality and the rehabilitation of Dr. Peirovy.

F. *Conclusion*

[93] For these reasons, I would allow the appeal and restore the penalty imposed by the Discipline Committee. I would award Dr. Peirovy his costs in the amounts agreed. Those amounts are \$15,000 for the appeal, \$1,500 for the application for leave to appeal and \$7,500 in the Divisional Court, all of which are inclusive of disbursements and applicable taxes.

[94] BENOTTO J.A. (dissenting): — This appeal concerns the duty of the Discipline Committee of the College of Physicians and Surgeons (the “Discipline Committee”) to protect the public from doctors who sexually abuse their patients.

[95] I agree with my colleague as to the standard of review to be applied to the Discipline Committee’s penalty decision. However, I do not agree that the Divisional Court erred in its application.

[96] I would dismiss the appeal.

Overview

[97] The College of Physicians and Surgeons (the “College”) received six separate complaints from young women seen by Dr. Peirovy at walk-in clinics. The complainants described that, while examining them with a stethoscope, Dr. Peirovy cupped their breasts, touched their nipples, in one case “tweak[ed]” a nipple, and asked one patient out on a date. Dr. Peirovy denied the inappropriate touching.

[98] Dr. Peirovy was charged criminally with six counts of sexual assault based on the complainants’ allegations. He pleaded guilty to simple assault of two of the complainants and the other charges were withdrawn.

[99] The Discipline Committee conducted a two-phase hearing regarding the complaints: a liability hearing and a penalty hearing. At the liability phase, the Discipline Committee found that Dr. Peirovy had committed acts of professional misconduct per s. 51(1) of the *Health Professions Procedural Code* (Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18) (“*Procedural Code*”). Specifically, it found that he sexually abused four patients; his conduct with respect to the four patients would also reasonably be regarded as “disgraceful, dishonourable or unprofessional”; his conduct with respect to a fifth patient would similarly reasonably be regarded as “disgraceful, dishonourable or unprofessional”; and he had been found guilty of offences relevant to his suitability to practise medicine.

[100] At the penalty phase, the Discipline Committee ordered that Dr. Peirovy’s certificate of registration be suspended for a period of six months and that certain conditions be imposed, including that Dr. Peirovy have a practice monitor present during all professional encounters with female patients and post a sign at his practice locations publicizing this requirement.

[101] The Divisional Court allowed the College’s appeal from the Discipline Committee’s penalty decision. I agree with my colleague that the Divisional Court correctly selected reasonableness as the applicable standard of review. The Divisional Court quite

rightly recognized that reasonableness in this context means a penalty can only be overturned if the Discipline Committee's reasons disclose an error in principle or if the penalty is clearly unfit: *Reid v. College of Chiropractors of Ontario*, [2016] O.J. No. 3080, 2016 ONSC 1041 (Div. Ct.), at para. 99.

[102] My colleague has determined that the Divisional Court failed to properly apply the standard it articulated, substituting instead its own assessment of the evidence and view of the penalty. With respect, I do not agree. The Divisional Court identified significant errors in principle in the Discipline Committee's reasons and found that the penalty imposed was clearly unfit. The Divisional Court concluded that the Discipline Committee's penalty decision was unreasonable and remitted the matter back to the Discipline Committee.

[103] In my view, the Divisional Court did not err in reaching this conclusion. In its penalty decision, the Discipline Committee made internally inconsistent findings of fact, reached a conclusion that was unsupported by the evidence, and imposed a penalty that does not fulfill its mandate. These errors in principle led to an unreasonable decision and a penalty that was clearly unfit.

Analysis

(1) Inconsistent findings

[104] The Discipline Committee contradicted its own factual findings from the liability phase during the penalty phase. As I will demonstrate, having rejected the submission that Dr. Peirovy's blatant sexual abuse could be explained by misunderstanding, the Discipline Committee accepted the opposite in its penalty decision.

[105] During the liability phase, the Discipline Committee

- rejected Dr. Peirovy's evidence that he did not touch the complainants' breasts as they alleged;
- accepted the complainants' evidence that Dr. Peirovy's conduct was "blatantly sexual", deliberate and could not be explained as inadvertent or incidental to a legitimate examination;
- expressly rejected misunderstanding as an explanation for the complaints;
- rejected Dr. Peirovy's submission that his guilty pleas to assault were not relevant to his suitability to practise (Dr. Peirovy had argued they were irrelevant since they arose from mere technical breaches of the *Criminal Code*, R.S.C.

1985, c. C-46, related to his failure to obtain specific consent to place his stethoscope on or near the patients' nipples. The Discipline Committee found it [at para. 152] "difficult . . . to imagine a clearer example of an offence relevant to a physician's suitability to practise" than a finding that the physician had assaulted his patients in his office during the course of a sensitive physical examination); and

- found Dr. Peirovy's evidence "evasive" and "somewhat lacking in credibility" with respect to the patient he asked out on a date during an examination.

[106] In rejecting Dr. Peirovy's submission that the sexual abuse could be explained by misunderstanding, the Discipline Committee stated, at para. 95:

[T]he Committee finds that the precise and detailed evidence of four of the complainants with respect to how Dr. Peirovy touched their breasts is not consistent with misunderstanding as the explanation for their complaints.

(Emphasis added)

[107] During the penalty phase, however, the Discipline Committee found the opposite. It accepted that Dr. Peirovy's communication deficits, insensitivity and awkward and unskilled manner were antecedents to, and factors in understanding, his sexual abuse. At para. 195, the Discipline Committee stated:

[T]he Committee was of the view that we do, in fact, understand some of the antecedents to Dr. Peirovy's sexual misconduct . . . Dr. Peirovy is a physician who, at the time this misconduct occurred, had very serious deficits in his communication skills, his sensitivity to the extent of his patients' vulnerability, and his understanding of boundaries and consent. These deficits in no way diminish or excuse the fact that he repeatedly subjected several patients to abusive experiences. In the view of the Committee, however, Dr. Peirovy's awkward, unskilled, and non-empathic manner with his female patients was a factor in understanding his abusive behaviour.

(Emphasis added)

[108] The Discipline Committee also endorsed, at para. 198, the "possible inference" that Dr. Peirovy was "genuinely and completely unaware" of the ways in which his behaviour was abusive.

[109] These findings are irreconcilably inconsistent with the Discipline Committee's own findings at the liability phase. While the Discipline Committee is entitled to make and rely on additional findings of fact during the penalty phase, these findings cannot be inconsistent with its earlier findings on liability: *College of Physicians and Surgeons of Ontario v. McIntyre*, [2017] O.J. No. 193, 2017 ONSC 116 (Div. Ct.), at para. 44, leave to appeal to Ont. C.A. refused, July 7, 2017.

[110] Where, as here, a decision is internally inconsistent, “this alone renders it unreasonable”: *Sangmo v. Canada (Minister of Citizenship and Immigration)*, [2016] F.C.J. No. 14, 2016 FC 17, at para. 21.

(2) *Unsupported conclusion*

[111] The Discipline Committee’s finding regarding the impact of Dr. Peirovy’s awkwardness, lack of skill and unawareness is also without foundation. I respectfully disagree with my colleague when he says that this finding is well supported by the testimony of the experts during the penalty phase.

[112] The Discipline Committee’s related finding regarding Dr. Peirovy’s motivations is similarly unfounded. Again, I respectfully disagree with my colleague when he characterizes the Discipline Committee’s finding on this point as “nuanced”. In my opinion, the evidence of Dawn Martin¹ and Dr. Rootenberg was not capable of supporting either of these conclusions.

[113] A decision may be unreasonable where the outcome ignores or cannot be supported by the evidence: *Intact Insurance Co. v. Allstate Insurance Co. of Canada* (2016), 131 O.R. (3d) 625, [2016] O.J. No. 4113, 2016 ONCA 609, at para. 65, leave to appeal to S.C.C. refused [2016] S.C.C.A. No. 392. In my view, the Discipline Committee’s unsupported findings regarding Dr. Peirovy’s motivations and the role of his manner in the sexual abuse, both of which it relied on in crafting the appropriate penalty, constitute further errors in principle that render its decision unreasonable.

(a) *Dawn Martin’s evidence*

[114] Dawn Martin is a Ph.D. who specializes in assessing and training physicians in communication, interviewing skills, collaboration and professionalism. Dr. Peirovy was referred to her for assessment and education with respect to his faulty communication skills. She worked with him to assist in that regard and provided a written report and testified at the penalty phase.

[115] The Discipline Committee summarized Ms. Martin’s evidence as follows, at para. 174:

[Ms. Martin]’s assessment of Dr. Peirovy indicated that, in her opinion, he had deficits in a number of areas. These included his interviewing skills, his manner (which was described as awkward and clumsy), his verbal communication, his awareness of issues pertaining to patient consent, his sensitivity to

¹ In order to distinguish medical doctors from Ph.D.’s, I do not use “Dr. Martin”, which appears in the majority decision.

how his patients were perceiving him, and how his behaviour was affecting his patients. [Ms. Martin] stated that Dr. Peirovy was largely unaware of his professional responsibilities in maintaining appropriate boundaries in the doctor/patient relationship.

[116] Ms. Martin's evidence presented no new information but repeated what had already been addressed at the liability phase: Dr. Peirovy has poor communication skills and this created a substantial risk of patient misunderstanding.

[117] Specifically, during the liability phase the Discipline Committee accepted expert evidence that the way Dr. Peirovy was practising placed him at "high risk" for misunderstandings with patients. Despite this, as previously mentioned, it found that the complainants' precise and detailed evidence regarding how Dr. Peirovy touched their breasts was inconsistent with misunderstanding as the explanation for their complaints. It similarly noted there was no evidence that the physical touching at issue was clinically necessary. The Discipline Committee stated, at paras. 95-96:

The Committee found that [the expert evidence] with respect to the general issue of patient complaints about physicians and the "risk factors" identified in the literature, which appeared to make complaints more likely, to be credible and informative. *This evidence, however, was of limited utility.* The Committee accepts that most of the identified risk factors are present with respect to the complaints of these six patients. The Committee accepts that Dr. Peirovy's walk-in practice, by its nature, may have been a high risk setting where complaints were more likely to occur than with other physicians practising in other ways. The position of the defence, essentially, is that the complainants misunderstood Dr. Peirovy's actions as sexual in nature, due in part to the presence of risk factors referred to above. *The Committee accepts that Dr. Peirovy, in relation to these complainants, was practising in a fashion in which the risks of poor communication and patient misunderstanding were substantial.* As will be stated below, *however, the Committee finds that the precise and detailed evidence of four of the complainants with respect to how Dr. Peirovy touched their breasts is not consistent with misunderstanding as the explanation for their complaints.*

... [The expert evidence did not offer] the opinion that there was a clinical necessity for Dr. Peirovy to have placed his stethoscope directly on the nipple of a patient, tweak the nipples of one complainant, or cup the breasts of two complainants with his hand.

(Emphasis added)

[118] Ms. Martin's evidence was therefore not relevant to the conduct Dr. Peirovy had been found liable for. Her evidence spoke to Dr. Peirovy's "awkward and clumsy" interviewing skills, and his insensitivity to how patients perceived him and how his behaviour affected them. It related to his conduct during "sensitive history taking and clinical exams".

[119] The professional misconduct found at the liability phase did not involve an interview, history taking or a clinically necessary exam. The Discipline Committee found that Dr. Peirovy had engaged in deliberate physical touching that violated the sexual integrity of his patients and was clinically unnecessary. Dr. Peirovy's inept verbal skills and poor sensitivity around intimate exams are not related to this conduct. Moreover, they could not have been a factor in his sexual abuse given the Discipline Committee's finding that his conduct could not be explained by misunderstanding.

[120] That Ms. Martin conflated Dr. Peirovy's communication deficits with his physical sexual abuse became evident when she was asked directly about the Discipline Committee's findings:

- Q. You have read the Committee's decision-making findings of sexual abuse in relation to the four patients and disgraceful, dishonourable and unprofessional conduct in relation to all four and also to [a fifth patient] . . . In your view, how has the work that you have done with Dr. Peirovy addressed the findings made by the Committee?
- A. Well, I think that the two are very inter-connected in the sense that he had poor interviewing skills, poor relationship-building skills that needed to be addressed. Intimate exams are — you're far more — you need to pay attention to how vulnerable the patient is. And I think there was a lot of reflection, skill building, decoding for him of how and who he needed to be in that relationship. I don't think it was so much as any mal intent as it was awkward and naïve, *making himself vulnerable to being — confusing people around not providing explanations*. And I think he is clear on that and what he needs to do now.

[121] This answer ignores the Discipline Committee's conclusion regarding the nature of Dr. Peirovy's conduct at the liability stage; the Discipline Committee had already accepted that his behaviour was not misunderstood or medically justified. There were no "explanations" that could justify his conduct.

(b) *Dr. Rootenberg's evidence*

[122] Dr. Rootenberg is an expert in forensic psychiatry. He specializes in the assessment and treatment of persons who have committed sexual and other offences, including their risk of re-offending. He assessed Dr. Peirovy at the request of Dr. Peirovy's counsel and provided a written report and testified at the penalty phase.

[123] In its penalty decision, the Discipline Committee relied upon Dr. Rootenberg's evidence to eliminate the possibility that Dr. Peirovy's conduct was motivated by a predatory intent or uncontrollable urges. It stated, at para. 194:

The expert evidence . . . now effectively rules out psychopathy or sexual deviance, and this is an important finding with respect to the issue of Dr. Peirovy's motivation.

[124] And later, at paras. 197-198:

The fact that Dr. Peirovy's sexual misconduct with these four patients occurred in fairly close succession, over a time frame of several months, and continued to occur even after he was aware that a complaint had been made, was considered by the Committee. The Committee did not, however, infer that this pattern is indicative of predatory intent or uncontrollable deviant urges on Dr. Peirovy's part, and thus a serious aggravating factor.

In fact, the expert evidence appears to rule out motivation of this nature.

(Emphasis added)

[125] In so doing, the Discipline Committee expanded Dr. Rootenberg's opinion evidence beyond its limits. Reasonably conceived, Dr. Rootenberg's evidence could not support the Discipline Committee's conclusions regarding Dr. Peirovy's motivation. I say this for two reasons.

[126] First, Dr. Rootenberg's evidence was not capable of supporting the conclusion that the absence of a psychiatric disorder rules out sexual motivation. There was no evidence before the Discipline Committee that sexual abuse is committed by persons with identifiable mental illness or deviant behaviours. In fact, courts have recognized that this is not true.

[127] In *R. v. Mohan*, [1994] 2 S.C.R. 9, [1994] S.C.J. No. 36, the Supreme Court of Canada considered the admissibility of expert evidence to show that a doctor accused of sexual misconduct with patients did not possess character traits fitting the psychological profile consistent with the abuse charged. The court concluded, at pp. 37-38 S.C.R., that the evidence was not admissible as "there is no acceptable body of evidence that doctors who commit sexual assaults fall into a distinctive class with identifiable characteristics".

[128] This holding is consistent with a long line of authority, including this court's decision in *R. v. McMillan* (1975), 7 O.R. (2d) 750, [1975] O.J. No. 2247 (C.A.), affd [1977] 2 S.C.R. 824, [1977] S.C.J. No. 32, in which Martin J.A. stated, at p. 764 O.R.:

Where the crime under consideration does not have features which indicate that the perpetrator was a member of an abnormal group, psychiatric evidence that the accused has a normal mental make-up . . . is inadmissible.

[129] The fact that Dr. Peirovy did not have sexual deviance or psychopathy does not relate to his degree of culpability. The Discipline Committee's reliance on this fact to find that a lesser penalty was called for was an error.

[130] Second, assuming he were qualified to opine on Dr. Peirovy's motivation, Dr. Rootenberg's opinion was based on evidence the Discipline Committee had rejected at the liability phase. One of the sources of information identified in Dr. Rootenberg's report

was assessment interviews conducted with Dr. Peirovy. Dr. Rootenberg testified that Dr. Peirovy's comments to him were the same as in his testimony before the Discipline Committee: Dr. Peirovy insisted that the sexually abusive conduct was inadvertent. It was illogical and inconsistent for the Discipline Committee to embark upon an analysis of Dr. Peirovy's motivation as gleaned from evidence it had heard itself and not accepted.

(3) *Failure to fulfill mandate*

[131] My colleague concludes that the penalty imposed by the Discipline Committee was one of the options available and thus deference requires that appellate courts not interfere. With respect, I again disagree.

[132] I recognize that the penalty imposed was within the range of penalties imposed in past Discipline Committee decisions involving sexual abuse. However, reasonableness is not a static concept and ranges are not set in stone. Our collective social conscience is continuously changing. What was once reasonable may no longer accord with the modern conscience. Where society has evolved such that a range no longer reflects societal values, there is reason to question the validity of the range.

[133] In this case, the Discipline Committee imposed a penalty that failed to fulfill its mandate and is clearly unfit. In my view, the mere fact that it falls within the historical penalty range is insufficient to render it reasonable.

(a) *The Discipline Committee's mandate*

[134] The legislature has entrusted the Discipline Committee with holding hearings of allegations of physician misconduct and fashioning penalties where it finds a member has committed an act of professional misconduct: *Procedural Code*, ss. 38(1) and 51.

[135] This role is crucial. As explained by LeBel J. in *Pharmascience Inc. v. Binet*, [2006] 2 S.C.R. 513, [2006] S.C.J. No. 48, 2006 SCC 48, at para. 36:

This Court has on many occasions noted the crucial role that professional orders play in protecting the public interest. As McLachlin J. stated in *Rocket v. Royal College of Dental Surgeons of Ontario*, [1990] 2 S.C.R. 232, "[i]t is difficult to overstate the importance in our society of the proper regulation of our learned professions" (p. 249). The importance of monitoring competence and supervising the conduct of professionals stems from the extent to which the public places trust in them. Also, it should not be forgotten that in the client-professional relationship, the client is often in a vulnerable position. The Court has already had occasion to address this point in respect of litigants who entrust their rights to lawyers (*Fortin v. Chretien*, [2001] 2 S.C.R. 500, 2001 SCC 45, at para. 17). The general public's lack of knowledge of the pharmaceutical field and high level of dependence on the advice of competent professionals means that pharmacists are another profession in which the public places great trust.

[136] As with litigants and their lawyers and the public and pharmacists, “[a]n unequal distribution of power is frequently a part of the doctor-patient relationship”. Patients seek the help of doctors when they are vulnerable — “when they are sick, when they are needy, and when they are uncertain about what needs to be done”: *Norberg v. Wynrib*, [1992] 2 S.C.R. 226, [1992] S.C.J. No. 60, at p. 258 S.C.R., citing *The Final Report of the Task Force on Sexual Abuse of Patients*, An Independent Task Force Commissioned by The College of Physicians and Surgeons of Ontario (November 25, 1991) (Chair: Marilou McPhedran), at p. 11.

[137] In exercising its delegated power, the Discipline Committee is guided first and foremost by a duty to protect the public: *McIntyre*, at para. 50. As stated by LeBel J. in *Pharmascience*, at para. 36:

I have no hesitation in applying the comments I wrote for this Court in *Finney*, at para. 16, generally to the health field to emphasize the importance of the obligations imposed by the state on the professional orders that are responsible for overseeing the competence and honesty of their members:

The primary objective of those orders is not to provide services to their members or represent their collective interests. They are created to protect the public, as s. 23 of the *Professional Code* makes clear. . . .

The privilege of professional self-regulation therefore places the individuals responsible for enforcing professional discipline under an onerous obligation. The delegation of powers by the state comes with the responsibility for providing adequate protection for the public. *Finney* confirms the importance of properly discharging this obligation and the seriousness of the consequences of failing to do so.

[138] In *McIntyre*, the Divisional Court described the Discipline Committee’s “broad policy-based view of its own mandate” as follows, at para. 62:

[T]o protect the public; to recognize the devastating impact on patients when the trust they place in doctors has been violated, particularly through sexual abuse; and to maintain public confidence in the ability of the medical profession to regulate itself in the public interest.

[139] Section 1.1 of the *Procedural Code* further specifies the purpose of its sexual abuse provisions as follows:

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

(Emphasis added)

[140] The Discipline Committee’s mandate to protect the public, maintain public confidence in the medical profession’s ability to self-regulate and — in acting pursuant to the *Procedural Code*’s

sexual abuse provisions — eradicate the sexual abuse of patients by members was not fulfilled with a penalty that is clearly unfit.

(b) *The penalty is clearly unfit*

[141] In its penalty decision, the Discipline Committee found, at para. 166, that Dr. Peirovy “demonstrated a pattern of behaviour over a period of time which was causing harm to the public” and noted it was “extremely concerned” by his actions.

[142] I agree with the Divisional Court that the short suspension imposed in this case, given the conduct found by the Discipline Committee, is “clearly inadequate to deter others and to contribute meaningfully to the eradication of sexual abuse in the profession”, and is “inadequate to protect the public and vindicate the integrity of the profession”: at paras. 37-38.

[143] Moreover, the conditions placed on Dr. Peirovy demonstrate a lack of confidence in his ability to practise medicine. It is unreasonable for a patient to attend a walk-in clinic with a physician who requires a chaperone with half the world’s population, and which features a prominent sign indicating his limited capacity. Such conditions — in these circumstances — belies the trust inherent in the doctor-patient relationship, undermines public confidence and fails to protect the public.

[144] Reasonableness “takes its colour from the context”: *Canada (Citizenship and Immigration) v. Khosa*, [2009] 1 S.C.R. 339, [2009] S.C.J. No. 12, 2009 SCC 12, at para. 59. Where a statutory mandate expressly tethers the scope of an administrative decision-making power, a decision that is inconsistent with, or undermines, that mandate will be unreasonable: *Williams Lake Indian Band v. Canada (Aboriginal Affairs and Northern Development)*, [2018] 1 S.C.R. 83, [2018] S.C.J. No. 4, 2018 SCC 4, 417 D.L.R. (4th) 239, at paras. 33-34.

[145] This is equally true where an administrative tribunal renders a decision that does not fulfill the values underlying its grant of discretion. In *Baker v. Canada (Minister of Citizenship and Immigration)*, [1999] 2 S.C.R. 817, [1999] S.C.J. No. 39, the Supreme Court considered the decision of an immigration official that failed to account for the applicant’s children. Justice L’Heureux-Dubé held that the decision was unreasonable since it failed to fulfill the mandate of protecting children. She stated, at p. 859 S.C.R.:

The reasons of the immigration officer show that his decision was inconsistent with the values underlying the grant of discretion. They therefore cannot stand up to the somewhat probing examination required by the standard of reasonableness.

[146] I acknowledge that the penalty the Discipline Committee imposed was statutorily available to it at the time of its decision.² However, the Discipline Committee's mandate and the stated purpose of the sexual abuse provisions restricted the range of acceptable and defensible outcomes in the circumstances. By imposing a penalty that undermines public confidence in the self-regulation of medical professionals, fails to protect the public and is inconsistent with the eradication of sexual abuse of patients by physicians, the Discipline Committee rendered an unreasonable decision.

[147] The fact that the penalty imposed was in line with past cases does not insulate the Discipline Committee's penalty decision from appellate interference. I agree with the College that a court or tribunal is entitled to look critically at the penalties imposed in prior cases and to conclude that those penalties are no longer appropriate. A deferential standard of review does not require the acceptance of an unreasonable decision in a contemporary context, much less create a static range from which no future development can be made.

[148] In the context of criminal law, courts have surpassed previous sentencing ranges where the penalty no longer reflected societal values. In *R. v. D. (D.)* (2002), 58 O.R. (3d) 788, [2002] O.J. No. 1061 (C.A.), this court approved a higher sentence in a case involving the long-term sexual assault of children, noting that the time had long since passed when the nature and extent of the damage caused by child sexual abuse was not known. Similarly, in *R. v. Klimovich*, [2013] O.J. No. 2346, 2013 ONSC 2888 (S.C.J.), the court declined to follow sentencing precedents which were out of step with social values regarding domestic assault.

[149] As with these examples, society has evolved in respect of the gravity of the breach of trust and damage caused by the sexual abuse of patients by their doctors. As noted by my colleague, since 1991, the College has recognized the devastating consequences of sexual abuse of patients by physicians. Over 25 years ago, *The Final Report of the Task Force on Sexual Abuse of Patients* reported:

The essence of the relationship between doctor and patient is trust. When this trust is abused, the results are devastating . . . For society as a whole, it is an act of trust to grant self-regulation to a profession, relying on the profession's leadership to govern itself in the public interest.

² As noted by my colleague and discussed below, the *Regulated Health Professions Act* was amended in 2017. Had Dr. Peirovy's conduct occurred following these amendments, it would likely be captured by the new mandatory revocation provision and a suspension would not have been available to the Discipline Committee.

[150] More broadly, courts have recognized the pervasiveness of sexual violence against women and its fundamental incompatibility with any concept of equality for women. As expressed by L'Heureux-Dubé J. in *R. v. Ewanchuk*, [1999] 1 S.C.R. 330, [1999] S.C.J. No. 10, at paras. 68-69:

In Canada, one-half of all women are said to have experienced at least one incident of physical or sexual violence since the age of 16 (Statistics Canada, "The Violence Against Women Survey", *The Daily*, November 18, 1993). The statistics demonstrate that 99 percent of the offenders in sexual assault cases are men and 90 percent of the victims are women (Gender Equality in the Canadian Justice System: Summary Document and Proposals for Action (April 1992), at p. 13, also cited in *R. v. Osolin*, [1993] 4 S.C.R. 595, at p. 669).

Violence against women is as much a matter of equality as it is an offence against human dignity and a violation of human rights. As Cory J. wrote in *Osolin, supra*, at p. 669, sexual assault "is an assault upon human dignity and constitutes a denial of any concept of equality for women".

[151] These concepts must inform the penalty here.

[152] In recent years, growing recognition and the resulting shift in societal standards have given rise to legislative change. In 2017 — after the Discipline Committee's decision — the legislature enacted the *Protecting Patients Act, 2017*, S.O. 2017, c. 11, which amended the *Procedural Code* to implement a zero-tolerance policy on sexual abuse of patients by any regulated health professional. Revocation of a member's certificate of registration is now mandatory in cases of sexual abuse consisting of touching of a sexual nature of the patient's genitals, anus, breasts or buttocks: s. 51(5). The amendments also introduced mandatory interim suspension orders upon findings of sexual abuse that would attract mandatory revocation: s. 51(4.2).

[153] I do not agree that the 2017 legislative amendments are irrelevant. In my opinion, they are indicative of and indeed confirm the shift that has taken place in society's understanding of the consequences of physician sexual abuse and its tolerance for such behaviour.

[154] It was incumbent on the Discipline Committee to look beyond the penalties imposed in previous decisions and craft a penalty consistent with the reality of society's values as they related to its mandate. In my view, its failure to take the relevant societal context into account was a serious error in principle and resulted in a penalty that was clearly unfit.

Conclusion

[155] For these reasons, I would dismiss the appeal.

Appeal allowed.

Subject: FW: Invitation to join Bencher Election 2019 Listserv

From: Jo-Ann Willson
Sent: Monday, March 11, 2019 7:11 AM
To: Rose Bustria <RBustria@cco.on.ca>
Cc: David Starmer <drstarmer@gmail.com>; Liz Anderson-Peacock <drliz@bellnet.ca>; Doug Cressman <doug.cressman@gmail.com>
Subject: Fwd: Invitation to join Bencher Election 2019 Listserv

Council.

Jo-Ann Willson, B.Sc., M.S.W., LL.B.
Registrar & General Counsel

Begin forwarded message:

From: Bencher Election 2019 <bencherelection2019@gmail.com>
Date: March 10, 2019 at 6:44:53 PM EDT
To: Client 7263 <jpwilson@cco.on.ca>
Subject: Invitation to join Bencher Election 2019 Listserv

Bencher Election 2019 Listserv

Invitation to join Bencher Election 2019 Listserv

Hello Client 7263,

You have been invited to join Bencher Election 2019 Listserv.

Bencher Election 2019 wrote the following message to you.

█ Please accept this invitation to join Bencher Election 2019 Listserv.

Click on the following link to accept or decline this invitation:

<https://bencherelection2019listserv.onlinegroups.net/r/rsvp/4117r0g7kmQNp45DhrCqON>

About Bencher Election 2019 Listserv

Bencher Election 2019 Listserv is an online group for people in Bencher Election 2019 Listserv. There are **46 members** of Bencher Election 2019 Listserv.

Bencher Election 2019 Listserv is a public group.

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- The group is visible to **anyone**.
- Posts made to the group are visible to **anyone**.

About Bencher Election 2019

Bencher Election 2019 is the administrator of Bencher Election 2019 Listserv. The main role of an administrator is to manage the members of a group.

If you have any problems, email us at support@onlinegroups.net

Kind regards

The Bencher Election 2019 Listserv Team

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Subject: FW: [bencher election 2019 listserv] Understanding the Bencher Election 2019 Listserv

From: Jo-Ann Willson
Sent: Monday, March 11, 2019 10:16 AM
To: Rose Bustria <RBustria@cco.on.ca>
Subject: FW: [bencher election 2019 listserv] Understanding the Bencher Election 2019 Listserv

Council – Elections discussion.

I'm liking that there has been a list serve established for the Bencher elections to the Law Society of Ontario. Thanks.

Jo-Ann Willson, B.Sc., M.S.W., LL.B.
Registrar & General Counsel

From: Bencher Election 2019 Listserv [<mailto:bencher-election-2019-listserv@onlinegroups.net>] **On Behalf Of** Bencher Election
Sent: Monday, March 11, 2019 10:00 AM
To: bencher-election-2019-listserv@onlinegroups.net
Subject: [bencher election 2019 listserv] Understanding the Bencher Election 2019 Listserv

Bencher Election 2019 Listserv



Understanding the Bencher Election 2019 Listserv
by **Bencher Election 2019**
in **Bencher Election 2019 Listserv**

Welcome to the Bencher Election 2019 Listserv!

This forum is meant to encourage reflection and debate on key issues facing the Law Society of Ontario. There are many insightful discussions taking place on social media (LinkedIn, Twitter, Facebook), but these platforms aren't widely used within the legal community. The Bencher Election 2019 Listserv has been created to ensure that lawyers who communicate primarily through email are not left out of the conversation.

To start a thread, send your message to bencher-election-2019-listserv@onlinegroups.net

To reply, select the "reply all" function in the thread.

Please keep posts civil and respectful. Membership to the Bencher Election 2019 Listserv is exclusive to lawyers. You may direct any questions or concerns to bencherelection2019@gmail.com

The administrator of this forum is a Recent Call based in the GTA. They are providing this service anonymously. The administrator will not make any endorsements. Their participation in the Bencher Election 2019 Listserv will be limited to posting about administrative and housekeeping matters.

*Don't forget to vote! *The polls are open from April 15 to 30, 2019. More details about the voting process will be posted as information becomes available.

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**Ministry of Health
and Long-Term Care**

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Toronto ON M5S 1S4

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et des Soins de longue durée**

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ATS 416-326-7889
ATS sans frais 1-877-301-0889
Télécopieur 416- 327-8524



February 28, 2019

MEMORANDUM

To: Registrars, Ontario Health Regulatory Colleges

From: Christy Hackney
Senior Manager, Health Boards Secretariat
Registrar, Health Professions Appeal and Review Board

Subject: Staffing Change

Effective March 4, 2019, I will be moving to a position with the Ministry of Government and Consumer Services. I am pleased to advise that Sandra Evora will be stepping into the role of Acting Senior Manager & Registrar. Most of you already know Sandra as she has been the Manager & Deputy Registrar of the Health Boards Secretariat and Health Professions Appeal and Review Board since 2013.

It has been a pleasure working with you and your teams!

All the best,
Christy Hackney

- c. John Amodeo, Director, Corporate Management Branch
Janice Vauthier, Chair, Health Professions Appeal and Review Board

Subject: FW: Health Workforce Regulatory Oversight Branch is Moving
Attachments: HWROB On the Move.pdf

From: Jo-Ann Willson
Sent: Friday, March 08, 2019 1:24 PM
To: Rose Bustria <RBustria@cco.on.ca>
Cc: David Starmer <drstarmer@gmail.com>; Liz Anderson-Peacock <drliz@bellnet.ca>
Subject: FW: Health Workforce Regulatory Oversight Branch is Moving

Exec and Council.

Jo-Ann Willson, B.Sc., M.S.W., LL.B.
Registrar & General Counsel

From: Cheng, Stephen (MOHLTC) [<mailto:Stephen.Cheng@ontario.ca>]
Sent: Friday, March 08, 2019 1:05 PM
To: info@regulatedhealthprofessions.on.ca; allan.mak@ctcmpao.on.ca; lbetteridge@ocswssw.org; taylor@crto.on.ca; d.adams@crpo.ca; rmorris@cpo.on.ca; rhamilton@collegept.org; nwhitmore@cpso.on.ca; nlumwilson@ocpinfo.com; PGarshowitz@collegeoptom.on.ca; fkhan@coptont.org; elarney@coto.org; ED@cnomail.org; andrew.parr@collegeofnaturopaths.on.ca; k.dobbin@cmo.on.ca; lgough@cmrto.org; kwilkie@cmlto.com; officeofregistrar@cmtto.com; Brenda.Kritzer@coko.ca; basil.ziv@collegeofhomeopaths.on.ca; melisse.willems@collegeofdietitians.org; gpettifer@denturists-cdo.com; jrigby@cdto.ca; ifefergrad@rcdso.org; ltaylor@cdho.org; Jo-Ann Willson <jwillson@cco.on.ca>; fsmith@cocoo.on.ca; boriordan@caslpo.com
Cc: info@regulatedhealthprofessions.on.ca
Subject: Health Workforce Regulatory Oversight Branch is Moving

Dear Registrars and Executive Directors,

Please find attached a letter regarding the Health Workforce Regulatory Oversight Branch.

Cheers,
Stephen.

Stephen D. Cheng
Manager, Strategic Regulatory Policy Unit
Health Workforce Regulatory Oversight Branch
Strategic Policy and Planning Division
Ministry of Health and Long-Term Care
Phone: 416-327-8540
Fax: 416-327-0167

Effective: March 11, 2019 our new address & phone number:
438 University Ave., 10th Floor
Toronto ON M5G 2K8
Phone: 416-471-9453

My email address will remain the same.

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and Long-Term Care**

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Tél.: 416 327-8464
Télééc.: 416 327-0187



March 8, 2019

HLTC2968IT-2019-25

Dear Registrars and Executive Directors:

As part of the Queen's Park Complex Redevelopment Project and recent realignment of the ministry, the Health Workforce Regulatory Oversight Branch is moving to a new office space alongside the other Branches within the Strategic Policy and Planning Division. The last day in which we will be in our current address is March 8, 2019.

As of March 11, 2019 the Branch mailing address will be:

Health Workforce Regulatory Oversight Branch
Ministry of Health and Long-Term Care
438 University Ave. 10th Floor
Toronto ON M5G 2K8

Aside from a few hours in the afternoon of March 8th, no interruption of work is anticipated and we will resume business as usual on March 11th.

Sincerely,

A handwritten signature in black ink, appearing to be "A. Henry", written over a horizontal line.

Allison Henry
Director

ITEM 7.19

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INSTITUT C.D. HOWE INSTITUTE

COMMENTARY

NO. 541

Regulating Alternative Medicines: Disorder in the Borderlands

With the use of alternative medicines increasing in Western countries, along with concerns about standards, an approach to regulating certain popular forms of these medicines is needed. Regulation should be calibrated to the degree of risk entailed.

Michael J. Trebilcock
and Kanksha Mahadevia Ghimire



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Daniel Schwanen

Daniel Schwanen
Vice President, Research

THE STUDY IN BRIEF

In many Western countries, the use of complementary and alternative medicines (CAMs) has been growing. Individuals in Western countries often use CAMs in conjunction with biomedicine (also referred to as allopathic or Western medicine), or sometimes choose to rely on CAMs as alternatives to biomedicine. In most contemporary Western societies, biomedicine is relatively strictly regulated, while regulation of CAMs reflects a much less settled regulatory landscape. With use of CAMs increasing and concerns about standards, an approach to regulating certain popular forms of CAMs is needed.

The central regulatory challenge is how to provide for patients' autonomy over their own treatment while addressing the core challenges of severe information asymmetries and negative externalities. Regulation of CAMs should be calibrated to the degree of risk entailed, especially where CAMs are promoted as substitutes for, rather than as complements to, biomedicine in treating potentially life-threatening health conditions.

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The field of complementary and alternative medicines (CAMs) groups together a vast array of medical treatments such as homeopathy, chiropractic, osteopathy, naturopathy, Ayurveda, Siddha, Unani, traditional Chinese medicine, and spiritual therapies (Bodeker et al. 2005).

In many Western countries, the use of CAMs has been growing (Clarke et al. 2015; Crouch et al. 2001; EUROCAM 2014). For example, a 2016 study by the Fraser Institute concluded: “More than three-quarters of Canadians (79%) had used at least one complementary or alternative therapy sometime in their lives in 2016. This compares to 74% in 2006 and 73% in 1997” (Esmail 2017, ii).

Relative to many other product and service classes, health-related products and procedures often pose severe information asymmetry problems for consumers: most individuals lack the expertise to diagnose disease or choose appropriate medical treatments. Moreover, although a medical professional offers expertise in diagnosing or treating disease, the potential patient faces an information asymmetry in evaluating the quality of the practitioner’s services. The information asymmetry is aggravated when professionals misrepresent their skills or the benefits of their services (see, for example, Cohen 2018). Regulation can play a critical role in addressing these information asymmetries by establishing standards of practice that assure potential patients that a practitioner provides competent services.

Most Western countries, however, recognize fundamental rights around an individual’s security

of the person, including competent, patient-informed consent for treatment and the refusal of treatment.¹ The central regulatory challenge is how to balance the aim of enabling individual autonomy in selecting treatment while addressing information asymmetry problems. As well, once a regulatory regime is imposed, regulation might become a barrier to entry. Specifically, (1) the design of regulations might be “captured” by established practitioners who limit entry by other professionals; and (2) established practitioners might be averse to new approaches to practice – for example, new treatments or technologies.

Most Western societies strictly regulate biomedicine – both the medicines and medical practitioners. For example,

- many medications may be accessed only with a prescription from a licensed medical practitioner and must be dispensed by a licensed pharmacist;
- medications are available only after extensive clinical trials and approval by a government drug safety agency that evaluates scientific efficacy and the risk of negative side effects;
- non-prescription medicines must often be accompanied by warnings of potential side effects or prior vulnerable predispositions;
- entry to medical professions is restricted, and

We are indebted to Grant Bishop, Tom Closson, Sherman Cohn, Kevin Davis, Colleen Flood, Noel Semple, Carolyn Tuohy, John Wallenburg and anonymous reviewers for helpful comments on earlier drafts and to comments of participants at a University of Toronto Faculty Workshop, November 6, 2017, and a Health Policy Council meeting at the C.D. Howe Institute, November 21, 2018.

1 The discussion in this *Commentary* concerns non-dependent adults with the capacity to choose their own treatment. Issues of treatment for children and other dependents and for those with mental incapacity are largely beyond the scope of this study.

those practising without a licence are subject to criminal prosecution; and

- physicians, medical specialists, pharmacists, dentists and nurses must undertake rigorous training programs and meet accreditation requirements established by applicable professional bodies.

Many Western countries have delegated regulation to self-governing professional organizations. These organizations have responsibility for the ongoing integrity and competence of their members through disciplinary regimes and continuing education requirements (see Dewees, Trebilcock, and Duff 1996, 122–35). For medical practitioners, the primary emphasis is on input regulation, focusing on ensuring that practitioners meet minimum educational and training requirements to qualify and continue to practise. Relatively less focus is placed on output or outcome regulation, which is addressed through the disciplinary procedures of self-governing bodies and the tort system in cases of alleged medical malpractice or negligence or defective products.

For the regulation of CAM products (non-biomedical medicines) and practitioners, the regulatory landscape is much more unsettled, as we briefly review below.² We propose that the regulation of CAMs should be calibrated to the degree of risk entailed.³ Certain commentators object to the regulation of CAMs on the basis that regulation would give legitimacy to practices that many regard of questionable therapeutic value. Where CAM treatments could displace biomedical treatments, however, we suggest that there is a role

for tailored regulation to balance the public interest in protecting individuals from misrepresentations with respect for individual autonomy.

More specifically: if a particular CAM treatment is not harmful and is not marketed to displace biomedical treatments, government should not intervene and should not inhibit individuals from accessing products. However, where CAMs are promoted as a substitute for, rather than a complement to, biomedicine in treating serious biomedical health conditions, government should require a minimum standard of scientific efficacy and should use appropriate penalties to restrain representations of CAM treatments that do not meet that standard. Table 1 outlines how these principles would apply to regulate certain forms of CAMs. Governments should create appropriate institutional machinery to delineate the appropriate thresholds for risk and contextual tests for “minimum scientific efficacy.” We suggest governments convene CAM advisory councils to provide independent advice to government on regulation and, where required, the monitoring of compliance by practitioners.

MAJOR SCHOOLS OF CAMS AND THEIR REGULATION

Approaches to regulating CAM products and service providers differ widely across the six jurisdictions in our sample: the United States, Canada, the United Kingdom, Europe⁴, New Zealand and Australia. This diversity is highlighted

2 For a more detailed discussion and citations, see our longer paper by the same title (available from the authors).

3 Certain reviewers of this *Commentary* noted that “quality,” “risk” and even “scientific efficacy” are not “neutral” concepts and do not involve consistent, objective standards. We agree, and therefore recommend an institutional approach to provide government an independent perspective to delineate appropriate context-specific thresholds.

4 The 2012 CAMbrella study (see footnote 5) by Wiesene et al. has surveyed 39 European countries, which includes the United Kingdom, although in our tables we have reported on the United Kingdom separately.

Table 1: Regulatory Principles for Complementary and Alternative Medicines

CAM Products and Procedures	Principle
CAM products and procedures that treat non-life threatening health conditions.	If treatment is not harmful, no government intervention.
CAM products and procedures that treat potentially life-threatening health conditions as a complement to biomedical products and procedures.	If treatment is not harmful, minimal government intervention to ensure that practitioners do not misrepresent therapeutic potential.
CAM products and procedures that treat potentially life-threatening health conditions as a substitute for biomedical products and procedures.	If treatment lacks minimum standard of proven scientific efficacy, it should be prohibited.

Source: Authors' compilation.

in a 2012 study⁵ (Wiesene et al. 2012) examining regulation of CAMs in 39 European countries. Here we discuss regulatory approaches to seven of the most common CAMs: naturopathy, homeopathy, chiropractic, osteopathy, acupuncture, traditional Chinese medicine and Western herbal medicine. For each, we provide a brief description and a table showing how each jurisdiction regulates the particular practice.

The three typical modes of regulation of CAMs are:

- *exclusive licensing regimes*, typically accompanied by government delegated self-regulation, which reserve certain fields of practice to licensed practitioners and render it illegal for unlicensed practitioners to practise in the reserved domains;
- *official certification*, which reserves certain titles to certified practitioners, typically under a government-delegated self-regulatory regime, but does not preclude uncertified practitioners from practising in the defined domains but under different designations; and

- *voluntary private certification regimes* administered by private professional associations (akin to private trademarks).

Naturopathy

Naturopathy seeks to prevent and cure illnesses by using materials that nature supplies. It promotes holistic healthcare by promoting a healthy lifestyle (WHO 2010, 3–4). To treat illnesses, naturopaths use an array of modalities, advising on nutrition and diet and prescribing botanical medicines and hydrotherapy, among many others (WHO 2010, 4).

The definition of naturopathy is controversial (Webb et al. 1977), with opinions differing as to whether it is distinct from or overlaps other forms of CAMs, particularly homeopathy (Ernst 2016, 293–4). The definition of naturopathy affects regulation – for example, whether to permit or promote the practice of homeopathy/acupuncture by licensed or certified naturopaths. For our

5 The study was undertaken by CAMbrella, a pan-European research network for complementary and alternative medicine. The research project was funded by the 7th Framework Programme of the European Commission. The research group consisted of 16 partner institutions from 12 European countries. It is asserted that the objective was to research CAMs, not to advocate them.

Table 2: Regulation of Naturopathy, Selected Jurisdictions

Jurisdiction	Regulatory Approach
Canada	<ul style="list-style-type: none"> Five provinces – British Columbia, Alberta, Saskatchewan, Manitoba and Ontario – statutorily regulate naturopathy, undertaken through a licensure regime. Unlicensed naturopaths are prohibited from practicing. Nova Scotia has enacted <i>The Naturopathic Doctors Act, 2008</i>. The act is limited in scope, the primary objective being to grant title protection for naturopathic doctors in Nova Scotia.
United States	<ul style="list-style-type: none"> 19 states statutorily regulate naturopathy, some through licensing (in these states, unlicensed naturopaths are prohibited from practising) and some through government-approved certification. Other states: voluntary, private certification.
United Kingdom	No statutory regulation; voluntary, private certification.
New Zealand	No statutory regulation; voluntary, private certification.
Australia	No statutory regulation; voluntary, private certification.
Europe	<ul style="list-style-type: none"> Of 39 countries, only 8 statutorily regulated as of 2012, some through a licensure regime and others through government-approved certification. Some countries categorize naturopathy as a “health profession.” Germany recognizes naturopathy as a “distinct therapeutic system” under the Code of Social Law (1998). In Switzerland, naturopaths fall under the category of “natural health practitioner,” a statutorily regulated profession.

Source: Authors' compilation.

purposes, naturopathy is treated as distinct from homeopathy, given our aim of exploring how each of these is currently regulated, as shown in Table 2.⁶

Homeopathy

Homeopathy was developed by Samuel Hahnemann, a German physician in the 1790s (Bodeker et al. 2005; Porter 2002, 48; WHO 2010, 3–4). The foundational principle of homeopathy is “like cures like” (Loudon 2006). To treat an illness, homeopaths prescribe “minute doses of [potentized]

natural substances that in larger amounts would produce symptoms of the ailment” (Ernst 2016, 36–7, 225). These substances are intended to stimulate the body to fight the disease, unlike biomedicine, which fights the disease directly (Bodeker et al. 2005). A crucial difference between homeopathic medicines and natural remedy treatments such as naturopathy and Western herbal medicines is that the former are made by potentizing natural substances, while the latter often use plant extracts in their crude form.⁷ Multiple schools of thought have evolved within homeopathy. Some schools

6 For citations supporting the regulatory approaches described in this and subsequent tables in the *Commentary*, see our longer paper by the same title (available from the authors).

7 European Committee for Homeopathy, “Homeopathy – Got Questions? We’ve Got Answers!” available online at <https://homeopathyeurope.org/practice/f-a-q/>.

Table 3: Regulation of Homeopathy, Selected Jurisdictions

Jurisdiction	Regulatory Approach
Canada	<ul style="list-style-type: none"> • Statutorily regulated only in Ontario through self-regulation via a certification regime, limiting the use of the title “homeopath” to certified practitioners. • Other provinces: voluntary, private certification.
United States	Regulation varies across states. Typically, states include homeopathy under chiropractic, naturopathy and physical therapy. Some states limit homeopathy to medical professionals and other licensed health care professionals (e.g. chiropractors).
United Kingdom	<ul style="list-style-type: none"> • Recognized as a distinct medical treatment system. • Can be practised by doctors (biomedicine), non-medical practitioners who are voluntarily registered with professional associations, and others who choose not to be registered. • Has established a self-regulatory registration system, and non-medically qualified homeopathy practitioners can register voluntarily with professional associations subject to meeting certain conditions.
New Zealand	No statutory regulation; voluntary, private certification.
Australia	No statutory regulation; voluntary, private certification.
Europe	<ul style="list-style-type: none"> • Of 39 countries, statutorily regulated in 24 as of 2012. • Recognized as a distinct medical treatment system in some countries, such as France and Germany. In others, falls under a more general category of alternative medicines, or is included under other CAM practices (similar to the United States). • Some countries strictly control the qualifications needed to practise, others permit a range of practitioners to practise. For example, in Austria, France and Italy, only biomedical practitioners such as doctors and dentists can practise homeopathy. In Germany, doctors (of biomedicine) with additional qualification in homeopathy and <i>Heilpraktiker</i> can prescribe homeopathic medicines. <i>Heilpraktiker</i> are entitled to practise CAMs, including homeopathy, subject to passing certain examinations and being licensed.

Source: Authors' compilation.

Table 4: Efficacy Requirements of Homeopathy, Canada and the United States

Jurisdiction	Regulatory Approach
Canada	<ul style="list-style-type: none"> • Proof of efficacy is accepted if listed in homeopathic pharmacopias, which may rely on historical use. • The Natural Health Products Regulations (SOR/2003-196) require that homeopathic products be approved by Health Canada prior to being sold. However, a 2015 CBC investigation concluded that Health Canada issued licences and permitted marketing of natural health products (which includes homeopathic medicines) without requiring submission of any scientific evidence.
United States	<ul style="list-style-type: none"> • Homeopathic medicines are regulated by the <i>Food, Drug, and Cosmetic Act</i>, but the Food and Drug Administration does not actively assess homeopathic medicines for their safety and efficacy.

Source: Authors' compilation.

oppose certain principles espoused by other schools. Table 3 shows how homeopathy is regulated in our sample jurisdictions. As Table 4 shows, homeopathic medicines are typically not required to meet proof of efficacy to the same degree as is biomedicine.

Chiropractic

Chiropractic was developed by Daniel David Palmer, a Canadian-born storekeeper from Iowa. He treated his first patient in 1895, restoring the patient's hearing by adjusting his spine (Duffin 2010, 159–60; Porter 2002, 50). Palmer defined chiropractic as “a system of adjusting the segments of the spinal column by hand only, for the correction of the cause of the [disease]” (Stephenson 1927). Chiropractic treats illnesses by associating the spine with the nervous system and relying on the self-healing attributes of the human body (Bodeker et al. 2005). Chiropractors hold diverse, indeed conflicting, views on the nature of illnesses chiropractic is efficacious in treating, its usefulness ranging from narrow to expansive (Benedetti and Macphail 2018).

Practitioners fall within two groups: the first group heals illnesses only through manipulation of spinal joints, while the second group combines chiropractic methods with other forms of CAMs, predominantly naturopathy, homeopathy and acupuncture, to heal patients; the majority of chiropractors are believed to fall into the latter group (Azari 1999).

Chiropractic and its practitioners are more closely regulated than are other CAMs, with the exception of osteopathy (see Table 5).

Osteopathy

Andrew Taylor Still, a physician from the United States, developed osteopathy in 1874 after he found biomedicine to be ineffective in curing his three children of meningitis (Baer 2009, 26; Duffin 2010, 159). Osteopathy is a form of musculoskeletal therapy that aims to restore movement and relieve pain by massaging bones and muscles, optimizing the body's self-healing capabilities. Therapy is combined with advice on diet and exercise. Some practitioners also use acupuncture to heal patients.⁸ Table 6 shows how osteopathy is regulated in our sample jurisdictions.

Acupuncture

Acupuncture, developed in China over two thousand years ago (see Barnes 2005), involves inserting fine needles at specific points in the body to treat illnesses. Originally considered to be a feature of traditional Chinese medicine (TCM), today acupuncture is practised under the theoretical frameworks of both TCM and biomedicine (Andrews 2014; Vickers and Zollman 1999; Welsh and Boon 2015, 248; Wiesene et al. 2012, 61). TCM acupuncture aims to correct the strength and quality of qi – energy that flows through the body – while biomedical practitioners such as doctors, physiotherapists, nurses and midwives diagnose and treat patients based on physiological and anatomical knowledge (Gale and McHale 2015; Vickers and Zollman 1999). Table 7 summarizes the regulatory regime for acupuncture in the sample jurisdictions.

Traditional Chinese Medicine

Traditional Chinese medicine originated over three

8 See National Academy of Osteopathy, “Frequently Asked Questions,” available online at <http://www.nationalacademyofosteopathy.com/faq.html>; OM Osteopathy, “What Is Osteopathy?” available online at http://www.omosteopathy.co.uk/omo_brochure.pdf; and Ontario School of Osteopathy and Alternative Medicine, “FAQ about Osteopathy,” available online at <http://www.osteopathycollege.com/faq-about-osteopathy.html>.

Table 5: Regulation of Chiropractic, Selected Jurisdictions

Jurisdiction	Regulatory Approach
Canada	<ul style="list-style-type: none"> • Statutorily regulated through a licensure regime in all provinces, and in Yukon Territory. • Subject to self-regulation by colleges (set up under provincial statutes).
United States	<ul style="list-style-type: none"> • Statutorily regulated through a licensure regime in all states. • In some states, the practice is subject to self-regulation; in others, it is a combination of “self-regulation under an interdisciplinary board” (e.g. a medical licensing board (Chapman-Smith 1997, 443)).
United Kingdom	Statutorily regulated through a licensure regime.
New Zealand	Statutorily regulated through a licensure regime.
Australia	Statutorily regulated through a licensure regime.
Europe	<ul style="list-style-type: none"> • Statutorily regulated in 26 out of 39 countries as of 2012. • Regulations vary: in Italy, chiropractic can be practised only by biomedical practitioners who have obtained a qualification in chiropractic, while in Germany, chiropractic is not specifically statutorily regulated and there are few restrictions on who may practise and call themselves a chiropractor.

Source: Authors' compilation.

thousand years ago (see Unschuld 1985; Yu et al. 2006). Based upon the Chinese philosophies of *yin* and *yang*, and *qi*, TCM treats illnesses by restoring balance and appropriate energy flow in the body (Keji and Hao 2003). TCM practitioners use a variety of methods to prevent and treat illnesses, often combining Chinese herbal medicines with nutritional advice, exercises (such as *tai chi* and *qigong*), massages (such as *tui na*), acupuncture and moxibustion (a form of heat therapy), to name a few (Chan et al. 2015, 68; Yu et al. 2006).⁹ Table 8 shows how TCM is regulated in the various jurisdictions. Several countries also regulate the sale

of Chinese herbal medicines, but in different ways, as Table 9 indicates.

Western Herbal Medicine

Western herbal medicine (WHM) is often viewed as having its roots in Greco-Roman medicine (Francia and Stobart 2014; Tierra 2017).¹⁰ To prevent and treat illnesses, practitioners use plants and their parts – root, stem, flower, bark – in their natural form, unlike biomedicine, which typically uses synthesized forms.¹¹ Currently, two forms of WHM are practised: traditional WHM

9 See also College of Traditional Chinese Medicine Practitioners and Acupuncturists in Ontario, “About TCM,” available online at <https://www.ctcmpao.on.ca/public/about-tcm/>.

10 See also Australian Natural Therapists Association Limited, “Courses,” available online at http://www.australiannaturaltherapistsassociation.com.au/courses/recognised_naturopathy.php.

11 See International Holistic Center of Natural Medicine, “Western Herbal Medicine,” available online at <http://www.iHCM.com/>; and Therapy Directory, “Western Herbal Medicine,” available online at <http://www.therapy-directory.org.uk>.

Table 6: Regulation of Osteopathy, Selected Jurisdictions

Jurisdiction	Regulatory Approach
Canada	<ul style="list-style-type: none"> In Ontario, British Columbia and Alberta only licensed biomedical practitioners registered with the provinces' College of Physicians and Surgeons fulfilling certain educational qualifications can call themselves osteopaths or osteopathic physicians. In these three provinces, non-medical practitioners refer to themselves as manual osteopathic practitioners, and are subject to voluntary, private certification. Other provinces: voluntary, private certification.
United States	<ul style="list-style-type: none"> Can be practised by osteopathic physicians and osteopaths. Osteopathic physicians, also referred to as doctors of osteopathy (DO), are biomedical doctors who have also studied osteopathy. Osteopaths are non-biomedical practitioners, and cannot prescribe biomedicines or perform surgery. All states statutorily regulate DOs and osteopaths through licensure regimes. Licensed osteopaths/DOs may choose to be certified by the American Medical Association or osteopathy specialty boards in specialized areas of practice.
United Kingdom	<ul style="list-style-type: none"> Statutorily regulated through a licensure regime: only individuals registered in the UK Statutory Register of Osteopaths are permitted to practise and call themselves an osteopath.
New Zealand	<ul style="list-style-type: none"> Statutorily regulated through a licensure regime: only individuals registered with the Osteopathic Council of New Zealand are permitted to practise and call themselves an osteopath.
Australia	<ul style="list-style-type: none"> Statutorily regulated through a licensure regime: only individuals registered with the Osteopathy Board of Australia are permitted to practise and call themselves an osteopath.
Europe	<ul style="list-style-type: none"> Of 39 countries, statutorily regulated in 15 as of 2012. Some countries have taken a strict view on who may practise osteopathy, while others have left the practice statutorily unregulated. For example, in Italy, osteopathy can be practised only by biomedical practitioners who have obtained a qualification in osteopathy; in Austria, osteopathy is neither recognized nor prohibited, and can be practised by individuals with or without medical training. In Germany, osteopathy is not a distinct profession; osteopathic practice is limited to biomedical physicians, physiotherapists and <i>Heilpraktiker</i>, but the training required for the three categories of professionals to be eligible to practise osteopathy differs.

Source: Authors' compilation.

and phytotherapy. The former relies primarily on traditional knowledge, and emphasizes holistic and individualistic treatment (Baer 2004; Coulter 2004), while phytotherapy relies on contemporary knowledge of physiology and anatomy, and uses

herbs whose efficacy and safety are substantiated by scientific empirical studies (Heinrich et al. 2004).¹²

WHM is often also referred to as "herbal medicine." Although other CAMs, such as traditional Chinese medicine, also use herbs to treat

12 See also Australia Traditional Medicine Society, "Western Herbal Medicine," available online at <http://www.atms.com.au/>; and Victoria Community Acupuncture, "Phytotherapy & the Benefits of Plant Medicine," available online at <http://www.vcaspa.com/>.

Table 7: Regulation of Acupuncture, Selected Jurisdictions

Jurisdiction	Regulatory Approach
Canada	<ul style="list-style-type: none"> • Medical doctors are permitted to practise in all provinces. • Practise by non-medical professionals is regulated through a certification regime in British Columbia, Alberta, Quebec, Ontario and Newfoundland and Labrador, and the title “acupuncturist” is protected. Non-medical professionals may include massage therapists, chiropodists, chiropractors, occupational therapists and TCM practitioners. • Saskatchewan and Yukon Territory have issued guidelines on the practice of acupuncture.
United States	<ul style="list-style-type: none"> • Most states statutorily regulate either through certification or licensure regimes.
United Kingdom	<ul style="list-style-type: none"> • Medical and non-medical practitioners may practise. • Practise by medical professionals is statutorily regulated – for example, practise by GPs, nurses and physiotherapists is regulated by the General Medical Council, the Nursing and Midwifery Council and the Health and Care Profession Council. • Non-medical members who practise acupuncture may choose to become members of private self-regulating associations. • Anyone practising acupuncture (whether a member or not) can call themselves an acupuncturist.
New Zealand	<p>No statutory regulation; voluntary, private certification.</p>
Australia	<ul style="list-style-type: none"> • Medical and non-medical professionals may practise. To call oneself an acupuncturist and claim to practise acupuncture, an individual must be registered with the Chinese Medicine Board of Australia (CMBA). The CMBA is established under the governance of the Australian Health Practitioner Regulation Agent (AHPRA), which is responsible for the registration of all health practitioners in Australia.
Europe	<ul style="list-style-type: none"> • Of 39 countries, statutorily regulated in 26 as of 2012 through a range of regulatory regimes: in some countries via government-approved certification, in others, practise is limited to physicians with specialization in acupuncture. • A few countries, such as Italy and France, have chosen to limit practise to biomedical professionals, such as doctors and midwives. • In Denmark and Sweden, both medical and non-medical professionals may perform acupuncture. There are no statutory qualification criteria that practitioners must fulfil prior to treating individuals. The only requirement is that patients must not be put at risk.

Source: Authors’ compilation.

illnesses, WHM practitioners argue that WHM is a distinct herbal medical practice. The commonly cited differences are that principles behind the treatments are vastly different – *yin* and *yang* and

qi in TCM, in contrast to anatomy and physiology in phytotherapy – and that herbal medicines used in TCM are a complex mix of herbs, while WHM typically employs a single herb or only two or

Table 8: Regulation of Traditional Chinese Medicine, Selected Jurisdictions

Jurisdiction	Regulatory Approach
Canada	<ul style="list-style-type: none"> Regulated only in British Columbia and Ontario. Only registered members of the College of Traditional Chinese Medicine Practitioners and Acupuncturists of British Columbia and the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario, respectively, are allowed to call themselves a TCM practitioner. Only registered members are permitted to prescribe a TCM diagnosis based on TCM philosophy. Other provinces: voluntary, private certification.
United States	<ul style="list-style-type: none"> Most states regulate through certification or licensure regimes.
United Kingdom	No statutory regulation; voluntary, private certification.
New Zealand	No statutory regulation; voluntary, private certification.
Australia	<ul style="list-style-type: none"> Regulated through a licensure regime: only “Chinese medicine practitioners” registered with the Chinese Medicine Board of Australia are permitted to practise.
Europe	<ul style="list-style-type: none"> Statutorily regulated in 10 of 39 countries as of 2012. In some countries, such as Italy and Austria, the practise of TCM is restricted to medical doctors. Several countries have permitted non-medical practitioners to practise subject to fulfilling conditions such as minimum educational requirements; others have not restricted who may be eligible to practise.

Note: In Newfoundland and Labrador, although the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Newfoundland and Labrador has been established, acupuncture is regulated, while TCM is not.

Source: Authors' compilation.

Table 9: Regulation of Chinese Herbal Medicines, Canada and the United States

Jurisdiction	Regulatory Approach
Canada	<ul style="list-style-type: none"> Fall under the category of “natural health products” along with vitamins, minerals and probiotics. Natural health products are available without prescription, but can be sold only after being licensed and issued a natural product number from Health Canada. The standard of safety and efficacy proofs needed to qualify for licensing differ from those needed for biomedicines, as continued historical use is accepted as evidence of efficacy.
United States	<ul style="list-style-type: none"> Sale of Chinese herbal medicines that qualify as “dietary supplements” are not subjected to mandatory review or testing for purity or potency of active ingredients.

Source: Authors' compilation.

three.¹³ Table 10 shows how WHM is regulated in the sample jurisdictions. As Table 11 shows, herbal medicinal products are more extensively regulated than WHM in most jurisdictions.

DISORDER IN THE BORDERLANDS

Divergences in Regulatory Practices and Reform Proposals

A striking, even disconcerting, feature of the evolution and regulation of the various CAMs is the lack of anything approaching consistency of approach across jurisdictions and categories of CAMs. Indeed, a range of regulatory options has found favour in one or another Western jurisdiction, with little evidence of a convergence toward a dominant regulatory paradigm.

This discordance in regulatory practice is echoed in scholarly and public policy literature debating the merits of alternative regulatory approaches to CAMs. Some authors oppose regulation of CAM practitioners and products, arguing that typical forms of regulation protect mainstream biomedicine and hinder innovation and competing methods of healing, including traditional CAM practices, some of which are of cultural significance to their communities of origin even where not based upon biomedical epistemology (Cohen 1996, 86; Ijaz et al. 2016, 97, 104; Lindsey and Teles 2017, chap. 5). Other commentators argue against regulation of CAM practitioners and products from opposing premises: that any form of regulation of CAMs is likely to legitimize and promote their use by the public, even though many, if not most, CAM practices and products lack adequate scientific justification or verification (McHale and Gale 2015, 375; Robbins 2010; Robotham 2012).

Among scholars who favour some form of regulation of CAM practitioners, proposals vary widely. Some argue for state-sanctioned forms of self-regulation for individual classes of CAMs, modelled on standard approaches of self-regulation of mainstream professions (Walker and Budd 2002, 10; Wardle 2014; Weir 2005, 179–80). Other scholars argue for an umbrella regulatory body that would regulate all or most forms of CAM practitioners according to a uniform and consistent set of principles (Ries and Fisher 2013, 295–6; Van Hemel 2001, 330). As to what form professional regulation should take, some scholars favour a form of licensure, on the grounds that only licensure regimes are capable of mandating appropriate training regimes, post-entry codes of conduct, and disciplinary and continuing education protocols, which in combination ideally would exclude inadequately trained, fraudulent, incompetent or deviant practitioners or aspiring practitioners from the domain of practice in question (Clark 2004, 392). Other scholars argue – convincingly, in our view – that any attempt to create multiple mutually exclusive licensure regimes across the entire landscape of healthcare provision inevitably would entail arbitrary boundary drawing, rigidities and interprofessional conflicts, as well as impeding innovation and discouraging the closer integration of biomedical and CAM health disciplines (Baron 1983, 346; Gellhorn 1976, 6; Hogan 1983, 126; Olson 1983; Weir 2005, 182–3).

We do not presume in this *Commentary* to offer detailed regulatory protocols for each individual category of CAM, or CAMs as a broader encompassing category. Rather, we propose general guiding regulatory principles for CAM products and practitioners.

13 See Healing Foundations, “Chinese Herbs and Western Herbs: Is There a Difference?” available online at <https://patch.com/>; and LAN Acupuncture and Herbal Medicine, “Herbal Medicine FAQ,” available online at <http://www.lanacupuncture.com/>.

Table 10: Regulation of Western Herbal Medicine, Selected Jurisdictions

Jurisdiction	Regulatory Approach
Canada	No statutory regulation; voluntary, private certification.
United States	No statutory regulation; voluntary, private certification.
United Kingdom	No statutory regulation; voluntary, private certification.
New Zealand	No statutory regulation; voluntary, private certification.
Australia	No statutory regulation; voluntary, private certification.
Europe	Of 39 countries, 10 statutorily regulate as of 2012.

Source: Authors' compilation.

Table 11: Regulation of Herbal Medicinal Products, Selected Jurisdictions

Jurisdiction	Regulatory Approach
Canada	Fall under the category of "natural health products" and are subject to a similar approval process.
United States	Fall under the category of "dietary supplements" subject to lower scrutiny than over-the-counter medicines.
United Kingdom	Sales and products regulated at the EU level since 2011 (see below); this might be subject to change on account of Brexit.
Australia	<ul style="list-style-type: none"> Regulates as therapeutic substances through a two-tiered system categorized on the basis of risk, requiring products to be either registered or listed prior to sale. Higher-risk medicines, including WHM, can be sold only after being registered with the Australian Register of Therapeutic Goods (ARTG), pursuant to which each product is individually evaluated for quality, safety and efficacy. Traditional use as proof of safety or efficacy is accepted to a very limited extent. Lower-risk medicines comprising pre-approved, low-risk ingredients and making limited claims are listed on the ARTG, and are not subject to the same individualized scrutiny as higher-risk medicines.
Europe	<ul style="list-style-type: none"> Prior to sale, all herbal medicinal products must obtain market authorization or be registered under the Traditional Herbal Registration process. Efficacy and safety must be substantiated, although, unlike biomedicines, they may be validated through traditional historical use since it was recognized that many herbal products would be unable to fulfil the evidentiary requirements imposed on biomedicine.

Source: Authors' compilation.

Risk Calibration

First, recognizing that the two principal motivating rationales for regulation of healthcare provision generally – severe information asymmetries between healthcare practitioners and patients and, to a lesser extent, negative externalities associated with patients' healthcare decisions or caregivers – it seems a relatively uncontroversial starting premise that regulatory responses should be calibrated to the degree of risk entailed, principally for patients, but in some cases for third parties. Risk is commonly thought of as a product of the probability of a negative contingency occurring and the severity of the consequences of that contingency in the event that it does occur – often characterized as the “expected cost” of a decision to assume the risk in question. This approach to health-related risks would seem to explain much, albeit not all, of the detailed regulation of biomedicine (both procedures and products) commonly observed in almost all Western countries.

One implication we draw from the biomedical regulatory paradigm now deeply entrenched and widely observed in most Western jurisdictions is that it is difficult, if not impossible, for the state to sustain a purely *laissez-faire* approach to the provision of CAM products or services. The consequence of not regulating CAMs might be that individuals erroneously believe that a public authority has determined that these products or services are at worst harmless and at best helpful in alleviating the medical conditions that proponents often claim they are able to address. In many cases, however, the lack of regulation of CAMs does not reflect a conscious decision by government: certain CAM products or services, such as Western herbal medicines or naturopathy, might be harmful if taken in concentrated form or in excessive doses or for protracted periods of time. Perhaps of greatest concern, claims of efficacy in dealing with serious health conditions often might be unwarranted, and

might deflect patients or caregivers from pursuing more efficacious biomedical treatments (Brody 2018).

Second, on the scale of risk, from trivial to severe, some forms of CAM products and services clearly fall toward the trivial end of the spectrum. For example, forms of CAM products or services that address dietary or lifestyle concerns or common forms of coughs and colds and aches and pains of the kind that many individuals treat with home remedies or over-the-counter medications would seem to warrant minimal regulation beyond mandatory warnings of potentially serious side effects if, as in the case of herbal medicines, taken in excess. In such cases, the absence of appropriate warnings might trigger penal sanctions and potential tortious liability, and would remain subject to general prohibitions against fraudulent, false or misleading advertising claims.

Third, other forms of risk fall toward the more serious end of the scale, where proponents claim that certain CAM products or services are able to address serious life-threatening forms of health conditions, including infectious diseases, as alternatives to conventional forms of biomedicine whose efficacy has been scientifically validated. Obviously, a lesser degree of risk is entailed where CAM practices or products are promoted as complements to biomedical treatments, rather than as substitutes, although negative interactions between two types of treatment for the same condition might increase risk factors in some contexts.

Fourth, we believe that some general policy orientations emerge from this risk calibration approach to the regulation of CAM products or services. For forms of CAMs that fall toward the trivial end of the risk spectrum, light-handed *ex ante* regulation seems appropriate, providing a relatively large scope for patients' autonomy in the choice of medical treatments. For forms of CAMs that fall toward the higher end of the risk spectrum, it seems difficult to justify a completely *laissez-faire*

position on the part of the state. In effect, where a CAM treatment is not directly harmful and is not marketed to displace biomedical treatments for serious health conditions, we recommend a “negative regulation” approach that exempts the treatment from regulation beyond general misleading advertising laws.

Certification but not Licensure

In general, with respect to the *ex ante* regulation of CAM practitioners, we favour state-sanctioned forms of delegated self-regulation of certification regimes by practitioners themselves, where designated titles would be reserved for accredited members of the state-recognized governing bodies, but not mutually exclusive areas of practice, as under licensure regimes. Formal certification regimes are likely to create a strong incentive for certification bodies and their members to promote their brand and reputational status among the public and medical practitioners generally. This would solidify internal norms by proscribing outlier practices without all the negative features of an exclusive licensure regime, as noted above. While not entitled to the protection of an exclusive licensure regime, members in good standing of an official certification regime might be granted immunity from prosecution for the unauthorized practise of medicine as a further inducement to seek and maintain accreditation. Members disciplined for malpractice could be decertified, but not prohibited from continuing as uncertified practitioners. Public records of suspensions and decertification of practitioners could partially address information asymmetry concerns on this score.

Supervised Self-regulation

To minimize the risk of overreach in the healthcare claims of members of CAM professional

certification bodies and their members, there might be merit in the creation by government of an overarching advisory body – a CAM advisory council – to which the various self-regulatory regimes would be required to submit their regulations governing education and training, codes of conduct, and disciplinary procedures. The council would review these and advise government whether to adopt or reject the proposed regulations (but not to initiate regulations). In exercising this review function, such an advisory body – ideally comprised of representatives of the various CAM disciplines, patient or consumer groups and the medical and scientific research communities – would identify practices that are high risk and that members of these governing bodies would be prohibited from engaging in or promoting, as well as practices that would facilitate the greater integration of CAMs and biomedicine. Prohibition of defined practices might also be extended to non-members.

In exercising this oversight function – in particular the determination of prohibited practices – such an advisory body might adopt a standard that, in the presence of scientific controversy or disagreement, might reflect minority, as opposed to mainstream, scientific opinion, provided the minority opinion comes from qualified and respected sources, recognizing that government would want to act from perspectives of prudence and caution where risks of irreversible damage to human health are concerned.

For an appropriate standard for regulated CAM treatments as substitutes for biomedical treatments for serious health conditions, we suggest adopting the “minimum standard of proven scientific efficacy” threshold. In the trade law context, this standard was employed by the World Trade Organization’s Appellate Body to adjudicate whether regulations restricting imports of beef hormones were an unjustified discriminatory trade measure or a legitimate protective measure.¹⁴ The Appellate Body

14 See the Appellate Body decision in the *Beef Hormones* case (1998), available online at https://www.wto.org/english/tratop_e/dispu_e/cases_e/ds26_e.htm.

held that a country imposing such restrictions for a purported precautionary purpose was not required to establish full scientific proof, but must show some minimum scientific basis for supporting a precautionary measure. We suggest that this is also an appropriate standard for determining whether CAM treatments that displace biomedical therapies for serious health conditions nonetheless should be permitted. This “minimum scientific basis” threshold would delineate a zone for individuals to choose their own treatment from a zone where a treatment lacks a basis for any reasonable claim of therapeutic effectiveness and the risk of misrepresentation is unacceptable.

We consider this approach equally appropriate for both CAM products and services. In the context of the regulation of CAM practitioners and products, an application would require that at least the minimum scientific justification be met for cases where CAM services or products are promoted as an alternative to biomedicine in treating conditions entailing potentially irreversible damage to human health.

CAMs as Complements to or Substitutes for Biomedicine

In cases where some forms of CAMs are promoted as complements to biomedical treatments of the same condition, perhaps a somewhat less demanding standard might be appropriate by way of promoting the greater integration of biomedicine and CAMs – for example, in the absence of scientific evidence that CAM products or services cause direct harm or raise the risk of serious side effects. Integration is a valuable tool for reducing information asymmetries and potentially decreasing negative externalities, as it might foster better referral practices between biomedical and CAM practitioners and better communication between practitioners and their patients.

Although CAM products should be subject to scrutiny by food-and-drug-safety agencies, given that they are often purchased without the intermediation or advice of a CAM practitioner,

there are limitations. For example, herbs prescribed in their natural form are likely to be freely available in markets, and hence would not fall under such agencies’ scrutiny or be subjected to prescribed labelling standards; some CAM prescriptions are individualized, as in TCM; and agencies’ limited resources of funds or time would preclude their scrutinizing each CAM product. Bearing in mind these limitations, regulation of commercial preparations of CAM products by food-and-drug-safety agencies should apply the following principles:

- for minor illnesses for which over-the-counter biomedicines are commonly purchased for self-medication, a “no harm” principle should apply to commercial preparations of CAMs;
- where CAM products are promoted as a complement to biomedicine, even for serious illnesses, a “no harm” principle should also apply to commercial preparations of CAMs; and
- where CAM products are promoted as an alternative to biomedicine in the treatment of serious health conditions, the minimum standard of proven scientific efficacy should apply.

***Ex post* Regulation of CAM Products and Services**

The *ex post* regulation of CAM products and services by courts, regardless of whether falling toward the trivial or the higher end of the risk spectrum, remains critical so as to ensure that persons responsible (including non-certified practitioners and other third parties) are held liable for fraudulent, false or misleading advertisements or claims, tortious liability for negligence or criminal liability for gross negligence. When determining such violations, the criterion of a minimum standard of proven scientific efficacy should be applied to cases where claims or advertisements promote a CAM product or service as an alternative to biomedicine in the treatment of life-threatening health conditions.

CONCLUSION

This paper has provided a framework for governments to structure the regulation of complementary and alternative medicines and develop appropriate institutions, such as a CAM advisory council, to provide independent advice to governments on appropriate standards for CAMs, especially when promoted as alternatives to biomedical treatments for serious health conditions.

Advice on medical treatments involves significant information asymmetries and potentially engages mortal risks for individuals. A principled and restrained approach to regulating CAM would focus on calibrating regulatory responses to the

seriousness of the risks involved and reflect an appropriate balance between personal autonomy/patient choice and the public interest in addressing misrepresentations.

We do not claim that this articulation of general principles would resolve regulatory debates on the ground with respect to the various classes of CAMs. However, although many question the legitimizing CAMs, the growth of the use of CAM treatments indicates that consumer demand for them is here to stay. What is needed are clear regulatory objectives, principles and independent, expert institutions in order to shape the appropriate regulation of complementary and alternative medicines.

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From: Grant Bishop <gbishop@cdhowe.org>
Sent: Monday, April 15, 2019 3:04 PM
To: Grant Bishop
Cc: Kristine Gray
Subject: Pre-publication copy: Regulating Alternative Medicines (embargoed until 16 April, 6am ET)
Attachments: CDHI Commentary_541.pdf

Please find attached a pre-publication copy of the forthcoming C.D. Howe Institute commentary, “Regulating Alternative Medicines: Disorder in the Borderlands” by authors Michael J. Trebilcock and Kanksha Mahadevia Ghimire of the University of Toronto Faculty of Law.

We will be publishing this report tomorrow morning at 6am ET. We provide the embargoed attached copy for your advance review and on condition that this not be further distributed.

The report recommends:

- That regulatory responses should be calibrated to the degree of risk entailed for patients.
- State-sanctioned forms of delegated self-regulation of certification regimes by practitioners themselves.
- The creation by government of an overarching advisory body – an alternative medicine advisory council
- Ensuring that persons responsible are held liable for fraudulent, false or misleading advertisements or claims, tortious liability for negligence or criminal liability for gross negligence.

As all Institute publications, the report was subjected to a rigorous review process that required the authors to address all feedback from external reviewers.

We look forward to any comments you have. We thank you for your support of the C.D. Howe Institute’s policy research.

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From: Jo-Ann Willson
Sent: Monday, April 01, 2019 9:16 AM
To: Rose Bustria
Subject: FW: Legislative Update - What Happened in March 2019?
Attachments: Legislative Update - March 2019.pdf

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Sent: Monday, April 01, 2019 8:54 AM
To: bakenny@regulatedhealthprofessions.on.ca
Cc: 'Richard Steinecke' <rsteinecke@sml-law.com>
Subject: Legislative Update - What Happened in March 2019?

Hi All:

Attached is the 83rd *Legislative Update* from Richard Steinecke, letting us know what happened in March 2019. Note that, in the *Salam Abdul v Ontario College of Pharmacists* matter, Mr. Abdul's leave to appeal to the Supreme Court of Canada was dismissed (see p.2).

Remember that the *Legislative Updates* are always available in the [vRoom](#) and our Policy Network members have access to it as well.

Take care!
Beth Ann



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FHRCO Legislative Update – What Happened in March 2019?*Prepared by Richard Steinecke***In this Issue:**

- Bill 74, *People's Health Care Act*, introduced, see pp. 1 -2
- Bill 68 to replace Liberal Act on oversight of police introduced, see p. 2
- Consultation on employers reporting gender pay transparency, see p. 2

Bonus Features:

- Abdul Leave to Appeal to the SCC Dismissed, see p. 2
- Incapacity Incongruity, see p. 3
- Time and Stability Is Not Enough, see p. 3
- Time Might Eventually Be Enough, see pp. 3-4
- Duty of Candour Exists in Canada, see p. 4
- Complaints Against Adjudicators, see p. 5
- Protecting Quality Assurance Information, see pp. 5-6
- Spence the Sequel, see p. 6

Ontario Bills*(See: <https://www.ola.org>)*

Bill 74, *The People's Health Care Act, 2019* – (*government Bill – passed second reading and referred to the Standing Committee on Social Policy*). The Bill will implement a significant restructuring of the provision of health care services in Ontario. The move was billed as a centralization of 20 agencies into one body called Ontario Health that will include the 14 LHINs, and:

- Cancer Care Ontario
- eHealth Ontario
- Trillium Gift of Life Network
- Health Shared Services
- Health Quality Ontario
- HealthForce Ontario Marketing and Recruitment Agency

However, the plan also envisions decentralization in the form of 30-50 provider groups, each providing coordinated care to about 300,000 persons each on average. The government is anticipating health care providers (likely anchored by at least one hospital) will make proposals that will be accepted by the government.

Details are scarce and so the impact on *RHPA* Colleges is unclear at this time. The most likely sources of impact are:

1. the push to finally develop centralized electronic health records for patients,
2. competition with Ontario Health as to who sets standards of practice,
3. competition as to who provides quality assurance, and
4. overlap between Ontario Health's investigative powers (re. quality of care provided) and the investigative and disciplinary power of RHPA Colleges.

Bill 68, *Comprehensive Ontario Police Services Act, 2019* – (government Bill – passed third reading and has received Royal Assent). Bill 68 replaces the comprehensive legislation enacted by the Liberal government, but not yet proclaimed, on the regulation of police officers. The provisions reduce the civilian oversight of police officers somewhat from the Liberal statute.

Proclamations

(See www.ontario.ca/en/ontgazette/gazlat/index.htm)

There were no relevant proclamations this month.

Regulations

(See www.ontario.ca/en/ontgazette/gazlat/index.htm)

There were no relevant regulations gazetted this month.

Proposed Regulations Registry

(See <http://www.ontariocanada.com/registry>)

Pay Transparency Act – This consultation is on a proposed regulation that would require “employers with 100 or more employees to annually calculate, and make available, information about organizational wage gaps and workforce composition with respect to gender”. Comments are due by April 5, 2019.

Bonus Features

(Includes Excerpts from our Blog and Twitter feed found at www.sml-law.com)

Abdul Leave to Appeal to the SCC Dismissed

The Federation intervened in this case to protect the discretion of Colleges and ICRCs to manage multiple complaints and investigations. A helpful decision was obtained from the Ontario Court of Appeal last August. Mr. Abdul sought leave to the Supreme Court of Canada. Leave was denied. See: *Salam Abdul v Ontario College of Pharmacists*, 2019 CanLII 21175 (SCC), <<http://canlii.ca/t/hz7km>>.

Incapacity Incongruity

Regulators encourage practitioners with a disability to participate in assessment and treatment with the hope that the practitioner can remain in practice. Correspondingly, practitioners with health issues often cooperate with their regulator in their assessment and treatment in the anticipation that they will remain in practice. However, what happens when the assessment and treatment indicate to the regulator that the practitioner may not be able to practise safely and the practitioner disagrees? While regulators try to be as accommodating as possible (not only because it is a human rights obligation, but also to encourage participation in remedial programs), client safety has to come first.

In *Collett v College of Physicians & Surgeons of Alberta*, 2019 ABCA 86 (CanLII), <<http://canlii.ca/t/hxvvm>>, a physician, on his own volition, attended a neuropsychological assessment that identified some cognitive concerns. The physician declined to pursue further investigation into the concerns and refused repeated requests to cease practising until the cognitive concerns could be addressed. The regulator suspended the physician's ability to practise until he could demonstrate that the cognitive concerns would not interfere with it. The physician applied to the courts to lift his suspension. The Court refused both on the basis that no error appeared to have been made in the process leading up to the suspension and because the public interest in allowing the regulator to fulfill its mandate outweighed the harm to the physician.

Time and Stability Is Not Enough

Seven years ago Ms. Chen was excluded from all gaming sites by the Alcohol and Gaming Commission for engaging in loan sharking: *Chen v Alcohol and Gaming Commission of Ontario*, 2019 ONSC 1680, <<http://canlii.ca/t/hz16b>>. The Registrar declined to lift the exclusion order despite the passage of time and a stable employment and family history during the past seven years. The Divisional Court upheld the Registrar's decision concluding that it "was reasonable, given the gravity of the past conduct and the applicant's failure to provide adequate information showing she appreciated the gravity of the past conduct and demonstrated there was not a risk of reoccurrence". The Court also found that the paper reinstatement process was procedurally fair given that Ms. Chen had a full opportunity to present her case and that meaningful reasons had been given.

Time and stability were insufficient on their own to warrant reinstatement, on these facts at least. However, in other cases, the courts hold out the promise that eventually the passage of time might be sufficient: *CS v Registrar, Real Estate and Business Brokers Act, 2002*, 2019 ONSC 1652 (CanLII), <<http://canlii.ca/t/hz16c>>.

Time Might Eventually Be Enough

How long should a major breach of trust of a sexual nature with a minor exclude someone from practising in a different profession with little exposure to minors? That was the issue in *CS v Registrar, Real Estate and Business Brokers Act, 2002*, 2019 ONSC 1652, <<http://canlii.ca/t/hz16c>>. The practitioner applied for registration as a real estate salesperson. However, she had been a teacher

and had participated in a long-term sexual relationship with a former student (who became her foster child) for which she was found criminally responsible. In addition, her status as teacher was revoked. The Registrar (and the appeal tribunal) found that this breach of trust was so serious that it was reasonable to assume she might not practise the real estate profession with honesty and integrity.

The Divisional Court upheld the finding:

The appellant committed a serious set of criminal acts involving violations of trust in the fairly recent past. She was not dissuaded by the school principal, her CAS training, or her own moral compass, from abusing someone to whom she was duty-bound and who she undertook to protect.

However, the Court indicated that it was unreasonable to expect the applicant to have self-reported her criminal conduct at the time; concealment was a natural aspect of the criminal conduct itself. In addition, the Court indicated that the passage of time may eventually be sufficient to permit registration as a real estate salesperson:

Almost nine years have now passed since the victim terminated his relationship with the appellant. I agree with the LAT [Licence Appeal Tribunal] that the reasonableness of relying upon past breaches of trust to ground an inference concerning future risks to the public may well be affected by the passage of time.

That passage contrasts with the perspective that the passage of time is not, in itself, sufficient in the case (albeit with different facts) of: *Chen v Alcohol and Gaming Commission of Ontario*, 2019 ONSC 1680 (CanLII), <<http://canlii.ca/t/hz16b>>.

Duty of Candour Exists in Canada

One of the more significant developments in the regulation of health professions in the UK is the codification of the duty of candour when an error is discovered: <https://www.sml-law.com/wp-content/uploads/2019/03/Greyar234.pdf>. Some professions in Canada have similar obligations. In *Law Society of Alberta v Schuster*, 2019 ABCA 111, <<http://canlii.ca/t/hzbjij>>, the Court upheld as reasonable the discipline finding against a lawyer who failed to inform his client of an error where \$300,000 was deposited into the wrong trust account and was not immediately retrievable. The Court agreed that this error was material and that, even though the client expressed the desire not to be kept informed of all the operational details of the project, this error should have been disclosed.

The Court also found that there was no unfairness in the discipline tribunal taking a different view of the nature of the conduct than that expressed in the original complaint and investigation report.

Complaints Against Adjudicators

Some practitioners act as adjudicators. What is the role of regulatory bodies when dealing with complaints about practitioners acting in their capacity as an adjudicator? This issue was touched upon, but not fully addressed, in *Cuhaci v College of Social Workers (Ontario)*, 2019 ONSC 1801, <<http://canlii.ca/t/hz74q>>. Ms. Cuhaci, a social worker, arbitrated a custody dispute. Afterwards, a complaint was made about her conduct. While the screening committee initially indicated it had no role in respect of the actual adjudication, it later on made some comments suggesting that it may have partially considered her actions in that capacity. Ultimately the screening committee issued advice about the clarity of the practitioner’s communications, which advice was not confined to the adjudication decision. The practitioner sought judicial review.

The Court held that the application was moot:

The applicant still has a license to practice as a social worker, and there are no conditions or restrictions on her license. She faces no professional jeopardy as a result of the outcome of this complaint.

The Court almost exercised its discretion to hear the matter anyway to clarify the jurisdictional issue, but declined to do so, in part because:

... counsel for the College conceded that the Complaints Committee may have overstepped in this case, and that the College does not have jurisdiction to investigate the decision making process of a social worker engaged in the functions of an arbitrator in the context of family law proceedings. She argued that there may be circumstances that would warrant the College's intervention, if for example the member had an intimate relationship with one of the parties, but she agreed that the decision making process and the decision itself do not fall within the College's jurisdiction.

Interestingly, there was also a procedural issue in that the screening committee made its decision without disclosing all of the complainant’s submissions to the practitioner. However, the Court was satisfied that the regulator cured the concern, on the facts of this case at least, by providing the materials after reaching its decision, receiving further submissions from the practitioner and then rendering an addendum to its decision.

Protecting Quality Assurance Information

Professional regulators in British Columbia are subject to freedom of information legislation. As a result, individuals can apply to the Information and Privacy Commissioner to review a regulator’s refusal to provide such access. This regime led to a showdown in *College of Physicians and Surgeons of British Columbia v British Columbia (Information and Privacy Commissioner)*, 2019 BCSC 354, <<http://canlii.ca/t/hz4n1>>.

A component of the quality assurance program for physicians in British Columbia involves multi-source feedback (MSF). Colleagues, coworkers and patients are asked to submit a confidential survey to a third party firm. The third party compiles the survey results in aggregate form and provides a report to both the practitioner and the regulator. This information is scored against results of the practitioners' peers and, along with information gathered by other components of the quality assurance program (e.g., an analysis of patient charts, a review of office procedures), results in feedback to the practitioner and potentially remedial action.

In this case the practitioner sought access to copies of the actual survey forms. The regulator refused. Recourse was sought before the Information and Privacy Commissioner whose representative ordered that the surveys be provided to the practitioner. The regulator sought judicial review. The Court concluded that a purposeful interpretation of the legislation required that the public interest in the effective quality assurance program took priority. This necessitated that the confidentiality interests of the individuals answering the survey took precedence over the access interests of the practitioner. Otherwise, the MSF component of the quality assurance program would be placed in jeopardy by a lack of candid (or any) participation.

The order of the Information and Privacy Commissioner was quashed.

Spence the Sequel

Mr. Spence faced two high profile hearings for allegations of plagiarism. In the first, a discipline hearing before the Ontario College of Teachers, a refusal of an adjournment on the basis of illness resulted in the Divisional Court setting aside the hearing: *Spence v Ontario College of Teachers*, 2018 ONSC 3335 (CanLII), <<http://canlii.ca/t/hs8tr>>. In the second, before the University of Toronto, a similar refusal of an adjournment was upheld: *Spence v University of Toronto*, 2019 ONSC 1085 (CanLII), <<http://canlii.ca/t/hxmjw>>. The differences in the two cases included the following aspects of the hearing before the university:

1. All of the information about Mr. Spence's ability to attend the hearing was disclosed to Mr. Spence.
2. The medical evidence of Mr. Spence's current state of health was different.
3. The final refusal of an adjournment was made after many more adjournments had been granted.

Adjournment requests depend entirely on the facts of the case.

Regulatory Oversight Bodies Proliferating in British Columbia

by Erica Richler
February 2019 - No. 233

Oversight bodies for professional regulators are well established in a number of jurisdictions around the world. Two prominent examples are the Office des professions du Québec and the Professional Standards Authority in the UK. Tentative steps in common law Canada include the Health Professions Regulatory Advisory Council of Ontario (HPRAC) and the Fairness Commissioners in some Canadian provinces. However, the activities of HPRAC have been scaled back in recent years to being almost exclusively a policy advisor to the government and Fairness Commissioners are limited to reviewing registration practices.

Following the 2016 report of the Independent Advisory Group, the Office of the Superintendent of Real Estate has been expanded to include oversight on both a policy level and for individual decisions by the Real Estate Council of British Columbia (RECBC). RECBC is no longer self-regulatory.

In the Summer 2018 issue of Grey Areas we reported on the report of Mark Haddock entitled: Professional Reliance Review: *The Final Report of the Review of Professional Reliance in Natural Resource Decision-Making*. That report has been implemented through Bill 49 creating the *Professional Governance Act (PGA)*. The *PGA* is not yet in force likely awaiting the required regulations to be put in place.

In short, the *PGA* establishes an overarching framework for the regulation of multiple professions.

At the current time, the *PGA* applies to five regulated professional bodies related to natural resources including those that regulate professional foresters, professional engineers and professional geoscientists. However, the *PGA* has the authority to designate additional regulatory bodies after conducting an investigation as to whether doing so is in the public interest. The Superintendent can also amalgamate two or more regulatory bodies.

The *PGA* has a number of similarities with the *Health Professions Act* of that province establishing (or continuing) regulators for different professions and providing for powers and procedures to address registration of practitioners, the handling of complaints and other concerns including through discipline, continuing competence provisions and other enforcement tools such as establishing restricted acts that unregistered persons cannot perform, providing for protected titles and creating offences and authorizing the obtaining of injunctions.

The most novel aspect of the *PGA* is the creation of the office of a Superintendent of Professional Governance operating under a single Ministry (the Attorney General). The Superintendent has the authority to:

- Monitor the performance of the regulatory bodies;
- Administer rosters of practitioners for practising professions that are not overseen by the Superintendent.
- Advise and submit reports to the Minister;
- Enforce compliance by regulatory bodies both informally (e.g., guidance and advice) and formally (e.g., conducting investigations and

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A COMMENTARY ON LEGAL ISSUES AFFECTING PROFESSIONAL REGULATION

audits, issuing public directives for which compliance is mandatory);

- Appoint a public administrator to assume the role of the Council of the regulatory body;
- Impose administrative penalties, similar to fines, on persons other than the regulatory bodies for not complying with the legislation;
- Disallow or rewrite by-laws proposed by the Council of a regulatory body where the Superintendent does not believe that it is necessary and advisable.
- Require annual reports from the Council or a regulatory body including specifying the information to be contained in the report.
- Receive declarations of conflicts of interest from practitioners and issue guidance to regulatory bodies on their use.

The Councils of the regulatory bodies will consist of twelve members, eight elected by the profession and four public members. However, only candidates from the profession who have successfully completed the nomination process and meet the established criteria can be elected. One professional member, the past-president, does not vote.

Unlike the Professional Standards Authority in the UK, there does not appear to be any built-in mechanism for the Superintendent to review individual decisions (e.g., complaints, discipline). However, the Superintendent may use its audit authority to review individual cases as part of an audit or investigation into a general or systemic matter.

The *PGA* also eliminates the concept of ‘members’ and much that flows from that relationship. It replaces it with ‘registrants’. Several of the regulators will face significant changes to their mandates, which had

traditionally included member advocacy but which will become limited to and focused only on professional regulation. For some, the work they currently do to support members, through branches and committee work, will need to find a new home, likely in the form of a professional association that is distinct from the regulator.

Darrel Pink, recently retired as Executive Director of the Nova Scotia Barristers’ Society, currently practising in association with Steinecke Maciura LeBlanc and frequent commentator on professional regulation, said this about the *PGA*:

Though the government’s stated intentions are limited to one sector, the Act gives significant authority to the Superintendent of Professional Governance. The authority given to the Superintendent is unique in Canada. Though there are other models where there is oversight of regulators (such as Québec) the power given to a single person who can make decisions without hearing from the affected regulators is exceptional. Most of the powers of the office are exercised with no hearing process before decisions are made.

So unilaterally the Superintendent could extend the reach of the Act to another sector. If the government is dissatisfied – on any basis – with how one or a number of regulated professions are acting, the Superintendent could, with the stroke of a pen, bring them under the Act with all the requirements of it.

That may be a very remote prospect, but it is a circumstance which no regulator in British Columbia can ignore. It will dramatically change the way regulators carry on as they

will now have one eye over their shoulder wondering if what they do may raise the ire of government, an outcome which strikes at the heart of independent regulation. I expect many regulators will be forced to strengthen their government relations portfolios in order to address the nature and extent of their dealings with the government of the day.

The *PGA* can be found at:

<https://www.leg.bc.ca/parliamentary-business/legislation-debates-proceedings/41st-parliament/3rd-session/bills/third-reading/gov49-3>

Five Years Later: UK Duty of Candour Matures

by Julie Maciura
March 2019 - No. 234

Regulators are increasingly experimenting with strategies to change the approaches and attitudes of the profession as a whole rather than just engaging in enforcement activities in relation to individual practitioners. One such experiment in the United Kingdom is celebrating its fifth birthday. The Professional Standards Authority (PSA) has recently released a report analyzing the outcome of the initiative, identifying barriers to its full implementation and suggesting enhancements.

In 2014 the health professional regulators in the UK published a joint statement expressing the expectation that practitioners be candid with patients when things went wrong. This was part of a coordinated effort that included health organizations and institutions that flowed from the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Also called the “Francis Report”, it concluded that a lack of openness contributed to the suffering and death of hundreds of patients from poor care.

The duty of candour is more than just being open with patients. It is defined in the joint statement as follows:

Every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress.

This duty includes:

- telling the patient when something has gone wrong;
- apologizing to the patient;
- offering an appropriate remedy or support to put matters right (if possible); and
- explaining fully the short and long-term effects of what has happened.

The joint statement also indicated that practitioners must likewise be open and honest with their colleagues, employers and regulators, raising concerns where appropriate and not stopping others from raising concerns.

In assessing the evolution and effectiveness of the duty of candour, the PSA report identified a number of barriers:

1. Organizations “which had a blame culture, or a culture of defensiveness, were not environments in which the professional duty of candour could thrive”. In those cultures being candid could adversely affect a practitioner’s career.
2. The passage of time, due to workload or discovering the error afterwards, can result in a closed “window of opportunity” reducing the authenticity of the disclosure and apology.
3. A lack of education and training in communication skills and the rationale for candour makes it difficult for practitioners to implement the obligation.
4. Fear of regulatory, civil or even criminal litigation discourages candour especially in light of the recent prosecution of Dr. Hadiza

FOR MORE INFORMATION

This newsletter is published by Steinecke Maciura LeBlanc, a law firm practising in the field of professional regulation. If you are not receiving a copy and would like one, please contact: Richard Steinecke, Steinecke Maciura LeBlanc, 401 Bay Street, Suite 2308, P.O. Box 23, Toronto, ON M5H 2Y4, Tel: 416-626-6897 Fax: 416-593-7867, E-Mail: rsteinecke@sml-law.com

WANT TO REPRINT AN ARTICLE

A number of readers have asked to reprint articles in their own newsletters. Our policy is that readers may reprint an article as long as credit is given to both the newsletter and the firm. Please send us a copy of the issue of the newsletter which contains a reprint from Grey Areas.

A COMMENTARY ON LEGAL ISSUES AFFECTING PROFESSIONAL REGULATION

Bawa-Garba¹. The PSA noted that many experts believed that being candid reduces legal liability, but that this is a difficult message to communicate to practitioners. There is also a “myth” that being candid or apologizing can result in higher insurance premiums and a denial of coverage.

5. Some felt that professional regulators had not done enough to set standards for and communicate the expectations of candour. Similar to the previous point, perceptions of a blame culture within regulators is a disincentive to being candid.
6. A few comments obtained by the PSA related to disclosure and overwhelming patients with information they did not particularly want to know. The PSA noted the risk of reverting to a paternalistic approach to disclosure associated with this concern.
7. High performing practitioners sometimes have personal difficulty acknowledging they have made an error.

The PSA then examined how regulators had already helped embed the duty of candour, including:

1. Health regulators had incorporated the obligation in their standards.
2. Many regulators had incorporated the duty, including its rationale and its benefits to practitioners in the education and training to become practitioners.

3. Many regulators also incorporated the requirement into the continuing professional development requirements for practitioners.
4. Some regulators have included an absence of candour as grounds for discipline and the presence of candour as a mitigating factor for penalty. However, the absence of candour is often part of a broader concern about dishonesty and was often not communicated as a separate concept.
5. Some regulators have communicated on the topic with other stakeholders in the health care system.

The PSA urged regulators to take additional measures to encourage candour including:

1. Publishing case studies, not only as an effective communications tool, but to help practitioners identify and relate the duty to their actual practices;
2. Ensuring that practitioners understand the positive impact candour can have on patients (and indeed the general public) and the adverse impact a lack of candour can have on them;
3. Shifting the communications message to practitioners away from the “stick” of complying with the requirement and toward the benefits to the practitioner and their practice setting flowing from openness;
4. Working with other stakeholders, especially employers and system regulators, to understand and promote candour together;
5. On a related point, collaboration by regulators to provide support in implementing candour in multi-disciplinary teams;

¹ Dr. Bawa-Garba was disciplined after having been found criminally responsible for manslaughter for the death of a child following a series of institutional and individual errors.

Grey Areas

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6. Joint action by regulators to communicate a consistent message about candour, just like they did with the initial joint statement;
7. Indicating how a practitioner being candid will be used positively in the complaints and discipline process;
8. Clarifying the scope of the duty (e.g., distinguishing patient “distress” which invokes the duty, from patient discomfort that does not), perhaps through case studies; and
9. Education and training in candour for all programs leading to registration.

The PSA report concludes: “This report has shown that there is not one way to embed a culture of candour, instead regulators, professional bodies, providers and education bodies need to work together.”

Regulators elsewhere can benefit from studying this report on the initiative in the UK. The duty of candour is a regulatory tool to try to change behaviour in a systemic way rather than by just disciplining individuals for misconduct. It is analogous to other initiatives regulators have developed in such areas as client-centred care, informed consent / choice, know your client, and sexual abuse prevention plans. It is a shame, as was noted by the PSA, that progress in such matters is so difficult to measure.

To view the PSA report, see:

https://www.professionalstandards.org.uk/docs/default-source/publications/research-paper/telling-patients-the-truth-when-something-goes-wrong---how-have-professional-regulators-encouraged-professionals-to-be-candid-to-patients.pdf?sfvrsn=100f7520_4

ITEM 7.22

Council Member Terms as at April 30, 2019 ¹

Name	District	Date First Elected/Appointed	Date Re-elected/ Reappointed	Date of Expiry of Current Term
<u>Elected Members</u>				
Dr. Peter Amlinger	5 (Central West)	April 2017	NA	April 2020
Dr. Brian Budgell	4 (Central)	April 2018	NA	April 2021
Dr. Janet D'Arcy	4 (Central)	April 2019	NA	April 2022
Dr. Paul Groulx	2 (Eastern)	April 2019	NA	April 2022
Dr. Cliff Hardick	6 (Western)	May 2011	April 2014 April 2017	April 2020
Dr. Steven Lester	3 (Central East)	April 2019	NA	April 2022
Dr. Dennis Mizel	5 (Central West)	April 2018	NA	April 2021
Dr. Kristina Peterson	1 (Northern)	April 2017	NA	April 2020
Dr. David Starmer	4 (Central)	April 2014	April 2017	April 2020
<u>Appointed Members ²</u>				
Ms Georgia Allan	Smiths Falls	September 8, 2014	September 8, 2017	September 7, 2020
Ms Karoline Bourdeau	Toronto	July 17, 2017	N/A	July 17, 2020
Mr. Douglas Cressman	Kitchener	June 30, 2016	N/A	June 29, 2019
Ms Tamara Gottlieb	Toronto	December 31, 2018	N/A	December 31, 2021
Ms Sheryn Posen	Toronto	November 28, 2018	N/A	November 27, 2021
Mr. Rob MacKay	Thunder Bay	November 28, 2018	N/A	November 27, 2021
Vacant				

¹ Please advise Ms Rose Bustria a.s.a.p. if you aware of aware of any discrepancies.

² CCO requires at least 6 public members to be properly constituted.