College of Chiropractors of Ontario
L'Ordre des Chiropraticiens de l'Ontario

CHIROCARE

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Version Date: June 2026

Contents

Tab	Title
1	About the College of Chiropractors of Ontario (CCO)
2	Legislation
3	Regulations
	Introduction
	R-137/11: Registration
	R-852/93: Professional Misconduct
	R-59/94: Funding for Therapy and Counselling for Patients Sexually Abused by Members
	R-107/97: Controlled Acts (Forms of Energy/Exemptions)
	R-223/05: Quality Assurance

Tab Title

4 Standards of Practice

S-001: Chiropractic Scope of Practice

S-002: Record Keeping

S-003: Professional Portfolio

S-004: Reporting of Diseases

S-005: Chiropractic Adjustment or Manipulation

S-006: Ordering, Taking and Interpreting Radiographs

S-007: Putting a Finger Beyond the Anal Verge for the Purpose of Manipulating the Tailbone

S-008: Communicating a Diagnosis

S-009: Chiropractic Care of Animals

S-011: Members of More Than One Health Profession

S-012: Orthotics

S-013: Consent

S-014: Prohibition of a Sexual Relationship with a Patient

S-016: Communication to the Public

S-017: Acupuncture

S-018: Third Party Independent Chiropractic Evaluations

S-019: Conflict of Interest in Commercial Ventures

S-020: Cooperation and Communication with CCO

S-021: Assistive Devices

S-022: Ownership, Storage, Security and Destruction of Records of Personal Health Information

5 Policies

Introduction

Tab Committee

1 Advertising Committee

P-004: Advertising Committee Protocol

P-016: Public Display Protocol

2 Discipline Committee

P-020: Adjournment of Discipline Hearings

P-046: Core Discipline Committee

3 Executive Committee

P-009: Presidential Memorial Award

P-010: Use of Professional Titles, Designation and Credentials

P-011: Conflict of Interest for Council, Non-Council Committee Members and Council Appointed Members ("Committee Members")

P-029: Chiropractic Specialties

4 Fitness to Practise Committee

P-035: Publication of Fitness to Practise Decisions

5 Inquiries, Complaints and Reports Committee

P-015: Consideration of Prior Decisions Involving a Member

6 Patient Relations Committee

P-003: Principle of Zero Tolerance

P-018: Funding for Therapy and Counselling for Patients Sexually Abused by Members

7 Quality Assurance Committee

P-017: Public Screenings

P-023: Participation in X-ray Peer Review Program

P-051: Peer Assessors

P-055: Non-compliance with the Continuing Education Requirements

8 Registration Committee

P-045: CCO's Legislation and Ethics Examinations

P-050: Supervision and Direction of Chiropractors in Training

P-053: Returning to the General Class of Certificate of Registration

P-054: Determination of Good Character of an Applicant or Member

P-056: Requirement to Disclose Police Criminal Record Checks

P-057: Accessibility Policy

6 Guidelines

Introduction

G-001: Communication with Patients

G-005: Guidelines for Members Concerning Office Staff

G-008: Business Practices

G-009: Code of Ethics

G-010: Mandatory and Permissive Reporting

G-011: Accommodation of Human Rights and Disabilities

G-013: Chiropractic Assessments

G-014: Delegation, Assignment and Referral of Care

G-015: Virtual Care

G-016: Communication to the Public

G-017: Use of Artificial Intelligence by CCO Members

7 Professional Portfolio

8 Other Quality Assurance Materials

Core Competencies for CCO Members

9 Annual Reports / Newsletters / Brochures

10 Other

Contents

About CCO

College of Chiropractors of Ontario (CCO)

CCO is the regulatory body for chiropractors in Ontario, governed by a 15 or 16-member Council comprised of six or seven public members appointed by the provincial government and nine registered chiropractors elected by the membership. The governing legislation for CCO is the *Regulated Health Professions Act, 1991* (*RHPA*) and the *Chiropractic Act, 1991*.

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;
- disciplining members who have committed acts of professional misconduct or who are incompetent or incapacitated; 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.

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
• Collaboration
• Innovation
• Transparency
• Responsiveness

Strategic Objectives

- Strengthen Governance and Leadership.
- Strengthen the understanding of CCO and the Profession's Role in the Healthcare System.
- Demonstrate a Proactive Approach to Regulatory Change.
- Enhance Member Engagement and Communication (internal and external).

Developed at the Strategic Planning Session: September 2024

Objects of the College

As defined by the Health Professions Procedural Code, Schedule 2 to the R*egulated Health Professions Act, 1991* (*RHPA)*, CCO 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.

Elections

CCO is governed by a 16-member Council comprised of nine chiropractors elected to represent a specific electoral district and seven public members appointed by the Lieutenant Governor in

Council. CCO's elections are generally held in March of each year and are conducted pursuant to the Election of Council Members regulation.

The province is divided into six electoral districts:

District 1: Northern: comprised of 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; and the regional municipality of Durham.

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

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

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 7: Academic: comprised of the entire province of Ontario.

Eligibility to Nominate and/or Vote

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.

A member is **not eligible 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 the College imposed by a college committee or court of law or is in default in completing and returning any form required by CCO.

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 at any time up to and including the date of the election:

(a) the member's primary practice of chiropractic is located in the electoral district in the member is nominated or, if the member is not engaged in the practice of chiropractic, the member's primary residence is located in the electoral district in which the member is nominated;

(b) the member is not in default of payments of any fees prescribed by by-law or any fine or order to pay 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 six years;

(f) if a member has been found to be incapacitated, CCO receives confirmation from their treating practitioner that the member is physically and mentally capable to serve on Council or a committee.

(g) the member has not resigned from a position on Council, before completing the term, within the last three years.

(h) the member does not have an outstanding code of conduct matter with the College.

(i) the member is not, and has not been in preceding three years, 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, director, or member of a committee, sub-committee or working group of the OCA, CCA, CCPA, AFC, CCEB, CSCE, the CCEC of the FCC, CCRF or CNAC;

(j) the member is not, and has not been in the preceding three years, 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;

(k) the member has not been disqualified from the Council or a committee of the Council in the previous six years;

(l) the member is not a member of the Council or of a committee of the College of any other health profession;

(m) the member has not been a member of the staff of CCO at any time within the preceding three years;

(n) for District 7 only, the member is a member of the faculty of an accredited educational institution;

(o) for any district other than District 7, the member is not eligible for election in District 7, and has not been eligible for election in District 7 in the preceding three years;

(p) the member is not, and has not been within the preceding six years, an adverse party in litigation against CCO, the Council of CCO, a committee of CCO, or any of CCO's directors, officers, employees or agents, on a matter related to CCO business;

(q) the members is not an accused currently charged with a criminal offence under the Criminal Code of Canada; and

(r) the member has not been convicted of a criminal offence for which the member has not received a pardon pursuant to the Criminal Code of Canada.

Please note: A member who has served on Council for nine consecutive years is ineligible for election to Council

Committee Structure and Composition

Council of CCO

The Council is a 15 or 16-member policy-making body composed of nine members elected by chiropractors from among their peers and six or seven members appointed by the government from the general public. The president and vice president of Council are elected from among its members by majority vote. CCO has seven statutory committees under the *RHPA* and one non-statutory committee:

- Executive - composed of four elected members and three public members;
- Inquiries, Complaints and Reports - composed of two elected members, one public member, one alternate public member, and one non-council member;
- Discipline - composed of two elected members, two public members, four non-Council members *(every member of Council may be a member of a Discipline Panel);*
- Fitness to Practise - composed of two elected members, and one public member;
- Patient Relations - composed of one elected member, two public members, two non-Council members, and one non-council alternate member

- Quality Assurance - composed of two elected members, two public members, and one non-council member;

- Registration - composed of two elected members, one public member, and one alternate public member.

Mandates

Executive Committee

- To exercise the powers of Council between meetings of Council with respect to any matter requiring immediate attention other than the power to make, amend or revoke a regulation or by-law;

- To provide leadership in exercising CCO's mandate to regulate chiropractic in the public interest.

Inquiries, Complaints and Reports Committee

- To respond to complaints in a manner consistent with its legislative mandate under the *RHPA;*

- To review reports of investigations carried out pursuant to subsection 75(a) of the *RHPA*, and to make decisions concerning the referral of specified allegations of professional misconduct to the Discipline Committee and the imposition of interim terms, conditions or limitations on a member's certificate of registration.

Discipline Committee

- To adjudicate specified allegations of professional misconduct or incompetence referred to the committee by the Inquiries, Complaints and Reports Committee;

- To review applications for reinstatement following a discipline finding.

Fitness to Practise Committee

- 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.

Patient Relations Committee

- To develop and implement a program/guidelines to enhance the doctor/patient relationship;

- To develop and implement measures for preventing and dealing with sexual abuse of patients;

- To develop, establish and maintain programs to assist individuals in exercising their rights under the *RHPA*.

Quality Assurance Committee

- To develop, establish and maintain:
    - programs and standards of practice to assure the quality of the profession;
    - standards of knowledge and skill and programs to promote continuing evaluation, competence and improvement among members; and
    - standards of professional ethics;

- To develop and mechanisms and protocols to assess the knowledge, skills and continuing competence of members.

Registration Committee

- To develop, establish and maintain standards of qualification for persons to be issued certificates of registration;

- To review applications for registration referred by the Registrar;

- To determine the terms, conditions or limitations, if any, for granting a certificate of registration to an applicant.

Advertising Committee

- To develop, establish and maintain standards of advertising for chiropractors.

- To advise CCO members of the Committee's procedures to determine if an advertisement 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.

The Public Register

The public register contains mandatory information as required in section 23 of the Health Professions Procedural Code under the *Regulated Health Professions Act, 1991* and CCO By-law 17: Public Register. Section 23 requires:

1. Each member's name, business address and business telephone number, and, if applicable, the name of every health profession corporation of which the member is a shareholder.

2. Where a member is deceased, the name of the deceased member and the date upon which the member died, if known to the Registrar.

3. The name, business address and business telephone number of every health profession corporation.

4. The names of the shareholders of each health profession corporation who are members of the College.

5. Each member's class of registration and specialist status.

6. The terms, conditions and limitations that are in effect on each certificate of registration.

7. A notation of every caution that a member has received from a panel of the Inquiries, Complaints and Reports Committee under paragraph 3 of subsection 26 (1), and any specified continuing education or remedial programs required by a panel of the Inquiries, Complaints and Reports Committee using its powers under paragraph 4 of subsection 26 (1).

8. A notation of every matter that has been referred by the Inquiries, Complaints and Reports Committee to the Discipline Committee under section 26 and that has not been finally resolved, including the date of the referral and the status of the hearing before a panel of the Discipline Committee, until the matter has been resolved.

9. A copy of the specified allegations against a member for every matter that has been referred by the Inquiries, Complaints and Reports Committee to the Discipline Committee under section 26 and that has not been finally resolved.

10. Every result of a disciplinary or incapacity proceeding.

11. A notation and synopsis of any acknowledgements and undertakings in relation to matters involving allegations of professional misconduct or incompetence before the Inquiries, Complaints and Reports Committee or the Discipline Committee that a member has entered into with the College and that are in effect.

12. A notation of every finding of professional negligence or malpractice, which may or may not relate to the member's suitability to practise, made against the member, unless the finding is reversed on appeal.

13. A notation of every revocation or suspension of a certificate of registration.

14. A notation of every revocation or suspension of a certificate of authorization.

15. Information that a panel of the Registration Committee, Discipline Committee or Fitness to Practise Committee specifies shall be included.

16. Where findings of the Discipline Committee are appealed, a notation that they are under appeal, until the appeal is finally disposed of.

17. Where, during or as a result of a proceeding under section 25, a member has resigned and agreed never to practise again in Ontario, a notation of the resignation and agreement.

18. Where the College has an inspection program established under clause 95 (1) (h) or (h.1), the outcomes of inspections conducted by the college.

19. Information that is required to be kept in the register in accordance with regulations made pursuant to clause 43 (1) (t) of the Regulated Health Professions Act, 1991.

20. Information that is required to be kept in the register in accordance with the by-laws.

Powers of Investigators

Appointment of Investigators

The Registrar may appoint one or more investigators to determine whether a member has committed an act of professional misconduct or is incompetent if:

- the Registrar believes, on reasonable and probable grounds, that the member has committed an act of professional misconduct or is incompetent, and the Inquiries, Complaints and Reports Committee approves of the appointment;

- the Executive Committee has received a report from the Quality Assurance Committee with respect to the member and has requested the Registrar to conduct an investigation; or

- the Inquiries, Complaints and Reports Committee has received a written complaint about the member and has requested the Registrar to conduct an investigation.

Powers of Investigators

An investigator may inquire into and examine the practice of the member to be investigated and has, for the purpose of the investigation, all the powers of a commission under Part II of the *Public Inquiries Act*.

An investigator may, on the production of his/her appointment, enter at any reasonable time the business premises of the member and may examine anything found there that is relevant to the investigation.

Obstruction Prohibited

No person shall obstruct an investigator or withhold or conceal from him/her or destroy anything that is relevant to the investigation. This section applies despite any provision to any act relating to the confidentiality of health records.

How to Contact CCO

College of Chiropractors of Ontario
59 Hayden Street, Suite 800
Toronto, ON M4Y 0E7
Tel.: (416) 922-6355
Toll free: 1-877-577-4772
Fax: (416) 925-9610
E-mail: cco.info@cco.on.ca
www.cco.on.ca

LEGISLATION

Legislation or statutes set overall guiding principles that reflect the government's policy decisions.

Becoming Law

The ordinary course for a statute to become law is as follows:

- a bill, the proposed statute, is introduced into the legislature for discussion by all political parties, a process known as first reading;
- the bill is referred to the appropriate committee (e.g., Social Development) responsible for consulting with members of the public between second and third readings;
- the bill receives third reading;
- the bill receives royal assent; and
- the bill is proclaimed as law.

Once a bill becomes law (on proclamation as published in the Ontario Gazette), it is referred to by its "short title" and is no longer a bill.

- Statutes provide the overall framework within which bodies, such as regulatory bodies, exist. For example, the *Regulated Health Professions Act, 1991* (*RHPA*) defines the objects of regulatory colleges, their overall structure and purpose;

- CCO has an enforcement mechanism to enforce both statutes and regulations because the following are acts of professional misconduct:
    - Contravening the *Chiropractic Act*, the *RHPA*, or the regulations under either of those Acts;
    - Contravening a federal, provincial or territorial 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;

- In theory, because of widespread public consultation, the statute reflects the "will" of the citizens of the province;

- There is increased public accountability because of the public process involved in passing statutes;

Relevant Legislation ("Statutes") for Ontario Chiropractors

- *Regulated Health Professions Act, 1991*
- *Health Insurance Act*
- *Healing Arts Radiation Protection Act, 1993*
- *Child and Family Services Act, 1990* (sections 82 and 73: Duty to Report)
- *Chiropractic Act, 1991*
- *Laboratory and Specimen Collection Centre Licensing Act, 1990*

REGULATIONS

Introduction

Regulations are the details that support the guiding principles of legislation. Regulations may only exist pursuant to legislation.

A certain number of topics may be the subject of regulations pursuant to the *Regulated Health Professions Act, 1991* (*RHPA*). Section 95 (1) of the *RHPA* provides:

> Subject to the approval of the Lieutenant Governor in Council and with prior review by the Minister, the Council of the College of Chiropractors of Ontario may make regulations. CCO may enforce regulations through the professional misconduct regulation.
>
> There is significant public accountability because of the requirement for consultation and various levels of review at the Ministry of Health and Long-Term Care.

Current Regulations

Ont. Reg.	Title	Effective Date
137/11	Registration	Aug. 31/23
952/93	Professional Misconduct	Dec. 31/93
059/94	Funding for Therapy Counselling for Patients Sexually Abused by Members	Dec. 31/93
107/96	Controlled Acts (Forms of Energy/Exemptions)	Mar. 29/96
233/05	Quality Assurance	May 18/05

ONTARIO REGULATION 137/11: REGISTRATION UNDER THE *CHIROPRACTIC ACT, 1991*
Effective Date: August 31, 2023

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

GENERAL

Classes of certificate

1. The following are prescribed as classes of certificate of registration:

    1. General.
    2. Temporary.
    3. Inactive.
    4. Retired.
    5. Emergency. O. Reg. 137/11, s. 1; O. Reg. 277/23, s. 1

Application

2. A person shall apply for a certificate of registration by submitting a completed application in the provided form together with the applicable fees under the by-laws. O. Reg. 137/11, s. 2.

Registration requirements, all classes

3. The following are registration requirements for a certificate of registration of any class:

    1. If the applicant has previously been or is registered or licensed to practise another health profession in Ontario, or chiropractic or another health profession in any other jurisdiction, the applicant must provide evidence that there has been no finding of, and that there is no current investigation or proceeding involving an allegation of, professional misconduct, incompetence or incapacity or similar conduct.

    2. The applicant must be able to speak and write either English or French with reasonable fluency.

    3. The applicant must be a Canadian citizen or a permanent resident of Canada or be authorized under the *Immigration and Refugee Protection Act* (Canada) to engage in the practice of the profession.

    4. The applicant's past and present conduct must afford reasonable grounds for belief that the applicant,

        i. is mentally and physically competent to practise chiropractic,

ii. will practise chiropractic with decency, integrity, honesty and in accordance with the law,

iii. has sufficient knowledge, skill and judgment to engage in chiropractic, and

iv. will display professional behaviour. O. Reg. 137/11, s. 3.

Requirement to provide details

4. Every applicant is required to provide the College with details of the following with respect to the applicant that occur or arise after the applicant has submitted his or her application, and if the applicant becomes a member, it is a condition of the member's certificate of registration that he or she provide such details:

1. A finding of professional misconduct, incompetence or incapacity or similar finding in Ontario in relation to another health profession or in any other jurisdiction in which the applicant is registered or licensed to practise chiropractic or another health profession.

2. An investigation or proceeding for professional misconduct, incompetence or incapacity or similar finding in Ontario in relation to another health profession or in any other jurisdiction in which the applicant is registered or licensed to practise chiropractic or another health profession.

3. A finding of guilt in relation to any offence. O. Reg. 137/11, s. 4.

Revocation for false and misleading statements

5. The Registrar may revoke the member's certificate of registration if the member made a false or misleading statement in his or her application for registration or on any form related to his or her renewal or reinstatement of registration. O. Reg. 137/11, s. 5.

General Certificates

Additional requirements, general certificate

6. The following are additional registration requirements for a general certificate of registration:

1. The applicant must have successfully completed the requirements for graduation from either a chiropractic education program that is accredited or recognized by the Council on Chiropractic Education (Canada) or a chiropractic education program considered equivalent by the Council to such a program. Subject to section 7, this requirement is non-exemptible.

2. Before applying for the certificate, the applicant must have passed,

   i. a legislation examination set by the Council or set by another person or body and accepted by the Council as sufficiently testing the applicant's knowledge of relevant legislation, and

   ii. the examinations set by the Canadian Chiropractic Examining Board or set by another person or association of persons and accepted by the Council as equivalent to the examinations set by the Board.

3. The applicant must complete a refresher course approved by the Registration Committee or otherwise satisfy the Registration Committee that he or she is currently competent to practise if the applicant applies for registration more than two years after completing the education program required under paragraph 1.

4. The applicant must provide evidence satisfactory to the Registrar that, as of the anticipated date for the issuance of his or her certificate of registration, the applicant,

   i. will have professional liability insurance in the amount and in the form as required by the by-laws, or

   ii. will belong to an association that is specified in the by-laws as providing the member with personal protection against professional liability. O. Reg. 137/11, s. 6.

Labour mobility, general certificate

7. (1) Where section 22.18 of the Health Professions Procedural Code applies to an applicant the requirements of paragraph 1, subparagraph 2 ii and paragraph 3 of section 6 are deemed to have been met by the applicant. O. Reg. 137/11, s. 7 (1).

(2) Despite subsection (1), it is a non-exemptible registration requirement that an applicant referred to in subsection (1) provide one or more certificates or letters or other evidence satisfactory to the Registrar or a panel of the Registration Committee establishing that the applicant is in good standing as a chiropractor in every jurisdiction where the applicant holds an out-of-province certificate. O. Reg. 137/11, s. 7 (2).

(3) An applicant referred to in subsection (1) is deemed to have met the requirements of paragraph 2 of section 3 where the requirements for the issuance of the applicant's out-of-province certificate of registration included language

proficiency requirements equivalent to those required by that paragraph. O. Reg. 137/11, s. 7 (3).

(4) Despite subsection (1), an applicant is not deemed to have met a requirement if that requirement is described in subsection 22.18 (3) of the Health Professions Procedural Code. O. Reg. 137/11, s. 7 (4).

Issuance of general certificate of registration to retired or inactive member

8. (1) The following rules apply where a member who holds a retired or inactive certificate of registration wishes to be issued a general certificate of registration:

1. An application must be made to the Registrar.

2. The member shall pay the applicable fee for a general certificate of registration.

3. A member who has held an inactive or retired certificate of registration for more than two consecutive years preceding his or her application for a general certificate of registration shall only be entitled to have a general certificate of registration issued if he or she satisfies the Registration Committee that he or she is currently competent to practise.

4. The member shall not resume active practice until his or her application for issuance of a general certificate of registration has been approved by the Registration Committee. O. Reg. 137/11, s. 8 (1).

(2) Where a member who wishes to be issued a general certificate of registration pursuant to subsection (1) was issued his or her inactive or retired certificate of registration pursuant to section 13 or 16, the reference to "inactive or retired certificate of registration" in paragraph 3 of subsection (1) shall be a reference to any out-of-province certificate that was, at the time he or she was issued their inactive or retired certificate of registration, considered by the Registration Committee to be substantially equivalent to an inactive or retired certificate of registration. O. Reg. 137/11, s. 8 (2).

Issuance of general certificate of registration to emergency certificate holders

8.1 (1) The following rules apply where a member who holds an emergency certificate of registration wishes to be issued a general certificate of registration:

1. An application must be made to the Registrar.

2. The member shall only be entitled to have a general certificate of registration issued if the member satisfies the Registration Committee that they are currently competent to practise. O. Reg. 277/23, s. 2.

(2) A member is exempt from the requirement to pay the application and initial certificate fee as set out in the College by-laws. O. Reg. 277/23, s. 2.

TEMPORARY CERTIFICATES

Additional requirements, temporary certificate

9. The following are additional registration requirements for a temporary certificate of registration:

1. The applicant must have successfully completed the requirements for graduation from either a chiropractic education program that is accredited or recognized by the Council on Chiropractic Education (Canada) or a chiropractic education program considered equivalent by the Council to such a program. This requirement is non-exemptible.

2. The applicant must be registered or licensed to practise chiropractic in another jurisdiction.

3. The applicant must provide evidence satisfactory to the Registrar that, as of the anticipated date for the issuance of his or her certificate of registration, the applicant,

i. will have professional liability insurance in the amount and in the form as required by the by-laws, or

ii. will belong to an association that is specified in the by-laws as providing the member with personal protection against professional liability. O. Reg. 137/11, s. 9.

Temporary certificate, expiry

10. A temporary certificate of registration expires on the earliest of the following:

1. The expiry date set out on the certificate.

2. Twelve weeks after the date the temporary certificate of registration was issued.

3. If the temporary certificate of registration was issued for a temporary appointment or exchange program, the date of termination of the temporary appointment or exchange program for which it was issued. O. Reg. 137/11, s. 10.

INACTIVE CERTIFICATES

Additional requirements, inactive certificate

11. The following are additional registration requirements for an inactive certificate of registration:

    1. The applicant must hold, or be eligible to hold, a general certificate of registration.

    2. The applicant must not be in default of any fee, fine or other amount owed to the College or in default in providing any information to the College.

    3. The applicant must give a written undertaking to the College not to engage in chiropractic practice in Ontario and not to submit accounts to the Workplace Safety and Insurance Board or any other third party payer in respect of chiropractic services. O. Reg. 137/11, s. 11.

Conditions, inactive certificate

12. The following are conditions of an inactive certificate of registration:

    1. The member shall not engage in chiropractic practice in Ontario.

    2. The member shall not submit an account to the Workplace Safety and Insurance Board or any other third party payer in respect of a chiropractic service. O. Reg. 137/11, s. 12.

Labour mobility, inactive certificate

13. Where an applicant holds an out-of-province certificate which, in the opinion of the Registration Committee, is substantially equivalent to an inactive certificate of registration, the requirement of paragraph 1 of section 11 is deemed to have been met by the applicant if he or she provides one or more certificates or letters or other evidence satisfactory to the Registrar or a panel of the Registration Committee establishing that the applicant is in good standing as a chiropractor in every jurisdiction where the applicant holds an out-of-province certificate. O. Reg. 137/11, s. 13.

RETIRED CERTIFICATES

Additional requirements, retired certificate

14. The following are additional requirements for a retired certificate of registration:

    1. The applicant must hold either a general or an inactive certificate of registration.

2. The applicant must not be in default of any fee, fine or other amount owed to the College or in default in providing any information to the College.

3. The applicant must give a written undertaking to the College not to engage in chiropractic practice in Ontario and not to submit accounts to the Workplace Safety and Insurance Board or any other third party payer in respect of chiropractic services. O. Reg. 137/11, s. 14.

Conditions, retired certificate

15. The following are conditions of a retired certificate of registration:

1. The member shall not engage in chiropractic practice in Ontario.

2. The member shall not submit an account to the Workplace Safety and Insurance Board or any other third party payer in respect of a chiropractic service. O. Reg. 137/11, s. 15.

Labour mobility, retired certificate

16. Where an applicant holds an out-of-province certificate which, in the opinion of the Registration Committee, is substantially equivalent to a retired certificate of registration, the requirement of paragraph 1 of section 14 is deemed to have been met by the applicant if he or she provides one or more certificates or letters or other evidence satisfactory to the Registrar or a panel of the Registration Committee establishing that the applicant is in good standing as a chiropractor in every jurisdiction where the applicant holds an out-of-province certificate. O. Reg. 137/11, s. 16.

EMERGENCY CERTIFICATES

Requirements, emergency certificate

16.1 (1) The following are requirements for an emergency certificate of registration:

1. The Minister must have requested that the College initiate registrations under this class based on the Minister's opinion that emergency circumstances call for it or the Council must have determined, after taking into account all of the relevant circumstances that impact the ability of applicants to meet the ordinary registration requirements, that there are emergency circumstances, and that it is in the public interest that the College issue emergency certificates.

2. The applicant must have satisfied the registration requirements in sections 3 and 4 and paragraph 1, subparagraph 2 i and paragraphs 3 and 4 of section 6. The requirement in paragraph 1 of section 6 is non-exemptible.

3. The applicant must submit a police record check. O. Reg. 277/23, s. 3.

(2) Every emergency certificate of registration is subject to the following terms, conditions and limitations:

1. The member shall at all times when providing chiropractic services identify themselves as a member registered in the emergency class of registration, only authorized to practise under supervision.

2. The member shall only use the title Chiropractor (Emergency Class).

3. The member shall only practise the profession while under the direct supervision of a member who holds a general certificate of registration, and who,

    i. is currently providing direct patient care to patients,

    ii. is not the subject of any disciplinary or incapacity proceeding and does not have an outstanding referral for a disciplinary of incapacity proceeding, and

    iii. is authorized to practise in any area of the profession that requires specific additional education or certification, if the member in the emergency class of registration is authorized to practise in these areas of practice. O. Reg. 277/23, s. 3.

(3) An emergency certificate of registration expires as follows:

1. Unless stated otherwise on the certificate, six months after it is issued, unless it is renewed.

2. Unless stated otherwise on the certificate, a renewed certificate expires six months after it is renewed, unless it is renewed again.

3. Despite paragraphs 1 and 2, an emergency certificate expires on the earlier of the following:

    i. Three months after the date the Council declares that the emergency circumstances referred to in paragraph 1 of subsection (1) have ended.

    ii. The date the member is issued a general certificate of registration. O. Reg. 277/23, s. 3.

INSURANCE

17. It is a condition of every general certificate of registration and of every temporary certificate of registration that the member continue,

(a) to maintain professional liability insurance in accordance with the by-laws; or

(b) to belong to an association that is specified in the by-laws as providing the member with personal protection against professional liability. O. Reg. 137/11, s. 17.

FAILURE TO PAY FEES

18. (1) If the Registrar suspends a member's certificate of registration for failure to pay a required fee, the Registrar shall lift the suspension on payment of,

(a) the fee the member failed to pay;

(b) the annual fee for the year in which the suspension is to be lifted; and

(c) any applicable penalty. O. Reg. 137/11, s. 18 (1).

(2) If a certificate of registration has been suspended for failure to pay a required fee for more than two years from the date of the suspension and the suspension has not been lifted under subsection (1), the certificate is automatically revoked. O. Reg. 137/11, s. 18 (2).

(3) A person whose certificate of registration was revoked under subsection (2) or a predecessor provision and who applies to be reinstated is required to pay,

(a) the applicable application fee under the by-laws;

(b) the annual fees and any applicable penalties the member failed to pay up to the date of revocation; and

(c) the annual fee for the year in which the member wishes to be reinstated. O. Reg. 137/11, s. 18 (3).

(4) A person whose certificate of registration was revoked pursuant to subsection (2) or a predecessor provision must successfully complete a refresher course approved by the Registration Committee, or otherwise satisfy the Registration Committee that he or she is currently competent to practise before being entitled to have his or her general certificate of registration reinstated. O. Reg. 137/11, s. 18 (4).

TRANSITIONAL

19. (1) A certificate of registration of any class that was valid immediately before the coming into force of this Regulation is deemed to be the equivalent certificate of registration under this Regulation, and continues until it is revoked or otherwise expires. O. Reg. 137/11, s. 19 (1).

(2) Where a person submitted an application for a certificate of registration before the coming into force of this Regulation, and that application was still being dealt with at the time this Regulation came into force, Ontario Regulation 862/93 (Registration) made under the Act, as it read immediately before this Regulation came into force, applies with respect to that application. O. Reg. 137/11, s. 19 (2).

20. Omitted (revokes other Regulations). O. Reg. 137/11, s. 20.

21. Omitted (provides for coming into force of provisions of this Regulation). O. Reg. 137/11, s. 21.

ONTARIO REGULATION 852/93: PROFESSIONAL MISCONDUCT UNDER THE *CHIROPRACTIC ACT, 1991*
Effective Date: December 31, 1993

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

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 term, condition or limitation imposed on the member's certificate of registration.

2. Contravening a standard of practice of the profession or failing to maintain the standard of practice expected of members of the profession.

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

4. Delegating a controlled act contrary to the Act or the *Regulated Health Professions Act, 1991* or the regulations under either of those Acts.

5. Abusing a patient verbally, physically, psychologically or emotionally.

6. Practising the profession while the member's ability to do so is impaired by any substance.

7. Discontinuing professional services that are needed unless,

    i. the patient requests the discontinuation,
    ii. alternative services are arranged, or
    iii. the patient is given a reasonable opportunity to arrange alternative services.

8. Discontinuing professional services contrary to the terms of an agreement between the member and a hospital, nursing home or other facility or agency that provides health services to the public unless,

    i. the discontinuation is requested by the hospital, nursing home or other facility or agency,
    ii. alternative services are arranged, or
    iii. a reasonable opportunity to arrange alternative services is provided.

9. Practising the profession while the member is in a conflict of interest.

10. Giving information about a patient to a person other than the patient, his or her authorized representative, or the member's legal counsel or insurer, except with the consent of the patient or his or her authorized representative or as required or allowed by law.

11. Breaching an agreement with a patient relating to professional services for the patient or fees for such services.

12. Failing to reveal the nature of a remedy or treatment used by the member following a patient's request to do so.

13. Failing to advise a patient to consult with another health professional when the member knows or ought to know that,

    i. the patient's condition is beyond the scope of practice and competence of the member,
    ii. the patient requires the care of another health professional, or
    iii. the patient would be most appropriately treated by another health professional.

14. Providing a diagnostic or therapeutic service that is not necessary.

15. Failing to maintain the member's practice premises in a safe and sanitary manner.

REPRESENTATIONS ABOUT MEMBERS AND THEIR QUALIFICATIONS

16. Using a term, title or designation in respect of a member's practice contrary to the policies of the College.

17. Using a term, title or designation indicating a specialization in the profession contrary to the policies of the College.

18. Using a name, other than the member's name as set out in the register, in the course of providing or offering to provide services within the scope of practice of the profession.

RECORD KEEPING AND REPORTS

19. Failing to keep records as required by the regulations.

20. Falsifying a record relating to the member's practice.

21. Failing, without reasonable cause, to provide a report or certificate relating to an examination or treatment performed by the member within a reasonable time after a patient has requested such a report or certificate.

22. Signing or issuing, in the member's professional capacity, a document that the member knows contains a false or misleading statement.

BUSINESS PRACTICES

23. Submitting an account or charge for services that 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 multiplied by the unit cost per service.

26. Failing to itemize an account for professional services,

    i. if requested to do so by the patient or the 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.

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.

30. Influencing a patient to change his or her will or other testamentary instrument for the benefit of the member or anyone not at arm's length from the member.

31. Failing to comply with an order of, or breaching an undertaking given to, the Complaints, Discipline or Fitness to Practise Committees or to the Registrar of the College.

32. Failing to carry out an agreement entered into with the College.

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.

ONTARIO REGULATION 59/94: FUNDING FOR THERAPY OR COUNSELLING FOR PATIENTS SEXUALLY ABUSED BY MEMBERS UNDER THE *CHIROPRACTIC ACT, 1991*

Effective Date: February 17, 1994

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

1. For the purposes of a program established under section 85.7 of the Code,

   (a) the maximum amount of funding that may be provided for a person in respect of a case of sexual abuse is the amount that the Ontario Health Insurance Plan would pay for 200 half-hour sessions of individual out-patient psychotherapy with a psychiatrist on the day the person becomes eligible under subsection 85.7 (4) of the Code; and

   (b) the period of time within which funding may be provided for a person in respect of a case of sexual abuse is five years from,

      (i) the day on which the person first received therapy or counselling for which funding is provided under subsection 85.7 (10) of the Code, or

      (ii) if funding is not provided under subsection 85.7 (10) of the Code, the day on which the person becomes eligible for funding under subsection 85.7 (4) of the Code. O.Reg. 59/94, s. 1.

ONTARIO REGULATION 107/96: CONTROLLED ACTS UNDER THE *REGULATED HEALTH PROFESSIONS ACT, 1991* Effective Date: March 29, 1996

FORMS OF ENERGY

1. The following forms of energy are prescribed for the purpose of paragraph 7 of subsection 27 (2) of the Act:

    1. Electricity for,

        i. aversive conditioning,
        ii. cardiac pacemaker therapy,
        iii. cardioversion,
        iv. defibrillation,
        v. electrocoagulation,
        vi. electroconvulsive shock therapy,
        vii. electromyography,
        viii. fulguration,
        ix. nerve conduction studies, or
        x. transcutaneous cardiac pacing.

    2. Electromagnetism for magnetic resonance imaging.

    3. Soundwaves for,

        i. diagnostic ultrasound, or
        ii. lithotripsy.

EXEMPTIONS

2. A member of the College of Chiropodists of Ontario is exempt from subsection 27 (1) of the Act for the purpose of applying electricity for electrocoagulation or fulguration. O. Reg. 107/96, s. 2.

3. (1) A member of the Royal College of Dental Surgeons of Ontario is exempt from subsection 27 (1) of the Act for the purpose of applying electricity for defibrillation or electrocoagulation. O. Reg. 107/96, s. 3 (1).

    (2) A member of the Royal College of Dental Surgeons of Ontario is exempt from subsection 27 (1) of the Act for the purpose of applying electricity for electromyography or nerve conduction studies, in the course of conducting research. O. Reg. 107/96, s. 3 (2).

3.1 A member of the College of Medical Radiation and Imaging Technologists of Ontario is exempt from subsection 27 (1) of the Act for the purpose of applying electromagnetism if the application is ordered by a member of the College of Physicians and Surgeons of Ontario and,

(a) the electromagnetism is applied for magnetic resonance imaging using equipment that is,

(i) installed in a site of a public hospital where the public hospital is approved as a public hospital under the *Public Hospitals Act* and the site of the public hospital is graded under that Act as a Group N site of a hospital, and

(ii) operated by the public hospital mentioned in subclause (i);

(a.1) the electromagnetism is applied for magnetic resonance imaging using equipment that is installed in, and operated by, the University of Ottawa Heart Institute;

(b) the electromagnetism is applied for magnetic resonance imaging and all of the following conditions are met:

(i) the electromagnetism is used to support, assist and be a necessary adjunct, or any of them, to an insured service within the meaning of the *Health Insurance Act*;

(ii) the magnetic resonance imaging is provided to persons who are insured persons within the meaning of the *Health Insurance Act*;

(iii) the electromagnetism is applied in an independent health facility licensed under the *Independent Health Facilities Act* in respect of magnetic resonance imaging; or

(c) the electromagnetism is applied for magnetic resonance imaging and all of the following conditions are met:

(i) the electromagnetism is not used to support, assist and be a necessary adjunct, or any of them, to an insured service within the meaning of the *Health Insurance Act*, or the magnetic resonance imaging is not provided to persons who are insured persons within the meaning of that Act, or both,

(ii) the electromagnetism is applied in a facility that is operated by an operator that holds a licence under the *Independent Health Facilities Act* in respect of magnetic resonance imaging,

(iii) the electromagnetism is applied in a facility that is operated on the same premises as the independent health facility licensed under the *Independent Health Facilities Act* in respect of magnetic resonance imaging that is operated by the operator mentioned in subclause (ii),

(iv) the electromagnetism is applied using the same equipment that is used to provide magnetic resonance imaging in the independent health facility licensed under the *Independent Health Facilities Act* in respect of magnetic resonance imaging that is operated by the operator mentioned in subclause (ii),

(v) the operator of the facility in which the electromagnetism is applied is a party to a valid and subsisting agreement with the Minister concerning the provision of magnetic resonance imaging. O. Reg. 228/03, s. 1; O. Reg. 566/17, s. 1; O. Reg. 360/19, s. 1.

4. A member of the College of Midwives of Ontario is exempt from subsection 27 (1) of the Act for the purpose of applying, or ordering the application of, soundwaves for pregnancy diagnostic ultrasound or pelvic diagnostic ultrasound. O. Reg. 566/17, s. 2.

4.1 (1) A member of the College of Nurses of Ontario, other than a member described in subsection (2), is exempt from subsection 27 (1) of the Act for the purpose of applying soundwaves for diagnostic ultrasound, as long as the member has a therapeutic nurse-patient relationship with the person to whom the soundwaves are being applied and the soundwaves are being applied for the purpose of conducting one or more routine nursing assessments of a patient to assist in the development or implementation of the patient's plan of care. O. Reg. 566/17, s. 2.

(2) A member of the College of Nurses of Ontario who is a registered nurse in the extended class is exempt from subsection 27 (1) of the Act for the purpose of applying, or ordering the application of, soundwaves for diagnostic ultrasound. O. Reg. 566/17, s. 2.

5. (1) A member of the College of Physicians and Surgeons of Ontario is exempt from subsection 27 (1) of the Act for the purpose of applying, or ordering the application of, electricity for a procedure listed in paragraph 1 of section 1 or soundwaves for a procedure listed in paragraph 3 of section 1. O. Reg. 107/96, s. 5 (1).

(2) A member of the College of Physicians and Surgeons of Ontario is exempt from subsection 27 (1) of the Act for the purpose of applying or ordering the application of electromagnetism if,

(a) the electromagnetism is applied for magnetic resonance imaging using equipment that is,

(i) installed in a site of a public hospital where the public hospital is approved as a public hospital under the *Public Hospitals Act* and the site of the public hospital is graded under that Act as a Group N site of a hospital, and

(ii) operated by the public hospital mentioned in subclause (i);

(a.1) the electromagnetism is applied for magnetic resonance imaging using equipment that is installed in, and operated by, the University of Ottawa Heart Institute;

(b) the electromagnetism is applied for magnetic resonance imaging and all of the following conditions are met:

(i) the electromagnetism is used to support, assist and be a necessary adjunct, or any of them, to an insured service within the meaning of the *Health Insurance Act*;

(ii) the magnetic resonance imaging is provided to persons who are insured persons within the meaning of the *Health Insurance Act*,

(iii) the electromagnetism is applied in an independent health facility licensed under the *Independent Health Facilities Act* in respect of magnetic resonance imaging; or

(c) the electromagnetism is applied for magnetic resonance imaging and all of the following conditions are met:

(i) the electromagnetism is not used to support, assist and be a necessary adjunct, or any of them, to an insured service within the meaning of the *Health Insurance Act*, or the magnetic resonance imaging is not provided to persons who are insured persons within the meaning of that Act, or both,

(ii) the electromagnetism is applied in a facility that is operated by an operator that holds a licence under the *Independent Health Facilities Act* in respect of magnetic resonance imaging,

(iii) the electromagnetism is applied in a facility that is operated on the same premises as the independent health facility licensed under the *Independent Health Facilities Act* in respect of magnetic resonance imaging that is operated by the operator mentioned in subclause (ii),

(iv) the electromagnetism is applied using the same equipment that is used to provide magnetic resonance imaging in the independent health facility licensed under the *Independent Health Facilities Act* in respect of magnetic resonance imaging that is operated by the operator mentioned in subclause (ii),

(v) the operator of the facility in which the electromagnetism is applied is a party to a valid and subsisting agreement with the Minister concerning the provision of magnetic resonance imaging. O. Reg. 228/03, s. 2; O. Reg. 566/17, s. 3.

6. A member of the College of Psychologists of Ontario is exempt from subsection 27 (1) of the Act for the purpose of applying, or ordering the application of, electricity for aversive conditioning. O. Reg. 107/96, s. 6.

7. A person is exempt from subsection 27 (1) of the Act for the purpose of applying electricity for aversive conditioning if the application is ordered and directed by a member of the College of Physicians and Surgeons of Ontario or by a member of the College of Psychologists of Ontario. O. Reg. 296/04, s. 2.

7.1 (1) A member of the College of Medical Radiation and Imaging Technologists of Ontario or a member of the College of Nurses of Ontario other than a member who is a registered nurse in the extended class is exempt from subsection 27 (1) of the Act for the purpose of applying soundwaves for diagnostic ultrasound if the application is ordered by a member with ordering authority, and the soundwaves for diagnostic ultrasound are applied,

(a) in a site of a public hospital where the public hospital is approved as a public hospital under the *Public Hospitals Act*, and the equipment is operated by the public hospital;

(b) in a private hospital operated under the authority of a licence issued under the *Private Hospitals Act* and the equipment is operated by the private hospital;

(b.1) in the University of Ottawa Heart Institute, and the equipment is operated by the University of Ottawa Heart Institute;

(c) in an independent health facility licensed under the *Independent Health Facilities Act* in respect of diagnostic ultrasound on a site for which that independent health facility is licensed in respect of diagnostic ultrasound; or

(d) in a fixed site where health services are customarily performed, and the application is ordered by a member with ordering authority who treats his or her own patients in the course of his or her health care practice, but only if,

(i) there exists an ongoing professional health care relationship between the patient and the member with ordering authority, or between the patient and a regulated health professional who ordinarily practises with that member at one or more sites in Ontario,

(ii) there exists an ongoing professional health care relationship between the patient and a regulated health professional who has given an opinion on the health of the patient, or between the patient and a regulated health professional who ordinarily practises at one or more sites in Ontario with the regulated health professional who has given the opinion, and the patient has requested that the member with ordering authority confirm, refute or vary that opinion and,

(A) the member orders the application of soundwaves for diagnostic ultrasound in the course of an assessment of the patient resulting from that request, and

(B) the diagnostic ultrasound is directly related to that assessment, or

(iii) there exists an ongoing professional health care relationship between the patient and a regulated health professional who has referred the patient to the member with ordering authority for the purpose of a consultation, or between the patient and a regulated health professional who ordinarily practises at one or more sites in Ontario with the regulated health professional who has made the referral and,

(A) the member conducts an assessment of the patient, and

(B) the diagnostic ultrasound is directly related to that assessment or services arising out of that assessment. O. Reg. 296/04, s. 2; O. Reg. 566/17, s. 4 (1, 2); O. Reg. 360/19, s. 2.

(2) In this section,

"member with ordering authority" means,

(a) a member of the College of Midwives of Ontario, with respect to ordering the application of soundwaves for pregnancy diagnostic ultrasound or pelvic diagnostic ultrasound,

(b) a member of the College of Nurses of Ontario who is a registered nurse in the extended class, with respect to ordering the application of soundwaves for diagnostic ultrasound, or

(c) a member of the College of Physicians and Surgeons of Ontario, with respect to ordering the application of soundwaves for diagnostic ultrasound. O. Reg. 296/04, s. 2; O. Reg. 566/17, s. 4 (3).

7.2 During the period that begins on December 30, 2017 and ends on December 31, 2019, a person is exempt from subsection 27 (1) of the Act for the purpose of treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning. O. Reg. 570/17, s. 1.

7.3 A person is exempt from subsections 27 (1) and 30 (1) of the Act for the purpose of treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning where such act is done as part of the requirements to become a member of the Ontario College of Social Workers and Social Service Workers and the act is done under the supervision or direction of a member of the Ontario College of Social Workers and Social Service Workers. O. Reg. 570/17, s. 1.

8. (1) The following activities are exempt from subsection 27 (1) of the Act:

1. Revoked: S.O. 2006, c. 27, s. 19 (1).

2. Ear or body piercing for the purpose of accommodating a piece of jewellery.

3. Electrolysis.

4. Tattooing for cosmetic purposes. O. Reg. 107/96, s. 8; S.O. 2006, c. 27, s. 19 (1).

(2) 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 performed 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.

TABLE

Item	Column 1	Column 2
1.	College of Chiropodists of Ontario	Chiropody
2.	College of Chiropractors of Ontario	Chiropractic
3.	College of Massage Therapists of Ontario	Massage Therapy
3.1	College of Naturopaths of Ontario	Naturopathy
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

S.O. 2006, c. 27, s. 19 (2); O. Reg. 167/15, s. 1 (1, 2).

(3) A person mentioned in subsection (2) is exempt from subsection 27 (1) of the Act for the purpose of performing acupuncture only if he or she has met the standards and qualifications set by the College. O. Reg. 167/15, s. 1 (3).

(4) Revoked: O. Reg. 167/15, s. 1 (3).

(5) A person is exempt from subsection 27 (1) of the Act for the purpose of performing acupuncture, a procedure performed on tissue below the dermis, if the acupuncture is performed as part of an addiction treatment program and the person performs the acupuncture within a health facility. S.O. 2006, c. 27, s. 19 (2).

(6) In subsection (5),
"health facility" means a facility governed by or funded under an Act set out in the Schedule. S.O. 2006, c. 27, s. 19 (2).

9. Male circumcision is an activity that is exempt from subsection 27 (1) of the Act if the circumcision is performed as part of a religious tradition or ceremony. O. Reg. 107/96, s. 9.

10. Revoked: O. Reg. 167/15, s. 2.

11. The taking of a blood sample from a vein or by skin pricking is an activity that is exempt from subsection 27 (1) of the Act if the person taking the blood sample is employed by a laboratory or specimen collection centre licensed under the *Laboratory and Specimen Collection Centre Licensing Act*. O. Reg. 107/96, s. 11.

12. (1) A medical geneticist who holds a doctorate is exempt from subsection 27 (1) of the Act for the purpose of communicating to an individual or his or her personal representative a diagnosis identifying a genetic disease or genetic disorder as the cause of the symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis, if,

(a) the disease or disorder identified is within the geneticist's area of expertise; and

(b) the geneticist is employed by a university or a health care facility and the communication of the diagnosis is performed in accordance with the university's or facility's guidelines or protocols. O. Reg. 107/96, s. 12 (1).

(2) In this section,
"health care facility" means a facility governed by or funded under an Act set out in the Schedule. O. Reg. 107/96, s. 12 (2).

13. A member of the College of Nurses of Ontario who holds a general certificate of registration as a registered nurse is exempt from subsection 27 (1) of the Act for the purpose of prescribing a solution of normal saline (0.9 per cent) for venipuncture performed to establish peripheral intravenous access and maintain patency. O. Reg. 107/96, s. 13.

14. (1) Subject to subsection (4), a member of the College of Respiratory Therapists of Ontario who holds a general or graduate certificate of registration is exempt from subsection 27 (1) of the Act for the purpose of performing a tracheostomy tube change for a stoma that is more than 24 hours old. O. Reg. 87/14, s. 1.

(2) Subject to subsection (4), a member of the College of Respiratory Therapists of Ontario who holds a limited certificate of registration is exempt from subsection 27 (1) of the Act for the purpose of performing a tracheostomy tube change for a stoma that is more than 24 hours old, as long as the performance of the procedure is permitted by the terms and conditions of his or her certificate of registration. O. Reg. 87/14, s. 1.

(3) Subject to subsection (4), a member of the College of Respiratory Therapists of Ontario who holds a general certificate of registration is exempt from subsection 27 (1) of the Act for the purpose of performing a tracheostomy tube change for a stoma that is less than 24 hours old. O. Reg. 87/14, s. 1.

(4) A member of the College of Respiratory Therapists of Ontario shall not perform a procedure described in subsection (1), (2) or (3) unless the procedure is ordered by,

(a) a member of the College of Physicians and Surgeons of Ontario, the College of Midwives of Ontario or the Royal College of Dental Surgeons of Ontario; or

(b) a member of the College of Nurses of Ontario who holds an extended certificate of registration under the *Nursing Act, 1991*. O. Reg. 87/14, s. 1.

SCHEDULE

1. *Alcoholism and Drug Addiction Research Foundation Act*.
2. Revoked: O. Reg. 64/20, s. 1.
3. *Child, Youth and Family Services Act, 2017*.
4. *Homes for Special Care Act*.
5. *Independent Health Facilities Act*.
6. *Long-Term Care Homes Act, 2007*.
7. *Mental Health Act*.
8. *Ministry of Community and Social Services Act*.
9. *Ministry of Correctional Services Act*.
10. *Ministry of Health and Long-Term Care Act*.
11. Revoked: O. Reg. 103/18, s. 1.
12. *Private Hospitals Act.*
13. *Public Hospitals Act*.
14. *University of Ottawa Heart Institute Act, 1999.*

O. Reg. 87/14, s. 2; O. Reg. 566/17, s. 5; O. Reg. 103/18, s. 1; O. Reg. 183/18, s. 1; O. Reg. 64/20, s. 1.

ONTARIO REGULATION 204/94: GENERAL
UNDER THE *CHIROPRACTIC ACT, 1991*
Effective Date: September 30, 2005

PART I (SS. 1-5) REVOKED: O. REG. 514/05, S. 1.

PART II (SS. 6-8) REVOKED: O. REG. 514/05, S. 1.

PART III

QUALITY ASSURANCE

GENERAL

9. In this Part,

"assessor" means an assessor appointed under section 81 of the Health Professions Procedural Code;

"Committee" means the Quality Assurance Committee of the College;

"deficient clinical ability" means, in relation to a member, a level of knowledge, skill or judgment that makes the member's clinical performance unsatisfactory;

"Program" means the Quality Assurance Program of the College. O. Reg. 233/05, s. 1.

10. The purposes of the Program are,

(a) to encourage continuous improvement in the quality of care provided by members; and

(b) to improve results in patient treatment. O. Reg. 233/05, s. 1.

11. Every member shall participate in the Program. O. Reg. 233/05, s. 1.

PROGRAM COMPONENTS

12. The Committee shall administer the Program, which shall include the following components:

1. Random peer assessments.

2. Individual member remediation.

3. X-ray peer reviews. O. Reg. 233/05, s. 1.

RANDOM PEER ASSESSMENT

13. (1) Each year, the College shall select at random the names of members required to undergo a peer assessment. O. Reg. 233/05, s. 1.

(2) A member shall undergo a peer assessment if selected at random under subsection (1). O. Reg. 233/05, s. 1.

(3) The purpose of a peer assessment is to evaluate a member's knowledge, skills or judgment to ensure his or her continuing competence and adherence to the standards of practice of the profession. O. Reg. 233/05, s. 1.

14. (1) In appointing an assessor to conduct a peer assessment, the Committee shall,

(a) appoint an assessor who is familiar with the methods used by the member who is to be assessed; and

(b) if the member being assessed is certified in a specialty recognized by the College, appoint an assessor who is certified in the same specialty. O. Reg. 233/05, s. 1.

(2) No member of the College who sat on a panel of the Discipline Committee that heard allegations against a member shall be appointed as an assessor in respect of that member. O. Reg. 233/05, s. 1.

(3) No member who has demonstrated antagonism towards another member or towards a form of treatment offered by that member shall be appointed as an assessor in respect of the member. O. Reg. 233/05, s. 1.

15. (1) The Registrar shall notify a member who is required to undergo a peer assessment of the name of the assessor. O. Reg. 233/05, s. 1.

(2) The member who is required to undergo a peer assessment may make one request that another assessor be appointed by the Committee upon being notified under subsection (1) and before the assessor commences the assessment. O. Reg. 233/05, s. 1.

(3) The Committee, on receiving a request under subsection (2), may replace the assessor with another assessor. O. Reg. 233/05, s. 1.

16. (1) After having completed an assessment, the assessor shall give the Committee and the member who was assessed a written report of the assessment. O. Reg. 233/05, s. 1.

(2) The member may submit to the Committee comments or responses that he or she wishes to have noted with respect to the assessment. O. Reg. 233/05, s. 1.

(3) The Committee may decide, after considering the assessor's report and the member's comments, if any,

(a) that no further action is necessary;

(b) to give the member an opportunity to correct a deficient clinical ability identified by the Committee as a result of the peer assessment; or

(c) to require the member to participate in a member remediation program and follow-up assessment under section 17. O. Reg. 233/05, s. 1.

(4) If the Committee gives the member an opportunity to correct a deficient clinical ability under clause (3) (b), it may require the member to undergo a peer reassessment. O. Reg. 233/05, s. 1.

(5) A member shall not be required to undergo more than two peer reassessments under subsection (4). O. Reg. 233/05, s. 1.

(6) Subsections (1), (2) and (3) apply with necessary modifications to a reassessment under subsection (4). O. Reg. 233/05, s. 1.

INDIVIDUAL MEMBER REMEDIATION

17. (1) The Committee may require a member to participate in a remediation program if,

(a) the member has been referred to the Committee from the Executive Committee or the Complaints Committee in relation to alleged behaviour or remarks of a sexual nature by the member towards a patient that are not of a clinical nature appropriate to the service provided and the member has undergone a psychological or other assessment relating to the alleged behaviour or remarks; or

(b) the Committee is, after the member has undergone a peer assessment under section 16, of the opinion that the member has a deficient clinical ability that may be remediable. O. Reg. 233/05, s. 1.

(2) The remediation program shall be an educational program designed specifically to reduce or eliminate the member's deficient clinical ability or propensity to engage in behaviour or remarks of a sexual nature towards patients that are not of a clinical nature appropriate to the service provided. O. Reg. 233/05, s. 1.

(3) In the case of a member who is required to participate in a remediation program under clause (1) (b), the Committee may, after a member has completed a remediation program under this section, require the member to undergo another peer assessment. O. Reg. 233/05, s. 1.

(4) A member shall not be required to undergo more than two reassessments under subsection (3). O. Reg. 233/05, s. 1.

(5) Subsections 16 (1), (2) and (3) apply with necessary modifications to a peer reassessment under subsection (3). O. Reg. 233/05, s. 1.

X-RAY PEER REVIEW

18. (1) Every member shall participate in the College's x-ray peer review program. O. Reg. 233/05, s. 1.

(2) The x-ray peer review program is an assessment and remediation program designed to reduce or eliminate the member's deficient clinical ability with respect to taking or interpreting x-rays. O. Reg. 233/05, s. 1.

(3) During an x-ray peer review, one or more assessors shall,

(a) review another member's reports written by the member in which he or she interprets x-rays; and

(b) in the case of a member who takes his or her own x-rays, review x-rays taken by the member. O. Reg. 233/05, s. 1.

(4) After having completed the x-ray peer review, the assessors who conducted the review shall submit a written report to the Committee and give the member a copy. O. Reg. 233/05, s. 1.

(5) The member may submit to the Committee comments or responses that he or she wishes to have noted with respect to the review. O. Reg. 233/05, s. 1.

(6) If, after having reviewed the report and the comments submitted by the member under subsection (5), if any, the Committee believes that the member is deficient in taking or interpreting x-rays, it may require that the member participate in a remediation program designed to correct the deficiency. O. Reg. 233/05, s. 1.

(7) The Committee may, after a member has completed a remediation program under this section, require the member to undergo one additional x-ray peer review. O. Reg. 233/05, s. 1.

(8) Subsections (1) to (6) apply with necessary modifications to an x-ray peer review under subsection (7). O. Reg. 233/05, s. 1.

STANDARDS OF PRACTICE

Introduction

Standards of practice are reflected in legislation. Covering a variety of subjects, standards of practice guide members of the profession in the delivery of health care services and ensure the quality of the profession. They also promote continuing competence among members.

Advantages

Easier to implement and quicker to change than statutes or regulations because standards of practice only require approval by Council.

CCO has a mechanism for enforcing standards of practice because contravening or failing to maintain a standard is an act of professional misconduct.

Current Standards of Practice

S-001: Chiropractic Scope of Practice

S-002: Record Keeping

S-003: Professional Portfolio

S-004: Reporting of Diseases

S-005: Chiropractic Adjustment or Manipulation

S-006: Ordering, Taking and Interpreting Radiographs

S-007: Putting a Finger Beyond the Anal Verge for the Purpose of Manipulating the Tailbone

S-008: Communicating a Diagnosis

S-009: Chiropractic Care of Animals

S-011: Members of More Than One Health Profession

S-012: Orthotics

S-013: Consent

S-014: Prohibition Against a Sexual Relationship with a Patient

S-016: Communication to the Public

S-017: Acupuncture

S-018: Third Party Independent Chiropractic Evaluations

S-019: Conflict of Interest in Commercial Ventures

S-020: Cooperation and Communication with CCO

S-021: Assistive Devices

S-022: Ownership, Storage, Security and Destruction of Records of Personal Health Information

CHIROPRACTIC SCOPE OF PRACTICE

Standard of Practice S-001
Quality Assurance Committee
Approved by Council: February 8, 2011
Amended: April 24, 2018, February 27, 2019, April 30, 2019, September 12, 2025
(came into effect November 20, 2025)

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 care provider 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.

- 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,

    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 or 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;
- 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, members must:

- achieve, maintain and be able to demonstrate clinical competency (e.g., examination, certification, or other 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 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.

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, breast examinations, and vega testing.

Matters Outside of the Chiropractic Scope of Practice and Responding to General Health-Related Questions

A member is restricted from treating or advising outside the chiropractic scope of practice by S. 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.[1]

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.

[1] Specific, limited exemptions are referenced in s. 30 of the *RHPA*.

As part of its role to protect the public interest, 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 not express views, or treat or advise patients or prospective patients with respect to vaccination, which includes, but is not limited to:

- Counselling or providing information to patients with respect to vaccination
- Conducting seminars on vaccination
- Providing information on vaccination on a member's website or social media account

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.

Responding to General Health-Related Questions

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*, and performing surgery) 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 care 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, composed of both elected (chiropractor) and appointed (public) members will review any inquiry, complaint or report to determine the member's compliance with all relevant standards of practice including 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.

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.

RECORD KEEPING

Standard of Practice S-002
Quality Assurance Committee
Approved by Council: May 24, 1996
Amended: November 18, 1999; November 30, 2002; November 26, 2004; April 22, 2005; November 25, 2005; December 1, 2006; February 23, 2010; September 22, 2011, September 20, 2013, April 24, 2018, November 24, 2022 (came into effect February 24, 2023), September 13, 2024 and November 28, 2024 (came into effect November 28, 2024)

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

INTENT

To ensure members maintain accurate, current records of personal health information.

OBJECTIVES

- To ensure patients have access to current, accurate information as reflected in their record of personal health information.
- To ensure continuity of care for patients from successive chiropractors or other treating health professionals.
- To provide members with a framework for organizing clinical notes and other records.
- To maintain confidentiality and prevent unauthorized disclosure of the patient health record and financial record.

DESCRIPTION OF STANDARD

Introduction

The record of personal health information must "tell the story" of the patient, as determined by the member, in the circumstances in which the patient was seen. The record is not just a personal memory aid for the member who creates it, but must allow other health care providers to review and understand the patient's past and current health history as well as future health goals.

Patients present to a member for a variety of reasons. However, patients should expect basic procedures to be followed and recorded 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 such a way as to accurately recreate the doctor/patient interaction.

Information in records of personal health information should be stated concisely. It is acceptable to use sentence fragments or outline forms and diagrams.

Records of personal health information may contain abbreviations, acronyms, or short forms ("abbreviations") and terminology unique to health care professions. In such cases, an up-to-date abbreviation legend/key that explains any abbreviation used in the record in a clear and consistent manner, must exist in a printed or electronic format. The legend/key must accompany the records of personal health information upon request. A record of personal health information, if requested, is not complete without an abbreviation legend/key.

CCO does not endorse any particular type, template or style of note taking. Whatever style is used, it is important to be consistent, comprehensive, accurate and legible to give a clear picture of the care being provided.

Types of Records to be Maintained

A member shall keep a daily appointment record, equipment service record, and record of personal health information, which includes a patient health record and financial record. All records shall be accurate, legible and comprehensive.

1. Daily Appointment Record

   The daily appointment record shall set out the surname and initials of each patient the member examines or treats or to whom the member renders any service.

2. Equipment Service Record

   The equipment service record shall set out the servicing of:
   - every x-ray machine in accordance with the *Healing Arts Radiation Protection Act, 1990*, and
   - every other piece of equipment used to emit a form of energy permitted for use by members under section 43(1)(a) of the *Regulated Health Professions Act, 1991*.

   Equipment service records shall be consistent with the manufacturer's recommendations.

3. Record of Personal Health Information

   The record of personal health information includes the patient health record and the financial record

Patient Health Record

(1) The patient health record shall contain:
- demographic information as necessary to identify, assess and treat patients, including but not limited to, a patient's name, address, and birth date;
- dates of each of the patient's visits to the member;
- a reference identifying the patient, and the name/address of the primary treating chiropractor, on each printed page, which may be recorded as a header/footer; and
- name(s) of relevant referring health professionals, if appropriate.

(2) The patient health record shall contain a history of the patient, including:
- patient's chief complaint(s)/concern(s) and supporting data;
- relevant past health history; and
- family and social history when indicated by the presenting complaint(s)/ concerns(s).

(3) The patient health record shall contain reasonable information about every initial examination, all assessments (for further information related to the various assessments that are an essential part of any chiropractic care/plan of care of a patient please refer to Guideline G-013: Chiropractic Assessments), all relevant diagnostic tests and all relevant diagnostic imaging (images and accompanying reports included) made by the member.

(4) The initial examination, as recorded in the patient health record, shall:

(a) be sufficiently comprehensive for the member to document:
- evidence of the patient's current condition;
- diagnosis or clinical impression; and
- plan of care for the patient.

(b) include documented evidence on the performance of the necessary clinically indicated analytical/assessment procedures listed below (not an exhaustive list) in order to demonstrate the need for care:
- activities of daily living questionnaires
- advanced diagnostic imaging (e.g., diagnostic ultrasound, CT Scan, MRI, bone scans)
- analog pain scales
- any questionnaire designed by the member to have the patient compare their current and past health and/or lifestyle ratings
- bilateral weight scales
- blood pressure/pulse testing
- disability questionnaires
- exercise compliance
- leg length checks
- malingerer testing
- muscle function testing
- neurological testing
- orthopedic testing
- palpation/motion palpation

- posture evaluation
- range of motion
- reflexes
- sEMG
- sensory testing
- thermography
- trigger points
- x-ray image.

(5) The patient health record shall contain a record of care of the patient, that includes:

- a copy of the patient's consent to any examination or care or course of care that shall be:
  - 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;

- reasonable information about who provided the care and the location of where the care was delivered;

- reasonable information about every subsequent treatment/visit, including level of spine or joint contacted for the purpose of adjusting or mobilizing, and technique(s) used[2];

- reasonable information about all advice given by the member to the patient;

- reasonable information about a procedure that was commenced but not completed, including reasons for non-completion;

- reasonable information about every order made by the member for examinations, including diagnostic images and accompanying reports, tests, consultations or treatments to be performed by any other person;

- reasonable information about when a member advises a patient to consult with another health professional; and

- every written report received by the member with respect to examinations, tests, consultations or treatments performed by other health professionals.

[2] Diagnostic and therapeutic procedures must comply with Standard of Practice S-001: Chiropractic Scope of Practice.

(6) Periodic and regular comparative assessments are a mandatory component of any care/plan of care and are based on the same clinical judgement components used in all phases of patient care.

Implementation of any evaluation, assessment or treatment is always a clinical judgement call made by the member and based on clinical indications, best evidence, best practices, experience, patient presentation and many other factors.

The timing and reason for each comparative assessment depends on a number of factors including but not limited to:

- patient progress;
- expectations of progress;
- presentation of new conditions; and
- requests from third-party payors such as WSIB, etc.

Therefore, comparative assessments must:

(a) be conducted when clinically indicated and, in any event, no later than each 24th visit.

(b) 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 their ongoing care; and
- affirm or revise the patient's diagnosis or clinical impression and plan of care.

(c) include documented evidence on the performance of three or more of the clinically indicated analytical/assessment procedures listed in 4(4)(b) (not an exhaustive list) in order to demonstrate the need for ongoing care. Members may use additional procedures not listed.

(7) Every entry in a patient health record shall be dated and clearly identify the person who made the entry.

Financial Record

The financial record, which is considered part of the record of patient personal health information, shall contain:

- date of service;
- services billed;
- location of service;
- payment received; and
- balance of account.

Please see Guideline G-008: Business Practices for further information about implementing and recording billing practices.

4. Electronic Record Keeping

- A member may maintain an electronic record keeping system in accordance with this standard.

- A member shall take reasonable steps to ensure the electronic record keeping system is so designed and operated that the electronic record of personal health information:

    - is compliant with the *Personal Health Information Protection Act, 2004 (PHIPA)*
    - has cyber security protections in place to ensure that personal health information is secure from loss, tampering, interference or unauthorized use or access,
    - has protocols in place on steps to take in the event of a privacy breach, and;
    - shall be available as hard copies in a printed form when requested.

- If patient credit card or banking information is stored as part of an electronic financial record, it must be encrypted, secure from loss, tampering, interference and unauthorized use or access, and comply with any applicable financial regulations.

- A member shall ensure that personal health information of patients that is stored on a mobile device is encrypted.

- Each entry in an electronic record shall be:

    - accurate and sufficiently comprehensive to reflect the care provided; and
    - individualized and personalized, capturing the unique aspects of that particular patient encounter.

    If the electronic format cannot do this, the member should consider using an alternative system. Members are discouraged from using systems that create "template-like" records. These may not be an adequate reflection of an individual patient's story.

- When requested to do so and within 30 days, members must provide printed copies of electronic records.

The Privacy section of CCO's website and the Information and Privacy Commissioner of Ontario has several resources available related to electronic health records and responding to privacy breaches:

- "Digital Health under *PHIPA*": Selected Overview
- "Responding to Privacy Breaches"
- Guideline G-010: Mandatory and Permissive Reporting

5. Confidentiality of and Access to Records

(1) A member shall not allow any person to examine a record of personal health information or give any information, copy or thing from a record of personal health information to any person except as required by law (see sections 38-50 of the *Personal Health Information Protection Act, 2004 (PHIPA))* or as required or allowed by this section

(2) A member shall take reasonable steps to ensure that records are protected from theft, loss and unauthorized use or disclosure, including photocopying, modification or disposal.[3]

(3) A member with primary responsibility for a record of personal health information shall provide, on request, copies of or access to a record of personal health information to any of the following persons, or any person authorized by the following persons:

- the patient;
- a personal representative authorized by the patient to obtain copies from or access to the record;
- if the patient is deceased, the patient's legal representative;
- if the patient is determined to be incapable of consenting to the collection, use or disclosure of personal health information:
  - the individual's guardian of the person or guardian of property, if the consent relates to the guardian's authority to make a decision on behalf of the individual;
  - the individual's attorney for personal care or attorney for property, if the consent relates to the attorney's authority to make a decision on behalf of the individual;
  - the individual's representative appointed by the Consent and Capacity Board under section 27, if the representative has authority to give the consent;
  - the individual's spouse or partner;
  - a child or parent of the individual, or a children's aid society or other person who is lawfully entitled to give or refuse consent in the place of the parent. This paragraph does not include a parent who has only a right of access to the individual. If a children's aid society or other person is lawfully entitled to consent in the place of the parent, this paragraph does not include the parent;
  - a parent of the individual with only a right of access to the individual;
  - a brother or sister of the individual; and
  - any other relative of the individual.[4]

The above list is in rank order. See s. 26 of *PHIPA* for further details.

(4) A member is not required to provide copies from or access to a patient health record if the member is of the opinion that disclosure of the record of personal health information would likely result in serious harm to the care of the patient or serious physical or emotional harm to the patient or another person.

[3] See Standard of Practice S-022: Ownership, Storage, Security and Destruction of Patient Health Records
[4] Section 26(1) of the *Personal Health Information Protection Act, 2004* (*PHIPA*).

(5) Where a member has primary responsibility for a record of personal health information, the member shall, at the request of the patient, cause a correction to be made to the patient's health record or attach a statement of disagreement reflecting the correction requested but not made.

(6) A member shall give notice of every correction made and statement of disagreement attached to a record of personal health information to every person and organization to whom the record was disclosed during the 12 months preceding the day the correction was requested.

(7) A member shall, upon receiving written authorization from the patient or a duly authorized person as described in section 5(3), provide a copy of the record of personal health information as soon as possible in the circumstances, but no later than 30 days after receiving the request, subject to exceptional circumstances (see sections 54(3) and 54(4) of *PHIPA*). The member shall maintain the original record of personal health information, as outlined in the Records Retention and Destruction section and Standard of Practice S-022: Ownership, Storage, Security and Destruction of Patient Health Records, even if the member is no longer providing chiropractic care to that patient.

In cases where a section of the patient record cannot be reasonably copied (e.g., diagnostic images, plain film radiographs), the member shall obtain a written authorization from the patient, or designate listed in section 5(3) which shall become part of the record of personal health information. This form should include the following:

- an agreement between the patient or designate listed in section 5(3) and member to release a section of the original record with recognition that no copies have been retained by the member;
- an agreement by the patient or designate listed in section 5(3) to return the section of the patient record to the member; and
- an acknowledgement of receipt by the patient or designate listed in section 6(3).

(8) A member may charge a reasonable fee prior to providing copies of a record of personal health information, including diagnostic images and accompanying reports, to reflect the cost, time and effort required to provide copies of the record of personal health information. If a member has refused a patient access to the patient's record of personal health information, the patient has the right to challenge the member's decision in Court under subsection of 54(8) of the *Personal Health Information Protection Act, 2004* (*PHIPA*).

(9) A member may provide copies of or access to a record of personal health information to their legal counsel or insurer where the record is relevant to advice being sought by the member or required by the policy of insurance or insurer.

(10)A member may, for the purpose of providing health care or assisting in the provision of health care to a patient, allow a health professional to examine the record of personal health information or give a health professional any information, copy or thing from the record.

(11)A member may provide information or copies of or access to a record of personal health information to a person if:

- the information or copies are to be used for health administration or planning, health research, or epidemiological studies;
- the use of the information or copies is in the public interest as determined by the Minister of Health and Long-Term Care; and
- anything that could identify the patient is removed from the information or copies.

6. Records Retention and Destruction

Every record of personal health information, which includes the patient health record, including diagnostic images and accompanying reports, and every financial record shall be retained in its entirety for at least seven years[5] following the patient's last visit, or, if the patient was less than 18 years old at the time of their last visit, at least seven years following the day the patient became or would have become 18 years old.

Destruction of the record of personal health information shall be done in a secure fashion to ensure that the records cannot be reproduced or identified in any form.

7. Member Resignation

As part of the resignation process, the member shall take reasonable steps to ensure with regard to each record of personal health information for which the member has primary responsibility:

- the record is transferred to another member and reasonable efforts are made to obtain the patient's consent;
- the patient is notified that the member intends to resign and the patient can obtain copies of the record of personal health information; and
- if the record transferred is not the original record of personal health information, the original record is stored in a secure location for seven years following the patient's last visit, or, if the patient was less than 18 years old at the time of their last visit, at least seven years following the day the patient became or would have become 18 years old.

[5] Even though records must be kept for a minimum of seven years, there is no limitation on a patient complaint or civil litigation.

LEGISLATIVE CONTEXT

Regulation pursuant to the *Chiropractic Act, 1991.* Further, it is an act of professional misconduct under *Ontario Regulation 852/93* (Professional Misconduct) to contravene or fail to comply with a standard of practice.

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 structures or functions of the joints.

Ontario Regulation 852/93

The following are acts of professional misconduct for the purposes of clause 51(1)(c) of the *Health Professions Procedural Code*:

10. Giving information about a patient to a person other than the patient, his or her authorized representative, or the member's legal counsel or insurer, except with the consent of the patient or his or her authorized representative or as required or allowed by law.

11. Breaching an agreement with a patient relating to professional services for the patient or fees for such services.

19. Failing to keep records as required by the regulations.

20. Falsifying a record relating to the member's practice.

21. Failing, without reasonable cause, to provide a report or certificate relating to an examination or treatment performed by the member within a reasonable time after a patient has requested such a report or certificate.

22. Signing or issuing, in the member's professional capacity, a document that the member knows contains a false or misleading statement.

Personal Health Information Protection Act, 2004

Sections 51-54 of the *Personal Health Information Protection Act, 2004,* outline a patient's right of access to their records and a health information custodian's obligation to provide information requested. Please consult these sections for further detail, specifically, section 54.

PROFESSIONAL PORTFOLIO

Standard of Practice S-003
Quality Assurance Committee
Approved by Council: May 24, 1996
Amended: February 28, 1998, and November 30, 2002, December 3, 2009, September 17, 2015, June 23, 2017, June 22, 2022 (came into effect July 1, 2022), April 16, 2024 (came into effect July 1, 2024)

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

NOTE: For the purposes of this standard of practice, "member" refers to a CCO member registered in the "General" class of registration.

INTENT

To advise members of their government-legislated obligation to quality improvement by participation in peer and practice assessment, self-assessment and self-directed, lifelong learning, through continuing education (CE) and professional development.

OBJECTIVES

- To fulfill the requirements of the Quality Assurance Committee as set out in section 80.1 of the Health Professions Procedural Code (the Code), Schedule 2 of the *Regulated Health Professions Act, 1991* (*RHPA*).
- To facilitate continuous quality improvement through the concepts of peer and practice assessment, self-assessment, self-assessment action plans, and lifelong learning.
- To emphasize that each member is responsible for their own continuing competency and professional growth.
- To enable the Quality Assurance Committee to assist a member with specific remediation if it is requested or deemed necessary.
- To ensure the ongoing development of CCO's quality assurance program.

DESCRIPTION OF STANDARD

A member is required to maintain a professional portfolio, which will be made available to the Quality Assurance Committee or a peer assessor upon request. The contents of the professional portfolio remain confidential within the Quality Assurance Committee and will not be shared with any other committee. A member is required to complete the four parts of the professional portfolio (as outlined below). A member must maintain their professional portfolio, including CE materials gathered in the current CE cycle and the immediate past complete CE cycle. Additional cycles may be discarded. However, CCO encourages every member to retain relevant materials for future use and reference.

For the purposes of this standard of practice and for compliance with the Quality Assurance program, it is acceptable and recommended for a member to use their Continuing Education and Professional Development Log in their CCO Member Portal as their Professional Portfolio/record of continuing education, in combination with the Self-Assessment Questionnaire 1.0 or 2.0 and Plan of Action Summary Sheet (fillable PDF), instead of the Fillable PDF Professional Portfolio.

Part 1: Professional Profile / Curriculum Vitae

Please note: this should be maintained by the member but does not need to be submitted unless required to do so.

Personal Data: Name, Address, Registration Number

Education: Post-Secondary/Academic Degrees Certificates; Specialties/Fellowships (if applicable)

Professional History: Practice History and Description

Professional Membership and Service: Names of professional organizations in which the member holds current membership, and the services and activities provided to professional organizations (including positions held).

Volunteer Work: Service to Profession; Service to Community

Awards / Recognition

Other Professional Activities: Professional Presentations; Professional Publications

References (optional): A separate sheet may be attached.

Part 2: Self-Assessment (1.0 or 2.0)

There are two versions of the mandatory self-assessment available for completion. Each self-assessment process consists of two parts: the self-assessment questionnaire with accompanying handbook and the plan of action summary sheet.

A member is required to complete, every two years, either

- Self-assessment 1.0 (recommended in the first two complete CE cycles) or
- Self-assessment 2.0 (recommended in all subsequent CE cycles).

It is highly recommended that the self-assessment is completed within 90 days from the start of a new CE cycle. The self-assessment questionnaire is completely confidential and will not be viewed by any committee.

Once a member has completed the self-assessment questionnaire and has identified areas that need improvement, the member should transfer the information to the self-assessment plan of action summary sheet. Using this summary sheet, a member shall develop a learning plan to help guide their CE and professional development to address those items identified in the completion of the self-assessment. Members should be aware that those areas identified for improvement or further learning in one's self-assessment should be addressed in appropriate and applicable CE activities in the CE cycle.

The plan of action summary sheet is a component of the member's professional portfolio and will be reviewed by a peer assessor during the peer and practice assessment to monitor compliance with the self-assessment process. A member may identify areas from the self-assessment questionnaire which they desire to strengthen and may incorporate these items into their CE activities.

Part 3: Continuing Education (CE) and Professional Development

CE activities should reflect the results of a member's self-assessment, and peer and practice assessment, in addition to any CE activities related to professional interests, adding to a member's strength or changing a member's practice.

A member is required to participate in 40 hours of CE over a two-year period in which they are a member in the General class of registration for entire two-year period, as determined by CCO. In accumulating the 40 hours, CCO requires every member to:

- participate in a ***minimum*** of 20 hours in structured CE activities (all 40 hours may be accumulated in structured activities);
- record up to a ***maximum*** of 20 hours towards unstructured CE activities;
- record participation in CE activities in their online continuing education and professional development log; and

- maintain materials gathered while fulfilling CE requirements for the current CE cycle (e.g., course outlines, brochures from conventions/conferences, certificates, letters of reference, receipts, etc.).

To monitor compliance with the Quality Assurance initiatives, members who are registered in the General class of registration for that entire cycle shall complete and submit the online Continuing Education and Professional Development Log, available in the online member portal.

CE activities must relate to a member's clinical practice and/or professional activities[1], with the goal of enhancing a member's professional knowledge and skill.

A member is not permitted to bank hours over the two-year period (i.e., transfer hours from one cycle to the next). The required 40 hours of CE is considered the minimum standard for the two-year cycle. CCO encourages all members to participate in additional CE on a regular basis.

Structured Activities (20 hours minimum)

Structured activities are active/interactive learning programs completed either in person or virtually. These activities generally have structured agendas, specified learning objectives and/or the opportunity for interaction with other members of the profession or other professions and the ability for the member to interact and/or gain feedback (e.g., live attendance at a seminar/webinar, question and answer period with presenters/others while participating in the program of study, interactive quiz/competency examinations at a prerecorded webinar, etc.).

Structured activities include:

- attending courses, seminars, workshops, presentations, conferences
- participating in interactive Internet courses, seminars, workshops, conferences, webinars
- participating in correspondence courses
- participating in clinical rounds
- participating in computer assisted learning

[1] N.B. – a member's CE activities are separate and apart from daily professional activities. For example, if the member is an educator, the preparation and presentation of classroom material would not be considered an acceptable CE credit.

Mandatory Components of Structured CE

The following are mandatory components of Structured CE for members in the General class of registration (all of which can be counted towards structured activities as outlined above):

1. As defined in the *RHPA*, the practice of chiropractic is the assessment of conditions related to the spine, nervous system and joints, and the diagnosis, prevention and treatment, primarily by adjustment, of: dysfunctions or disorders arising from the structures or functions of the spine and the effects of those dysfunctions or disorders on the nervous system; and dysfunctions or disorders arising from the structures or functions of the joints.

   In accordance with section 4 of the *Chiropractic Act, 1991*, a member is authorized to perform the following controlled acts:

   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.

   CCO requires 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[2]. These mandatory five hours should be relevant to the member's clinical practice, but may not include adjunctive therapies, such as acupuncture, soft tissue therapies, exercise or nutritional counseling.

2. It is a requirement that every member complete a minimum of 5 hours of structured CE activity, that primarily focuses on an in-person hands-on or hand-held instrument adjustment or manipulation activity, and includes training in the competency of manual or hand-held instrument spinal adjustment or manipulation skills, at least once every three CE cycles (or six years).

3. CCO requires that every member successfully completes and remains current with emergency first aid/CPR certification[3].

[2] See Standard of Practice S-001: Chiropractic Scope of Practice for an explanation of "diagnostic or therapeutic procedures". Controlled acts may include the authorized activities listed in section 4 of the *Chiropractic Act, 1991* or the authorization to operate an X-ray machine or prescribe the operation of an X-ray machine under sections 5-6 of the *Healing Arts Radiation Protection Act, 1990*.

[3] The minimum requirement is emergency first aid: CPR Level C + AED. This can be achieved through providers such as Red Cross and St John Ambulance as a 6.5 hour classroom instruction program.

4. It is a requirement that every member attend CCO's Regulatory Excellence for CCO Members Online/Virtual Workshop **at least once every three CE cycles (or six years).** This workshop is offered free to members and applicants online three times per year (Dates and times posted on the CCO website).

Unstructured Activities (20 hours maximum)

Unstructured activities are self-directed, independent learning activities.

Unstructured activities include:

- reading professional books, journals, articles, research papers
- viewing/reading/listening to professional audio/video, Internet material
- reviewing CCO regulations, standards of practice, policies, guidelines, other CCO material
- preparing/presenting professional presentations
- researching/writing/editing professional publications
- other (specify)

Guidelines for CE Activities

CCO requires that every member participate in CE activities that relate directly to their clinical practice and/or professional activities. These activities may include, but are not limited to, subjects such as communication, assessment, diagnosis/clinical impression, diagnostic imaging, patient care, and specialty training.

CCO will continue to review the CE process and make appropriate changes as necessary, which may include the introduction of mandatory elements to the program and/or approval/disapproval of specific programs.

Documentation of CE Activities

Every member is required to log and submit their CE activities in the CCO member portal as part of each CE cycle.

Part 4: Accompanying Folder

A member is required to maintain the following in their professional portfolio:

- materials gathered while fulfilling their CE requirements (e.g., course outlines, brochures from conventions/conferences, certificates, letters of reference, receipts, etc.);
- samples of their recent advertising; and
- the disposition reports following the peer and practice assessment

LEGISLATIVE CONTEXT

Health Professions Procedural 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*

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

Section 80.1 of the Code defines the minimum requirements for a quality assurance program as follows:

(a) "A quality assurance program prescribed under section 80 shall include, continuing education or professional development designed to,

(i) promote continuing competence and continuing quality improvement among the members,

(ii) address changes in practice environments, and

(iii)incorporate standards of practice, advances in technology, changes made to entry to practice competencies and other relevant issues in the discretion of the Council;

(b) self, peer and practice assessments; and

(c) a mechanism for the College to monitor members' participation in, and compliance with, the quality assurance program.

Section 80.2 of the Code outlines the powers of the QA Committee as follows:

"The Quality Assurance Committee may do only one or more of the following:

1. Require individual members whose knowledge, skill and judgment have been assessed under section 82 and found to be unsatisfactory to participate in specified continuing education or remediation programs.

2. Direct the Registrar to impose terms, conditions or limitations for a specified period to be determined by the Committee on the certificate of registration of a member,

    i. whose knowledge, skill and judgment have been assessed or reassessed under section 82 and have been found to be unsatisfactory, or

    ii. who has been directed to participate in specified continuing education or remediation programs as required by the Committee under paragraph 1 and has not completed those programs successfully.

3. Direct the Registrar to remove terms, conditions or limitations before the end of the specified period, if the Committee is satisfied that the member's knowledge, skill and judgment are now satisfactory.

4. Disclose the name of the member and allegations against the member to the Inquiries, Complaints and Reports Committee if the Quality Assurance Committee is of the opinion that the member may have committed an act of professional misconduct, or may be incompetent or incapacitated.

REPORTING OF DESIGNATED DISEASES

Standard of Practice S-004
Quality Assurance Committee
Approved by Council: November 16, 1996
Amended: November 30, 2002, September 28, 2012, 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

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

Diseases that must be reported by members are listed in *Ontario Regulation 135/18* 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.

- Members are 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)*.

- Members are protected from liability for making a report in good faith.

- It is an offence punishable by fine for members to fail to comply with their 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.

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 his or her 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

Members are 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*, which provides:

> "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
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
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

Chiropractic Adjustment or Manipulation

Standard of Practice S-005
Quality Assurance Committee
Approved by Council: February 28, 1998
Amended: December 1, 2011, September 15, 2016, September 12, 2025 (came into effect November 20, 2025)

INTENT

To assist members in maintaining a minimum standard of care that must be met prior to performing a chiropractic adjustment or manipulation.

OVERVIEW

Performing a chiropractic adjustment or manipulation requires proper training and much practice to develop the necessary skill and competence. The prime areas necessary for specialized training are:

- theory, including principles, applied anatomy, biomechanics, neuro-physiology and radiology;
- examination and diagnosis; and
- treatment techniques.

Chiropractic adjustment or manipulation is an authorized Act requiring a high degree of skill. This standard outlines the necessary elements to maintain that level of skill.

DESCRIPTION OF STANDARD

Consideration of Public Safety

In deciding to perform a chiropractic adjustment or manipulation a member shall, in the interest of public safety, know which form of adjustive or manipulative technique to use in specific situations. This includes knowing proper protocols for patient selection, indications and contraindications to application of a chiropractic adjustment or manipulation, the patient's health, proper assessment of the patient, the goal of care, and prognosis.

Degree of Skill

The following are important features of the skills required for a chiropractic adjustment or manipulation:

- accurate amplitude (speed, force, depth and distance) for the adjustive or manipulative thrust;
- quantity of thrust for the procedure or modified accordingly for the patient; and
- good sense in providing minimum risk to the patient. Consider when, where and how a particular adjustment or manipulation is given.

Continuing Education

Members shall be current with their knowledge and skills level to enable safe and effective care for the patient. CCO requires 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[1]. 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.

It is a requirement that every member complete a minimum of 5 hours of structured CE activity, that primarily focuses on an in-person hands-on or hand-held instrument adjustment or manipulation activity, and includes training in the competency of manual or hand-held instrument spinal adjustment or manipulation skills, at least once every three CE cycles (or six years).

Protocol

The following protocol shall be adhered to prior to performing a chiropractic adjustment or manipulation:

(1) Diagnosis or Clinical Impression[2]

- case history (patient interview);
- examination (physical, diagnostic imaging, laboratory); and
- interpretation and differential diagnosis to rule out possible pathologies.

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[1] See Standard of Practice S-001: Chiropractic Scope of Practice for an explanation of "diagnostic or therapeutic procedures". Controlled acts may include the authorized activities listed in section 4 of the *Chiropractic Act, 1991* or the authorization to operate an X-ray machine or prescribe the operation of an X-ray machine under sections 5-6 of the *Healing Arts Radiation Protection Act, 1990*.

[2] See standards of practice S-002: Record Keeping, S-006: Ordering, Taking and Interpreting Radiographs, and S-008: Communicating a Diagnosis.

(2) Informed Consent

Members shall obtain the patient's consent to the proposed care, consistent with standard of practice S-013: Consent, includes:

- 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.

(3) Care Protocols

- therapeutic trial of care;

- assessing the outcome of care; and

- timely re-assessment to determine if there is a need for different care and/or referral to a colleague or other health care provider.

LEGISLATIVE CONTEXT

Controlled Acts

The *Regulated Health Professions Act, 1991 (RHPA)*. Specific provisions as outlined below:

Ss. 27 (1) "No person shall perform a controlled act set out in subsection 2 in the course of providing health care services to an individual unless, (a) the person is a member authorized by a health profession Act to perform the controlled act."

Ss. 27 (2) "A 'controlled act' is any one of the following done with respect to an individual: (4) Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust."

Scope of Practice

The scope of practice of chiropractic is defined in section 3 of 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:

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

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

Authorized Acts

The authorized acts for chiropractors are outlined in section 4 of the Chiropractic Act, 1991, and include the following definition of chiropractic adjustment or manipulation.

"Moving the joints of the spine beyond a person's usual physiological range of motion using a fast, low amplitude thrust."

ORDERING, TAKING AND INTERPRETING RADIOGRAPHS

Standard of Practice S-006
Quality Assurance Committee
Approved by Council: February 18, 1998
Amended: November 27, 1999, September 20, 2014, November 23, 2023 (came into effect February 23, 2024)
(Previously titled "Technical and Interpretative Components for X-ray")

INTENT

This standard of practice advises members of the practices and procedures for ordering, taking and interpreting radiographs.

Chiropractors are primary health care practitioners, are authorized to use the "doctor" title, and have been granted the legislative authority under the *Chiropractic Act, 1991* to:

> communicate 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,
> ii. or a disorder arising from the structures or functions of the joints of the extremities.

A member is authorized under the *Regulated Health Professions Act, 1991* (*RHPA*) and the *Healing Arts Radiation Protection Act, 1990 (HARP)* to order radiographs and operate an x-ray machine for the irradiation of a human.

OBJECTIVES

- To enhance the effectiveness and quality of chiropractic diagnosis and care provided to the patient by the member.
- To identify when it is appropriate for a member to order or take a radiograph for a patient.
- To ensure the safety of both patient and the member during the taking of a radiograph.
- To advise members of the practices and procedures in interpreting, documenting and organizing radiographic films, notes, logs, reports and other records.

DESCRIPTION OF STANDARD

Members Who Order Radiographs

Procedures for Patient Selection

A member shall only order radiographs as a component of an examination of a patient when the history, examination or diagnostic tests clinically indicate a finding which would be better identified, confirmed or eliminated by the ordering or taking of radiographs.

In ordering a radiograph for a patient, a member shall:

- perform a history and examination of the patient, as described in Standard of Practice S-001: Chiropractic Scope of Practice and Standard of Practice S-002: Record Keeping;
- consider whether the radiograph is required to reach an appropriate diagnosis, clinical impression and/or plan of care;
- make reasonable attempts to avoid unnecessary duplication;
- consider the benefits, limitations, contraindications, including pregnancy, and risks; and
- communicate effectively to the patient the reason and process for ordering or taking the radiograph, and record this rationale in the patient health record.

A member shall use proper patient selection protocols with reference to age, child-bearing status and clinical indications of need, such as testing the structure and alignment of the spine. In the acquisition of radiological studies, a member shall consider the risk/benefit ratio and the "as low as reasonably achievable" (A.L.A.R.A.) principle of dosage. The number of views and when they are taken shall be based upon clinical indications. The minimum number of views to reach a diagnostic conclusion shall be the prime objective. Generally, two views at right angles are the minimum number of projections for diagnosis of osseous structures.

Follow-up

A member is required to conduct appropriate follow-up with a patient following the ordering of a radiograph. In performing such follow up, a member shall:

- analyze the results of the radiograph based on the results and/or interpretive reports. If no report is included with the radiograph, a member shall create a radiological report consistent with this standard of practice;
- record in the patient health record any additional observations or conclusions made after reviewing the radiograph and accompanying report, if a radiological report accompanies the radiographic study;

- ensure that an appropriate and timely follow-up occurs based on the results of the radiographic study and clinical investigation;

- select care options within the chiropractic scope of practice, based on the results of the history, examination and diagnostic results, including the radiographic study;

- report the radiographic findings to the patient in a manner understandable to the patient;

- advise the patient to consult with the appropriate health care professional, if the results of a radiograph reveal a diagnosis, clinical impression or findings that may fall outside the chiropractic scope of practice; and

- when appropriate, advise a patient to consult with an appropriate health professional.

Radiological Report

A member shall ensure that a narrative report accompanies all radiographs ordered or taken by the member, which shall contain the following information[1]:

- patient information (demographic information as necessary to identify, assess and treat patients, which may include, but not limited to a patient's name, address, birth date, and pregnancy status)
- date radiograph taken
- examination (series and views)
- description (radiographic features, usually in order of importance or anatomical sequence)
- radiological impressions (list radiological diagnosis in order of importance)
- recommendations (suggestions for further studies, additional specific views or other imaging modalities).

Billing Guidelines

Billing procedures with respect to radiographs must comply with Guideline G-008: Business Practices. Billing procedures relate to the technical and professional components, whether rendered separately or as full service. A member may establish a fee schedule and divide the fee structure into technical (production) and professional (interpretative) components.

[1] Please see Standard of Practice S-002: Record Keeping, for requirements on maintaining reports and records for all diagnostic images.

Members Who Take Their Own Radiographs

A member who takes their own radiographs shall comply with the procedures for patient selection, follow up and billing guidelines section as described above in this standard of practice.

Additionally, a member who takes their own radiographs is required to:

- ensure that the member's equipment is properly registered and compliant with *HARP* and its regulations;
- ensure the member's use of x-ray equipment is compliant with the safety protocols of *HARP* and its regulations;
- obtain informed consent for the taking of the radiograph;
- maintain radiological records;
- produce a radiological report; and
- maintain a radiological log, as follows:

Equipment Registration

A member shall ensure that all x-ray installations are registered with the X-ray Inspection Service, Ministry of Health and Long-Term Care. This applies to all x-ray installations - whether new or used equipment, recently installed or relocated.

Compliance with *HARP*

Members must keep records of compliance with the procedures and tests of the *HARP* and its regulations, which may be accessed at www.canlii.org/en/on/laws/stat/rso-1990-c-h2/latest/rso-1990-c-h2.html.

Consent

The responsibility for obtaining consent from the patient is on the member or other regulated health professional who is taking the radiograph at the time the radiograph is taken.

A member who is taking a radiograph of a patient is required to obtain patient consent, 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.

X-Ray Safety and Quality Assurance

A member shall ensure compliance with the safety and quality assurance protocols for operating an x-ray machine of *HARP*, its regulations, and Health Canada's Technical Reports and Publications, including but not limited to:

- positioning the patient as required to provide optimum image quality while using minimum radiation;
- using radiation protection devices and other patient protection devices as required;
- ensuring the intended area will be displayed optimally on the radiograph; and
- ensuring the radiograph taken creates an image and data that are sufficiently accurate and clear for the indicated diagnostic or therapeutic purpose

Radiological Records

A member shall ensure that a radiological record accompanies every radiograph, which shall include:

- recent radiographs, when appropriate and available;
- the specific reason for which the radiodiagnostic examination is being conducted (e.g., differential diagnosis, treatment planning indicators);
- the results and conclusions (diagnosis or clinical impression) of the reading of the radiograph; and
- the recommendation and plan or care based on the radiograph.

Radiological Log

The radiological log shall be part of the patient health record and shall contain the following:

- patient's identification
- date of study
- projection or view
- part thickness in centimeter
- kilo Voltage/peak (k.V.p.)
- milli Amperage x seconds (m.A.s)
- comments

Continuing Education

It is strongly recommended that a member who orders, takes and/or interprets radiographs as part of their practice participate in ongoing continuing education relevant to the ordering, taking and /or interpreting of radiographs.

A member who orders, takes and/or interprets radiographs as part of their practice shall:

- maintain current knowledge of all applicable legislation, regulations, standards of practice, policies and guidelines;
- apply the member's relevant knowledge, skills and professional judgment to the process of ordering, taking and interpreting radiographs; and

- maintain up-to-date knowledge of new and emerging trends, practices and advances in technology

LEGISLATIVE CONTEXT

Chiropractic Act, 1991

The scope of practice is defined in the *Chiropractic Act, 1991* 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 and 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.

Healing Arts Radiation Protection Act, 1990

The following sections are excerpts from *HARP* authorizing members of CCO to operate x-ray machines for the irradiation of a human being. Please see the *HARP* and its regulation at http://canlii.org/en/on/laws/stat/rso-1990-c-h2/latest/rso-1990-c-h2.html for further detail.

Section 5

(1) No person shall operate an X-ray machine for the irradiation of a human being unless the person meets the qualifications and requirements prescribed by the regulations.

(2) The following persons shall be deemed to meet the qualifications prescribed by the regulations:

1. A legally qualified medical practitioner.
2. A member of the Royal College of Dental Surgeons of Ontario.
3. A member of the College of Chiropodists of Ontario who has been continuously registered as a chiropodist under the *Chiropody Act* and the *Chiropody Act, 1991* since before November 1, 1980 or who is a graduate of a four-year course of instruction in chiropody.
4. A member of the College of Chiropractors of Ontario.
5. Repealed: 1998, c. 18, Sched. G, s. 51 (2).
6. Repealed: 2011, c. 1, Sched. 6, s. 2 (1).
7. A member of the College of Medical Radiation Technologists of Ontario.
8. A member of the College of Dental Hygienists of Ontario.

Section 6

(1) No person shall operate an X-ray machine for the irradiation of a human being unless the irradiation has been prescribed by,

(a) a legally qualified medical practitioner;

(b) a member of the Royal College of Dental Surgeons of Ontario;

(c) a member of the College of Chiropodists of Ontario who has been continuously registered as a chiropodist under the *Chiropody Act* and the *Chiropody Act, 1991* since before November 1, 1980 or who is a graduate of a four-year course of instruction in chiropody; or

(d) a member of the College of Chiropractors of Ontario.

(e) Repealed: 1998, c. 18, Sched. G, s. 51 (4).

(f) Repealed: 2011, c. 1, Sched. 6, s. 2 (2).

This standard of practice should be read in conjunction with:

- *Healing Arts Radiation Protection Act, 1990 (HARP)*
- Standard of Practice S-001: Chiropractic Scope of Practice
- Standard of Practice S-002: Record Keeping
- Standard of Practice S-013: Consent
- Guideline G-008: Business Practices

PUTTING A FINGER BEYOND THE ANAL VERGE FOR THE PURPOSE OF MANIPULATING THE TAILBONE

Standard of Practice S-007
Quality Assurance Committee
Approved by Council: February 28, 1998
Amended: June 22, 2012, September 15, 2016

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

INTENT

To assist a member in maintaining a minimum standard of care that must be met prior to performing manipulation of the tailbone.

OBJECTIVES

- To facilitate the care of patients.
- To provide appropriate protocol for this procedure.

DESCRIPTION OF STANDARD

Overview

Member compliance with the protocol and procedure described herein will ensure safer administration of putting a finger beyond the anal verge for the purpose of manipulating the tailbone.

Performing a sacro-coccygeal adjustment requires appropriate training, skillset, and practice to develop competency. Competency in the following areas is essential for the adjustment of the sacro-coccygeal joint:

- the anatomic structures of the sacro-coccygeal joint and the surrounding area;
- the presentation of coccydynia and the ability to differentiate this pain from that of a referred pattern;
- the examination and diagnostic procedures of the sacro-coccygeal joint; and
- the care and adjustive techniques for coccygeal correction.

Consideration of Public Safety

To perform manipulative procedures of the sacro-coccygeal joint, a member shall have achieved and be able to demonstrate clinical competency with the procedure. The member must rule out possible fracture of the coccyx before proceeding with the manipulation.

Degree of Skill

The following are important features of the skill required for manipulation of the sacro-coccygeal joint:

- knowledge of anatomical structures;
- knowledge of protocol for coccygeal correction;
- the member's mindfulness of the patient's reaction to this procedure.

Informed Consent

Members shall fully explain the diagnosis or clinical impression, care procedure and prognosis to the patient before proceeding with the manipulation of the tailbone.

Members are required to obtain patient consent, consistent with Standard of Practice S-013: Consent, prior to proceeding with the manipulation of the tailbone, 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.

Performance of the controlled act of putting a finger beyond the anal verge for the purpose of manipulating the tailbone involves providing care in a sensitive area. Therefore, specific consideration shall be given to explaining the procedure to the patient, ensuring the patient fully understands the procedure, and considering any language or cultural barriers to care. See Guideline G-001: Communication with Patients for more information.

Legislative Context

Controlled Acts

The governing legislation is the *Regulated Health Professions Act, 1991 (RHPA)*. Specific provisions are outlined below:

> subsection 27 (2) A 'controlled act' is any one of the following done with respect to an individual: Putting an instrument, hand or finger beyond the anal verge."

Authorized Acts

The authorized acts for chiropractors are outlined in section 4 of the Chiropractic Act, 1991, and include:

> In the course of engaging in the practice of chiropractic, a member is authorized, subject to the terms, conditions and limitation imposed on his/her certificate of registration, to perform the following: Putting a finger beyond the anal verge for the purpose of manipulating the tailbone.

COMMUNICATING A DIAGNOSIS

Standard of Practice S-008
Quality Assurance Committee
Approved by Council: February 28, 1998
Amended: April 16, 2013, September 10, 2021 (came into effect November 25, 2021)

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

INTENT

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

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

OBJECTIVES

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

DEFINITION

"Subluxation" (as used as an example of a diagnostic term in the "Terminology" section of this standard of practice), is: "a complex of functional and/or structural and/or pathological articular changes that compromise neural integrity and may influence organ system function and general health.

A subluxation is evaluated, diagnosed, and managed through the use of chiropractic procedures based on the best available rational and empirical evidence."[1]

[1] Adopted from the Association of Chiropractic Colleges https://www.chirocolleges.org/chiropractic-paradigm-scope-practice.

DESCRIPTION OF STANDARD

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

> In the course of engaging in the practice of chiropractic, a member is authorized, subject to the terms, conditions and limitations imposed on his/her certificate of registration, to perform the following:
>
> Communicating a diagnosis identifying, as the cause of a person's symptoms,
>
> i. a disorder arising from the structures or functions of the spine and their effects on the nervous system; or
> ii. a disorder arising from the structures or functions of the joints of the extremities."

Diagnosis

When a diagnosis is made, a member shall:

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

Clinical Impression

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

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

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

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

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

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

Terminology

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

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

This standard of practice should be read in conjunction with:

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

LEGISLATIVE CONTEXT

Chiropractic Act, 1991

Scope of Practice

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

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

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

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

Authorized Acts

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

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

communicating a diagnosis identifying, as the cause of a person's symptoms,
i. a disorder arising from the structures or functions of the spine and their effects on the nervous system; or
ii. a disorder arising from the structures or functions of the joints of the extremities."

Ontario Regulation 852/93 under the *Chiropractic Act, 1991*[2]

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

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

Health Care Consent Act, 1996

Section 9: "substitute decision-maker" means a person who is authorized under section 20 to give or refuse consent to a treatment on behalf of a person who is incapable with respect to treatment.[3]

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

CHIROPRACTIC CARE OF ANIMALS

Standard of Practice S-009
Quality Assurance Committee
Approved by Council: April 25, 1998
Amended: February 19, 2008, December 4, 2015, November 24, 2022 (came into effect February 24, 2023), February 21, 2025 (came into effect April 24, 2025)

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 on when and how they can conduct chiropractic care of animals, and to remind them that the primary responsibility for the health care of animals is with veterinarians.

OBJECTIVES

- To promote professionalism, safety and effectiveness in the chiropractic care of animals.
- To inform members of CCO of their obligations relating to the chiropractic care of animals.
- To ensure appropriate coordination and consultation between chiropractors and veterinarians in the chiropractic care of animals.
- To educate the public as to the appropriate nature of the chiropractic care of animals.

DESCRIPTION OF STANDARD

A member is advised that:

- The primary responsibility for the health care of animals is with registrants of the CVO, who are responsible for appropriate history taking, comprehensive examination, including clinical pathology, and imaging, and the overall care/management of animals.
- Consent to the chiropractic care of animals must be fully informed and voluntarily given by the owner of the animal, and members are required to comply with all standards of practice and applicable legislation relating to chiropractic.

In providing chiropractic care to an animal, a member shall:

- demonstrate successful completion of a program in animal chiropractic of a minimum of 200 hours of formal training that includes, but is not limited to, studies in the following subject

areas: anatomy, neurology, biomechanics, animal adjustment technique, diagnosis, pathology, chiropractic philosophy, and ethics and legalities;

- ensure the record of care includes the name of the treating registrant of CVO and the relevant portions of the veterinary record;

- achieve, maintain and be able to demonstrate clinical competency in diagnostic or therapeutic procedures authorized to members, performed on animals in practice;

- provide, upon request and only with the consent from the owner of the animal or otherwise in accordance with the *Personal Information Protection and Electronic Documents Act, 2000 (PIPEDA)*[1] a copy of relevant portions of the record to the treating registrant of CVO within a reasonable time of providing chiropractic care to an animal;

- maintain separate appointment books, separate health and financial records and, where animals are provided with chiropractic care in the same office as humans, maintain a separate portion of the office devoted to animal chiropractic[2]; and

- ensure that the owner of the animal(s) is fully informed about the member's insurance coverage[3].

Exemption

A member will be exempted from the first bulleted item above if the member:

- is enrolled and participating in an approved program in animal chiropractic, leading to the successful completion of a program in animal chiropractic of a minimum of 200 hours of formal training that includes, but is not limited to, studies in the following subject areas, anatomy, neurology, biomechanics, animal adjustment technique, diagnosis, pathology, chiropractic philosophy, and ethics and legalities;

- completes the approved program in animal chiropractic within two years of their enrolment;

- provides chiropractic care to animals within the parameters of their course of study;

- provides chiropractic care only under the supervision and direction of a member who has completed the 200 hours of formal training as listed above and

[1] Since the chiropractic care of animals does not involve human health care, the *Personal Information Protection and Electronic Documents Act, 2000 (PIPEDA*) and not the *Personal Health Information Protection Act, 2004 (PHIPA)* would apply to the collection, use and disclosure of information related to the chiropractic care of animals.
[2] Maintenance of separate office space is a minimum requirement for health and sanitation reasons, particularly in light of the various communicable diseases common to human and animals.
[3] This requires the member to advise the owner of the animal if the member's policy of insurance or membership in a protective association does not provide coverage for the chiropractic care of animals. The owner should be informed about the member's insurance coverage as part of the general requirement that there be "informed" consent.

- informs the owner of the animal(s) that they have enrolled and are participating in but have not yet graduated from an approved program in animal chiropractic.

LEGISLATIVE CONTEXT

The governing legislation as it relates to human health care is the *Regulated Health Professions Act, 1991*, as amended (*RHPA*) and the *Chiropractic Act, 1991*. The governing legislation as it relates to animal health care is the *Veterinarians Act, 1990*. Specific relevant provisions are outlined below. The *RHPA* and the *Chiropractic Act* are administered by CCO and the *Veterinarians Act* is administered by CVO.

Sections of the *RHPA*

Objects and Duty of the CCO – Section 3 of the Regulated Health Professions (Code), Schedule 2 to *RHPA* (Code):

(1) [CCO] has the following objects:

- To develop, establish and maintain programs and standards of practice to assure the quality of the practice of the profession.

- To develop, establish and maintain standards of knowledge, skill and programs to promote continuing competence among the members.

(2) In carrying out its objects, the [CCO] has a duty to serve and protect the public interest."

Sections of the *Chiropractic Act*

Section 3: 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,

- 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."

Section 9: Restricted Titles for Chiropractic

"(1) No person other than a member shall use the title 'chiropractor', a variation or abbreviation or an equivalent in another language.

(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 chiropractor or in a specialty of chiropractic.

(3) In this section, 'abbreviation' includes an abbreviation of a variation."

Sections of Regulation 852/93 under the *Chiropractic Act*

Section 1 (2): Definition of Professional Misconduct for Chiropractors (Standards of Practice)

"The following are acts of professional misconduct for the purposes of clause 51 (1) (c) of the Health Professions Procedural Code: Contravening a standard of practice of the profession or failing to maintain the standard of practice expected of members of the profession."

Sections of the *Veterinarians Act*

Subsection 1 (1): Definition of Veterinary Medicine

"The 'practice of veterinary medicine' includes the practice of dentistry, obstetrics (including ova and embryo transfer) and surgery in relation to an animal other than a human being."

Section 3: Objects of CVO

"(1) The principal object of the [CVO] is to regulate the practice of veterinary medicine and to govern its members in accordance with this Act, the regulations and the by-laws so as to serve and protect the public interest.

(2) For the purpose of carrying out its principal object, the [CVO] has the following additional objects:

- establish, maintain and develop standards of knowledge and skill among its members; and
- establish, maintain and develop standards of qualification and standards of practice for the practice of veterinary medicine."

Subsection 11 (1): Licence Required to Practice Veterinary Medicine

"No person shall engage in the practice of veterinary medicine or hold himself/herself out as engaging in the practice of veterinary medicine unless the person is the holder of a license."

Sections of Regulation 1093 (General – Part II Practice Standards) under the *Veterinarians Act*

Section 17: Definition of Professional Misconduct for Veterinarians (Standards of Practice)

"For the purposes of the Act, professional misconduct includes the following: Failing to maintain the standard of practice of the profession."

MEMBERS OF MORE THAN ONE HEALTH PROFESSION

Standard of Practice S-011
Quality Assurance Committee
Approved by Council: April 20, 2002
Amendments approved by Council: February 26, 2013

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

INTENT

To inform CCO members, who are also members of another health profession, of their disclosure obligations. In particular, it is their responsibility to communicate clearly to a patient in what capacity they are acting when they provide a service, whether as a chiropractor or as a member of another health profession.

DESCRIPTION OF STANDARD

This standard concerns CCO members who are also members of another health profession. The other health profession may be unregulated or be regulated under the *Regulated Health Professions Act, 1991* (*RHPA*), the *Drugless Practitioners Act, 1990,* or under other health-related legislation.

Members must comply with the regulatory framework of the profession in which they are practising. Members are reminded that it is the patient's perception as a recipient of treatment/care that is of critical importance. The patient must understand when he/she is receiving treatment/care from the member in his/her capacity as a chiropractor, and when the patient is receiving treatment/care from the member in his/her capacity as a member of another health profession.

Requirements for Members

A member is required to:

- inform the patient when the member is providing treatment/care in his/her capacity as a chiropractor;

- ensure that consent to chiropractic treatment/care 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; and

- inform the patient when the member is providing services as a member of a health profession other than chiropractic, and that regulation of those services falls under the jurisdiction of the regulatory body of that health profession.

Health Records and Business Practices

A member must communicate clearly to patients in which professional capacity he/she is providing services. This separation of professional services must be clearly delineated and documented in the patient health record, financial record, billing policies and procedures, and any documentation related to consent.

A member must ensure that in his/her use and maintenance of health records, office policies and business practices, that he/she is practising within the regulatory framework of the appropriate regulatory body which regulates the profession in which he/she is practising, and complies with any other relevant legislation.

A member may bill third-party payors for chiropractic when providing services within the chiropractic scope of practice. When billing for services outside the chiropractic scope of practice, members shall bill third-party payors in accordance with the regulatory framework of the appropriate health profession in which they are practising and billing, and any other relevant legislation.

Legislative Context

All CCO members-are expected to conform to the standards of practice for chiropractic. Contravening a standard of practice or failing to maintain a standard of practice may be found to be an act of professional misconduct pursuant to section 1 (2) of the professional misconduct regulation under the *Chiropractic Act, 1991*.

ORTHOTICS

Standard of Practice S-012
Quality Assurance Committee
Approved by Council: November 28, 2003
Amended by Council: September 24, 2009, June 18, 2014, September 9, 2022
(came into effect November 24, 2022)

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

INTRODUCTION

Orthotics may be used by chiropractors as an integral part of patient care for the management of pedal pathologies and neuromusculoskeletal symptomatology, to alleviate pain and discomfort from abnormal foot function. Abnormal foot function may affect a patient's kinetic chain, including legs, knees, hips and spine. Orthotics may be used to improve spinal stabilization and optimize structure and function.

INTENT

To facilitate appropriate care of patients by advising members of their obligations when prescribing, manufacturing, selling or dispensing orthotics.

OBJECTIVES

- To facilitate appropriate care of patients who may benefit from orthotics.
- To inform members of their obligations for prescribing, manufacturing, selling and dispensing orthotics.
- To ensure members respond to clinical situations in a manner consistent with the best interests of their patients.

DESCRIPTION OF STANDARD

Training, Skill and Competence

Every member of CCO who prescribes, manufactures, sells or dispenses orthotics is required to have appropriate training, skill and competence, including:

- training, skill and competence in applied anatomy, biomechanics and physiology of the foot;
- appropriate examination and diagnosis of patients with conditions within the scope of practice of chiropractic which may reasonably be expected to benefit from the use of orthotics;

- understanding of the indications and contraindications to orthotics for any individual patient; and
- participation in appropriate ongoing continuing education.[1]

Protocol

A member may prescribe orthotics on a case-by-case basis for each individual patient when, in the member's clinical judgment or opinion, the orthotics are required to improve the patient's health and/or wellness.

A member shall adhere to the following protocols when prescribing, manufacturing, selling or dispensing orthotics, which is to be documented in the patient health record:

1. *Diagnosis*
   - relevant case history;
   - examination (physical, diagnostic imaging, laboratory), including gait and postural analysis as determined by the member; and
   - interpretation and differential diagnosis to rule out possible pathologies.

2. *Consent*
   - Consent from the patient shall be:
     - fully informed about the purpose of the orthotics. A member shall explain the benefits and risks of the orthotics as compared to other care or no care;
     - 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, which may be part of the general consent.

   - Members shall otherwise comply with Standard of Practice S-013: Consent.

3. *Dispensing of Orthotics to Patient*

A member shall ensure that orthotics dispensed meet the prescription and the contours of the patient's foot.

A member shall provide advice to a patient in a manner that can be understood by the patient on the following;
- short-term instructions for usage of the orthotics;
- recommendations for developing tolerance and acceptance of orthotics;
- reasonable expectations as to the outcomes of the orthotics; and
- examples of appropriate use of orthotics in footwear, based on the patient's condition and/or activities.

[1] For example, programs offered by accredited chiropractic educational institutions or manufacturers of orthotics.

4. *Follow-up*

   In the patient's best interests, members should advise patients to seek timely follow-up and re-assessment from the health care provider who originally recommended and/or prescribed the orthotics.

Billing

When billing for orthotics, a member shall comply with the following:

- the business practices provisions of the Profession Misconduct Regulation under the *Chiropractic Act, 1991*, including that it is a potential act of professional misconduct to:
    - submit an account or charge for services that the member knows is false or misleading;
    - fail to disclose to a patient the fee for service before the service is provided, including a fee not payable by the patient; and
    - fail to itemize an account for professional services,
        - if requested to do so by the patient or the person or agency who is to pay, in whole or in part, for the services, or
        - if the account includes a fee for a product or device or a service other than a treatment.

- The cost of the orthotics shall reasonably relate to the time and expertise of, and cost to, the member when prescribing, manufacturing, selling or dispensing orthotics.

- Treatment, services and products associated with the prescription and dispensing of orthotics, including any discounted or complimentary services or products, shall be applied consistently with the member's fee schedule, clearly documented in the patient health record and financial record and invoice, clearly communicated to the patient before services are rendered, and clearly itemized accordingly. Any documentation, record or invoice associated with orthotics shall not be false or misleading.

- Fees charged for treatment, services and products associated with the prescription of orthotics shall be based on clinical history, examination, diagnosis or clinical impression, consent, instructions and recommendations and follow-up, as recorded in the patient health record.

- Guideline G-008: Business Practices which provides that members may not bill any payor fees in excess of his/her normal fee billed to a private patient for similar services.

- A member shall only issue a receipt for payments that have been received.

- If billing practices related to orthotics and ancillary services and products involve the billing or submitting of invoices to the patient's insurance company or third-party payor, the member should familiarize themselves with and ensure they are complying with the policies and procedures of the insurance company or third-party payor.

Conflict of Interest

For the purpose of this standard, a conflict of interest may arise when a member refers a patient to facilities, services or suppliers in which the member or the member's immediate family has an interest or gains a benefit.

A member may make such a referral provided that the member:

- discloses to the patient that the member or their immediate family member has an interest or gains a benefit from the referral;

- has assured the member's patient that the patient's choice of services or suppliers will not affect the quality of health care services provided by the member;

- has informed the member's patients that the patient has an option of using alternative facilities, services or suppliers; and

- upon request, advises CCO of any conflict of interest.

LEGISLATIVE CONTEXT

Section 3 (1) of the Health Professions Procedural Code – One of CCO's objects under the *Regulated Health Professions Act, 1991* (*RHPA*) is to "develop, establish and maintain programs and standards of practice to assure the quality of the practice of the profession."

The Quality Assurance program is defined in Ss. 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 the members."

The Professional Misconduct Regulation under the *Chiropractic Act, 1991*, includes the following as an act of 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."

Explanatory Notes

This standard of practice should be read in conjunction with the Business Practices provisions of the Professional Misconduct Regulation, S-002: Record Keeping, S-013: Consent, and Guideline G-008: Business Practices.

CONSENT

Standard of Practice S-013
Quality Assurance Committee
Approved by Council: November 30, 2002
Amended: November 24, 2004, September 20, 2013, February 23, 2016, September 15, 2018, April 20, 2022 (came into effect June 22, 2022), November 28, 2024 (came into effect February 21, 2025)

INTENT

To advise members of their obligations relating to consent for examination, care and plans of care.

The intent of the informed consent process is to ensure that the patient is fully informed and the member and patient are in agreement to the examination, care and plan of care. A member shall ensure that they obtain informed consent, in accordance with this standard of practice, by providing the patient with complete and accurate information in order to make an informed decision as to examination, care and a plan of care, without using any undue pressure or duress.

A member shall accommodate reasonable patient requests and preferences, while ensuring that the member makes clinical decisions and provides safe, ethical chiropractic care, consistent with the chiropractic scope of practice and CCO standards of practice, policies and guidelines.

OBJECTIVES

- To clarify the consent requirements outlined in legislation, case law and CCO standards of practice, policies and guidelines as they relate to examinations, care and plans of care.
- To ensure patients receive appropriate information about the benefits and risks of examinations, care and plans care.
- To facilitate discussion and dialogue between members and patients relating to chiropractic care.
- To ensure members and the public are aware of the mutual benefits of fully informed, voluntarily given consent to examinations, care and plans of care.

DESCRIPTION OF STANDARD

Elements of Consent to Examination

A member is to obtain consent to an examination, including diagnostic imaging, from a patient or his/her substitute decision-maker (patient)[1], that is:

- fully informed;
- voluntarily given;
- related to the patient's condition and circumstances;
- not obtained through fraud or misrepresentations;
- obtained following a consultation and history taking, but prior to any physical examination or diagnostic testing of the patient; and
- evidenced in a written form signed by the patient or otherwise documented in the patient health record. It is sufficient to obtain verbal consent to examination from the patient and document this consent in the patient health record.

Elements of Consent to Care

A member is to obtain patient consent to care or to a plan of care, that is:

- fully informed;
- voluntarily given;
- related to the patient's condition and circumstances;
- not obtained through fraud or misrepresentations;
- obtained following the examination and report of findings, but before any chiropractic care is delivered; and
- evidenced in a written form signed by the patient or otherwise documented in the patient health record.

Implied Consent

In certain limited circumstances, consent to an examination, care or plan of care may be implied. However, the onus is on a member to substantiate that circumstances warranted a variation from the requirements for obtaining consent as outlined in this standard of practice.

[1] See the section "Capacity to Consent" for information relating to determining the capacity of a patient to consent and obtaining consent from a substitute decision maker, if necessary.

Appropriate Discussion and Dialogue for Consent

In order to be *informed*, consent to examination, (including diagnostic imaging), care or a plan of care, shall include a discussion of these items:

- What is the recommended examination, care or plan of care?
- Why should the patient have the examination, care or plan of care?
- What are the alternatives to the examination, care or plan of care?
- What are the effects, material risks and side effects of the proposed examination, care or plan of care and how they compare to the alternatives?
- What are the likely consequences if the patient does not have the examination, care or plan of care?

In discussing the effects, material risks and side effects of the proposed examination or treatment and alternative examinations or treatments, members shall disclose improbable risks particularly if the effects are serious. Accordingly, members shall include a discussion with patients of the rare but potentially serious risk of stroke associated with cervical adjustments.

During discussions, a member shall provide patients with an opportunity to ask questions concerning the proposed examination, care or plan of care and shall answer questions prior to the commencement of the examination or care.

A patient may withdraw his/her consent to any examination, care or plan of care at any time.

The standard of disclosure focuses on the patient and what a reasonable person in the patient's position would need to know to make an informed decision. A member is advised to err on the side of caution in providing comprehensive disclosure.

A member shall take appropriate measures to ensure there is proper disclosure and consent especially if the examination and/or care involves the touching of a sensitive area (e.g., chest, gluteal and inner thigh regions). Disclosure and consent shall include respecting and accommodating reasonable patient requests and preferences. See Guideline G-001: Communication with Patients for further details.

There is an expectation that a member fully informs the patient of the identity and professional status of any health care professional providing professional services, especially in, but not limited to, a multi-disciplinary practice or when a member assigns any part of an examination, care or plan of care to an assistant or another health care professional.

The consent process may involve a discussion around accommodating any patient requests and preferences for examination, care and a plan of care. In attempting to accommodate patient requests, it may become apparent that the member may not be able to maintain a level of safe

and ethical care. The member shall discuss and attempt to resolve this issue with the patient, and document it in the patient health record. The member shall ensure that safe, ethical chiropractic care is delivered in accordance with CCO standards of practice, while ensuring that reasonable patient requests and preferences are accommodated.

Requiring a patient to bring another individual to any future appointment is considered a breach of privacy and is inappropriate, unless there is a question or concern regarding capacity and/or substitute decision-makers. Please see the "Capacity to Consent" section of this standard of practice for further procedures and protocols around capacity to consent and substitute decision-makers.

Appropriate Setting of Examination or Care

A member shall ensure that, as part of the consent process, the patient is comfortable with the setting of examination and care and that the member accommodates reasonable patient requests and preferences. These include, but are not limited to, providing a private room for examination, treatment or any disrobing required for care, and accommodating a patient request that the examination or treatment room door be opened or closed.

If the member and patient cannot agree on the examination protocol, plan of care and/or setting for examination and/or care, it may be appropriate for the member not to proceed with the examination, care or plan of care, refer the patient to another member and record this in the patient health record.

Consent to a New Examination and Consent to Care or Plan of Care

A member shall recognize that obtaining consent is an ongoing and evolving process involving continuous discussions with a patient and not a one-time event of a patient's signature on a consent form. If a member recommends a new examination, care or plan of care, there are significant changes in a patient's condition, or there are significant changes in the material risks to a patient, a member shall continue to dialogue with the patient. This discussion should be about the material risks, benefits and side-effects of the recommended examination, care or plan of care, including potential risks that may be of a special or unusual nature. A member shall make a notation of the discussion in the patient health record.

Emergency Care[2][3]

An emergency is defined in section 25(1) of the *HCCA* as follows: "there is an emergency if the person for whom the treatment is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm."

[2] See sections 25-28 of the *HCCA*
[3] See The *Good Samaritan Act, 2001* for an explanation of immunity from liability for health professionals and individuals providing emergency health care in certain circumstances

A member may provide care without consent to a person who is incapable with respect to the care, if, in the opinion of the member:

- there is an emergency; and
- the delay required to obtain a consent or refusal on the person's behalf will prolong the suffering that the person is apparently experiencing or will put the person at risk of sustaining serious bodily harm.

A member may provide care without consent to a person who is apparently capable with respect to the care, if, in the opinion of the member:

- there is an emergency;
- the communication required in order for the person to give or refuse consent to care cannot take place because of a language barrier or because the person has a disability that prevents the communication from taking place;
- steps that are reasonable in the circumstances have been taken to find a practical means of enabling the communication to take place, but no such means has been found;
- the delay required to find a practical means of enabling the communication to take place will prolong the suffering that the person is apparently experiencing or will put the person at risk of sustaining serious bodily harm; and
- there is no reason to believe that the person does not want the treatment.

Capacity to Consent

The *HCCA* section 4, provides the following definition and procedure with respect to capacity:

(1) A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

(2) A person is presumed to be capable with respect to treatment, admission to a care facility and personal assistance services.

(3) A person is entitled to rely on the presumption of capacity with respect to another person unless he or she has reasonable grounds to believe that the other person is incapable with respect to the treatment, the admission or the personal assistance service, as the case may be.

Examples of incapable patients include those who have lost mental capacity due to an illness and those minors who do not have an understanding of the examination/care or plan of care or consequences of a decision or lack of decision.

Upon determining that a patient is incapable to consent, in accordance with section 15-19 of the *HCCA*, a member shall follow the following procedures:

- Inform the patient that the member is of the opinion that the patient is incapable with respect to consent to examination, care or plan of care.

- Identify the patient's substitute decision-maker in accordance with sections 20-24 of the *HCCA*.

- Obtain consent from the patient's substitute decision-maker in accordance with sections 20-24 of the *HCCA*.

- If the patient objects to the finding of incapacity or the substitute decision-maker, inform the patient of his/her right to appeal this decision to the Consent and Capacity Board[4]. This information should be communicated to the patient in a manner the patient is best able to understand.

- Relevant information related to a determination of incapacity and a patient's substitute decision-maker must be documented in the patient health record.

The *HCCA* contains provisions regarding determination of incapacity, obtaining consent from a substitute-decision maker and applications to the Consent and Capacity Board. The complete *HCCA* is available at http://canlii.org/en/on/laws/stat/so-1996-c-2-sch-a/latest/so-1996-c-2-sch-a.html.

Examination or Care of Minors

The HCCA does not identify an age at which minors may exercise independent consent for health care because it is accepted that the capacity to exercise independent judgment for health care decisions varies according to the individual and the complexity of the decision at hand. A member is encouraged to seek consent from the appropriate substitute decision-maker (usually the parent or guardian or person with authority to make health care decisions on behalf of the child) before providing care to a minor who does not clearly have the capacity to consent to an examination, care or plan of care.

[4] The Consent and Capacity Board is an independent body created by the provincial government of Ontario under the *Health Care Consent Act, 1996*. It conducts hearings under the *Mental Health Act, the Health Care Consent Act, the Personal Health Information Protection Act, the Substitute Decisions Act* and the *Mandatory Blood Testing Act*. Board members are psychiatrists, lawyers and members of the general public appointed by the Lieutenant Governor in Council. The Board sits with one, three, or five members. Hearings are usually recorded in case a transcript is required.

LEGISLATIVE CONTEXT

Section 3 (1) of the *Health Professions Procedural Code* - One of CCO's objects under the *Regulated Health Professions Act, 1991* (*RHPA*) is to "develop, establish and maintain programs and standards of practice to assure the quality of the practice of the profession."

The Quality Assurance program is defined in Ss 1(1) of the Code as "a program to assure the quality of the practice of the profession and to promote continuing competency among members."

The Professional Misconduct Regulation under the *Chiropractic Act, 1991*, includes the following as an act of 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.

3. Doing anything to a patient for therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

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.

Health Care Consent Act, 1996

This standard of practice includes sections of the *HCCA*. The complete *HCCA* is available at **http://canlii.org/en/on/laws/stat/so-1996-c-2-sch-a/latest/so-1996-c-2-sch-a.html**.

The *HCCA* contains a number of provisions relating to consent, including Ss.11 which defines the requisite elements of consent to treatment as follows:

(1)
1. The consent shall relate to the treatment.
2. The consent shall be informed.
3. The consent shall be given voluntarily.
4. The consent shall not be obtained through misrepresentation or fraud.

(2) A consent to treatment is informed if, before giving it,

(a) the person received the information about the matters set out in subsection (3) that a reasonable person in the same circumstances would require in order to make a decision about the treatment; and
(b) the person received responses to his or her requests for additional information about those matters.

(3) The matters referred to in subsection (2) are:

1. The nature of the treatment.
2. The expected benefits of the treatment.
3. The material risks of the treatment.
4. The material side effects of the treatment.
5. Alternative courses of action.
6. The likely consequences of not having the treatment.

In addition, there is a body of case law which supports the principle that members shall ensure patient consent is fully informed and voluntarily given before patients are examined or treated.

Sections 15 – 19 of the *HCCA* discuss the rules related to determining capacity of patients. Please see the complete *HCCA* for further details.

Section 20 – 24 of the *HCCA* discuss the rules related to obtaining consent from a substitute decision-maker. Included in this section is the list of persons who may give or refuse consent on behalf of an incapable person. Please see the complete *HCCA* for further details.

List of persons who may give or refuse consent

20. (1) If a person is incapable with respect to a treatment, consent may be given or refused on his or her behalf by a person described in one of the following paragraphs:

1. The incapable person's guardian of the person, if the guardian has authority to give or refuse consent to the treatment.
2. The incapable person's attorney for personal care, if the power of attorney confers authority to give or refuse consent to the treatment.
3. The incapable person's representative appointed by the Board under section 33, if the representative has authority to give or refuse consent to the treatment.
4. The incapable person's spouse or partner.
5. A child or parent of the incapable person, or a children's aid society or other person who is lawfully entitled to give or refuse consent to the treatment in the place of the parent. This paragraph does not include a parent who has only a right of access. If a children's aid society or other person is lawfully entitled to give or refuse consent to the treatment in the place of the parent, this paragraph does not include the parent.
6. A parent of the incapable person who has only a right of access.
7. A brother or sister of the incapable person.
8. Any other relative of the incapable person.

Requirements

(2) A person described in subsection (1) may give or refuse consent only if he or she,

(a) is capable with respect to the treatment;

(b) is at least 16 years old, unless he or she is the incapable person's parent;

(c) is not prohibited by court order or separation agreement from having access to the incapable person or giving or refusing consent on his or her behalf;

(d) is available; and

(e) is willing to assume the responsibility of giving or refusing consent.

Ranking

(3) A person described in a paragraph of subsection (1) may give or refuse consent only if no person described in an earlier paragraph meets the requirements of subsection (2).

Section 25-28 of the *HCCA* discuss the rules related to examination and treatment without consent in emergency situations.

Explanatory Notes

This standard of practice should be read in conjunction with the following, all of which require that consent be fully informed, voluntarily given and evidenced in a written form signed by the patient or otherwise documented in the patient's chart:

- S-001: Chiropractic Scope of Practice
- S-002: Record Keeping
- S-005: Chiropractic Adjustment or Manipulation
- S-006: Ordering, Taking and Interpreting Radiographs
- S-007: Putting a Finger Beyond the Anal Verge for the Purpose of Manipulating the Tailbone
- S-011: Members of More Than One Health Profession
- S-013: Orthotics
- G-001: Communication with a Patient
- G-009: Code of Ethics
- G-014: Delegation, Assignment and Referral of Care

PROHIBITION OF A SEXUAL RELATIONSHIP WITH A PATIENT

Standard of Practice S-014
Patient Relations Committee
APPROVED BY COUNCIL: FEBRUARY 8, 2005
RE-AFFIRMED BY COUNCIL: FEBRUARY 19, 2009
Amended: April 14, 2010, September 22, 2011, February 14, 2012, September 20, 2013, September 16, 2017, April 24, 2018, September 15, 2018, November 25, 2021 (came into effect February 25, 2022), November 24, 2022 (came into effect February 24, 2023)

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

INTENT

To inform members that a sexual relationship with a patient is strictly forbidden by law.

DESCRIPTION OF STANDARD

Under no circumstances should a member have a sexual relationship with a patient.

Sexualizing a professional relationship is against the law. In Ontario, the *Regulated Health Professions Act* (*RHPA*) prohibits sexual involvement of health care professionals with patients. The *RHPA* defines sexual abuse as sexual intercourse or other forms of physical sexual relations, touching of a sexual nature, or behaviour or remarks of a sexual nature, between a member and a patient.

Because of the broad definition of sexual abuse outlined in the *RHPA*, it is prohibited for a member to have a sexual relationship with a patient. A concurrent sexual and doctor-patient relationship is strictly against the law, no matter which relationship was established first. This prohibition includes providing patient care to anyone with whom the member has a sexual relationship, with the exception of a spouse in accordance with the definition of a "spouse" under the *RHPA* or incidental or emergency treatment. (See *Spousal Exception to the Sexual Abuse Provisions of the RHPA* and *Incidental or Emergency Treatment* sections of this standard of practice). Even the most casual dating relationship may lead to forms of affectionate behaviour that would fall under this definition and could leave the member open to a possible complaint to CCO.

- A sexual relationship with a patient is prohibited. Under the *RHPA*, the following types of sexual abuse will result in the revocation of a member's licence:
  - sexual intercourse
  - genital to genital, genital to anal, oral to genital, or oral to anal contact,
  - masturbation of the member by, or in the presence of, the patient,
  - masturbation of the patient by the member,
  - encouraging of the patient by the member to masturbate in the presence of the member,
  - touching of a sexual nature of the patient's genitals, anus, breasts or buttocks, and
  - other conduct of a sexual nature prescribed in regulations made pursuant to clause 43 (1) (u) of the *Regulated Health Professions Act, 1991.*

  For the purposes of this section, "sexual nature does not include touching, behaviour or remarks of a clinical nature appropriate to the service provided."

- For the purposes of the sexual provisions, the *RHPA* defines "patient" as

  "patient", without restricting the ordinary meaning of the term, includes,
  (a) an individual who was a member's patient within one year or such longer period of time as may be prescribed from the date on which the individual ceased to be the member's patient, and
  (b) an individual who is determined to be a patient in accordance with the criteria in any regulations made under clause 43 (1) (o) of the *Regulated Health Professions Act, 1991*; ("patient")

  Therefore, a member shall not commence a sexual relationship with an individual who is a patient, as defined in the *RHPA*, until at least one year from the date on which the individual ceased to be the member's patient.

- Sexual abuse under the *RHPA* has a different legal description from sexual assault under the *Criminal Code of Canada*[1]. Unlike the criminal act of sexual abuse, consent is not a defence to sexual abuse under the *RHPA* and acts of a sexual nature by a regulated health professional may constitute sexual abuse under the *RHPA* and result in regulatory consequences, including the revocation of a member's certificate of registration, without it being sexual assault under the *Criminal Code of Canada*.

[1] *Criminal Code of Canada RSC 1985, c C-46, section 150 – 150.1.*

- There is a history of complaints against members who have had sexual relationships with their patients/former patients. Complaints have been made by patients, significant others (including spouses of both members and patients) and former significant others. Therefore, the member shall ensure that there is a termination of the doctor-patient relationship, and at least one year has passed from the date the individual ceased to be the member's patient, before commencing a sexual relationship with a former patient. The one-year time period begins when the individual ceased to be a member's patient and there is termination of the doctor-patient relationship. In such circumstances, the member shall perform the following actions to terminate the doctor-patient relationship:
    - terminate the care of the patient,
    - provide a referral to another chiropractor,
    - document these actions in the patient health record,
    - formally notify such correspondence to the patient, and
    - maintain a second copy in the file.

  At the patient's request, the member shall transfer patient records to the new attending chiropractor.

- A member is reminded that they have an ethical obligation not to exploit the trust, knowledge and dependence that develops during the doctor-patient relationship. Before determining the appropriateness of a sexual relationship with a former patient, a member must think and act cautiously. A panel of the Inquiries, Complaints and Reports Committee, Discipline Committee or Fitness to Practise Committee will consider a number of factors in determining the appropriateness of a sexual relationship with a former patient, including but not limited to:
    - the nature, length and intensity of the former doctor-patient relationship,
    - the nature of the patient's clinical problem,
    - the type of care provided by the member,
    - the length of time following the termination of the doctor-patient relationship before the commencement of a sexual relationship, and
    - the vulnerability of the patient during and following the doctor-patient relationship and the patient's understanding of the dynamics and boundaries of the doctor-patient relationship.

  It may never be appropriate for a member to have a sexual relationship with a former patient or for a member to provide patient care to someone with whom they previously had a sexual relationship (for example, when there is a continued power imbalance between the member and the former patient, or the former patient is physically or emotionally vulnerable).

- A member is reminded that they are a primary health care provider who is authorized to use the "doctor" title, perform certain controlled act under the *RHPA,* and provides "hands on" therapies and treatments. As such, the member should recognize that a power imbalance exists between the member and patients and patients are often in a physically and/or emotionally vulnerable position.

If a patient suggests or attempts to develop a sexual relationship:

- inform the patient of the legal restrictions and prohibitions and communicate proper boundaries for the doctor-patient relationship.

- refer the patient to another chiropractor if the above actions do not resolve the situation.

- document actions on the patient's chart.

Evidence of a Doctor-patient Relationship

Regulation 260/18 under the *RHPA* establishes criteria for the purposes of determining whether an individual is a patient of a member, as follows:

"An individual is a patient of a member if there is direct interaction between the member and the individual and any of the following conditions are satisfied:

i. The member has, in respect of a health care service provided by the member to the individual, charged or received payment from the individual or a third party on behalf of the individual.
ii. The member has contributed to a health record or file for the individual.
iii. The individual has consented to the health care service recommended by the member."

Case law, including *Leering v. College of Chiropractors of Ontario, 2010 ONCA (Leering v. CCO),* has identified factors that would indicate the existence of a doctor-patient relationship. From *Leering v. CCO*, evidence of a doctor-patient relationship includes, but is not limited to:

- opening of a patient file that includes one or more of the following:
    - patient history
    - physical examination
    - diagnosis
    - plan of management
    - prognosis
    - diagnostic imaging reports
    - written record of treatment
    - informed consent to treatment
    - billing information
- commencement of billings, including billing to third parties, such as insurance companies
- financial records
- letters of consultation to and from other health professionals
- written communications or statements referring to an individual as a patient
- formal letter of discharge

A panel of the Inquiries, Complaints and Reports Committee, Discipline Committee or Fitness to Practise Committee will consider various factors central to the doctor-patient relationship, including those identified in Regulation 260/18 and caselaw in determining whether a doctor-patient relationship exists.

Evidence of the Termination of a Doctor-patient Relationship and/or Discharge of the Patient from Care

In accordance with the sexual abuse provisions of the *RHPA*, factors that would indicate the termination of a doctor-patient relationship or a discharge of care by either the member or patient, include, but are not limited to:

- a termination of care of the patient and/or discharge of care by either the member of patient, indicating the date of termination of care (i.e., the date of the last examination or treatment),
- communication/correspondence between the member and patient indicating the termination of care and/or discharge of care, and the date this correspondence,
- a referral of the patient to another chiropractor,
- documentation of any of these actions in the patient health record,
- providing a copy of such correspondence to the patient, and
- maintaining a second copy in the file.

Spousal Exception to the Sexual Abuse Provisions of the *RHPA*

As of October 22, 2021, the Government of Ontario passed a regulation under the *Chiropractic Act, 1991* for a spousal exception to the sexual abuse provisions of the *RHPA*. The spousal exception regulation permits members to provide chiropractic care to their spouses, without it constituting sexual abuse, in accordance with the regulation:

Conduct, behaviour, or remarks that would otherwise constitute sexual abuse of a patient by a member under the definition of "sexual abuse" in subsection 1(3) of the Health Professions Procedural Code of the Regulated Health Professions Act, 1991, shall not constitute sexual abuse, if:

(a) The patient is the member's spouse, and

(b) The member is not engaged in the practice of chiropractic at the time the conduct, behaviour or remarks occur.

The definition of "spouse" for the purposes of this regulation is very narrowly defined in the Health Professions Procedural Code of the *RHPA*, and includes only:

(a) A person who is the member's spouse as defined in section 1 of the Family Law Act, or

(b) A person who has lived with the member in a conjugal relationship outside of marriage continuously for a period of not less than three years.

Incidental or Emergency Treatment

Regulation 260/18 under the *RHPA* states that an individual is not a patient of a member if all the following conditions are satisfied:

"i. There is, at the time the member provides the health care services, a sexual relationship between the individual and the member.

ii. The member provided the health care service to the individual in emergency circumstances or in circumstances where the service is minor in nature.

iii. The member has taken reasonable steps to transfer the care of the individual to another member or there is no reasonable opportunity to transfer care to another member."

A panel of the Inquiries, Complaints and Reports Committee, Discipline Committee or Fitness to Practise Committee will determine if a concurrent doctor-patient relationship and sexual relationship occurred, as follows:

- Review the factors of incidental or emergency treatment, as determined by Regulation 260/18 under the *RHPA* and the Ontario Court of Appeal
- Apply these factors to the specific facts of a complaint or hearing

If a finding of a concurrent doctor-patient relationship and sexual relationship is made, the sexual abuse provisions of the *RHPA* will apply.

A member who provides incidental or emergency treatment to someone with whom they are engaging in a sexual relationship and decides that the person would benefit from receiving additional chiropractic care must refer that person to another chiropractor and/or health care professional and document this referral.

FINAL WORDS

- A sexual relationship with a patient is strictly forbidden by law, with the exception of the spousal exception regulation.

- Information regarding allegations of sexual abuse comes to the attention of CCO through the ICRC, and/or mandatory reporting by a member or another health professional.

- The penalties for a finding of professional misconduct relating to sexual abuse of a patient, which are found in section 51(2) of the *Code*, include:
  - revocation of a member's licence for five years;
  - stringent conditions on a member's licence before applying for reinstatement;
  - results of the discipline proceedings will remain on the public register indefinitely; and
  - financial obligations, such as paying for therapy and/or counselling for the victims and reimbursing CCO for legal and investigative costs.

LEGISLATIVE CONTEXT

Health Professions Procedural Code, Schedule 2 to the *Regulated Health Professions Act, 1991*

Sexual Abuse of a patient

Section 1(3): In this *Code*, "sexual abuse" of a patient by a member means,

(a) sexual intercourse or other forms of physical relations between the member and the patient,
(b) touching, of a sexual nature, of the patient by the member, or
(c) behaviour or remarks of a sexual nature by the member towards the patient.

Exception

Section 1(4): For the purposes of subsection (3), "sexual nature does not include touching, behaviour or remarks of a clinical nature appropriate to the service provided.

Definition of Patient

Section 1(6): For the purposes of subsections (3) and (5), "patient", without restricting the ordinary meaning of the term, includes,

(a) an individual who was a member's patient within one year or such longer period of time as may be prescribed from the date on which the individual ceased to be the member's patient, and

(b) an individual who is determined to be a patient in accordance with the criteria in any regulations made under clause 43 (1) (o) of the *Regulated Health Professions Act, 1991*; ("patient")

Exception

Section 1(4): For the purposes of subsection (3), "sexual nature does not include touching, behaviour or remarks of a clinical nature appropriate to the service provided."

Statement of purpose, sexual abuse provisions

1.1 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.

Orders relating to sexual abuse

Section 51(5): If a panel finds a member has committed an act of professional misconduct by sexually abusing a patient, the panel shall do the following in addition to anything else the panel may do under subsection (2):

1. Reprimand the member.
2. Revoke the member's certificate of registration if the sexual abuse consisted of, or included, any of the following,
   i. Sexual intercourse
   ii. Genital to genital, genital to anal, oral to genital, or oral to anal contact,
   iii. Masturbation of the member by, or in the presence of, the patient,
   iv. Masturbation of the patient by the member,
   v. Encouraging of the patient by the member to masturbate in the presence of the member,
   vi. touching of a sexual nature of the patient's genitals, anus, breasts or buttocks, and
   vii. other conduct of a sexual nature prescribed in regulations made pursuant to clause 43 (1) (u) of the *Regulated Health Professions Act, 1991.*

Interpretation

(5.1) For greater certainty, for the purposes of subsection (5),
"sexual nature" does not include touching or conduct of a clinical nature appropriate to the service provided. 2017, c. 11, Sched. 5, s. 19 (3).

Mandatory revocation

(5.2) The panel shall, in addition to anything else the panel may do under subsection (2), reprimand the member and revoke the member's certificate of registration if,
   (a) the member has been found guilty of professional misconduct under clause (1) (a) and the offence is prescribed in a regulation made under clause 43 (1) (v) of the Regulated Health Professions Act, 1991; or
   (b) the member has been found guilty of professional misconduct under clause (1) (b) and the misconduct includes or consists of any of the conduct listed in paragraph 3 of subsection (5). 2017, c. 11, Sched. 5, s. 19 (3).

Statement re: impact of sexual abuse

Section 51(6): Before making an order under subsection (5), the panel shall consider any written statement that has been filed, and any oral statement that has been made to the panel, describing the impact of the sexual abuse on the patient.

Same

Section 51(7): The statement may be made by the patient or by his or her representative.

Notice to member

Section 51(8): The panel shall not consider the statement unless a finding of professional misconduct has been made.

Section 51(9): When a written statement is filed, the panel shall, as soon as possible, have copies of it provided to the member, to his or her counsel and the College.

Application for Reinstatement

Section 72(1): A person whose certificate of registration has been revoked or suspended as a result of disciplinary or incapacity proceedings may apply in writing to the Registrar to have a new certificate issued or the suspension removed.

Section 72 (3): An application under subsection (1), in relation to a revocation for sexual abuse of a patient, shall not be made earlier than,

(a) five years after the date on which the certificate of registration was revoked; or
(b) six months after a decision has been made in a previous application under subsection (1).

Ontario Regulation 260/18

1. The following criteria are prescribed criteria for the purposes of determining whether an individual is a patient of a member for the purposes of subsection 1 (6) of the Health Professions Procedural Code in Schedule 2 to the Act:

1. An individual is a patient of a member if there is direct interaction between the member and the individual and any of the following conditions are satisfied:

i. The member has, in respect of a health care service provided by the member to the individual, charged or received payment from the individual or a third party on behalf of the individual.
ii. The member has contributed to a health record or file for the individual.
iii. The individual has consented to the health care service recommended by the member.
iv. The member prescribed a drug for which a prescription is needed to the individual.

2. Despite paragraph 1, an individual is not a patient of a member if all of the following conditions are satisfied:

i. There is, at the time the member provides the health care services, a sexual relationship between the individual and the member.
ii. The member provided the health care service to the individual in emergency circumstances or in circumstances where the service is minor in nature.
iii. The member has taken reasonable steps to transfer the care of the individual to another member or there is no reasonable opportunity to transfer care to another member.

Ontario Regulation 716/21

Spousal Exception

1. The spousal exception in subsection 1 (5) of the Health Professions Procedural Code applies in respect of the College.

Section 1(5) of the Health Professions Procedural Code

Conduct, behaviour, or remarks that would otherwise constitute sexual abuse of a patient by a member under the definition of "sexual abuse" in subsection 1(3) of the Health Professions Procedural Code of the Regulated Health Professions Act, 1991, shall not constitute sexual abuse, if:

(a) The patient is the member's spouse, and
(b) The member is not engaged in the practice of chiropractic at the time the conduct, behaviour or remarks occur.

For the purposes of this regulation, "spouse", in relation to a member, means:

(a) A person who is the member's spouse as defined in section 1 of the Family Law Act, or
(b) A person who has lived with the member in a conjugal relationship outside of marriage continuously for a period of not less than three years.

Ontario Regulation 262/18

Prescribed offences

1. The offences mentioned in sections 151, 152, 153, 153.1, subsection 160 (3) and sections 162, 162.1, 163.1, 170, 171.1, 172.1, 172.2, 271, 272 and 273 of the Criminal Code (Canada) are prescribed offences for the purposes of clause 51 (5.2) (a) of the Health Professions Procedural Code in Schedule 2 to the Act.

COMMUNICATION TO THE PUBLIC

Standard of Practice S-016
Quality Assurance Committee
Approved by Council: November 28, 2024 (came into effect February 21, 2025)

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

INTENT

1. To uphold the public interest by ensuring that members' communication to the public is:
    - accurate, factual and verifiable;
    - maintains a professional image in communicating the delivery of safe, ethical chiropractic care
    - supported by generally acceptable evidence; and
    - within the chiropractic scope of practice.

2. To ensure that the public has the information to make rational choices and obtain the health care services of their choice.

3. To provide guidance to members on how to engage in social media in a professional context and meeting legal, regulatory and professional obligation.

DEFINITIONS

"Communication to the Public" is any message communicated through a public medium, promoting chiropractic services and/or products, including but not limited to: print advertising, materials and posters in member's office, video, audio, websites, social media, and podcasts, that can be seen or heard by the public, or any subset of the public.

"Social media" refers to all web and mobile technologies and practices that are used to share content, opinions, expressions and perspectives online. Social media has become widely used as a means of communication and in many instances, has become the preferred method of communication. Examples of social media platforms, including, but are not limited to: Facebook, X, YouTube, LinkedIn, TikTok, Snapchat and Pinterest.

This standard applies equally to members acting individually, as a group, such as a multi-disciplinary office, or as a professional health corporation. A member is responsible for any communication to the public that is produced on their behalf by an employee or third-party and must ensure that any such communication to the public is compliant with CCO standards of practice and guidelines.

DESCRIPTION OF STANDARD

I. GENERAL COMMUNICATION TO THE PUBLIC REQUIREMENTS

Accuracy and Verifiability

1. A communication to the public must:

   (a) be accurate, factual and contain information that is verifiable;

   (b) be readily comprehensible by the target audience; and

   (c) clearly communicate that the member is a registered chiropractor in Ontario and a member of the College of Chiropractors of Ontario.

Permissible Content

2. A communication to the public may:

   (a) name a specific diagnostic or therapeutic procedure within the chiropractic scope of practice in accordance with Standard of Practice S-001: Chiropractic Scope of Practice, but cannot claim superiority or endorse the exclusive use of such a procedure;

   (b) make reference to the member being a specialist, provided the member is a recognized specialist in accordance with Policy P-029: Chiropractic Specialties;

   (c) make reference to the member being affiliated with any professional association, society or body, other than CCO, only on curriculum vitae, a biographical section of a member's website or social media account, business stationery and recognized public displays;

   (d) allow an individual or organization to endorse a member, provided,
   (i) the endorser has sufficient expertise relevant to the subject matter being endorsed;
   (ii) the member has been appropriately assessed as providing the subject matter being endorsed; and
   (ii) the member has disclosed any financial or other benefit given or received for the endorsement, if such a benefit has been exchanged.

(e) include testimonials[1], that refer only to the benefits of chiropractic and not to a particular member or office, or testimonials that refer to a particular member or office only in a member's website, provided the testimonials:
(i) are accurate, verifiable, and recorded in the patient health record;
(ii) are used only in accordance with the written consent of the patient;
(iii) are not obtained using any undue pressure, duress, coercion or incentives;
(iv) include a disclaimer stating that the results of the testimonial may not be typical of all patients or that results of patients may vary,
(v) do not include any information, testimonial or narrative about the member providing care to the member's own family, and
(vi) are otherwise compliant and consistent with the chiropractic scope of practice, privacy legislation, and CCO standards of practice, policies and guidelines.

Prohibited Content

3. Any communication to the public with respect to a member's practice must not contain:

(a) anything false or misleading[2];

(b) an express or implied 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;

(e) material that, having regard to all the circumstances, would reasonably be regarded as disgraceful, dishonourable or unprofessional.

[1] *Canadian Code of Advertising Standards* from Advertising Standards Canada, section 7 states: "Testimonials, endorsements or representations of opinion or preference, must reflect the genuine, reasonably current opinion of the individual(s), group or organization making such representations, and must be based upon adequate information about or experience with the product or service being advertised, and must not otherwise be deceptive."
[2] *The Competition Act, 1985* states: "that a misleading "general impression" could be created if an advertisement claim is literally true but misleads by failing to disclose additional vital details needed to interpret claims and make informed purchase decisions. The Competition Bureau of Canada has interpreted "false or misleading" under the *Competition Act, 1985,* to mean that the representation leads a person to a course of conduct that, on the basis of the representation, he or she believes to be advantageous. "Material" does not refer to the value of the product to the purchaser but, rather, the degree to which the purchaser is affected by the representation in deciding whether to purchase the product." Please see a link to the Competition Bureau https://www.competitionbureau.gc.ca/eic/site/cb-bc.nsf/eng/01315.html for further information.

Communication of Fees

4. A member may communicate to the public their fee(s) for chiropractic services[3], provided:

   (a) the communication is accurate, complete, clear and not misleading (e.g., no hidden fees);

   (b) the communication of a promotional fee:
      a. expressly states the timeframe of the promotion,
      b. does not limit the promotional fee to a specific number of participants, and
      c. does not place an obligation on the patient for any follow-up appointments as a result of the promotional fee; and

   (c) the communication of fees is presented in a professional manner.

Communication of Exchange of Products/Services for Charitable Donations/Proceeds

5. A member may communicate to the public the exchange of products/services for charitable donations, provided:

   (a) the donations/proceeds are being collected for a registered charity, school or other organization that services the public interest ("charity");

   (b) the charity is disclosed in the communication; and

   (c) the amount/percentage donated to the charity is disclosed in the communication.

Solicitation of Business

6. A communication to a patient or prospective patient for the purposes of soliciting business must be appropriate to the standards of the profession, comply with anti-spam legislation, be respectful of patient choice, and must not involve undue pressure, including pressuring a patient to bring a family member or guest to a subsequent treatment or appointment, 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.

[3] Please see Guideline G-008: Business Practices for more information about billing practices requirements.

II. Use of Social Media

Social media may present opportunities for enhancement of patient care, education about chiropractic care, intra and inter-professional communication and collaboration, and opportunities for continuing education and professional development.

A member is expected to comply with all existing legal, regulatory and professional obligations when engaging in the use of social media, including all relevant legislation, regulation, standards of practice, policies and guidelines.

Privacy and Confidentiality

A member must comply with all legal and professional obligations to maintain privacy and confidentiality in accordance with the *Personal Health Information Protection Act, 2004 (PHIPA)* and CCO standards of practice, including:

(a) not divulge information through social media that identifies a patient by name or through a combination of other identifying information. While patients or members of the public may make themselves publicly known through posting, a member must not breach the privacy or confidentiality of a patient in any context.

(b) only communicating through secure private messaging for the purposes of scheduling, providing information and other doctor/patient communications.

Clinical Information and Advice

A member:

(a) may provide general health information only related to the chiropractic scope of practice for educational or informational purposes,

(b) must not provide any clinical advice, communicate a diagnosis and/or guarantee results to a patient or any member of the public through social media.

(c) must be cognizant of the risks of using social media for professional reasons, such as a member of the public incorrectly applying information found online to their personal health situation. Whenever a member uses their professional designation or provides health related information, that member is viewed as acting in a professional capacity.

Copyright Considerations

A member must exercise caution when posting health related information and links to journal articles or academic information to ensure he/she is not infringing on any copyrighted material.

Professional Conduct and Boundaries

A member:

(a) must maintain appropriate professional boundaries, and avoid posting information, comments or images that may reasonably be perceived as disgraceful, dishonourable or unprofessional or as harassment, bullying, or inflammatory comments.

(b) is encouraged to have separate personal and professional social media pages,

(c) must consider their legal, professional and regulatory obligations and exercise good judgment and caution before posting material to social media.

III. Health Care Claims in Communication to the Public

A member must give consideration to the following factors when making health care claims as to the benefit of chiropractic care in communication to the public:

- Does the claim fall within the chiropractic scope of practice?
- Is the claim based on accurate, factual, verifiable, and objective information?
- Is the claim supported by generally acceptable evidence?
- Is the claim otherwise compliant with CCO standards of practice, policies and guidelines?

Generally Acceptable Evidence

When assessing whether there is acceptable evidence for making health care claims in communication to the public, a member must comply with the following:

- The health care claim must relate to the chiropractic scope of practice;

- Evidence supporting the health care claim must be properly communicated to the public in a manner that:
    - Is accurate, verifiable, objective, clear and concise,
    - Is not false or misleading,
    - Does not include a guarantee of success of care,
    - Clearly communicates what is the level of evidence and source of any cited study,
    - Does not exaggerate or extrapolate the results of any evidence,
    - Is communicated in a manner that is understandable to the public, providing appropriate citation(s) from reputable source(s).

- The member must use caution in communicating a health care claim related to a case study or similar study. This includes citing a reputable source, clearly communicating that the results of a study may not be typical of patients, and neither exaggerating nor extrapolating the results of a study;

- In communicating a health care claim in advertising, websites and social media, the member must not communicate a health care claim that is beyond the chiropractic scope of practice, includes a possible breach of a CCO standard of practice, policy or guideline, is not supported by generally acceptable evidence, or involves a risk of harm to the public.

LEGISLATIVE CONTEXT

This standard of practice should be read in conjunction with:

- Regulation R-008: Professional Misconduct
- Standard of Practice S-001: Chiropractic Scope of Practice
- Guideline G-008: Business Practices
- Guideline G-016: Communication to the Public
- Policy P-016: Public Display Protocol

ACUPUNCTURE

Standard of Practice S-017
Quality Assurance Committee
Distributed for Feedback: September 2006
Approved by Council: June 22, 2007
Amended: September 11, 2007, 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 OF PRACTICE

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 is defined in the *Chiropractic Act 1991,* 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."

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

Members are reminded that the use of any acupuncture procedure or protocol may have significant benefits for patients, but also carries some risk. As such, members 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;
- aware of precautions necessary to prevent injury.

Members are 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, members 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 training[2] is required for those members who intend to use acupuncture as an adjunctive procedure in their 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

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

Chiropractors 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.

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

[2] The 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;
   - 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
   - principal clinical conditions in which acupuncture has been shown to be beneficial;
   - selection of patients and evaluation of progress/benefit;
   - 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;
   - specific clinical conditions.

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.

PROFESSIONAL LIABILITY INSURANCE

Members must 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 *Regulation 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*

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

5. To develop, establish and maintain standards of practice to assure the quality of the practice of the profession

6. 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 performed 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.

Table

	Column 1	Column 2
1.	College of Chiropodists of Ontario	Chiropody
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.

Chiropractic Act, 1991

Scope of Practice

Members who use acupuncture as an adjunctive therapy are 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-001: Chiropractic Scope of Practice, S-003: Professional Portfolio, S-011: Members of More Than One Health Profession, and S-013: Consent.

THIRD PARTY INDEPENDENT CHIROPRACTIC EVALUATIONS

Standard of Practice S-018
Quality Assurance Committee
Approved by Council: February 23, 2010
Amended: February 8, 2011, September 20, 2013

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

INTRODUCTION

Chiropractors are permitted to perform many types of third-party evaluations in their professional capacity as a chiropractor, including but not limited to, independent chiropractic evaluations/examinations, file reviews, functional capacity evaluations, in-home assessments and ergonomic assessments. Evaluations of this nature may be requested by a third party and require a report to be prepared and provided to the third party. These evaluations, examinations and/or reports often include a review of clinical data and the answering of questions concerning diagnoses, impairment, functional capabilities, causal linkage and plan of care/management.

INTENT

The purpose of this standard of practice is to:

- clarify CCO's expectations regarding the role of members in conducting evaluations, examinations and/or reports for third parties;
- provide guidance to members conducting evaluations, examinations and/or reports for third parties;
- ensure that independent chiropractic examiners have the appropriate education, skill and training to perform the specific type of evaluation requested; and
- ensure members communicate clearly their role to the patient being assessed.

DEFINITIONS

- An independent chiropractic examiner (ICE) is a chiropractor performing any evaluation and/or a third-party report at the request of a third party. An ICE is not the treating chiropractor of the patient.
- A treating chiropractor is the chiropractor with whom the patient has an on-going doctor-patient relationship.

- A third party is any person or organization other than the treating chiropractor and/or patient, including but not limited to, an insurance company, lawyer, employer, worker's compensation organization, regulatory college or educational institution.

DESCRIPTION OF STANDARD

An independent chiropractic examiner (ICE), like all members of CCO, has a primary duty to serve and protect the public interest as set out in the *Regulated Health Professions Act, 1991* (*RHPA*), the *Chiropractic Act, 1991* and its regulations, and CCO standards of practice, policies and guidelines.

All parties involved in this type of independent chiropractic evaluation, examination, file review, or preparation of a third-party report should recognize that the process may be inherently adversarial in nature. Since an ICE does not develop an ongoing doctor-patient relationship with the patient being assessed, this may result in a more impersonal and stressful experience for that patient. An ICE shall treat the patient being assessed with dignity and respect as befits his/her status as a professional healthcare provider.

Communication and Conduct with Patient Being Assessed

An ICE shall:

- take the necessary care to act in a professional and caring manner, and communicate his/her role clearly to the patient being assessed;

- communicate to the patient being assessed that he/she has a separate obligation to a third party and that the evaluation is being performed at the request of a third party;

- communicate to the patient being assessed that no ongoing doctor-patient relationship will be established and that if ongoing care is necessary, he/she will not be providing ongoing chiropractic care to the patient;

- allow ample opportunity during the interview portion of any evaluation for the patient to share information that he/she feels is relevant to the evaluation and have any of his/her questions answered concerning the purpose and procedures of the evaluation; and

- adhere to professional cooperation and timely communication with the treating chiropractor, as necessary; and

- ensure that a chaperone is present during the examination of a patient being assessed, when requested by that patient. If an ICE chooses to have a chaperone present on his/her behalf, the ICE shall notify the patient being assessed that a chaperone will be present for his/her examination in a timely manner before that patient's appointment with the ICE.

Consent

- An ICE shall obtain consent to every third party independent chiropractic evaluation (excluding a file review) as outlined in Standard of Practice S-013: Consent. Consent to any examination must be:

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

- An ICE performing any evaluation shall take necessary care to ensure that the patient being assessed understands the purpose of the evaluation, what questions will be answered as a result of the evaluation, how the evaluation will proceed, and where the report will be sent.

- An ICE shall take care to avoid causing undue harm to the patient. During a physical examination, an ICE shall inform the patient being assessed that physical symptoms may be elicited or aggravated due to the nature of functional evaluations, which may challenge the individual's physiological limits.

- An ICE shall answer all questions to the best of his/her ability relating to the process and purpose of any evaluation.

Record Keeping

- An ICE has an obligation to create a file and maintain a proper patient health record as outlined in Standard of Practice S-002: Record Keeping.

Privacy

- An ICE shall not disclose personal health information, as defined in the *Personal Health Information Protection Act, 2004*, to a third party without proper consent from the patient, unless required by law.

- In circumstances where the patient gives limited consent with respect to his/her patient records, an ICE shall ensure that only personal health information to which the patient consents is disclosed to a third party. If limited consent affects the preparation of a report, the ICE shall include a notation that certain personal health information has been excluded from the report due to limited consent.

Preparation of Report

- An ICE shall provide a professional opinion in an accurate, impartial and objective manner that is substantiated by fact and sound clinical judgment and defensible through the identification of objectives related to the issues under dispute.

- An ICE report shall:
    - include: relevant qualifications, extent of evaluation, source and purpose of evaluation conclusion and recommendations as requested re: diagnoses, impairment, functional capabilities, causal linkage and plan of care/management.
    - be based on all relevant health information available to the ICE.
- An ICE shall, when in the best interest of the patient and if permitted by law, take measures to ensure that the treating chiropractor and patient receive copies of the original report prepared by the ICE.

Assessor Qualifications

An ICE shall:

- be registered in the 'General' class of registration and be providing clinical care in Ontario;
- only perform independent chiropractic evaluations and file reviews within his/her area of expertise and within the scope of practice of chiropractic as defined in the *Chiropractic Act, 1991*;
- have necessary and relevant education, training, experience, and expertise to offer an opinion regarding the issue in dispute;
- maintain professional liability protection as outlined in Regulation R-137/11: Registration, and CCO By-law 16: Professional Liability Insurance;

It is strongly recommended that an ICE maintain a reasonably balanced practice and not solely perform third party independent chiropractic evaluations.

Conflict of Interest

An ICE shall not allow his/her responsibility to prepare a report for a third party or any fee received from a third party to compromise his/her paramount duty to act in the best interests of the patient being assessed, and his/her obligation to practise chiropractic in accordance with the *RHPA, the Chiropractic Act, 1991* and its regulations, and CCO standards of practice, policies and guidelines.

Continuing Education

An ICE shall participate in ongoing continuing education. There are many continuing education courses specific to independent chiropractic evaluations/examinations that are offered, including clinical sciences, accident reconstruction, independent chiropractic evaluations, rehabilitation, radiology, functional capacity evaluations, disability and impairment rating, and treatment protocols. To serve and protect the public interest, it is important that an ICE remain current with his/her training.

LEGISLATIVE CONTEXT

Quality Assurance

Health Professions Procedural Code, Schedule 2 to the *Regulated Health Professions Act, 1991*

Section 1(1): "quality assurance program" means a program to assure the quality of the practice of the profession and to promote continuing evaluation, competence and improvement among the members.

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

3. To develop, establish and maintain standards of qualification for persons to assure the quality of the profession.

Scope of Practice

The scope of practice of chiropractic is defined in section 3 of 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:
>
> - dysfunctions or disorders arising from the structures or functions of the spine and the effects of those dysfunctions or disorders on the nervous system; and
> - dysfunctions or disorders arising from the structures or functions of the joints."

Authorized Acts

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

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.

Unfair and Deceptive Acts and Practices in the Business of Insurance

Insurance Act, 1990

Definitions, Part XVIII

438. For the purposes of this Part,

"person" includes an individual, corporation, association, partnership, organization, reciprocal or insurance exchange, member of the society known as Lloyd's, fraternal society, mutual benefit society or syndicate;

"Superintendent" means the Superintendent of Financial Services appointed under the *Financial Services Commission of Ontario Act, 1997*

"unfair or deceptive acts or practices" means any activity or failure to act that is prescribed as an unfair or deceptive act or practice.

Unfair or deceptive acts, etc., prohibited

439. No person shall engage in any unfair or deceptive act or practice.

Superintendent may investigate

440. The Superintendent may examine and investigate the affairs of every person engaged in the business of insurance in Ontario in order to determine whether such person has been, or is, engaged in any unfair or deceptive act or practice.

CONFLICT OF INTEREST IN COMMERCIAL VENTURES

Standard of Practice S-019
Quality Assurance Committee
Approved by Council: February 14, 2012
Amended: February 11, 2014, February 6, 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 describe for members what a conflict of interest is for the purposes of section 1(9) of Ontario Regulation 852/93.

To advise members that:

- they may engage in commercial ventures in accordance with this standard of practice and all relevant CCO standards of practice.
- there is an inherent power imbalance that exists in the doctor/patient relationship.
- they must protect the interests of all patients above the commercial interests of the member.
- it is a potential conflict of interest to solicit patients for commercial ventures, such as self referral and selling or dispensing of products.

It is expected that a member's practice be conducted in a professional manner and that the focus of the practice be on the health care of the patients. A patient's need for health care must be the first priority over any financial considerations of the member.

A member must disclose to a patient prior to the performance of an act that is considered to be a conflict of interest. Failure to do so may be considered to be disgraceful, dishonourable or unprofessional conduct. A member must also be aware of the possibility of damage to the reputation of the profession by the appearance of a conflict of interest, even though an actual conflict of interest may not exist, and avoid creating such a perception.

A member must record any disclosure of a conflict of interest in the patient health record.

DESCRIPTION OF STANDARD

Conflict of Interest

- It is a conflict of interest for the purposes of section 1(9) of the professional misconduct regulation for a member to engage in a relationship or arrangement as a result of which the

member's personal interests could improperly influence his/her professional judgment or conflict with his/her duty to act in the best interest of the patient.

- Without limiting the generality of section 1(9), it is a conflict of interest for a member to:
    - give or receive a rebate, gift or benefit to or from a supplier of health care products or services or to or from a health, legal or any other professional or practitioner for a patient referral;
    - give or accept credit to or from a supplier or give or receive a benefit from a supplier of health care products or services or to or from a health, legal or any other professional or practitioner for a patient referral, unless the terms of credit provide a reasonable time for repayment and a reasonable rate of interest;
    - refer or receive a referral of a patient to or from a supplier of health care products or services in which the member has a financial interest unless the member discloses the interest to the patient; and
    - sell a product to a patient for more than fair market value plus a reasonable and customary dispensing fee.
- In disclosing any conflict of interest, the member shall:
    - disclose the member's conflict of interest to the patient when giving or receiving a rebate, gift, benefit or credit, or making or receiving a referral;
    - advise the patient that his/her choice of professionals, facilities, services or suppliers will not affect the quality of the health services provided by the member;
    - record the disclosure of the conflict of interest in the patient health record; and
    - disclose information related to the referral to CCO upon request.
- A member shall not subject a patient to any undue pressure or duress in giving or receiving any referral to or from a supplier of health care products or services, or a health, legal or any other professional or practitioner;
- A member is reminded that he/she is responsible for:
    - the actions of his/her staff, while performing their roles as members of staff;
    - any communications of a commercial nature made by staff to a patient; and
    - any potential conflicts of interest staff has with a patient.

Please see Guideline G-005: Guidelines Related to Office Staff for further detail.

Self Referral

Self referral means a member's referral of a patient to facilities, services or suppliers outside the member's practice, in which the member has a direct or indirect financial interest or gains any benefit. A member may undertake self referral provided that:

- the member has advised the patient that his/her choice of facilities, services or suppliers will not affect the quality of the health services provided by the member;
- the member has disclosed his/her interest to the patient when making a referral
- the member has recorded the disclosure of the conflict of interest in the patient health record; and
- information about the referral will be disclosed to CCO upon request.

Selling or Dispensing of Products

In the context of his/her chiropractic practice, a member may market and sell products that are within the scope of the chiropractic practice. Examples include orthotics, braces, pillows and nutritional supplements. In doing so, a member shall:

- establish a reasonable and customary fee for the sale of a product and advise the patient if there are ongoing fees;
- inform the patient that the patient's choice of health care products will not adversely affect the quality of health services provided by the member;
- recognize the inherent power imbalance in the doctor/patient relationship and ensure patient interests are protected above any commercial interests of the member or staff;
- record the disclosure in the patient health record; and
- comply with, and ensure staff comply with, any conflict of interest and advertising regulations, standards of practice, policies and guidelines of CCO.

LEGISLATIVE CONTEXT

Chiropractic Act, 1991

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.

Ontario Regulation 852/93: Professional Misconduct

The following are acts of professional misconduct for the purposes of clause 51 (c) of the *Health Professions Procedural Code*:

2. Contravening a standard of practice of the profession or failing to maintain the standard of practice expected of members of the profession.
9. Practising the profession while the member is in a conflict of interest.
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.
33. Engaging in conduct or performing an act that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishounorable or unprofessional.

COOPERATION AND COMMUNICATION WITH CCO

Standard of Practice S-020
Executive Committee
Approved by Council: December 1, 2011
Amended: February 11, 2014, September 12, 2025 (came into effect November 20, 2025)

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

INTENT

To communicate the importance of members' cooperation and timely communication with CCO.

DESCRIPTION OF STANDARD

CCO's ability to fulfil its mandate is dependent upon the cooperation and timely communication with all members.

Members are required under the *Regulated Health Professions Act, 1991* (*RHPA*), regulations made under the *Chiropractic Act, 1991* and CCO by-laws to cooperate with CCO and its statutory committees. It is the professional responsibility of a member to cooperate in a timely manner when CCO makes reasonable requests for information, when CCO requires a specific action from a member or CCO requests attendance at a meeting or hearing to address an area of concern.

Such requests for information, cooperation and/or attendance from CCO include, but are not limited to, the following:

- a request for written submissions in response to an inquiry, complaint or report to the Inquiries, Complaints and Reports Committee;
- a request to cooperate with a CCO investigator appointed by the Registrar;
- a request to appear before a panel of the Inquiries, Complaints and Reports Committee for an oral caution or other disposition;
- a request for disclosure regarding participation in initiatives of the Quality Assurance Committee, such as participation in peer and practice assessment, attendance at a regulatory excellence workshop, and participation in continuing education, professional development and self assessment;
- timely communication and cooperation with peer assessors;

- complying with a signed undertaking or other agreement with CCO;
- responding to allegations regarding improper advertising; and
- requests for information on registration and renewal forms.

It may be considered an act of professional misconduct for a member to refuse to reasonably cooperate with CCO and could lead to a referral to the Discipline Committee.

LEGISLATIVE CONTEXT

Health Professions Procedural Code, Schedule 2 to the *Regulated Health Professions Act, 1991*

Section 25.2(1): A member who is the subject of a complaint or report may make written submissions to the Inquiries, Complaints and Reports Committee within 30 days of receiving notice under subsection 25(6).

Section 76 (1): An investigator may inquire into and examine the practice of the member to be investigated and section 33 of the *Public Inquiries Act, 2009* applies to that inquiry and examination.

(1.1) An investigator may make reasonable inquiries of any person, including the member who is the subject of the investigation, on matters relevant to the investigation.

(2) An investigator may, on the production of his or her appointment, enter at any reasonable time the place of practice of the member and may examine anything found there that is relevant to the investigation.

(3) No person shall obstruct an investigator or withhold or conceal from him or her or destroy anything that is relevant to the investigation.

(3.1) A member shall co-operate fully with an investigator.

(4) This section applies despite any provision in any Act relating to the confidentiality of health records.

Section 81: The Quality Assurance Committee may appoint assessors for the purposes of a quality assurance program.

Section 82(1): Every member shall co-operate with the Quality Assurance Committee and with any assessor it appoints and in particular every member shall,

(a) permit the assessor to enter and inspect the premises where the member practises;
(b) permit the assessor to inspect the member's records of the care of patients;
(c) give the Committee or the assessor the information in respect of the care of patients or in respect of the member's records of the care of patients the Committee or assessor requests in the form the Committee or assessor specifies;
(d) confer with the Committee or the assessor if requested to do so by either of them; and
(e) participate in a program designed to evaluate the knowledge, skill and judgment of the member, if requested to do so by the Committee.

Section 82(2): Every person who controls premises where a member practises, other than a private dwelling, shall allow an assessor to enter and inspect the premises.

Section 82(3): Every person who controls records relating to a member's care of patients shall allow an assessor to inspect the records.

Section 82(4): Subsection (3) does not require a patient or his or her representative to allow an assessor to inspect records relating to the patient's care.

Section 82(5): This section applies despite any provision in any Act relating to the confidentiality of health records.

Ontario Regulation 204/94 made under the *Chiropractic Act, 1991*

Section 13(1): Each year, the College shall select at random the names of members required to undergo a peer and practice assessment.

Section 13(2): A member shall undergo a peer and practice assessment if selected at random under subsection (1).

Ontario Regulation 852/93 made under the *Chiropractic Act, 1991*

28. Contravening the Act, the *Regulated Health Professions Act, 1991* or the regulations under either of those Acts.
31. Failing to comply with an order of, or breaching an undertaking given to, the Complaints, Discipline or Fitness to Practise Committees or to the Registrar of the College.
32. Failing to carry out an agreement entered into with the College.
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.

By-law 13: Fees

Appropriate fees may be paid in accordance with By-law 13: Fees.

ASSISTIVE DEVICES

Standard of Practice S-021
Quality Assurance Committee
Approved by Council: September 17, 2015
Amended: November 29, 2018, April 14, 2021 (came into effect June 16, 2021), September 9, 2022 (came into effect November 24, 2022)

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

INTENT

Assistive devices are intended to enable people with physical disabilities to increase their independence by addressing their individual needs. Assistive devices may be used by chiropractors as an adjunctive therapy to patient care for managing certain conditions within the chiropractic scope of practice. This standard of practice advises members of their obligations when examining a patient and recommending assistive devices or dispensing prescribed assistive devices.

Note: Standards related to orthotics are addressed in Standard of Practice S-012: Orthotics.

OBJECTIVES

- To facilitate appropriate care of patients who may benefit from assistive devices, whether determined by the member or another health professional who has provided a prescription.

- To inform members of their obligations for providing examinations, obtaining consent and making recommendations for assistive devices.

- To ensure members respond to clinical situations in a manner consistent with the best interests of their patients.

- To ensure members advise patients to consult with another health professional when:
  - the patient's condition is beyond the chiropractic scope of practice or competence of the member,
  - the patient requires the care of another health professional, or
  - the patient would be most appropriately treated by another health professional.

DESCRIPTION OF STANDARD

Training, Skill and Competence

A member who examines patients for assistive devices or recommends and/or dispenses assistive devices is required to have achieved, maintain and be able to demonstrate clinical competency, and have appropriate training, skill and competence, including:

- applied anatomy, biomechanics and physiology related to the application, fitting and dispensing of the specific assistive devices;
- examination and diagnosis of patients with conditions within the scope of practice of chiropractic who may reasonably be expected to benefit from the use of assistive devices;
- understanding of the indications and contraindications to assistive devices for any individual patient;
- understanding of the outcomes, benefits and risks of assistive devices; and
- participation in appropriate ongoing continuing education.[1]

Protocol

A member may recommend assistive devices related to the chiropractic scope of practice on a case-by-case basis for a patient. In the member's clinical judgment or opinion, an assistive device is intended to improve the patient's health, wellness and/or function when applied as an adjunctive therapy to a patient's chiropractic care.

A member shall adhere to the following protocols when recommending an assistive device which is to be documented in the patient health record:

1. *Diagnosis or Clinical Impression*

    - relevant case history, including neuro-musculoskeletal, orthopaedic and biomechanical conditions;
    - neuro-musculoskeletal examination (physical, diagnostic imaging, laboratory);
    - assessment of a patient's physical and functional limitations, including activities of daily living, that may benefit from an assistive device; and
    - interpretation and differential diagnosis to rule out possible contraindications.

2. *Consent*

    - A member shall obtain informed consent for the examination, prescription and/or dispensing of the assistive device, which otherwise complies with Standard of Practice S-013: Consent. Consent from the patient shall be:
        - fully informed about the purpose of the assistive device. A member shall explain the benefits and risks of the assistive device as compared to other care or no care;
        - voluntarily given;

[1] eg., programs offered by accredited chiropractic educational institutions or manufacturers of assistive devices.

- related to the patient's condition and circumstances; and
- evidenced in a written form signed by the patient or otherwise documented in the patient health record, which may be part of the general consent.

3. *Dispensing Prescribed Assisted Devices to a Patient*

A member shall only prescribe or dispense an assistive device, for a patient when the examination and diagnosis or clinical impression indicate a condition within the chiropractic scope of practice that would reasonably benefit the patient from that assistive device. If a prescription has been ordered by another regulated health professional and is related to the chiropractic scope of practice, the member may dispense that device.

A member shall provide advice to a patient in a manner that can be understood by the patient on the following:

- instructions for usage of the assistive device;
- reasonable expectations as to the outcomes of the assistive device; and
- time frames for achieving potential results.

4. Conditions Outside the Chiropractic Scope of Practice

A member shall advise the patient to consult with another health professional when the member knows or ought to know that:

- the patient's condition is beyond the chiropractic scope of practice;
- the patient's condition is beyond the competence of the member;
- the patient requires the care of another health professional, or
- the patient would be most appropriately treated by another health professional.

5. *Follow-up*

In the patient's best interests, a member shall advise a patient to seek timely follow-up and re-assessment relating to the assistive device and noted in the patient health record.

Billing

When billing for assistive devices, a member shall comply with the following:

- the business practices provisions of the Profession Misconduct Regulation under the *Chiropractic Act, 1991*, including that it is a potential act of professional misconduct to:
    - submit an account or charge for services that the member knows is false or misleading;
    - fail to disclose to a patient the fee for service before the service is provided, including a fee not payable by the patient; and
    - fail to itemize an account for professional services,
        - if requested to do so by the patient or the person or agency who is to pay, in whole or in part, for the services, or

    - if the account includes a fee for a product or device or a service other than a treatment

- The cost of the assistive devices shall reasonably relate to the time and expertise of, and cost to, the member when prescribing, manufacturing, selling or dispensing orthotics.

- Treatment, services and products associated with the prescription and dispensing of orthotics, including any discounted or complimentary services or products, shall be applied consistently with the member's fee schedule, clearly documented in the patient health record and financial record and invoice, clearly communicated to the patient before services are rendered, and clearly itemized accordingly. Any documentation, record or invoice associated with orthotics shall not be false or misleading.

- Fees charged for treatment, services and products associated with the prescription of assistive devices shall be based on clinical history, examination, diagnosis or clinical impression, consent, instructions and recommendations and follow-up, as recorded in the patient health record;

- Guideline G-008: Business Practices which provides that members may not bill any payor fees in excess of his/her normal fee billed to a private patient for similar services.

- A member shall only issue a receipt for payments that have been received.

- If billing practices related to assistive devices involve the billing or submitting of invoices to the patient's insurance company or third-party payor, the member should familiarize themselves with and ensure they are complying with the policies and procedures of the insurance company or third-party payor.

Conflict of Interest

For the purpose of this standard, a conflict of interest may arise when a member refers a patient to facilities, services or suppliers in which the member or the member's immediate family has an interest or gains a benefit.

A member may make such a referral provided that the member:

- discloses to the patient that the member or their immediate family member has an interest or gains a benefit from the referral;

- has assured the patient that the patient's choice of services or suppliers will not affect the quality of health care services provided by the member;

- has informed the patient that the patient has an option of using alternative facilities, services or suppliers; and

- upon request, advises CCO of any conflict of interest.

LEGISLATIVE CONTEXT

Regulated Health Professions Act, 1991

Section 3 (1) of the Health Professions Procedural Code – One of CCO's objects under the *Regulated Health Professions Act, 1991* (*RHPA*) is to "develop, establish and maintain programs and standards of practice to assure the quality of the practice of the profession."

The Quality Assurance program is defined in Ss. 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 the members."

Chiropractic Act, 1991

Scope of Practice

The scope of practice is defined in the *Chiropractic Act, 1991* 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 and 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.

Sections of Regulation 852/93 under the *Chiropractic Act, 1991*

The following are acts of professional conduct misconduct for the purposes of clause 51(1)(c) of the Health Professions Procedural Code:

3. Contravening a standard of practice of the profession or failing to maintain the standard of practice expected of members of the profession.

4. Doing anything to a patient for therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purposes in a situation in which consent is required by law, without such consent

5. Delegating a controlled act contrary to *the Act* or the *Regulated Health Professions Act, 1991*, or the regulations under either of those Acts.

14. Failing to reveal the nature of a remedy or treatment used by the member following a patient's request to do so.

15. 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 diagnosis or therapeutic service that is not necessary.

Explanatory Notes

This standard of practice should be read in conjunction with the Business Practices Provisions of the Professional Misconduct Regulation, Standard of Practice S-002 Record Keeping, Standard of Practice S-013: Consent, and Guideline G-008: Business Practices.

OWNERSHIP, STORAGE, SECURITY AND DESTRUCTION OF RECORDS OF PERSONAL HEALTH INFORMATION

Standard of Practice S-022
Quality Assurance Committee
Approved by Council: February 11, 2014
Amendments approved by Council: September 20, 2014, September 15, 2018
(Formerly Guideline G-017, approved by Council February 8, 2011), November 24, 2022 (came into effect February 24, 2023)

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

INTENT

Good practices relating to record keeping are essential in providing the best quality patient care, acting in accordance with professional, legal and ethical obligations, and establishing and maintaining trust in the doctor/patient relationship.

This standard of practice advises members of their obligations relating to ownership, storage, security and destruction of records of personal health information, whether in a solo or group practice setting.

All of the items discussed in this document apply equally to paper and electronic records.

DESCRIPTION

The record of personal health information includes the patient health record and the financial record.

Section 4 of the *Personal Health Information Protection Act, 2004 (PHIPA)* defines "personal health information", as subject to certain exceptions, identifying information about an individual in oral or recorded form, if the information,

a) relates to the physical or mental health of the individual, including information that consists of the health history of the individual's family;
b) relates to the providing of health care to the individual, including the identification of a person as a provider of health care to the individual;
c) is a plan of service within the meaning of the *Long-Term Care Act, 1994* for the individual;
d) relates to the payments or eligibility for health care in respect of the individual;
e) relates to the donation by the individual or any body part or bodily substance;
f) identifies an individual's substitute-decision maker.

"Identifying information" mean information that identifies an individual or for which it is reasonably foreseeable in the circumstances that it could be utilized, either alone or with other information, to identify an individual.

Ownership of the Record of Personal Health Information

The Supreme Court of Canada decision of McInerney v MacDonald held that information in the record of personal health information is owned by the patient.[1] The patient may access and obtain copies of the record of personal health information, including records, diagnostic images and reports prepared by other health care practitioners relevant to the doctor/patient relationship, in accordance with the *Personal Health Information Protection Act, 2004* (*PHIPA*) and standard of practice S-002: Record Keeping. A member owns the physical records or computer hardware on which records are stored, but holds the information in trust and confidence for the patient.

Designation of Health Information Custodian

Under *PHIPA*, a health information custodian is responsible for the record of personal health information. A member must satisfy themselves that for each practice, a health information custodian is designated to be responsible for records and to establish policies consistent with *PHIPA,* this standard and S-002: Record Keeping. A health information custodian may be an individual member, a group of members, a chiropractic health corporation or the facility from where the member practises.

Storage and Security of the Record of Personal Health Information

To safeguard their physical integrity and confidentiality, records of personal health information must be stored in a safe and secure environment. This applies to all records stored at the primary chiropractic facility or any files stored off-site. Members must take reasonable steps to ensure that records are protected from theft, loss, damages and unauthorized use or disclosure, including photocopying, modification or disposal.

What is reasonable depends on the threats, risks and vulnerabilities to which the information is exposed, the sensitivity of the information, and the extent to which it can be linked to the individual. Consideration must be given to each of the following aspects of record protection:

- physical security (e.g., locking file cabinets, restricted office access, alarm systems, protection from damage)
- technological security (e.g., password protection, code encryption, firewalls)
- administrative controls (e.g., security clearances, access restriction, staff training, confidentiality agreements)

[1] McInerney v. MacDonald [1992] 2 S.C.R. 138

A member must take reasonable precautions to protect records of personal health information from damage, especially when records are maintained in an offsite facility or an area that is susceptible to environmental hazards (e.g. flood and fire).

Records of personal health information should be kept in restricted access areas or locked filing cabinets, and measures should be in place to ensure that only those who need access to the records for a legitimate purpose are able to see them. A member needs to consider that non-chiropractic care staff, such as maintenance staff, may have access to records, and must take appropriate steps ensure that access to the records is limited, or that those who have access to the records are bound by an appropriate confidentiality agreement.

Confidentiality of Personal Health Information

A member is required to maintain the privacy and confidentiality in the collection, use and disclosure of the record of personal health information in accordance with *PHIPA* and CCO standards of practice (see sections 36-37 for provisions relating to the collection and use of personal health information www.ontario.ca/laws/statute/04p03#BK47).

A member generally requires express or implied consent before collecting, using or disclosing personal health information. In accordance with *PHIPA*, consent must be:

- of the individual;
- knowledgeable;
- related to the information; and
- not obtained through deception or coercion.

A member may assume that they have the patient's implied consent for providing or assisting in providing health care, unless the patient has expressly withheld or withdrawn consent (except as required by law under *PHIPA*). The patient's express consent is required for providing their personal health information outside the circle of care.

A member may only disclose a patient's personal health information:

- when the member has the patient's or substitute decision-maker's consent and it is necessary for a lawful purpose;
- where it is permitted under legislation, without the patient's or substitute decision-maker's consent; or;
- where it is required by law.

PHIPA allows the disclosure of personal health information without a patient's consent under certain circumstances. A member shall, whenever possible, make every reasonable effort to obtain the patient's consent before disclosing their personal health information. Please see sections 38-50 of *PHIPA* for further information on disclosure of personal health information.

In the event of a breach or suspected breach in confidentiality of patient personal health information or damage to records of personal health information, the member shall:

- notify affected patients, CCO and only when there is a suspected breach of confidentiality, the Ontario Office of the Privacy Commissioner
- mitigate consequences that have resulted from this breach or damage; and
- take measures to avoid a similar breach in confidentiality or damage in the future.

Please see the Information and Privacy Commissioner of Ontario's document "Responding to Privacy Breaches" the Privacy section of CCO's website for further information.

Electronic Records

Please see the requirement for maintain electronic record keeping in Standard of Practice S-002: Keeping.

In certain cases, the printable version of the electronic record may not readily enable a reviewer to understand the whole patient record. Some of the systems do not readily allow the chiropractor to capture nuances of the patient encounter. A member using such systems must ensure that each record entry captures the unique aspects of that particular patient encounter. A member is discouraged from using systems that create "template-like" records. These may not be an adequate reflection of an individual patient's story.

A member has an obligation to provide printed copies of electronic records when asked to do so. To ensure they can be understood, a member may be asked to provide a print-out from the electronic record, together with a dictated summary, to allow an overview of the patient's story.

Ownership Agreements Concerning Records of Personal Health Information

It is in the best interest of patients, and a member practising in a group setting, such as an associateship, partnership or corporation, to have a written contract that establishes responsibility for maintaining and transferring records of personal health information upon dissolution of the practice. Typically, these contracts will address such items as:

- the method for division of records upon termination of the practice arrangement; and
- reasonable access to the content of the records for each member to allow the member to defend any legal actions or respond to CCO investigations or to appropriately respond to requests from third-party insurance providers.

Any contract, agreement or arrangement addressing division of records upon dissolution of a practice may not restrict a patient from accessing their record of personal health information or having copies of their records transferred to their treating chiropractor.

If no such ownership contract or agreement exists, a member dissolving a group practice should determine who is the most responsible for each record of personal health information. The patient's best interests will be served by ascertaining from which member the patient wishes to continue receiving care.

A member who is an employee or who works as a locum must satisfy themselves that there is a contract, agreement or written arrangement with the employer about access, retention and transfer of records of personal health information, consistent with *PHIPA*, and CCO standards of practice, policies and guidelines.

There may be circumstances where a member practises in a group setting where the owner of the clinic is not a member of CCO or not a member of an Ontario regulated health profession. CCO reminds members that although the principles of *PHIPA* apply to owners of health care facilities, CCO does not have jurisdiction over individuals who are not members of CCO. Moreover, an owner of a clinic who is not a regulated health professional may not be regulated by any health regulatory college. A member practising in such a group setting must ensure that the member is compliant with privacy legislation and standards of practice, including but not limited to those related to access, retention and transfer of records of personal health information.

Termination or Disruption of Practice

Possible reasons for termination or disruption (temporary or permanent) of practice may include the following:

- dissolution of practice
- leave of absence (maternity, sabbatical)
- incapacity to practise
- retirement
- suspension of registration
- revocation of registration
- death

A member shall make appropriate arrangements for their records of personal health information when there is a termination or disruption from practice. A member may still need to access records. Patients may need to access information from their records for ongoing treatment. As well, a member may need to access information from records to respond to complaints or civil lawsuits. There are several options available to a member:

- a member is given access to their records of personal health information after resigning from practice to fulfil a professional obligation;
- a resigning member keeps their records of personal health information and gives access to the new treating member to fulfil a professional obligation;
- a resigning member takes a copy of the original records of personal health information with them, leaving the originals with the new treating member.

Whichever option is selected will depend on the contract or agreements among the parties, the circumstances, and the preferences of the patients. What is essential is that a resigning member follow a practice to ensure patients can access or obtain a copy of theirs records of personal health information and that the member can access their records after resigning from practice or following a dissolution of a practice.

A member must give active patients advance notice of any change to their records of personal health information, enable them to access or acquire a copy of their records and make secure arrangements for the transfer of records to the patients. This can be accomplished by communicating the information to patients through various methods, such as letters to individual patients, and/or postings in the office, on the member's website or in the local newspaper.

It is important to remember that records must be maintained or be accessible even after a practice has dissolved.

Retention and Destruction of Records of Personal Health Information

Every record of personal health information, including diagnostic images and accompanying reports, and every financial record shall be retained for at least seven years following the patient's last visit, or, if the patient was less than 18 years old at the time of their last visit, the day the patient became or would have become 18 years old. For example, for a patient less than 18 years old at the time of their last visit, patient records should be kept until the patient turns 25.

When considering the destruction of records of personal health information, the following should be taken into consideration:

- match the destruction method to the medium (e.g., paper vs. electronic vs. radiographic records)
- select and engage a destruction service provider with due diligence

Legislative Context

Members are advised to consult the *Personal Health Information Protection Act, 2004*, the website of the Office of the Privacy Commissioner at www.ipc.on.ca, and CCO standard of practice S-002: Record Keeping and guideline G-004: Documentation of a Chiropractic Visit.

POLICIES

Introduction

Policies aim to help members understand their professional responsibilities, clarify and interpret regulations, and state the position of CCO on a variety of topics.

Current Policies

Advertising

P-004: Advertising Committee Protocol
P-016: Public Display Protocol

Discipline

P-020: Adjournment of Discipline Hearings
P-046: Core Discipline Committee

Executive

P-009: Presidential Memorial Award
P-010: Use of Professional Titles, Designations and Credentials
P-011: Conflict of Interest for Council, Non-Council Committee Members and Council Appointed Members ("Committee Members")
P-029: Chiropractic Specialties
P-045: CCO's Legislation and Ethics Examination

Fitness to Practise

P-035: Publication of Fitness to Practise Decisions

Inquiries, Complaints & Reports

P-015: Consideration of Prior Decisions Involving a Member

Patient Relations

P-003: Principle of Zero Tolerance
P-018: Funding for Therapy and Counselling for Patients Sexually Abused by Members

Quality Assurance

P-017: Public Screenings
P-023: Participation in X-ray Peer Review Program
P-051: Peer Assessors
P-055: Non-compliance with Continuing Education Requirements

Registration

P-050: Supervision and Direction of Chiropractors in Training
P-053: Returning to the General Class of Certificate of Registration
P-054: Determination of Good Character of an Applicant or Member
P-056: Requirement to Disclose Police Criminal Record Checks
P-057: Accessibility Policy

ADVERTISING COMMITTEE

ADVERTISING COMMITTEE PROTOCOL

Policy P-004
Advertising Committee
Approved by Council: November 25, 1994
Amended by Council: 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 CCO 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.

PROTOCOL

1. Members considering advertising are encouraged to forward their advertisements to CCO for review.

2. CCO forwards the advertisement to the Advertising Committee for review (preferably via e-mail).

3. The members of the Advertising Committee review the advertisement and provide feedback to CCO (preferably via e-mail).

4. CCO aggregates the feedback and, on behalf of the 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 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.

PUBLIC DISPLAY PROTOCOL

Policy P-016
Advertising Committee
Approved by Council: June 22, 2007
Amended: September 13, 2008, September 24, 2009, December 1, 2011, June 19, 2019 (came into effect September 13, 2019)

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

INTENT

The College of Chiropractors of Ontario (CCO) developed the Public Display Protocol to ensure that chiropractic is consistently promoted in a professional manner with personal accountability. This protocol provides members with practical approaches to community event planning and implementation.

Public outreach can be of value to the public because it can educate the public about chiropractic, build a stronger chiropractic presence in the professional and public communities, and promote chiropractic as a safe and effective health care choice.

Members are reminded that in conducting any public outreach, they are representing the chiropractic profession, and are expected to conduct themselves in a professional manner, maintain the dignity and integrity of the profession, and adhere to CCO regulations, standards of practice, policies and guidelines.

DESCRIPTION OF POLICY

Definitions

A "public display" is a type of public event that is a presentation of printed or other visual/audio material and/or educational sessions to 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. It does not include signage, billboards, or other forms of visual advertising that do not ordinarily require that the person advertising be physically present.

A "health fair" is a community event focused on the promotion of health.

A "trade show" is an exhibition for people or companies to demonstrate products and services.

Procedures

A member is required to comply with the following procedures in conducting a public display or outreach.

Purpose

The primary purpose of a public display is to educate the public and not to solicit patients. Therefore, a member may not subject a member of the public to any undue pressure or duress to participate in public outreach or follow up with chiropractic care. It is always the choice of a member of the public whether to participate in a public display presentation or to follow up with chiropractic care.

Location

A member may only conduct a public display at an appropriate and suitable public location, such as a health fair or trade show, and must ensure that they have the necessary permission and/or permits from the owners or authority in charge.

Chiropractic Representation

CCO requires at least one registered member of the CCO to be present at a public display at all times.

Public Display Set-up/Presentation

All aspects of a public display, including signs, pamphlets, posters, handouts, video/audio materials, marketing and presentation materials, and professional appearance will be evaluated by the participating public and other professions and therefore shall remain professional, maintain the dignity and integrity of the profession and comply with CCO regulations, standards of practice, policies and guidelines, and specifically Standard of Practice S-016: Advertising.

Signs should state the purpose and intent of the public display. A member may have signage listing his/her affiliation with groups, societies or associations, provided that the affiliated group officially recognizes the event.

A member shall prominently display as part of his/her setup/presentation the "CCO Public Display Statement", which communicates that he/she is a licensed chiropractor and a member of CCO and includes a link to CCO's website for information (www.cco.on.ca).

Follow-up

The primary purpose of a public display is to educate the public and not to solicit business.

If a member of the public wishes to follow up with further chiropractic care, a member may recommend that the participant or member of the public visit a chiropractor of his/her choice. A member may not subject a member of the public to any undue pressure or duress to follow up with chiropractic care. It remains a participant's choice to follow up with a more complete evaluation at a chiropractic office.

Any collection of contact information from the public or communication of the member's contact information shall be voluntary without any undue pressure or duress applied by the member. A

member shall disclose to a participant the purpose of collecting their contact information, including if it includes the distribution of communication materials, such as mass emails and/or newsletters, and ensure the participant consents to receiving such communications. Any mass communications shall comply with Canada's Anti-Spam Legislation http://fightspam.gc.ca/eic/site/030.nsf/eng/home.

Any personal or contact information from a participant or member of the public shall be maintained in a private and confidential manner, in accordance with the *Personal Health Information Protection Act, 2004*.

A member shall consider that some of the participants at the public display will be under the active care of another chiropractor. In compliance with Guideline G-001: Code of Ethics, a member may not attempt to take over the care of a participant who is under active chiropractic care.

Notification to CCO

CCO requires notification, in writing, informing of a public display at least ten business days prior to the event. The notification shall include the names of participating member(s), a description of the event, and the date, time and location of the event. CCO recommends that any materials be forwarded to CCO for pre-approval. Turnaround time for approval is approximately ten business days.

DISCIPLINE COMMITTEE

ADJOURNMENT OF DISCIPLINE HEARINGS

Policy P-020
Discipline Committee
Approved by Council: October 28, 1995
Amended: November 15, 1996, November 30, 2012, April 16, 2024 (came into effect June 14, 2024)

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

STRICT ADJOURNMENT POLICY

The Discipline Committee is committed to using hearing and pre-hearing time efficiently and to avoiding the cost and wasted resources caused by unnecessary adjournments. Requests for adjournments, particularly at the last minute, are a significant impediment to fair and timely protection of the public and access to justice.

Once hearing dates are scheduled, parties are expected to be ready to proceed on those dates. Adjournment requests are discouraged except where necessary due to extenuating circumstances, especially on short notice before a scheduled hearing date. The timing of an adjournment request will be a factor to be considered.

The Registrar will advise all parties and representatives that:

- If, a party or their representative determines that they have a conflict with respect to a hearing date that has been set, they shall immediately contact the Chair of the Discipline Committee through Independent Legal Counsel (ILC) if appointed, to advise them of the conflict.

- Motions for an adjournment of discipline hearings will be refused except in extenuating circumstances. Examples of the types of extenuating circumstances that may persuade the Chair of the Discipline Committee (or designate) to exercise their discretion to grant an adjournment include:

    - death in the immediate family;

    - emergency health situation;

    - personal crises;

    - uncovering of new evidence that is critical and, despite reasonable efforts, was not available at an earlier point in time; and

- a party's representative is required to attend to another matter that was scheduled before receipt of the Notice of Hearing and about which the representative immediately advised the Chair of the Discipline Committee.

Requests for Adjournment

All motions for adjournments must:

- be made in accordance with the Rules of Procedure of the Discipline Committee respecting motions;
- be made at the earliest opportunity following the moving party becoming aware that an adjournment is required; and
- provide sworn direct evidence of the extenuating circumstances which necessitate an adjournment, or other evidence acceptable to the Chair of the Discipline Committee or designate.

If the motion is dismissed, legal costs may be awarded pursuant to section 17.1 of the *Statutory Powers Procedures Act*. In any event, costs of the motion may be reserved to be decided at the conclusion of the proceeding.

CORE DISCIPLINE COMMITTEE

Policy P-046
Discipline Committee
Approved: April 16, 2004
Amended: November 30, 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 identify a core discipline committee.

Description of Policy

Pursuant to CCO's by-laws, the Discipline Committee is composed of every member of Council and two members of the College who are not members of Council. Every member of Council is potentially a member of a discipline panel.

Pursuant to this policy, in or about April of every year when elections to committees are made, CCO will elect a core Discipline Committee composed of:

- two members of Council who are members of the College;
- two members of Council appointed to the Council by the Lieutenant Governor in Council; and
- two or more members of the College who are not members of Council.

Policy P-046: Core Discipline Committee

EXECUTIVE COMMITTEE

PRESIDENTIAL MEMORIAL AWARD

Policy P-009
Executive Committee and Registration Committee
Approved by Council: September 17, 1994
Amended: November 30, 2002, September 20, 2013, November 29, 2018, September 12, 2025 (came into effect: November 20, 2025)

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

INTENT

CCO will present an annual award to a graduating student of an accredited chiropractic program, who intends to practise in Ontario, for demonstrating excellence in Ontario jurisprudence. The award is named the Presidential Memorial Award.

DESCRIPTION OF POLICY

A graduate of an accredited chiropractic program may apply for the Presidential Memorial Award, as follows:

- The candidate shall be registered or have successfully completed CCO's Legislation and Ethics Examination;
- The candidate shall submit an essay to CCO, no longer than 1000 words, on a subject related to the regulation of health care in Ontario;
- CCO will specify the criteria, details and timing of submission of the essay as part of the communication materials to candidates for CCO's Legislation and Ethics Examination;
- The Executive Committee, as delegated to staff, will review the submitted essays and select the winner of the Presidential Memorial Award in or around November 1st every year; and
- The winner of the Presidential Memorial Award will be notified, have their fees for first year registration renewal with CCO waived, recognized at the CCO's Annual General.

USE OF PROFESSIONAL TITLES, DESIGNATIONS AND CREDENTIALS

Policy P-010
Executive Committee
Approved by Council: April 30, 2019
Amended: September 10, 2021 (came into effect November 25, 2021)

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

INTENT

To summarize and describe the legislative and regulatory requirements for CCO members' uses of professional titles, designations and credentials.

DESCRIPTION OF POLICY

One of the objectives of the *Regulated Health Professions Act, 1991 (RHPA)* is that the public of Ontario is able to make an informed decision about their health care choices. It is essential that members of regulated health professions in Ontario clearly and accurately communicate to the public their professional titles, designations and credentials, so the public knows which regulated health professional they are seeking care from.

The *RHPA,* profession specific legislation (such as the *Chiropractic Act, 1991)*, and CCO regulations, standards of practice, policies and guidelines outline certain requirements for the use of professional titles, designations and credentials. The following policy summarizes and describes several of those requirements that apply to members of CCO.

Use of the Title "Doctor"

Legislative and Regulatory Context

Section 33 of the *RHPA* authorizes members of the College of Chiropractors of Ontario to use the title "doctor", a variation or abbreviation or an equivalent in another language in the course of providing or offering to provide, in Ontario, health care to individual. No person shall use the title "doctor" in this context, except for those regulated health professionals listed in section 33 of the *RHPA*.

Application to CCO Members

Members of CCO may use the title "doctor" in the course of providing or offering to provide, in Ontario health care to individuals. A member shall ensure that their professional representation to the public is clear and unambiguous that they are a member of CCO and does not misrepresent to the public that they are a member of another regulated health profession.

Chiropractic Specialties

Legislative and Regulatory Context

It is an act of professional misconduct for a member of CCO to "use(ing) a term, title or designation indicating a specialization in the profession contrary to the policies of the College".

Policy P-029: Chiropractic Specialties https://www.cco.on.ca/wp-content/uploads/2017/11/P-029.pdf indicates the following as approved 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)

Application to Members

Members of CCO may not indicate a specialization in the profession of chiropractic, except for those members who belong to the specialty colleges listed above.

This policy does not restrict a member from indicating educational degrees and professional credentials that are accurate, verifiable and not misleading to the public.

Restricted Titles of Other Regulated Health Professions Acts

Legislative and Regulatory Context

Regulated health professions in Ontario each have specific acts governing their professions, which restrict titles to members of that regulated health profession. For example, under the *Chiropractic Act, 1991*, only members of CCO may use the title of "chiropractor" or hold themselves out as a person who is qualified to practise in Ontario as a chiropractor or in a specialty of chiropractic.

The following are examples from selected Ontario Regulated Health Professions Act, restricting the use of certain professional titles and representations to the public.

Medicine Act, 1991

9 (1) No person other than a member shall use the titles "osteopath", "physician" or "surgeon", a variation or abbreviation or an equivalent in another language.
Dentists excepted

(2) Subsection (1) does not apply to the use of the title "surgeon", a variation or abbreviation or an equivalent in another language by a member of the Royal College of Dental Surgeons of Ontario.

Representations of qualification, etc.

(3) No person other than a member shall hold himself or herself out as a person who is qualified to practise in Ontario as an osteopath, physician or surgeon or in a specialty of medicine.

Definition

(4) In this section,

"abbreviation" includes an abbreviation of a variation.

Physiotherapy Act, 1991

8 (1) No person other than a member shall use the title "physiotherapist" or "physical therapist", a variation or abbreviation or an equivalent in another language.

Representations of qualification, etc.

(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 physiotherapist or in a specialty of physiotherapy.

Definition

(3) In this section,

"abbreviation" includes an abbreviation of a variation.

Traditional Chinese Medicine Act, 2006[1]

8. (1) No person other than a member shall use the titles "traditional Chinese medicine practitioner" or "acupuncturist", a variation or abbreviation or an equivalent in another language.

Representations of qualification, etc.

(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.

Definition

(3) In this section,

"abbreviation" includes an abbreviation of a variation.

Naturopathy Act, 2006

8. (1) No person other than a member shall use the title "naturopath", a variation or abbreviation or an equivalent in another language.

Representations of qualification, etc.

(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 naturopath or in a specialty of naturopathy.

Definition

(3) In this section,

"abbreviation" includes an abbreviation of a variation.

[1] Please see Standard of Practice S-017: Acupuncture https://www.cco.on.ca/wp-content/uploads/2017/10/S-017.pdf for further details about use of titles related to the use of acupuncture.

Massage Therapy Act, 1991

7 (1) No person other than a member shall use the title "massage therapist" or "registered massage therapist", a variation or abbreviation or an equivalent in another language. 2009, c. 26, s. 13 (2).
Representations of qualifications, etc.
(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 massage therapist or registered massage therapist or in a specialty of massage therapy.
Definition
(3) In this section,
"abbreviation" includes an abbreviation of a variation.

Veterinary Act, 1990

40. (2) Every person who is not a holder of a licence and who,
(a) uses the title "veterinarian", "vétérinaire", or "veterinary surgeon", "chirurgien vétérinaire" or an abbreviation or variation thereof as an occupational or business designation; or
(b) uses a term, title or description that will lead to the belief that the person may engage in the practice of veterinary medicine,
is guilty of an offence and on conviction is liable for the first offence to a fine of not more than $5,000 and for each subsequent offence to a fine of not more than $15,000.

Application to CCO Members

Please note: This section does not apply to members who are also members of more than one regulated health profession in Ontario. For more information on practising as a member of more than one regulated health professional in Ontario, please see Standard of Practice S-011: Members of More Than One Health Profession https://www.cco.on.ca/wp-content/uploads/2017/10/S-011.pdf.

Members of CCO must clearly, accurately and unambiguously communicate to the public, including in their patient care and communication, record keeping, financial and billing practices, and advertising, websites and social media, that they are members of CCO and must not hold themselves out or misrepresent to the public that they are members of another regulated health profession.

CCO considers the use of titles and professional representations, including but not limited to "chiropractic physician", "medicine", "orthopractic", "functional neurologist", functional medicine" and "osteopath", and other abbreviations or variations of any of the legislatively restricted titles or specialties, as misleading to the public and must not be used.

A member may communicate modalities that the member uses in practice, consistent with CCO standards of practice, such as physical therapy, acupuncture as an adjunctive treatment[2] and chiropractic care of animals. These modalities must be communicated as services rather than titles. It must always be clear and unambiguous to the public that the member is using these modalities as a member of CCO, practising within the chiropractic scope of practice.

A member who holds themselves out falsely or inaccurately as practising a profession or using a title that is not authorized to them is risking being prosecuted for practising without a certificate of registration by the appropriate college.

LEGISLATIVE CONTEXT

Ontario Regulation 852/93: Professional Misconduct

The following are acts of professional misconduct for the purposes of clause 51.1 (c) of the Health Professionals Procedural Code.

16. Using a term, title or designation in respect of a member's practice contrary to the policies of the College.

17. Using a term, title or designation indicating a specialization in the profession contrary to the policies of the College.

18. Using a name, other than the member's name as set out in the register, in the course of providing or offering to provide services within the scope of practice of the profession.

This policy should be read in conjunction with:

- Standard of Practice S-011: Members of More Than One Health Profession
- Standard of Practice S-016: Advertising
- Standard of Practice S-017: Acupuncture
- Policy P-029: Chiropractic Specialties
- Guideline G-016: Advertising

[2] Please see Standard of Practice S-017: Acupuncture https://www.cco.on.ca/wp-content/uploads/2017/10/S-017.pdf for further details about use of titles related to the use of acupuncture.

CONFLICT OF INTEREST FOR COUNCIL, NON-COUNCIL COMMITTEE MEMBERS AND COUNCIL APPOINTED MEMBERS ("COMMITTEE MEMBERS")

Policy P-011
Executive Committee
Approved by Council: February 18, 1995
Amended: November 15, 1996, November 26, 2004, September 11, 2007, June 16, 2016, November 29, 2018, June 21, 2023 (came into effect September 8, 2023)

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

INTENT

To determine and define circumstances in which a potential and/or appearance of conflict of interest or appearance of bias ("conflict of interest") may exist or arise for a CCO Council or committee member so the council or committee member may declare the conflict and Council or a CCO committee can take appropriate action.

DESCRIPTION OF POLICY

A conflict of interest arises when a relationship or activity is reasonably seen as influencing a council or committee member's ability to make a decision solely in the public interest and/or consistent with the objectives of CCO.

Reporting and Responding to a Potential Conflict of Interest

Where a Council member or committee member has a potential conflict of interest in a matter coming before Council or a committee, the member shall declare the conflict prior to the matter being considered by Council or the committee. Council or the committee will analyse the potential conflict of interest, without that member present.

If Council or a committee determines that the member has a conflict of interest or appearance of conflict of interest on the matter, the member shall not participate in activity, the discussion of the matter, nor vote on the matter, and if the particular meeting is not open to the public, the member with the conflict shall leave the room both during the discussion and vote on the matter.

A member of the Inquiries, Complaints and Reports, Registration, Discipline and/or Fitness to Practise Committees who finds himself/herself faced with a conflict of interest shall disclose the situation to the committee for decision and, in the case of the Discipline Committee, the disclosure will also be made to both counsel. The decision as to whether the member is in a conflict situation will be determined by the committee as a whole.

An elected or appointed member of Council or committee member who becomes aware of any unreported potential conflict of interest shall immediately advise the President and Registrar, or if the potential breach involves the President, advise the Vice President and Registrar

Reporting of Conflict in Minutes

The minutes of every meeting or hearing where a conflict of interest or a potential conflict of interest has been disclosed shall record the information.

Conflicts of Interest Arising from Position on Council or Committee(s)

It is considered a conflict of interest for a Council member or committee member to use their position on Council or a committee to:

- further or promote any activity, service or product in which the member of Council or a committee (or any member of their immediate family, employer or affiliated organization) has a financial interest;

- obtain, by virtue of their position on Council or a committee, any benefit, privilege, money, appointment, employment or any other personal gain[1];

- be employed (either full-time or part-time) by any chiropractic association/society, other health profession council or association, or other organization that may be in conflict with the mandate of CCO (this excludes a teaching position at any chiropractic educational institution or the facilitation/presentation of a seminar, conference or workshop for which a per diem and/or expenses will be paid);

- campaign publicly for or on behalf of any person, other than themselves:

    - in any election to CCO Council; or

    - in any other political election in Ontario.

    (e.g., it would be inappropriate for a candidate to use election material which includes comments such as “endorsed by Dr. X, CCO Committee Chair,” etc.);

- be involved in discussions and/or decisions regarding elections to CCO Council for a particular district if the Council member is eligible for election in that particular year for that particular district.

- receive information as a Council member or committee member which is, in turn, used for a personal benefit;

[1] Excluding a CCO per diem and reimbursement of expenses.

- evaluate or take part in an evaluation of staff members when the Council member or committee member has a personal or professional relationship with the staff member outside the office; or

- makes threats or promises or agreements related to their position on Council.

Conflicts of Interest Arising from Affiliations with other Organizations

A conflict of interest may arise where a council or committee member, a close relative or friend or another close entity has a role or interest in an organization that may be in conflict with CCO's mandate, such as a chiropractic organization, society or specialty group, another health profession council or association, or government ("affiliated organization").

It is considered a potential conflict of interest for a council member or committee member to:

- be an employee, officer or director of any affiliated organization, as identified in By-law 6.9;

- have an interest in a specific issue before CCO that is related to an affiliated organization;

- receive or use confidential information relevant to CCO from their role at an affiliated organization; or

- receive or use confidential information relevant to an affiliated organization from their role at CCO.

Conflicts of Interest Arising from Other Activities

A conflict of interest may arise where a council member or committee member engages in an activity or is approached by an affiliated organization to engage in an activity that may be in conflict with CCO's mandate.

It is considered a potential conflict of interest for a council member or committee member to:

- give a presentation or participate in a working group or task force for an affiliated organization;

- communicate with an affiliated organization on matters related to CCO, without the authorization of CCO;

- communicate to the public, including on social media
    - on matters or opinions related to CCO without the authorization of CCO, or
    - messages inconsistent with CCO's mandate; or

- engage in legal proceedings against CCO.

Conflicts of Interest Involving Inquiries, Complaints and Reports Process

Where a Council member or committee member or anyone associated in an official capacity with CCO:

- has an official complaint registered against them,
- that complaint has been validated by the Inquiries, Complaints and Reports Committee as being within the jurisdiction of CCO, and
- the complaint has been referred by the Inquiries, Complaints and Reports Committee to either the Discipline or Fitness to Practise Committees,

that Council member or committee member shall be considered to be in a conflict of interest and shall not be active on Council or any committee until such time as the complaint has been disposed of. Should this occur, the Council member or committee member has the right to an expeditious process.

Conflicts of Interest Involving Investigations, Assessments or Hearings of Related Members

A Council member or committee member shall not participate in the investigation, assessment or hearing of a member to whom the member is related by blood, marriage, adoption, or who is a partner or associate of the member being investigated, or who is engaged in a relationship or strong friendship with the member being investigated, which might reasonably impair the member's objectivity.

If a Council member or committee member has a professional or personal connection to a member or issue under investigation or before a discipline or fitness to practise panel, including a connection on social media, the Council or committee member shall disclose this connection to the committee for a determination of a real or perceived conflict of interest and, in the case of the Discipline Committee, the disclosure will also be made to both counsel.

A connection on social media includes but is not limited to: being a friend, following or being followed by the member, and belonging to the same social media group as the member. The committee will then consider this conflict in accordance with the “Reporting and Responding to a Potential Conflict of Interest” section of this policy.

Conclusion

The reputation and high standards of the Council must be protected. Therefore, members of Council will avoid and/or report to Council any situation that could lead to a real or apparent conflict of interest which exists or may arise.

CHIROPRACTIC SPECIALTIES

Policy P-029
Executive Committee
Approved by Council: September 7, 1996
Amended: November 1, 1997, April 20, 2002, June 22, 2012, April 22, 2015

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 which specialty designations are recognized by CCO for the purpose of the professional misconduct regulation and the advertising regulation.

DESCRIPTION OF POLICY

CCO recognizes the following as approved 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)

Procedure for Review

This policy will be reviewed annually by CCO's Executive Committee taking into account the recommendations of the Federation of Canadian Chiropractic.

CCO'S LEGISLATION AND ETHICS EXAMINATION

Policy P-045
Executive Committee
Approved by Council: April 15, 2000
Amended: April 14, 2010, April 24, 2012, February 26, 2013, September 2014, 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 clarify CCO's policies and procedures concerning administration of CCO's Legislation and Ethics examination.

- To determine the requirements for retaking CCO's Legislation and Ethics examination.

DESCRIPTION OF POLICY

Under Ontario Regulation R-137/11, it is a condition of initial registration with CCO for applicants to have successfully completed CCO's Legislation and Ethics examination.

Additionally, a member may be required to successfully complete CCO's Legislation and Ethics examination for other purposes, including but not limited to, complying with a decision of the Discipline Committee, or complying with a term, condition, limitation or undertaking on a member's condition of registration for re-entering the General class of certificate of registration in Ontario. The purpose of this examination is to test the applicant's or member's knowledge of the legal, professional and ethical responsibilities and obligations governing the practice of chiropractic in Ontario.

CCO administers the Legislation and Ethics examination three times per year. CCO presents the Regulatory Excellence Workshop soon after the Legislation and Ethics Examination.

CCO will provide candidates with study material upon receipt of the examination application fee.

If a candidate is unsuccessful in passing CCO's Legislation and Ethics examination, they will be given an opportunity to write a supplemental examination at the next available sitting or, at the discretion of the Registration Committee, at an earlier date.

A candidate who is successful on CCO's Legislation and Ethics examination but unsuccessful on the clinical competency examinations conducted by the Canadian Chiropractic Examining Board (CCEB), or an examination accepted by CCO Council as equivalent, shall not be required to retake the Legislation and Ethics examination provided the candidate is successful on the clinical competency examinations within two years of successfully completing CCO's Legislation and

Ethics examination. If a candidate is unsuccessful on the CCEB clinical competency examinations within two years of successfully completing CCO's Legislation and Ethics examination, the candidate shall retake CCO's Legislation and Ethics examination.

CCO is committed to accommodating candidates with physical and/or learning disabilities in completing its Legislation and Ethics examination.

Under the *Ontario Human Rights Code*, 1990 and the *Accessibility for Ontarians with Disabilities Act, 2005*, disability means:

1. Any degree of physical disability, infirmity, malformation or disfigurement that is caused by bodily injury, birth defect or illness and, without limiting the generality of the foregoing, includes diabetes mellitus, epilepsy, a brain injury, any degree of paralysis, amputation, lack of physical co-ordination, blindness or visual impediment, deafness or hearing impediment, muteness or speech impediment, or physical reliance on a guide dog or other animal or on a wheelchair or other remedial appliance or device,

2. A condition of mental impairment or a developmental disability,

3. A learning disability, or a dysfunction in one or more of the processes involved in understanding or using symbols or spoken language,

4. A mental disorder, or

5. An injury or disability for which benefits were claimed or received under the insurance plan established under the *Workplace Safety and Insurance Act, 1997*.

The definition includes disabilities of different severity, visible as well as non-visible disabilities, and disabilities the effects of which may come and go.

A candidate who is otherwise eligible to write the Legislation and Ethics examination may file a written request to the Registrar, along with proof of the disability, for reasonable, alternative testing accommodations if the candidate is unable to write the examination under standard circumstances. CCO will make reasonable efforts to accommodate individuals with disabilities in accordance with the *Ontario Human Rights Code, 1990* and the *Accessibility for Ontarians with Disabilities Act, 2005*.

Fitness to Practise Committee

PUBLICATION OF FITNESS TO PRACTISE DECISIONS

Policy P-035
Fitness to Practise Committee
Approved by Council: November 16, 1996

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 information to CCO Council, members and the general public on Fitness to Practise Committee decisions.

DESCRIPTION OF POLICY

The Fitness to Practise Committee shall, in the annual report of its activities to Council, report on decisions of panels, including the substance of the proceedings and the results, without identifying the members who were the subject of the proceedings.

Procedure

The report is to be prepared by the Fitness to Practise Committee.

Inquiries, Complaints and Reports Committee

CONSIDERATIONS OF PRIOR DECISIONS INVOLVING A MEMBER

Policy P-015
Inquiries, Complaints and Reports Committee
Approved by Council: April 29, 1995
Amended: December 3, 2009

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

INTENT

To establish the procedure for when and how information regarding prior decisions about a member is brought before the Inquiries, Complaints and Reports Committee (ICRC).

DESCRIPTION OF POLICY

Under subsection 26(2) of the Health Professions Procedural Code (schedule 2 to the *Regulated Health Professions Act, 1991* as amended, and the *Chiropractic Act, 1991* as amended) when investigating a complaint or considering a report, a panel of the ICRC is required to consider all available prior decisions involving the member. Prior decisions are those made by the former Complaints Committee, the current ICRC, the Discipline Committee, the Executive Committee and the Fitness to Practise Committee, unless the decision was to take no further action under subsection 26(5), i.e., where no action was taken because the complaint was frivolous or vexatious. Information from the Quality Assurance Committee is protected by a special confidentiality provision and is not available to the ICRC.

Procedure

Within 14 days of receipt of a formal complaint, the member must receive notice of such complaint in order to provide an opportunity for the member to make written submissions in response to the complaint. The member has 30 days to provide a response.

At the same time and under separate cover, the member will be sent information about available prior decisions and be informed that in preparing a response to the present complaint, the member may wish to comment on these past decisions. The member will be advised that he/she may wish to comment on the prior decisions in a separate letter, given that the member's written submissions in response to the present complaint will be provided to the complainant. The member has 30 days to provide written comments on the previous decisions if he/she chooses. The member is also advised that in the event that a review is sought before the Health Professions Appeal and Review Board (HPARB), CCO is obliged to release to HPARB the entire record of investigation, including any submissions made by the member about a prior decision. HPARB has discretion to provide a copy of the prior decisions to all parties to the review, including the complainant.

Patient Relations Committee

PRINCIPLE OF ZERO TOLERANCE

Policy P-003
Patient Relations Committee
Approved by Council: September 17, 1994
Amended: June 7, 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 advise members that CCO endorses the guiding principle of zero tolerance for sexual abuse.

DESCRIPTION OF POLICY

To ensure CCO members understand that sexual abuse and/or impropriety in any form is unacceptable and will not be tolerated.

Procedure

CCO will deal with any violation to the fullest extent of the disciplinary process granted under the statutes and regulations governing the profession.

CCO accepts the responsibility to protect the public interest by addressing the issue openly and prioritizing prevention through education of the profession and the public.

FUNDING FOR THERAPY OR COUNSELLING FOR PATIENTS SEXUALLY ABUSED BY MEMBERS

Policy P-018
Patient Relations Committee
Approved by Council: June 29, 1995
Amended: September 16, 1995, June 7, 1997 and June 17, 2005, June 18, 2010, June 18, 2014, September 15, 2016, September 16, 2017, September 8, 2023 (came into effect November 23, 2023), April 23, 2026 (came into effect June 5, 2026)

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

INTENT

- To establish a program to provide funding for therapy and counselling for persons who, while patients, were sexually abused by a member of CCO, as stipulated in section 85 (7) of the Health Professions Procedural Code of the Chiropractic Act, 1991, as amended (Code).

- To expand the criteria for funding eligibility beyond what is stipulated in the Code, section 85.7 (4) (a).

DESCRIPTION OF POLICY

This policy is to be proactive, meaning that every person who may be eligible for funding shall be advised in writing of their right to apply for funding consideration.

PROCEDURE

The Patient Relations Committee may review and determine eligibility of funding for therapy and counselling for a person:

- who has been acknowledged by a member, as part of a statement to or an agreement with CCO, as a person who was sexually abused by the member while a patient of that member;

- who has been found by a court to have been sexually assaulted by a member within the meaning of the Criminal Code of Canada while a patient of the member, if that person is not eligible for funding from the Criminal Injuries Compensation Fund;

- who satisfies the Patient Relations Committee that the person, while a patient, was sexually abused by a member and the Inquiries, Complaints and Reports Committee concludes that the public interest would not be served by holding a hearing before the Discipline Committee;

- who testifies before a panel of the Discipline Committee of CCO against a member and the panel states in its reasons that the person, while a patient, was sexually abused by the member (a similar fact witness);

- who is a complainant in a matter involving allegations of sexual abuse by a member; or

- if it is alleged, in a complaint or report, that the person was sexually abused by a member while the person was a patient of the member.

Additional Conditions

In every case, the applicant must comply with the following application requirements:

- submit a completed application in the form provided by the Committee naming the member or members whose conduct may entitle the applicant to funding; and

- undertake to keep all information originating from the application and funding confidential, including the basis upon which the funding was granted, and to refrain from using the information for any collateral or ulterior purpose.

Procedural Safeguards

In every case, the Committee must adhere to the following procedural safeguards:

- the Committee shall review and approve funding in accordance with section 85.7 of the *Health Professions Procedural Code*, and Regulation 59/94 under the *Regulated Health Professions Act, 1991*. This includes, but is not limited to that:

    - "the maximum amount of funding that may be provided for a person in respect of a case of sexual abuse is the amount that the Ontario Health Insurance Plan would pay for 200 half-hour sessions of individual out-patient psychotherapy with a psychiatrist on the day the person becomes eligible under subsection 85.7 (4) of the Code; and

    - the period of time within which funding may be provided for a person in respect of a case of sexual abuse is five years from,
      (i) the day on which the person first received therapy or counselling for which funding is provided under subsection 85.7 (10) of the Code, or
      (ii) if funding is not provided under subsection 85.7 (10) of the Code, the day on which the person becomes eligible for funding under subsection 85.7 (4) of the Code."

- the Committee shall consider all the information before it, including but not limited to the nature and relevance of the therapy and the jurisdiction in which the therapy is provided, and shall render a decision as to the time limits of funding and the reasons for its decision to the applicant;

- unless there are extenuating circumstances, such as the residence of the person applying for funding or the availability of therapy, the therapy shall take place in the province of Ontario;

- the decision of the Committee shall be considered final if there is no written request for a review from the applicant within 30 days of their notification of decision;

- the Committee shall consider alternative requirements for eligibility for funding, in accordance with this policy and in accordance with Section 85.7 (6) (7) (8) (9) (10) (11) (12) and (13) of the Code; and

- a decision by the Committee to provide funding to a person does not constitute a finding against a member and shall not be considered by any other committee of the College dealing with the member.

Information from Applicant

A person must submit an application to the College to obtain funding. The application must contain the following:

- the name and address of the applicant;

- the name and address of the member;

- if the funding is for a retroactive request, copies of invoices for therapy already provided;

- if the funding is for a prepayment for a program of therapy, information from the therapist of the details of the program, and an undertaking from the person and therapist that the program of therapy will be provided in the manner described in the application;

- the name and address of the therapist or counsellor; and

- if the therapist is unregulated, a document signed by the applicant confirming that the person understands the therapist is not subject to professional discipline and the CCO cannot verify, with any degree of certainty, whether an unregulated therapist has ever been found guilty of sexual abuse, etc., and that the applicant recognizes the significance of this.

Information from Therapist

Accompanying information from the therapist must include:

- information on the therapist's background;

- a statement signed by the applicant and the therapist attesting the therapy is actually being provided, and the therapist is not a family member of the applicant;

- a statement that the therapy being provided is not eligible for reimbursement from other sources; and

- a statement that the therapy being provided is related to practitioner sexual abuse.

Information from CCO

CCO staff will provide the following information to accompany the application to the Committee:

- a statement describing the applicant's possible eligibility, i.e., the filing of a complaint, finding of a Discipline Panel, Alternate Dispute Resolution, etc.;

- the name of the member involved in the case;

- the date of the complaint, discipline decision or other eligibility factors; and

- if the therapist is a regulated health professional, a document from his/her College certifying that the therapist has not been found guilty of sexual abuse, consistent with what is public information or on the public register, and a statement that there are no outstanding matters before the College.

Program Monitoring

Once an applicant has been established by the Committee as eligible for funding, the Committee will provide staff with all relevant information. The claim will be handled at the staff level and the monies paid to the therapist upon presentation of invoices.

The Committee will review the funding account at regular intervals.

The Committee will report to Council on the funding being provided and on the status of the fund itself.

Quality Assurance Committee

PUBLIC SCREENINGS

Policy P-017
Quality Assurance Committee
Approved by Council: November 29, 2018
Amended: November 25, 2021 (came into effect February 25, 2022)

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

INTENT

Chiropractors may perform screenings and provide care in public settings. This policy is intended to provide members with practical approaches to public event planning and implementation and ensure that chiropractic is consistently promoted in a professional manner with personal accountability.

Public screenings can be of value to the public because they can educate the public about chiropractic, build a stronger chiropractic presence in the professional and public communities, and promote chiropractic as a safe and effective health care choice

Members are reminded that in conducting any public screenings or care, they are representing the chiropractic profession, and are expected to conduct themselves in a professional manner, maintain the dignity and integrity of the profession, and adhere to CCO regulations, standards of practice, policies and guidelines.

DESCRIPTION OF POLICY

Definitions

A "public health screening" is a public event where a member conducts assessment procedures on the public to identify possible chiropractic/health concerns that may require attention.

A "health fair" is a community event focused on the promotion of health.

A "trade show" is an exhibition for people or companies to demonstrate products and services.

I. Public Health Screening

Purpose

A public health screening is the application of a test to detect a possible condition in a person who has no known sign or symptoms of that condition. It is performed on in order to identify potential health problems and determine appropriate interventions.

Public health screenings that promote public health and preventative health strategies are commonly used by health professionals. These screenings are of value to the public because they may identify early signs of potential health problems and educate the public about chiropractic.

The purpose of a public screening is not to diagnose, but to identify possible health problems that may need attention. A public health screening may not be used to conduct a full examination, render a diagnosis[1], recommend a plan of care, or solicit patients. A member may not subject the public or participants to undue pressure or duress to participate in a public health screening or follow up with chiropractic care.

Location

A member may only conduct a public health screening at an appropriate and suitable public location, such as a health fair or trade show, and must ensure that he/she has the necessary permission and/or permits from the owners or authority in charge.

Chiropractic Representation

CCO requires that at least one registered member of the CCO be present at a public screening at all times.

Public Screening Set-up/Presentation

All public display material used in a public health screening shall comply with the *Public Screening Setup/Presentation* section of this policy.

Any written material shall include a disclaimer that the public health screening does not constitute an examination, and therefore is not sufficient to render a diagnosis of any condition, or recommend a plan of care.

Screening Procedures

A member shall provide the public and the participant with a clear description and explanation of the purpose of the screening procedure.

For the purpose of this policy, "fully informed" consent means a participant understands that the purpose of the screening is not to conduct an examination, render a diagnosis, or recommend a plan of care, but rather to educate the participant on chiropractic, explain the nature and purpose of the screening procedures, demonstrate the screenings procedures, and screen the participant for potential health concerns that may require further investigation in a formal office setting.

[1] See Standard of Practice S-008: Communicating a Diagnosis

Prior to performing any screening procedure, a member shall obtain consent that is:

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

A member shall:

- advise the participant that he/she may withdraw their consent at any time;
- offer the participant the option of having the screening procedure performed in a private area (e.g., separated or sectioned off with a curtain);
- maintain records in accordance with Standard of Practice S-002: Record Keeping; and
- perform a screening in compliance with current privacy legislation.

A member shall not:

- disrobe or gown any participant at a public display/health screening;
- use a method of screening that uncovers, shifts or alters a participant's clothing (e.g., shirts, slacks, dresses, etc.) in a way that would be construed as disrespectful, embarrassing and/or inappropriate; and
- conduct a full examination, communicate a diagnosis or perform therapeutic interventions or care (e.g., soft tissue therapy or massage, stretching, mobilizations, manipulation or adjustment (manual/instrumented).

A member is reminded:

- if a fee is charged for the screening procedure, the fee shall be disclosed to the participant before the service is provided and be in compliance with section 4 of Standard of Practice S-016: Advertising;
- to be sensitive to the fact that the member may be screening participants who are already receiving chiropractic care; and
- not to compare their services to any other chiropractor, directly or indirectly.

Use of screening procedures shall conform to CCO standards of practice and shall follow generally accepted protocols. Any use of screening equipment shall be for educational and demonstrative purposes only, and shall not be used to conduct a full examination, render a diagnosis, recommend a plan of care, or pressure patients to continue with chiropractic care.

It is recommended that screening procedures be limited to questionnaires, and simple functional and physiological testing.

A member is reminded that he/she represents a profession with high standards and, when performing any of the above screening procedures, the member may be compared to other professions.

Follow-up

Following a screening, a member may provide the participant with a simple explanation of the results. A member may not render a diagnosis or recommend a plan of care.

If a member of the public wishes to follow up with further chiropractic care, a member may recommend that the participant or member of the public visit a chiropractor of their choice. Any collection of contact information from the public or communication of the member's contact information shall be voluntary. A member may not subject a participant to undue pressure or duress to follow up with chiropractic care. It remains a participant's choice to follow up with a more complete evaluation at a chiropractic office. The participant's right to choose their health care provider shall be respected and thus the member shall provide to the participant or the participant's health care professional upon request any information available from the screening process.

A member shall consider that some of the participants being screened will be under the active care of another chiropractor. In compliance with Guideline G-009: Code of Ethics, a member may not attempt to take over the care of a participants who is under active chiropractic care.

Recommendation to Submit Advertising to CCO

CCO recommends submitting advertising to CCO for review and feedback, with reference to Standard of Practice S-016: Advertising and Guideline G-016: Advertising. CCO will provide a response within approximately 10 business.

Professional Conduct

A member shall adhere to CCO regulations and standards of practice, policies and guidelines at all times when participating in a public outreach. A complaint of professional misconduct may occur if, having regard to all the circumstances, a member's conduct would reasonably be regarded as disgraceful, dishonourable or unprofessional.

PARTICIPATION IN X-RAY PEER REVIEW PROGRAM

Policy P-023
Quality Assurance Committee
Approved by Council: November 1, 1997, November 27, 1999

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 responsibility of each member to demonstrate radiographic competence under CCO's X-ray Peer Review Program.

DESCRIPTION OF POLICY

On an ongoing basis, a member must demonstrate his/her individual radiographic competence. Radiographic examinations and radiographic reports are required of the following:

- a member who operates his/her own active x-ray facility;
- a member who has his/her own x-ray facility which has been dormant less than two years; and
- a member who does not have his/her own x-ray facility, or who has a facility which has been dormant more than two years.

Procedure

Active X-ray Facility

A member with an active x-ray facility or who is on record as having a dormant facility less than two years should follow stream A of the X-ray Peer Review Program Algorithm (the algorithm).

No X-ray Facility or Dormant Facility

A member who does not have an x-ray facility or who is on record as having an x-ray facility dormant more than two years should follow stream B of the Algorithm.

Moving from Dormant to Active

A member is required to notify CCO as soon as a dormant facility becomes active, and he/she will then enter stream A of the Algorithm.

Members Who Take Radiographs

For the purpose of the mail-in audit, CCO will mail to each member on record as taking his/her own radiographs a notice of requirement to participate in the Peer Review Program (stream A of the Algorithm), a pre-printed CCO label, and directions on how to comply with the program.

Within 15 days of receipt of the notice, a member shall be required to submit the following to CCO:

- two radiographic series performed within the last 90 days in the member's facility;
- a photocopy of the corresponding page from the member's x-ray log book; and
- a radiological report of findings for each series.

The films will be critiqued and peer reviewed by a chiropractic generalist and returned to the member with a report.

Members whose radiographs and accompanying reports are deemed to meet acceptable standards will return to stream A of the Algorithm. Members whose radiographs and accompanying reports are not of an acceptable standard shall be required to participate in an X-ray Remediation Program, as determined by CCO's Quality Assurance Committee.

Members Who Do Not Take Radiographs

For the purpose of the mail-in audit, CCO will mail to each member on record as not taking his/her own radiographs a notice of requirement to participate in the Peer Review Program (stream B of the Algorithm), a pre-printed CCO label, and directions on how to comply with the program.

Within 15 days of receipt of the notice and subject to a reasonable length of time to gain access to the film, a member shall be required to submit the following to CCO:

- two radiographic series performed within the last 90 days; and
- a radiological report of findings for each series.

The report of findings for each series will be critiqued and peer reviewed by a chiropractic generalist and returned to the member with a report.

Members whose radiological report of findings are not of an acceptable standards will return to stream B of the Algorithm. Members whose radiological report of findings are not of an acceptable standard shall be required to participate in an X-ray Remediation Program, as determined by CCO's Quality Assurance Committee.

Remediation

The Quality Assurance Committee may require a member to participate in a remediation program if, through the X-ray Mail-in Audit Program, he/she demonstrates deficient x-ray ability.

Working with the chiropractic generalist, the member must complete a program specifically designed to address his/her x-ray deficiencies. The cost of this program will be the responsibility of the member.

Once the remedial program has been completed, and any terms or limitations on the member's x-ray practice have been removed, it may be necessary for a confirmation audit (either mail-in or on-site facility audit) to ensure the member has corrected any x-ray deficiencies.

X-ray Facility On-Site Program

Poor results in the X-ray Mail-in Audit Program regarding x-ray safety and general radiological competence may trigger an on-site x-ray facility audit.

Program Protocol

The protocol for the on-site x-ray facility and audit shall be as follows:

- a pre-visit information package and brief practice questionnaire will be sent to the member prior to the review. The completed questionnaire will be forwarded to the assessor prior to the office visit; and

- the assessor will contact the member to make a convenient appointment to conduct the office x-ray practice review. It is anticipated this visit will last one hour.

The protocol for the actual visit shall be as follows:

- a short introductory meeting with the assessor and the member;

- an escorted tour of the x-ray facility with the member or a staff member;

- a review of x-ray safety and competence;

- the assessor to randomly select radiographs of five recent patients;

- a record review done by the assessor in a private area of the office, including:

    - log organization;
    - completeness of radiological reports;
    - number and quality of radiographs; and

    - presence of written radiological impressions and completeness of relevant clinical entries.

- a short exit meeting with the member and the assessor;

- the assessor will prepare a report and submit it to CCO with any recommendations for remediation; and

- the report will be reviewed by the Quality Assurance Committee and a copy sent to the member within a prescribed time frame with any recommendations for remediation.

Algorithm of the X-ray Peer Review Process

For the purpose of this policy, the following X-ray Peer Review Program Algorithm, approved by Council on November 1, 1997, shall apply.

PEER ASSESSORS

Policy P-051
Quality Assurance Committee
Approved by Council: September 13, 2008
Amended: April 16, 2013, June 17, 2015, September 15, 2018, June 14, 2024 (came into effect June 14, 2024), February 21, 2025 (came into effect April 24, 2025)

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

INTENT

To outline the Quality Assurance Committee's process and criteria for appointing, re-appointing, discharging and thanking peer assessors for the Peer and Practice Assessment Program.

DESCRIPTION OF PROGRAM

The Peer and Practice Assessment Program is one component of the quality assurance program. The Quality Assurance Committee developed the Peer and Practice Assessment Program to enhance members' learning opportunities and ensure their compliance to CCO's regulations, standards of practice, policies and guidelines.

- The program is designed to be educational, not punitive, in nature;
- Participation in all Quality Assurance initiatives is mandatory for all CCO members holding a General ('Active') certificate of registration, as set out by the *Regulated Health Professions Act, 1991 (RHPA)*.
- CCO randomly selects members to participate in the program and matches the selected member with an assessor.
- Members may volunteer to participate in the program before being chosen through random selection.
- Information gathered during the peer and practice assessment is only shared within the Quality Assurance Committee, subject to the provisions of *RHPA*.

PROCEDURE FOR MEMBERS TO APPLY OR RE-APPLY FOR PEER ASSESSOR APPOINTMENT

A member may apply or re-apply to CCO to become a peer assessor by submitting their curriculum vitae and a cover letter outlining the reason(s) the member is interested in being appointed or re-appointed as a peer assessor.

A member is eligible for appointment as a peer assessor if, on the date of the appointment, the member:

- is registered in the General ('active') class of registration of CCO;
- has been registered in the General class of registration for at least five years;
- has actively practised chiropractic in Ontario for at least five consecutive years;
- is currently actively providing direct care to patients;
- has been peer assessed. The member must have completed Peer and Practice Assessment 1.0 and 2.0, with the conditions that if the member has not completed Peer and Practice Assessment 2.0, they must agree to complete Peer and Practice Assessment 2.0 within six months;
- practises primarily in Ontario;
- is not a CCO Council member;
- is not a CCO committee member of the Inquiries, Complaints and Reports, Discipline or Fitness to Practise Committee;
- is not 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;
- is not in default in completing and returning any form required by CCO;
- is not the subject of any disciplinary or incapacity proceeding;
- has not had a finding of professional misconduct, incompetence or incapacity in the preceding six years;
- if a member has been found to be incapacitated, CCO receives confirmation from their treating practitioner that the member is physically and mentally capable to serve on Council or a committee;
- has not been disqualified from Council or a committee of CCO in the previous six years;
- has not resigned from a position on Council, before completing the term, within the last three years;
- does not have an outstanding code of conduct matter with the College;
- is not a member of the Council of a college of any other health profession;
- is not, and has not been within the preceding six years, an adverse party in litigation against CCO, the Council or CCO, a committee of CCO, or any of CCO's directors, officers, employees, agents, on a matter related to CCO business;
- is not an accused currently charged with a criminal offence under the Criminal Code of Canada;
- has not been convicted of a criminal offence for which the member has not received a pardon pursuant to the Criminal Code of Canada;
- declares that all content on their professional websites and social media accounts is in compliance with CCO standards of practice, policies and guidelines; and
- is not currently or has not been a member of the CCO's staff at any time within the preceding three years.

Process for Appointment and Retention of Peer Assessors

The Quality Assurance Committee shall appoint and re-appoint peer assessors at the first Quality Assurance Committee meeting following the annual CCO elections, or as soon thereafter as practicable.

The term of a peer assessor is approximately three years from the date the assessor is appointed.

A peer assessor may request a deferral for appointment and/or leave of absence for up to one year if the assessor provides the Quality Assurance Committee with reasons for the request that are satisfactory to the Committee including but not limited to, stopping to provide direct care to patients.

When the member's three-year appointment nears its completion, the member will be re-appointed if they express interest in continuing to serve as a peer assessor.

A member who has served as a peer assessor for nine consecutive years, or three consecutive terms, is ineligible for re-appointment as a peer assessor until a full three-year term has passed since the member last served as a peer assessor.

Appointment Criteria

When appointing peer assessors, the Quality Assurance Committee will consider the following:

- interview evaluation;
- need for peer assessor(s) in each CCO district;
- geographical location of the member's practice;
- type of practice and/or practice style;
- experience;
- additional professional qualifications, expertise and/or specialty;
- languages spoken;
- communication skills;
- successful completion of both the internal and field training portions of the Assessor-In-Training program;
- additional qualifications and characteristics to complement the attributes of the Peer and Practice Assessment program.

Disqualification of Peer Assessors

A member will be discharged as a peer assessor if the assessor:

- breaches one of the qualifications required to become a peer assessor as outlined in this policy;
- breaches confidentiality of any information learned through the peer and practice assessment and/or other Quality Assurance programs;
- breaches the Peer Assessor Code of Conduct;

- is absent from two consecutive CCO peer assessor training days; or
- fails to discharge properly or honestly any office to which the assessor has been appointed, in the opinion of the CCO.

COMPLETION OF APPOINTMENT

A member will be considered to have completed their appointment and thanked for their services if the member does any of the following:

- resigns in writing;
- requests an extended leave of absence as a peer assessor;
- completes their term of service and is not re-appointed; or
- completes nine consecutive years or three consecutive terms.

NON-COMPLIANCE WITH CONTINUING EDUCATION

Policy P-055
Quality Assurance Committee
Approved by Council: September 17, 2015
Amended: September 15, 2016

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

INTENT

To clarify the process of the Quality Assurance (QA) Committee in addressing members who are non-compliant with CCO's Continuing Education (CE) program.

DESCRIPTION OF POLICY

CCO administers the CE program in accordance with sections 80.1, 80.2 and 82 of the Health Professions Procedural Code, Schedule 2 of the *Regulated Health Professions Act, 1991*, and standards of practice S-003: Professional Portfolio and S-020: Cooperation and Communication with CCO.

If a member is non-compliant with the CE requirements, the QA Committee may take any action consistent with its powers under sections 80.1, 80.2 and 82 of the Health Professions Procedural Code, Schedule 2 of the Regulated Health Professions Act, 1991, and standards of practice S-003: Professional Portfolio and S-020: Cooperation and Communication with CCO.

Although the QA Committee may exercise discretion, consistent with its committee powers, the following procedure summarizes the sequence of events of the QA Committee in addressing members are non-complaint with the CE program:

1) CCO communicates to members who have not submitted their CE Log by the due date, requiring them to return to CCO, no later than 60 days from the date of the communication:
   - A completed CE log;
   - A copy of their completed professional portfolio;
   - An administrative fee of $50 for non-compliance with CCO's Quality Assurance program in accordance with By-law 13: Fees (cheque made out to College of Chiropractors of Ontario).

2) CCO communicates a second time via registered mail to members who have not complied with the above requirement, requiring them to comply with the above requirement, no later than 30 days from the date of the communication, or else the QA Committee will refer the names of those non-compliant members to the Inquiries, Complaints and Reports Committee for non-compliance with the QA Program.

3) The QA Committee refers those members are still non-complaint after two communications to the Inquiries, Complaints and Reports Committee.

LEGISLATIVE CONTEXT

Health Professions Procedural Code, Schedule 2 of the Regulation 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

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

Section 80.1 of the Code defines the minimum requirements for a quality assurance program as follows:

(a) "A quality assurance program prescribed under section 80 shall include, continuing education or professional development designed to,
  (d) promote continuing competence and continuing quality improvement among the members,
  (ii) address changes in practice environments, and
  (iii) incorporate standards of practice, advances in technology, changes made to entry to practice competencies and other relevant issues in the discretion of the Council;
(b) self, peer and practice assessments; and
(c) a mechanism for the College to monitor members' participation in, and compliance with, the quality assurance program.

Section 80.2 of the Code outlines the powers of the QA Committee as follows:

"The Quality Assurance Committee may do only one or more of the following:

1. Require individual members whose knowledge, skill and judgment have been assessed under section 82 and found to be unsatisfactory to participate in specified continuing education or remediation programs.

2. Direct the Registrar to impose terms, conditions or limitations for a specified period to be determined by the Committee on the certificate of registration of a member,
   i. whose knowledge, skill and judgment have been assessed or reassessed under section 82 and have been found to be unsatisfactory, or
   ii. who has been directed to participate in specified continuing education or remediation programs as required by the Committee under paragraph 1 and has not completed those programs successfully.

3. Direct the Registrar to remove terms, conditions or limitations before the end of the specified period, if the Committee is satisfied that the member's knowledge, skill and judgment are now satisfactory.

4. Disclose the name of the member and allegations against the member to the Inquiries, Complaints and Reports Committee if the Quality Assurance Committee is of the opinion that the member may have committed an act of professional misconduct, or may be incompetent or incapacitated.

REGISTRATION COMMITTEE

SUPERVISION AND DIRECTION OF CHIROPRACTORS IN TRAINING

Policy P-050
Registration Committee
Approved by Council: December 3, 2010
Amended: November 29, 2018, November 25, 2021 (came into effect February 25, 2022)
*This policy replaces the former policy entitled "Student Field Placement Temporary Policy

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

INTENT

To clarify for members CCO's interpretation of section 29(1)(b) of the *Regulated Health Professions Act, 1991,* which provides:

"29(1) An act by a person is not in contravention of subsection 27(1) [the provision prohibiting the performance of controlled acts] if it is done in the course of,

> (b) fulfilling the requirements to become a member of a health profession and the act is within the scope of practice of the profession and is done under the supervision or direction or a member of the profession."

For the purposes of this policy:

- "Accredited Chiropractic Programme" means a chiropractic programme accredited or recognized by the Council on Chiropractic Education (Canada) or a chiropractic education program considered equivalent by the Council to such a program.

- "Preceptorship Programme" means a student practice placement programme of an accredited chiropractic program. A chiropractic student is required to practise under the supervision or direction of a member of the profession.

Chiropractic students participating in an accredited school's preceptorship programme will be considered to be "fulfilling the requirements" of becoming a chiropractor for the purposes of section 29(1) and 30(5) of the *RHPA* if they are enrolled in an accredited chiropractic programme.

For the purposes of this policy, the following principles shall be applied:

- Safe and effective care of the patient takes priority over the training endeavour;

- Proper training optimizes patient care as well as the educational experience;

- The autonomy and personal dignity of students and patients must be respected;

- Joint decision-making and exchange of information between the supervising member and student provides an optimal educational experience;

- Professionalism, which includes demonstration of compassion, service, altruism and trustworthiness is essential in all interactions in the supervision environment in order to provide the best quality care to patient.

DESCRIPTION OF POLICY

- Chiropractic students participating in an accredited school's preceptorship programme will be considered to be "fulfilling the requirements" of becoming a chiropractor for the purposes of section 29(1) and 30(5) of the *RHPA* if they are enrolled in an accredited chiropractic programme.

- A member may participate in a preceptorship programme of an accredited chiropractic programme by providing supervision or direction of a student performing a controlled act, provided the member:

    - holds a General (i.e. active) certificate of registration
    - is in good standing with CCO[1]
    - is a qualified participant in a preceptorship programme of an accredited chiropractic programme
    - has appropriate malpractice protection which provides coverage for controlled acts performed by students

- For the purposes of section 29(1) and 30(5) of the *RHPA*, the supervision or direction of a student participating in the preceptorship programme requires that the supervising chiropractor be present on the premises and available for consultation at all times during the student's performance of patient-related activities.

- The supervision and direction of the student must comply with the standards adopted by the accredited chiropractic programme with regard to the preceptorship placement.

[1] "Good Standing" refers to the status of a member if they do not have a past discipline or incapacity finding with CCO. The Registration Committee may consider General (Provisional) applications involving a member with a past discipline or fitness to practise finding in a supervisory role to determine if the member may act in a supervisory role. Considerations of the Registration Committee will include but are not limited to: the nature, date and penalty of the discipline or fitness to practise finding, any other regulatory findings involving the member, whether the finding has been expunged or reversed on appeal, and any steps the member has taken to address the findings of the discipline or fitness to practise decision.

- The member shall ensure that the student obtains consent to any examination or treatment, 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 record

  As part of the informed consent process, the member shall inform, discuss and ensure that the patient has an understanding that they will be receiving examination or treatment from a student under the supervision of the member. The member shall ensure that the patient has an opportunity to request not to receive and examination and treatment from a student.

  Any record of consent shall indicate that the patient has an understanding and has consented to receiving examination and treatment from a student, and the examination or treatment was being provided by a student under the member's supervision or direction.

- The member shall ensure that the student complies with all CCO regulations, standard of practice, policies and guidelines.

LEGISLATIVE CONTEXT

All activities and services performed by members must relate directly 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:

4. 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.

5. Moving the joints of the spine beyond a person's usual physiological range of motion using a fast, low amplitude thrust.

6. Putting a finger beyond the anal verge for the purpose of manipulating the tailbone.

Section 30(1) of the *RHPA*:

No person, other than a member treating or advising within the scope of practice of his or her profession may 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 omission from them.

Section 30(5)(b) of the *RHPA*:

Subsection (1) does not apply with respect to anything done by a person in the course of,

(b) fulfilling the requirements to become a member of a health profession in the person is acting within the scope of practice of the profession under the supervision or direction of a member of the profession.

RETURNING TO THE GENERAL CLASS OF CERTIFICATE OF REGISTRATION

Policy P-053
Registration Committee
Approved by Council: December 1, 2011
Amended: September 20, 2013, December 4, 2015, November 25, 2021 (came into effect February 25, 2022)

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

INTENT

To clarify what is required of a member in order to return to the General Class of Certificate of Registration after being in an Inactive or Retired Class of Certificate of Registration.

DESCRIPTION OF POLICY

Under Ontario Regulation 137/11, the following are the prescribed classes of certificates of registration available to members of CCO.

1. General
2. Temporary
3. Inactive
4. Retired

Ontario Regulation 137/11 sets out for members the requirements of each different class of registration. Section 8(1) states the following rules apply when a member, who holds a Retired or Inactive Class of certificate of registration, wishes to be issued a General Class of Certificate of Registration as follows:

Issuance of general certificate of registration to retired or inactive member

8(1) The following rules apply where a member who holds a Retired or Inactive Certificate of Registration wishes to be issued a General Certificate of Registration:

1. An application must be made to the Registrar.
2. The member shall pay the applicable fee for a General Certificate of Registration.
3. A member who has held an Inactive or Retired Certificate of Registration for more than two consecutive years preceding his or her application for a General Certificate of Registration shall only be entitled to have a general certificate of registration issued if he or she satisfies the Registration Committee that he or she is currently competent to practise.
4. The member shall not resume active practice until his or her application for issuance of a General Certificate of Registration has been approved by the Registration Committee.

This policy details what may be required of a member to regain his/her General Class of Certificate of Registration and what it means to "satisfy the Registration Committee that the member is competent to practise." These requirements apply to a member who has been in the Inactive or Retired Class of Certificate of Registration for a specified period of time.

The Registration Committee is required to examine all the relevant facts and make decisions consistent with Ontario legislation, CCO regulations, standards of practice, policies and guidelines. The Registration Committee will make decisions on each case based on the specific facts known and the facts supplied by the applicant on his/her application for registration.

The Registration Committee shall consider the following guidelines in rendering a decision of what may be required for a member to satisfy the Committee that the member is competent to practise.

Inactive

If a member has been inactive for a specified period of time, and not registered in a CCO recognized regulated jurisdiction[1] outside of Ontario with an equivalent to CCO's General (Active) Class of Certificate of Registration, the Registration Committee may require the member to take the following action(s) as outlined in Appendix 1 before or upon returning to the General Class of Certificate of Registration.

Retired

The Retired Class of Certificate of Registration is intended for members who intend to permanently retire from the General Class of Certificate of Registration.

If a member has been in the Retired Class of Certificate of Registration, and not registered in a CCO recognized regulated jurisdiction outside of Ontario with an equivalent to CCO's General (active) Class of Certificate of Registration, then before the member will be permitted to return to the General Class of Certificate of Registration the following actions would be required:

- pay the difference in the annual fees between the Retired Class and Inactive Class for each year the member was in the Retired Class instead of the Inactive Class; and

- meet the same criteria as all other inactive members as stated in Appendix 1 (inactive chart) within this policy.

All members are reminded that applicants for a General Class of Certificate of Registration are required to obtain professional liability protection before engaging in the practise of chiropractic in Ontario.

[1] "Recognized regulated jurisdiction" mean "Legal pursuant to legislation to accept and regulate chiropractic practice".

Partial Exemption of Fees

Under By-law 13.14, The Registration Committee may grant a partial exemption from the fees payable by a member pursuant to this by-law if the committee is satisfied that extraordinary circumstances exist which justify the exemption.

Appendix 1

Inactive for 2 to 5 years	Inactive for more than 5 years
• submit a professional portfolio within a specified period of time as determined by the Registration Committee • attend a regulatory excellence workshop within a specified period of time as determined by the Registration Committee • undergo a peer and practice assessment within a specified period of time as determined by the Registration Committee • successfully pass the legislation and ethics examination set or approved by Council • complete an in-person workshop or course on the controlled acts authorized to chiropractors in Ontario; • otherwise satisfy the Registration Committee that the member is competent to practise in Ontario	• submit a professional portfolio within a specified period of time as determined by the Registration Committee • attend a regulatory excellence workshop within a specified period of time as determined by the Registration Committee • undergo a peer and practice assessment within a specified period of time as determined by the Registration Committee • successfully pass the legislation and ethics examination set or approved by Council • as determined by the Registration Committee, successfully pass the appropriate examinations administered by the Canadian Chiropractic Examining Board or approved by Council as equivalent • otherwise satisfy the Registration Committee that the member is competent to practise in Ontario

Fees:

- Application fee for a General Class of Certificate of Registration; and
- Renewal fee for a General Class of Certificate of Registration (or difference between Inactive and General Class, if applicable)

DETERMINATION OF GOOD CHARACTER OF AN APPLICANT OR MEMBER

Policy P-054
Registration Committee
Approved by Council: April 22, 2015

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

INTENT

To outline the considerations in determining if an applicant or member meets the good character requirements of Regulation 137/11 (Registration Regulation)

DESCRIPTION OF POLICY

Introduction

CCO's Registration Regulation has several requirements that are collectively known as the "good character" requirement. These requirements read as follows:

Section 3 (in part)

The applicant's past and present conduct must afford reasonable grounds for belief that the applicant,

i. is mentally and physically competent to practise chiropractic,
ii. will practise chiropractic with decency, integrity, honesty and in accordance with the law,
iii. has sufficient knowledge, skill and judgment to engage in chiropractic, and
iv. will display professional behaviour.

Section 4

Every applicant is required to provide the College with details of the following with respect to the applicant that occur or arise after the applicant has submitted his or her application, and if the applicant becomes a member, it is a condition of the member's certificate of registration that he or she provide such details:

1. A finding of professional misconduct, incompetence or incapacity or similar finding in Ontario in relation to another health profession or in any other jurisdiction in which the applicant is registered or licensed to practise chiropractic or another health profession.
2. An investigation or proceeding for professional misconduct, incompetence or incapacity or similar finding in Ontario in relation to another health profession or in any other jurisdiction in which the applicant is registered or licensed to practise chiropractic or another health profession.

3. A finding of guilt in relation to any offence.

The purpose of these requirements is to protect the public through the maintenance of high ethical standards and ensuring that an applicant for registration meets those standards.

Applicants for registration and members are required to self-disclose any past and current findings of professional misconduct, incompetence, incapacity, professional negligence or malpractice, and offences ("conduct").

If an applicant discloses this conduct, the Registrar will refer the applicant to the Registration Committee for a determination of whether the applicant meets the good character requirements.

If a member discloses this conduct, the Registrar will refer the member to the Inquiries, Complaints and Reports (ICR) Committee for a determination of whether the member requires remedial or disciplinary measures. In addition, the Registrar can administratively revoke a member's certificate of registration where the member made a false or misleading statement in their application for registration or on any form related to their renewal or reinstatement of registration.

It is important, therefore, for applicants and members to recognize that declaring conduct does not automatically disqualify an applicant from registration or automatically result in disciplinary action. The consequence of the conduct depends on all of the circumstances of the case. It is helpful for applicants and members to provide full and accurate details of the conduct and to offer as much relevant information as possible on subsequent events.

CCO reminds applicants and members that information provided on the registration and renewal forms must be true and complete and that it may demonstrate unsuitability to become a member or be considered an act of professional misconduct to provide false information to CCO.

This policy outlines the considerations and procedures in determining if an applicant or member meets the good character requirements of the Registration Regulation.

Considerations

Nature of Conduct

The Registration or ICR Committee will consider a number of factors related to the nature of the finding, including but not limited to:

- is the conduct a criminal offence;
- does the conduct relate to the practice of chiropractic or another regulated health profession;
- was there a termination, suspension or limitation of employment or studies as a result of this conduct; and
- was a there a revocation, suspension or limitation of a professional licence, or a denial of a licence or certificate of registration as a result of this conduct.

Does the Conduct Reflect the Suitability of the Applicant to Practise Chiropractic

The Registration or ICR Committee will consider a number of factors in determining if the conduct affects suitability to practise, including but not limited to:

- nature of the conduct, including the degree of dishonesty or breach of trust;
- motivation;
- duration;
- isolated or repeated incident;
- prior history and/or warning;
- concealment;
- intoxication or impairment; and
- issues related to physical or mental capacity.

Subsequent Conduct

The Registration or ICR Committee will consider a number of factors relevant to the subsequent conduct of the applicant or member, including but not limited to:

- has the applicant or member recognized the inappropriateness of the conduct and accepted responsibility for it;
- has the applicant or member implemented changes to prevent a repetition of the conduct;
- how long ago the conduct occurred and subsequent demonstration of good character since; and
- has the applicant or member participated in any treatment, education or other activity to address the conduct.

Procedure

In considering the conduct as it relates to the registration of the applicant, the Registration or ICR Committee may request additional information from the applicant or member, including but not limited to:

- a detailed account of the conduct;
- relevant documents related to the conduct (e.g., court documents, regulatory files);
- an explanation from the applicant;
- evidence of prior and subsequent behaviour;
- a completed professional portfolio detailing past work history, volunteer work, education and continuing education and professional development;
- reference letter(s) from past employers, professional colleagues and other sources;
- letter(s) of good standing from regulators where the applicant practised chiropractic or another health profession;
- current police check;
- details of actions taken to address the conduct; and

- any other relevant documents

Following consideration of all relevant information, the Registration Committee may:

- Register the applicant;
- Register the applicant with terms, conditions and limitations;
- Register the applicant, after requiring the applicant to sign an undertaking agreeing to terms conditions and limitations;
- Defer the decision pending receipt of additional information; or
- Not register the applicant

The ICR Committee may take any action consistent with its powers under section 26 of the Health Professions Procedural Code, Schedule 2 to the *Regulated Health Professions Act, 1991*.

LEGISLATIVE CONTEXT

Health Professions Procedural Code, Schedule 2 to the *Regulated Health Professions Act, 1991*

26 (1) A panel, after investigating a complaint or considering a report, considering the submissions of the member and making reasonable efforts to consider all records and documents it considers relevant to the complaint or the report, may do any one or more of the following:

1. Refer a specified allegation of the member's professional misconduct or incompetence to the Discipline Committee if the allegation is related to the complaint or the report.
2. Refer the member to a panel of the Inquiries, Complaints and Reports Committee under section 58 for incapacity proceedings.
3. Require the member to appear before a panel of the Inquiries, Complaints and Reports Committee to be cautioned.
4. Take action it considers appropriate that is not inconsistent with the health profession Act, this Code, the regulations or by-laws. 2007, c. 10, Sched. M, s. 30.

Prior decisions
(2) A panel of the Inquiries, Complaints and Reports Committee shall, when investigating a complaint or considering a report currently before it, consider all of its available prior decisions involving the member, including decisions made when that committee was known as the Complaints Committee, and all available prior decisions involving the member of the Discipline Committee, the Fitness to Practise Committee and the Executive Committee, unless the decision was to take no further action under subsection (5). 2007, c. 10, Sched. M, s. 30.

Quality assurance
(3) In exercising its powers under paragraph 4 of subsection (1), the panel may not refer the matter to the Quality Assurance Committee, but may require a member to complete a specified continuing education or remediation program. 2007, c. 10, Sched. M, s. 30.

Reporting by members re: offences

85.6.1 (1) A member shall file a report in writing with the Registrar if the member has been found guilty of an offence. 2007, c. 10, Sched. M, s. 63; 2009, c. 26, s. 24 (15).

Timing of report

(2) The report must be filed as soon as reasonably practicable after the member receives notice of the finding of guilt. 2007, c. 10, Sched. M, s. 63.

Contents of report

(3) The report must contain,

(a) the name of the member filing the report;

(b) the nature of, and a description of the offence;

(c) the date the member was found guilty of the offence;

(d) the name and location of the court that found the member guilty of the offence; and

(e) the status of any appeal initiated respecting the finding of guilt. 2007, c. 10, Sched. M, s. 63.

Publication ban

(4) The report shall not contain any information that violates a publication ban. 2007, c. 10, Sched. M, s. 63.

Same

(5) No action shall be taken under this section which violates a publication ban and nothing in this section requires or authorizes the violation of a publication ban. 2007, c. 10, Sched. M, s. 63.

Additional reports

(6) A member who files a report under subsection (1) shall file an additional report if there is a change in status of the finding of guilt as the result of an appeal. 2007, c. 10, Sched. M, s. 63.

Reporting by members re: professional negligence and malpractice

85.6.2 (1) A member shall file a report in writing with the Registrar if there has been a finding of professional negligence or malpractice made against the member. 2007, c. 10, Sched. M, s. 63; 2009, c. 26, s. 24 (16).

Timing of report

(2) The report must be filed as soon as reasonably practicable after the member receives notice of the finding made against the member. 2007, c. 10, Sched. M, s. 63.

Contents of report

(3) The report must contain,

(a) the name of the member filing the report;

(b) the nature of, and a description of the finding;

(c) the date that the finding was made against the member;

(d) the name and location of the court that made the finding against the member; and

(e) the status of any appeal initiated respecting the finding made against the member. 2007, c. 10, Sched. M, s. 63.

Publication ban

(4) The report shall not contain any information that violates a publication ban. 2007, c. 10, Sched. M, s. 63.

Same

(5) No action shall be taken under this section which violates a publication ban and nothing in this section requires or authorizes the violation of a publication ban. 2007, c. 10, Sched. M, s. 63.

Additional reports
(6) A member who files a report under subsection (1) shall file an additional report if there is a change in status of the finding made against the member as the result of an appeal. 2007, c. 10, Sched. M, s. 63.

Ontario Regulation 137/93 under the *Chiropractic Act, 1991*

Section 2

2. A person shall apply for a certificate of registration by submitting a completed application in the provided form together with the applicable fees under the by-laws.

Section 3

3. The following are registration requirements for a certificate of registration of any class:

1. If the applicant has previously been or is registered or licensed to practise another health profession in Ontario, or chiropractic or another health profession in any other jurisdiction, the applicant must provide evidence that there has been no finding of, and that there is no current investigation or proceeding involving an allegation of, professional misconduct, incompetence or incapacity or similar conduct….
4. The applicant's past and present conduct must afford reasonable grounds for belief that the applicant,
   i. is mentally and physically competent to practise chiropractic,
   ii. will practise chiropractic with decency, integrity, honesty and in accordance with the law,
   iii. has sufficient knowledge, skill and judgment to engage in chiropractic, and
   iv. will display professional behaviour.

Section 4

4. Every applicant is required to provide the College with details of the following with respect to the applicant that occur or arise after the applicant has submitted his or her application, and if the applicant becomes a member, it is a condition of the member's certificate of registration that he or she provide such details:
   1. A finding of professional misconduct, incompetence or incapacity or similar finding in Ontario in relation to another health profession or in any other jurisdiction in which the applicant is registered or licensed to practise chiropractic or another health profession.
   2. An investigation or proceeding for professional misconduct, incompetence or incapacity or similar finding in Ontario in relation to another health profession or in any other jurisdiction in which the applicant is registered or licensed to practise chiropractic or another health profession.
   3. A finding of guilt in relation to any offence.

Section 5

5. The Registrar may revoke the member's certificate of registration if the member made a false or misleading statement in his or her application for registration or on any form related to his or her renewal or reinstatement of registration.

By-law 17: Public Register

17.7 If requested, the member shall immediately provide the College with the following information, in the form requested by the College:

(i) information about any finding of professional misconduct or incompetence or similar finding that has been made against the member by a body that governs a profession, inside or outside of Ontario, where the finding has not been reversed on appeal, including;
  (i) the finding,
  (ii) the name of the governing body that made the finding,
  (iii) a brief summary of the facts on which the finding was based,
  (iv) the penalty and any other orders made relative to the finding,
  (v) the date the finding was made, and
  (vi) information regarding any appeals of the finding.

(j) information about any finding of incapacity or similar finding that has been made against the member by a body that governs a profession, inside or outside of Ontario, where that finding has not been reversed on appeal, including:
  (i) the finding
  (ii) the name of the governing body that made the finding,
  (iii) the date the finding was made,
  (iv) a summary of any order made, and
  (v) information regarding any appeals of the finding.

(k) information about the member's participation in the Quality Assurance Program,

(l) information for the purpose of compiling statistical data,

(m) information about any finding by a court made after June 3, 2009 that the member is guilty of any of the following:
  (i) an offence under the *Criminal Code of Canada*;
  (ii) an offence related to prescribing, compounding, dispensing, selling or administering drugs;
  (iii) an offence that occurred while the member was practising or that was related to the practice of the member (other than a municipal by-law infraction or an offence under the *Highway Traffic Act)*;
  (iv) an offence in which the member was impaired or intoxicated; or
  (v) any other offence relevant to the member's suitability to practise the profession.
  (n) information about any finding by a court made after June 3,2009 of professional negligence or malpractice against the member.

REQUIREMENT TO DISCLOSE POLICE CRIMINAL RECORD CHECKS

Policy P-056
Registration Committee
Approved by Council: April 26, 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 clarify the College of Chiropractors of Ontario's (CCO) responsibility to protect the public interest by ensuring that only competent, safe and ethical applicants are registered.

To ensure that applicants for registration to CCO provide a police criminal record check for the purposes of demonstrating good character and disclosing findings of guilt in relation to an offence.

OBJECTIVES

As part of its mandate to regulate the chiropractic profession in the public interest, CCO requires applicants for registration to demonstrate good character in accordance with section 3(4) and disclose findings of guilt in relation to an offence in accordance with section 4(3) of Regulation 137/11 under the *Chiropractic Act, 1991*, as follows:

Section 3(4): The applicant's past and present conduct must afford reasonable grounds for belief that the applicant,

i. is mentally and physically competent to practise chiropractic,
ii. will practise chiropractic with decency, integrity, honesty and in accordance with the law,
iii. has sufficient knowledge, skill and judgment to engage in chiropractic, and
iv. will display professional behaviour.

Section 4(3): Every applicant is required to provide the College with details of the following with respect to the applicant that occur or arise after the applicant has submitted his or her application, and if the applicant becomes a member, it is a condition of the member's certificate of registration that he or she provide such details:
A finding of guilt in relation to any offence.

As part of its due diligence and efforts to promote openness and accountability, CCO requires applicants for registration to provide a Canadian Police Information Centre (CPIC) Vulnerable Sector (VS) check from the applicant's current jurisdiction in Canada as well as any past jurisdiction(s) in which the applicant has practised. The CPIC VS check verifies whether an

applicant has a criminal record or any record suspensions for sexual offences, and searches local police records for information relevant to the CPIC VS check.

Applicants who are applying from an international jurisdiction shall provide a documentation from their jurisdiction that is substantially equivalent to the CPIC VS.

DESCRIPTION OF POLICY

Procedures

1. The following applicants and members shall submit a CPIC VS check with their application for registration:
    - all applicants for initial registration with CCO, including those moving from another Canadian jurisdiction under the Agreement on Internal Trade,
    - individuals suspended from the findings of a discipline hearing seeking reinstatement with CCO, and
    - Individuals with a revoked license seeking reinstatement with CCO.

    The CPIC VS check can be obtained from a local police department or the Royal Canadian Mounted Police (RCMP).

2. The CPIC VS check must show that the search of the CPIC database was conducted no more than six months before the date of application for registration.

3. The CPIC VS check must include the following information:

    - Records of discharge which have not been removed from the CPIC system in accordance with the *Criminal Records Act, 1985*, and records of outstanding criminal charges of which the police are aware;
    - The name on the report must match the name that appears on the applicant's registration application;
    - The report must indicate that the search was completed on all names the applicant is currently using or has used;
    - The date of birth that appears on the report must match that on the application;

4. The results of the CPIC VS check must be submitted to CCO directly from the police or RMCP or in a sealed envelope provided to the applicant by the police or RCMP.

5. If the report indicates a criminal record, applicants are required to submit sufficient documentation regarding the criminal charge to facilitate an assessment of the report by the Registration Committee.

6. All reports indicating a criminal record will be referred to the Registration Committee for review. The Registration Committee will review the report and application, consistent with Policy P-054: Determination of Good Character of an Applicant or Member http://cco.on.ca/site_documents/P-054.pdf.

For more resources and instructions on how to obtain a CPIC VS, please consult the following websites:

- Canadian Police Information Centre www.cpic-cpic.ca
- Ontario Provincial Police: www.opp.ca
- Royal Canadian Mounted Police: http://www.rcmp-grc.gc.ca

LEGISLATIVE CONTEXT

Regulation 137/11 under the *Chiropractic Act, 1991*

Section 3(4): The applicant's past and present conduct must afford reasonable grounds for belief that the applicant,

i. is mentally and physically competent to practise chiropractic,
ii. will practise chiropractic with decency, integrity, honesty and in accordance with the law,
iii. has sufficient knowledge, skill and judgment to engage in chiropractic, and
iv. will display professional behaviour.

Section 4(3): Every applicant is required to provide the College with details of the following with respect to the applicant that occur or arise after the applicant has submitted his or her application, and if the applicant becomes a member, it is a condition of the member's certificate of registration that he or she provide such details:
A finding of guilt in relation to any offence.

ACCESSIBILITY POLICY

Policy P-057
Registration Committee
Approved by Council: November 30, 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 College of Chiropractors of Ontario (CCO) is committed to providing inclusive and responsive services, in accordance with the *Ontario Human Rights Code*, 1990, the *Accessibility for Ontarians with Disabilities Act, 2004*, that accommodates applicants, members of CCO and members of the public with disabilities in accessing CCO services.

DESCRIPTION OF POLICY

Definitions

Under the Human Rights Code, disability means:

6. Any degree of physical disability, infirmity, malformation or disfigurement that is caused by bodily injury, birth defect or illness and, without limiting the generality of the foregoing, includes diabetes mellitus, epilepsy, a brain injury, any degree of paralysis, amputation, lack of physical co-ordination, blindness or visual impediment, deafness or hearing impediment, muteness or speech impediment, or physical reliance on a guide dog or other animal or on a wheelchair or other remedial appliance or device,

7. A condition of mental impairment or a developmental disability,

8. A learning disability, or a dysfunction in one or more of the processes involved in understanding or using symbols or spoken language,

9. A mental disorder, or

10. An injury or disability for which benefits were claimed or received under the insurance plan established under the *Workplace Safety and Insurance Act, 1997*.

The definition includes disabilities of different severity, visible as well as non-visible disabilities, and disabilities the effects of which may come and go.

Information and Communications

CCO will communicate with people with disabilities in ways that take into account their disability.

CCO will endeavour to provide communications and documents in alternate formats upon user request and maintain a simple typeface that is easy and large enough to read and where possible allow the user to increase the font size to suit their needs.

Assistive Devices

CCO is committed to serving people with disabilities who use assistive devices to obtain, use or access CCO's location and services. When the need arises, CCO will ensure that staff are trained and familiar with assistive devices that may be used by people with disabilities while accessing CCO services.

Use of Service Animals and Support Persons

CCO is committed to accommodating people with disabilities who are accompanied by a service animal or support person to access CCO's location and services.

Notice of Temporary Disruption

CCO will provide members and the public with notice in the event of a planned or unexpected disruption in the facilities or services usually used by people with disabilities (such as elevators). This notice will include information about the reason for the disruption, its anticipated duration, and a description of alternative facilities or services, if available.

Questions or Feedback

CCO welcomes questions or feedback regarding our barrier-free services and programs. Please direct any questions or feedback in person or by mail to cco.info@cco.on.ca.

GUIDELINES

Introduction

Guidelines provide advice or recommendations intended to guide members of the profession.

Advantages

Guidelines are flexible, informal and "user-friendly" for members. Guidelines are easy to implement and change because they only require approval by Council.

Current Guidelines

CCO #	Title
G-001	Communication with Patients
G-005	Guidelines for Members Concerning Office Staff
G-008	Business Practices
G-009	Code of Ethics
G-010:	Mandatory and Permissive Reporting
G-011:	Accommodation of Human Rights and Disabilities
G-013:	Chiropractic Assessments
G-014:	Delegation, Assignment and Referral of Care
G-015	Virtual Care
G-016	Communication to the Public
G-017	Use of Artificial Intelligence by Members

COMMUNICATION WITH PATIENTS

Guideline G-001
Patient Relations Committee
Approved by Council: December 4, 2015 (replaced current G-001: Prevention of Sexual Abuse of Patients)
Amended: September 15, 2016, February 6, 2018
Amendments recommended to Council for Approval: April 20, 2022 (came into effect June 22, 2022)

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 importance of communication with patients as a fundamental component of the doctor/patient relationship.

OBJECTIVES

To emphasize the importance of:

- verbal and non-verbal communication with the patient in the doctor/patient relationship;
- effectively communicating and touching a patient in a sensitive, therapeutically and culturally appropriate manner;
- avoiding any boundary crossings and grooming behaviour and preventing any sexual abuse of a patient.

DESCRIPTION OF GUIDELINE

Proper communication between the member and a patient is essential in establishing a trusting doctor/patient relationship. The following guideline describes the importance of appropriate communication in all aspects of the doctor/patient relationship.

Verbal Communication

A member can help enhance the trust and care in the doctor/patient relationship by using appropriate communication practices in all verbal interactions with the patient at all times. A member shall ensure that the way he/she verbally conveys information to the patient is understandable and comfortable for the patient, by:

- using language associated with chiropractic care that is clear and comprehensible to the patient;

- using charts and diagrams to help explain elements of chiropractic care and overcome any conceptual difficulties;

- being particularly sensitive to the patient's comprehension of all verbal, written and non-verbal communication, and provide plain language options where possible. Should interpretation services be required, the member should support the patient in identifying potential resources and receiving services during treatment;

- talking directly to a patient when working with an interpreter or any support staff;

- encouraging the patient to ask any questions to clarify any misunderstandings and providing clear and concise answers;

- being honest, straightforward and tactful;

- demonstrating respect and empathy for the patient;

- acknowledging and legitimizing any fears, embarrassment or discomfort of the patient; and

- avoiding any misunderstandings by asking the patient to verify the intended message, and if appropriate, asking the patient to repeat it in his/her own words.

Non-Verbal Communication

The non-verbal component of communication can convey a great deal to patients at all times. A member shall ensure they use appropriate non-verbal communication with patients, by:

- maintaining appropriate eye contact with the patient;

- adopting appropriate facial expressions and body language that are consistent with the verbal communication;

- listening attentively to the patient; and

- acknowledging the communication from the patient.

Professional verbal and non-verbal communication with the patient can greatly enhance the doctor/patient relationship by:

- assisting the patient in making informed health care decisions;

- increasing the patient's confidence in the member;

- creating an environment that is relaxed, cooperative and avoids conflict; and

- increasing the patient's understanding of the care provided.

Communication Relating to the Chiropractic Scope of Practice

Members shall ensure that communication to patients is within the chiropractic scope of practice and consistent with relevant standards of practice, including but not limited to Standard of Practice S-001: Chiropractic Scope of Practice and Standard of Practice S-013: Consent. This includes:

- focusing communication on patient-centred care, based on the specific patient's reasons, objectives and goals for seeking chiropractic care;

- providing care within the chiropractic scope of practice, including diagnostic and therapeutic procedures and adjunctive therapies, as described in Standard of Practice S-001: Chiropractic Scope of Practice;

- using clear and concise communication and language to communicate matters related to informed consent and chiropractic examination and care, including but not limited to:

    - communicating the description, benefits, materials risks, side effects and alternatives to chiropractic care
    - not guaranteeing success of care nor exaggerating health care claims related to chiropractic care
    - providing a patient an opportunity to ask questions and addressing those questions in a clear and concise manner.

- referring patients to an appropriate health professional if a matter is beyond the chiropractic scope of practice;

Communication Relating to Touching for Examination and Treatment

Members are reminded that procedures requiring touching of the patient may be open to misinterpretation. Ensuring that the patient understands at all times what is being done and why will greatly enhance the doctor/patient relationship.

A member shall use professional and appropriate care when touching a patient, by:

- obtaining proper consent consistent with Standard of Practice S-013: Consent, which includes an explanation of why, where and when the patient is to be touched and an informed agreement from the patient, prior to touching a patient;

- advising patients that they may have a third-party of their choosing present (e.g., spouse, trusted friend) for their examination and treatment and providing appropriate accommodations to reasonable patient requests to have a third-party present, subject to any safety, public health and privacy measures;

- continuously checking for the patient's level of understanding and consent throughout the care provided;
- acknowledging that consent to touching may be withdrawn at any time during a procedure;
- providing reassurance and explanations during all professional encounters;
- involving the patient in some aspects of the procedure, such as moving him/herself in response to clear instructions;
- avoiding causing any unnecessary distress or embarrassment to the patient;
- respecting the patient's dignity and personal space;
- using firm, appropriate pressure when touching the patient to give reassurance and produce a relaxed response;
- using gloves for reasons relating to quality assurance, hygiene and decreased intimacy, when appropriate;
- demonstrating particular awareness when palpation involves a sensitive area (e.g., breast, gluteal and inner thigh) and when appropriate, palpating carefully with the patient's guidance, participation and consent; and
- demonstrating sensitivity to patients with cultural or religious considerations.

Privacy with Respect to Touching

A member shall demonstrate respect for a patient's privacy and dignity, by:

- allowing the patient independence and enough time and privacy while disrobing;
- informing the patient to only remove clothing that would materially impede a thorough physical examination of the spinal column and pelvis, or any local area the member may wish to examine (e.g., shoulder) and ensuring the patient puts on a gown opening to the back;
- ensuring the patient, who must necessarily be partially unclothed for therapeutic reasons, is as comfortable as possible;
- using appropriate gowning methods to maintain the respect for a patient's privacy and dignity; and
- requesting the patient's permission for students or staff to observe.

Communication by Email, Texting, Social Media and Other Electronic Methods

A member is expected to comply with all existing legal, regulatory and professional obligations when engaging in electronic communication with a patient. A member shall ensure that any electronic communication is:

- private and confidential, in accordance with privacy legislation and CCO standards of practice;
- secure from loss, tampering, interference or unauthorized use or access;
- done only with the authorization or direction of the patient; and
- recorded in the patient health record and available in hard copy.

Avoiding Boundary Crossings and Grooming Behaviour and Prevention of Sexual Abuse of Patients

Members are reminded that CCO has a policy of zero tolerance and no act of sexual abuse, as defined by the *Regulated Health Professions Act, 1991* (*RHPA*) is acceptable. Sexual abuse, as it is defined in the *RHPA*, includes:

(d) sexual intercourse or other forms of physical relations between the member and the patient,
(e) touching, of a sexual nature, of the patient by the member, or
(f) behaviour or remarks of a sexual nature by the member towards the patient.

For the purposes of subsection (3), "sexual nature does not include touching, behaviour or remarks of a clinical nature appropriate to the service provided."

Members are reminded that the sexual abuse of a patient may be preceded by certain grooming behaviour or boundary crossings. Examples of this include:

- sharing intimate details of the member's personal life with the patient;
- probing patients for inappropriate personal information;
- giving or receiving extravagant gifts from the patient;
- becoming involved with a patient 's personal life;
- influencing a patient to change his/her will or other testamentary instrument;
- excessive complimenting and/or flirting with a patient;

- assuming patients' values are the same as their own (e.g., patients could feel pressured to support their chiropractors' causes for fear of receiving inferior care)

- initiating non-clinical touch with a patient or clinical touch without consent;

- offering unsolicited advice regarding non-clinical issues;

- engaging in other business ventures with a patient that may be in a conflict of interest with providing chiropractic care;

- engaging in certain social activities with a patient, such as getting a drink at a bar; and

- engaging in texting, emailing or social media communication that is unrelated to chiropractic care;

In assessing whether grooming behaviour or a boundary crossing may be occurring, a member shall consider the following:

- Is this in my patient's best interest?
- Whose needs are being served?
- Could this action affect my services to the patient?
- Could I tell a colleague about this?
- Could I tell my spouse about this?
- Am I treating this patient differently than others?
- Is this patient becoming special to me?

A member shall avoid grooming behaviour and boundary crossings or any behaviour that may lead to the potential sexual abuse of a patient.

LEGISLATIVE CONTEXT

Health Professions Procedural Code, Schedule 2 to the *Regulated Health Professions Act, 1991*

Sexual Abuse of a patient

Section 1(3): In this Code, "sexual abuse" of a patient by a member means,

(g) sexual intercourse or other forms of physical relations between the member and the patient,

(h) touching, of a sexual nature, of the patient by the member, or

(i) Behaviour or remarks of a sexual nature by the member towards the patient.

Exception

Section 1(4): For the purposes of subsection (3), "sexual nature does not include touching, behaviour or remarks of a clinical nature appropriate to the service provided.

Definition of Patient

Section 1(6): For the purposes of subsections (3) and (5), "patient", without restricting the ordinary meaning of the term, includes,

(a) an individual who was a member's patient within one year or such longer period of time as may be prescribed from the date on which the individual ceased to be the member's patient, and

(b) an individual who is determined to be a patient in accordance with the criteria in any regulations made under clause 43 (1) (o) of the *Regulated Health Professions Act, 1991*; ("patient")

Statement of purpose, sexual abuse provisions

1.2 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 eradiate the sexual abuse of patients by members.

Register

Section 23(2): The Register shall contain the following:

(7): The result, including a synopsis of the decision, of every disciplinary and incapacity proceeding, unless a panel of the relevant committee makes no finding with regard to the proceeding.

Section 23(11): The Registrar shall refuse to disclose to an individual or to post on the College's website information required by paragraph 7 of subsection (2) if,

(a) a finding of professional misconduct was made against the member and the order made was only a reprimand or only a fine, or a finding of incapacity was made against the member;

(b) more than six years have passed since the information was prepared or last updated;

(c) the member has made an application to the relevant committee for the removal of the information from public access because the information is no longer relevant to the member's suitability to practise, and if,

  (i) the relevant committee believes that a refusal to disclose the information outweighs the desirability of public access to the information in the interest of any person affected or the public interest, and

  (ii) the relevant committee has directed the Registrar to remove the information from public access; and

(d) the information does not relate to disciplinary proceedings concerning sexual abuse as defined in clause (a) or (b) of the definition of "sexual abuse" in subsection 1 (3).

Orders relating to sexual abuse

Section 51(5): If a panel finds a member has committed an act of professional misconduct by sexually abusing a patient, the panel shall do the following in addition to anything else the panel may do under subsection (2):

3. Reprimand the member.
4. Revoke the member's certificate of registration if the sexual abuse consisted of, or included, any of the following,
    i. Sexual intercourse
    ii. Genital to genital, genital to anal, oral to genital, or oral to anal contact,
    iii. Masturbation of the member by, or in the presence of, the patient,
    iv. Masturbation of the patient by the member,
    v. Encouraging of the patient by the member to masturbate in the presence of the member,
    vi. touching of a sexual nature of the patient's genitals, anus, breasts or buttocks,
    vii. other conduct of a sexual nature prescribed in regulations made pursuant to clause 43 (1) (u) of the *Regulated Health Professions Act, 1991.*

Statement re: impact of sexual abuse

Section 51(6): Before making an order under subsection (5), the panel shall consider any written statement that has been filed, and any oral statement that has been made to the panel, describing the impact of the sexual abuse on the patient.

Same

Section 51(7): The statement may be made by the patient or by his or her representative.

Notice to member

Section 51(8): The panel shall not consider the statement unless a finding of professional misconduct has been made.

Section 51(9): When a written statement is filed, the panel shall, as soon as possible, have copies of it provided to the member, to his or her counsel and the College.

Application for Reinstatement

Section 72(1): A person whose certificate of registration has been revoked or suspended as a result of disciplinary or incapacity proceedings may apply in writing to the Registrar to have a new certificate issued or the suspension removed.

Section 72 (3): An application under subsection (1), in relation to a revocation for sexual abuse of a patient, shall not be made earlier than,

(a) five years after the date on which the certificate of registration was revoked; or
(b) six months after a decision has been made in a previous application under subsection (1).

NOTE TO MEMBERS

Guideline G-001: Communication with Patients should be read in conjunction with:

- The sexual abuse provisions of the *RHPA*
- Standard of Practice S-001: Chiropractic Scope of Practice
- Standard of Practice S-013: Consent
- Standard of Practice S-014: Prevention of Sexual Abuse of Patients
- Policy P-003: Principle of Zero Tolerance

GUIDELINES FOR MEMBERS CONCERNING OFFICE STAFF

Guideline G-005
Patient Relations Committee
Approved by Council: July 6, 1996
Amended: June 27 and October 14, 2000, September 21, 2010, September 28, 2012, February 11, 2014, September 15, 2016

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 guidelines to members related to supervision of their office staff on issues such as communication with patients, the use of gowns, language used with patients, confidentiality of personal health information and disclosure of professional fees.

DESCRIPTION OF GUIDELINE

It is recommended that a member review this guideline with his/her office staff and ensure staff comply with the provisions of this guideline. A member is responsible for the actions of his/her office staff and must ensure that any act delegated to office staff is performed in accordance with CCO regulations, standards of practice, policies and guidelines.

Note: For the purposes of this guideline, "staff" does not refer to another member of CCO, a member of another Ontario regulated health profession, or a student of an accredited chiropractic program working under the supervision of a member. See Policy P-050: Supervision and Direction of Chiropractors in Training.

Office Staff

Members are reminded that they are responsible for the supervision and are ultimately responsible for the actions of their office staff, and shall adhere to the following procedures when delegating to staff:

- A member may not delegate to staff the performance of any controlled acts under the *Chiropractic Act, 1991*, subject to any exceptions of the *Regulated Health Professions Act, 1991*. The *Regulated Health Professions Act, 1991, s. 29* allows delegation of a controlled act under certain circumstances, such as a student fulfilling the requirements to become a member of a health profession and the act is within the scope of practice of the profession and is done under the supervision or direction of a member of the profession. Please see Policy P-050: Supervision and Direction of Chiropractors in Training for more information.

- A member shall ensure he/she only delegates to staff responsibilities within the chiropractic scope of practice, and consistent with CCO legislation, regulations, standards of practice, policies and guidelines. A member must ensure that staff is competent and properly trained to perform the act.

- A member shall ensure that staff does not offer health care or treatment/care advice to patients, except as directed by the member, including but not limited to in-person, on the phone or through electronic communication. It is the responsibility of the member to ensure that the information is communicated and documented.

Communication Related to Touching and Patient Sensitivity

A member shall ensure staff is educated and informed about communication, appropriate vs. inappropriate touching of patients and any cultural sensitivities of patients. See Guideline G-001: Prevention of Sexual Abuse of Patients for further guidelines around interacting with patients.

Gowns

When delegating the gowning of a patient to staff, a member shall ensure that staff:

- use appropriate gowning methods to maintain respect for a patient's privacy and dignity.

- inform the patient to only remove clothing that would materially impede a thorough physical examination of the spinal column and pelvis, or any local area the member may wish to examine (e.g., shoulder).

- ensure the patient puts on a gown opening to the back.

Language

- It is a member's responsibility to ensure that all language used by the member and staff to communicate with patients is professional and sensitive to the culture and language of the patient.

- A member must ensure that staff avoid remarks or comments that could, in any way, be construed by a reasonable person as offensive in nature.

Confidentiality

- A member is ultimately responsible for ensuring that all staff maintain confidentiality of personal health information of patients, consistent with the *Personal Health Information Protection Act, 2004* (*PHIPA*) and CCO policy.

- All personal health information must be maintained in strict confidence in or outside the office. Personal information may only be disclosed to the patient, the patient's substitute-

decision maker, or in accordance with *PHIPA* and Standard of Practice S-002: Record Keeping.

- A member shall ensure that staff complies with all existing legal, regulatory and professional obligations when engaging in electronic communication with a patient, and that all communication is:
    - private and confidential, in accordance with privacy legislation and CCO standard of practice;
    - secure from loss, tampering, interference or unauthorized use or access;
    - done only with the authorization or direction of the patient; and
    - recorded in the patient health record and available in hard copy.

Professional Fees

- The member's office fee structure, including the commencement of billing services, must be fully disclosed to a patient prior to treatment. It is the member's ultimate responsibility to ensure that the patient is informed of the exact nature of the fee structure, how and when it will be implemented and all questions related to professional fees are addressed.
- The member is ultimately responsible for ensuring that staff can provide a clear explanation of the fee structure in the office.
- Disputes related to fees are a common aspect of practice in the member's office. To avoid potential dispute, the patient should be informed of the professional fees for each service to be rendered prior to commencement of treatment.
- For further details, please see Guideline G-008: Business Practices

Procedure

CCO recommends that members and their staff implement the above into their office setting. Members are reminded that it is their professional obligation to review all materials from CCO to ensure they are current with their professional responsibilities.

Legislative Context

This guideline should be read in conjunction with the following CCO documents:

- Regulation R-008: Professional Misconduct
- Standard of Practice S-014: Prohibition of a Sexual Relationship with a Patient
- Policy P-050: Supervision and Direction of Chiropractors in Training
- Guideline G-001: Prevention of Sexual Abuse of Patients
- Guideline G-008: Business Practices

BUSINESS PRACTICES

Guideline G-008
Quality Assurance Committee
Approved by Council: November 29, 2007
Amended: February 26, 2013, April 26, 2017, November 29, 2018, February 26, 2020 and August 12, 2020 (amendments from February 26, 2020 and August 12, 2020 came into effect September 12, 2020), September 9, 2022 (came into effect November 24, 2022)

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/financial 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 *Professional Misconduct Regulation 852/93* concerning Business Practices.
- To establish requirements for members to provide accurate and complete information to patients regarding fees, unit billing, and/or billing/financial arrangements, as they relate to the delivery of care and services.
- To establish requirements for members to clearly communicate to patients their rights when discussing fees for service provided. This includes the patient's right to choose and/or refuse billing/financial arrangements (as outlined below) and their right to opt out of such plans at any time during care.
- To establish requirements for members to 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 and be consistent with 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, a member must adhere to the following conditions:

- fees must be for services that are diagnostically or therapeutically necessary, and provided in accordance with accepted CCO regulations, standards of practice, policies and guidelines;

- 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:
    - the nature of the consultation, examination, care or plan of care or other services to be provided,
    - who is delivering the care,
    - if any care is to be delegated, assigned or referred,
    - the use of any adjunctive therapies and/or services,
    - the sale of any products, and/or
    - practices relating to billing third-party payors (see section on "Billing Third Party Payors");

- fees must be documented in the financial record and invoice and consistent with the member's fee schedule;

- fees, including the documentation of fees in a financial record, invoices and itemization of an account for professional services, must not be false or misleading.

- an account for professional services must be itemized and readily available, if:
    - 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
    - the account includes a fee for a product or device or a service other than care;

- a comparative re-assessment, as set out in standard of practice S-002: Record Keeping and Guideline G-013: Chiropractic Assessments, must:
        - be conducted when clinically necessary and, in any event, no later than each 24th visit;
        - 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, which includes a discussion of any billing/financial arrangement.

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.

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 (i.e. all components of a visit billed as one item). 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 Arrangements

A billing/financial arrangement, which includes a block fee or any other payment plan (billing/financial arrangement), is any fee arrangement where the patient is charged for multiple services and/or treatments, including the pre-payment of fees, at any time other than when the services and/or treatments are provided.

A member offering a billing/financial 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.

Any billing/financial arrangement must be directly representative of and connected to the treatment/care plan agreed upon by the member and patient. This includes considerations of:

- the patient's complaint, symptoms and/or reasons for visiting a chiropractor;
- the patient's diagnosis or clinical impression;
- the informed consent process;
- the nature of the treatment plan;
- the patient's objectives and goals for treatment;
- the type of care plan (e.g. acute, preventative, wellness, etc.); and
- the patient's comfort level in agreement to a billing/financial arrangement.

Periodic reassessments are a mandatory part of any care/plan of care and are based on the same clinical judgement components used in all phases of patient care. Additionally, periodic reassessments are valuable opportunities to revisit informed consent with the patient. The timing and reason for each comparative assessment depends on:

- patient progress;
- expectations of progress;
- presentation of new conditions; and
- requests from third-party payors such as WSIB, etc.

Any billing/financial arrangement must include regular re-assessments, as described in Guideline G-013: Chiropractic Assessments, which must be conducted when clinically necessary and, in any event no later than each 24th visit. At every comparative re-assessment, a member must review:

- the patient's progress as it relates to the plan of care recommendation;
- the patient progress to date;
- the patient's objectives and goals at this point compared to the initial presentation;
- the appropriate recommendation for continued care, referral or discharge; and
- discussion /review and documentation of any billing/financial arrangements for payment of care/treatment/services.

In offering a billing/financial arrangement, a member must:

- consider the appropriateness of offering a billing/financial arrangement which reflects: the plan of care, the objectives and planned outcomes of care, patient goals and requests, patient comfort, and the member's ability to provide a prognosis of the length of time required to reach the stated outcomes;

- discuss with the patient the appropriateness of a billing/financial arrangement as it relates to a plan of care, prior to the offering of a billing/financial arrangement, including but not limited to:
    - informed consent to care, as described in Standard of Practice S-013: Consent
    - the nature of the treatment plan,
    - the health care goals and objectives for the patient,
    - the patient's comfort in agreement to a billing/financial arrangement,
    - the value and outcomes of the billing/financial arrangement, and
    - any billing or reimbursement from insurance companies or third-party payors that would be affected by a billing/financial arrangement;

- make all reasonable efforts to ensure the patient is comfortable with and understands all aspects of the billing/financial arrangement, including the right of the patient to pay for each services as it is provided and the right to opt out of the billing/financial 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/financial arrangement, or opt out of a billing/financial arrangement;

- offer the option to pay for each service, which must be clearly communicated to the patient and not affect a patient's ability to access chiropractic care. A member must never deny a patient chiropractic care if a patient does not agree to billing/financial arrangement;

- ensure there are protections for the patient to receive a refund for any unused portion of the billing/financial arrangement in case of bankruptcy, death, dissolution of practice and other incidences which may interrupt a course of care;

- respect a patient request to pay for each service as it is provided;

- if a discount is offered as part of the billing/financial arrangement, it must be clear, agreed upon by the member and patient and applied contemporaneously with the agreement of the billing/financial arrangement – i.e. at the beginning of the treatment plan;

- notify the patient if any additional services or products are not covered under the billing/financial arrangement; and

- provide the patient with monthly written updates upon request from the patient, which includes how much of the billing/financial arrangement the patient has used, and the fees that the patient has paid.

When charging a billing/financial arrangement, the member must have a written agreement signed by the member and the patient. The written agreement must include:

- details the billing/financial arrangement;

- includes a link to the CCO website www.cco.on.ca;

- includes the following provisions, that 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/financial arrangement if the fees differ; and

    - fully informed the patient of his/her right to opt out of a billing/financial arrangement at any time during care, and the patient's right to a refund of any unspent portion of the billing/financial arrangement, calculated by reference to the number of services provided multiplied by the billing/financial arrangement unit cost per service.

A member must provide a patient with:

- a copy of the signed, written agreement relating to a billing/financial arrangement; and
- an itemized account of the billing/financial arrangement upon request by the patient.

A member shall not subject the patient to any undue pressure and/or duress when offering a billing/financial arrangement.

Repayment of Unused Billing Arrangement

- A patient may choose to opt out of a billing/financial 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/financial arrangement.

- A member must fully refund to the patient any unused portion of the billing/financial arrangement calculated by multiplying the number of services provided by the established unit cost per service of the billing/financial arrangement within 30 days of the patient request.

- A member must ensure they have the resources to provide the patient with a refund for any unused portion of a billing/financial arrangement, upon request of the patient, within 30 days of the patient request. Any fees collected by the member through a billing/financial arrangement for future care is in a sense held in trust by the member, until the care is provided.

- If a patient opts out of the billing/financial 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/financial arrangement. A refund must reference the unit cost per service, which may be complimentary or discounted, of the billing/financial arrangement

Example of Calculation of Refund Billing/Financial Arrangement (which include additional services)

Guideline G-008: Business Practices provides the following example for a patient who wants to opt out of a billing/financial arrangement and how to provide a refund to a patient who opts out.

Service	Fee for Service	Billing Arrangement
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/financial arrangement pays $900 up front, and opts out of the billing/financial arrangement plan after receiving 10 chiropractic treatments, 2 re-evaluations, cervical traction and radiographs.

Total amount of billing/financial arrangement ($900)

Services Received:

- Billing/financial 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/financial arrangement) - $450 (spent portion of billing/financial arrangement) = $450 (unused portion of billing/financial arrangement)

Billing Third-Party Payors

A member may not bill any third-party payor in excess of his/her 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 CONTENT

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,

ii. 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.

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.

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.

CODE OF ETHICS

Guideline G-009
Quality Assurance Committee
Approved by Council: November 29, 2007
Amended: February 14, 2012, November 29, 2018, February 26, 2020 (came into effect April 15, 2020)

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

INTENT

To advise members of their obligation to act competently and ethically in the practice of their profession.

DESCRIPTION OF GUIDELINE

Chiropractors have been granted the privilege of self regulation, a privilege that obliges them to act competently and ethically in the practice of their profession. In so doing, they shall maintain recognized standards of practice of chiropractic care while also observing professional values. Their commitment to such practice shall ensure public trust, collaboration with their colleagues, and the integrity and dignity of the profession.

The ethical values that guide the profession are identified here. These principles are intended to aid chiropractors individually and collectively in maintaining a high level of ethical conduct.

Chiropractors shall:

1. practise only within the limits of professional and personal competence;

2. practise in surroundings that shall not compromise the quality of care offered;

3. act always with personal integrity while also trying to acquire and maintain the confidence and respect of their patients;

4. render care to those who seek it, without discrimination on the basis of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status, socio-economic status or disability, and interact truthfully with their patients;

5. have the well-being of patients as their paramount objective and shall:
   - provide appropriate and necessary care;
   - not offer to guarantee a cure to his/her patients, either verbally or in writing;
   - clearly communicate to patients all fees and practices related to chiropractic care, including policies and procedures related to billing arrangements, billing of insurance companies and third-party payors;
   - neither exaggerate nor minimize the gravity of a patient's condition, nor apply pressure or duress to a patient;
   - collaborate with other recognized health care practitioners so the patient shall have the benefit of coordinated team care;
   - never abandon patients without due regard for their welfare once they have been accepted into the practice. If, for any reason, a member wishes to withdraw from a case (e.g., an issue of self-respect or dignity, or the need for assistance for the patient of someone more skilled), the member shall give the patient sufficient notice of withdrawal of care so as to permit them to secure an alternate care provider, if appropriate;
   - avoid conflict of interest in caring for their patients (i.e., they shall not take physical, mental, social, sexual, cultural or financial advantage of patients); and
   - endeavour to ensure, in advance of any examination or care, that patients understand any legal responsibility of the member to third parties (so as to protect the patient's interests);

6. ensure that the capable patient has an ongoing opportunity to make an informed and voluntary choice for chiropractic intervention or non-intervention, and ensure that the non-capable patient has a capable substitute decision maker who acts for the patient in making choices that are informed, voluntary, continuing and non-contrary to the previously expressed wishes of the patient. In the absence of such previously expressed wishes, or in the ignorance of them, the member shall ensure that any decision taken by the substitute decision-maker is in the best interest of the patient;

7. respect and maintain privacy and confidentiality with regard to personal health information obtained from patients or from colleagues concerning patients. Such information shall be disclosed only with the consent of the patient (except when the law requires the member to do otherwise), in circumstances of inter-professional consultation or when the harm of keeping confidentiality is greater than the harm that results from breaching confidentiality.

8. not judge fellow members, their qualifications or the procedures they use, including in public forums and social media, except as may be required in the interests of the health of patients;

9. not take over a case which, or recently has been, under the care of another member, except:
   - in an emergency;
   - in consultation with the previous member;
   - when the previous member has relinquished the case; or
   - the patient has stated he/she no longer wishes to attend the previous member;

10. work collaboratively with other members and health professionals in terms of patient care (e.g., information sharing, care, consultation and education);

11. engage in professional, respectful communications with other members and health professionals and not engage in any in-person or online bullying, intimidation or harassment;

12. only enter contractual agreements, regarding his/her professional services, which have terms that are equitable and agreeable to all parties and maintain professional integrity and offer high quality care.

13. conduct him/herself with dignity so as to bring honour to the profession;

14. have one level of billing, except on compassionate grounds or when professional bodies have negotiated fee schedules with different payor agencies. They shall bring their practice to public attention only in accordance with acceptable professional standards of practice and within applicable legislation;

15. encourage ongoing professional and public education regarding chiropractic practice, and assist in educating new members of the profession;

16. recognize that ongoing professional research is necessary so as to advance the practice of the profession;

17. claim only qualifications possessed, represent accurately the nature of chiropractic treatment, and convey correct information when interpreting scientific knowledge;

18. comply with all governing legislation (with ongoing attention given to current requirements under the *Regulated Health Professions Act, 1991*, as amended, *Chiropractic Act, 1991*, the *Healing Arts Radiation Protection Act*, and the regulations under those acts);

19. endeavour to improve the standards of chiropractic services within the community;

20. comply with the code of ethics, by-laws, standards of practice, policies and guidelines duly approved by CCO and report unprofessional conduct on the part of other members to the appropriate review body of CCO; and

21. cooperate and assist CCO in a timely manner and assist CCO in its professional work.

MANDATORY AND PERMISSIVE REPORTING

Guideline G-010
Patient Relations Committee
Approved by Council: February 11, 2014
Minor Amendments Approved by Council: September 14, 2019 (came into effect November 28, 2019), November 28, 2024 (came into effect February 21, 2025)

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

INTENT

To explain CCO's expectations of members regarding and permissive reporting of patient information.

DESCRIPTION OF GUIDELINE

Members have a legal and professional obligation to maintain the confidentiality of patient personal health information. There are circumstances, however, where members are either required or permitted to report particular events to the appropriate government or regulatory agency. This guideline clarifies the circumstances under which a member's reporting duties are mandatory or permissive.

A member is expected to:

- protect patient trust by maintaining confidentiality and privacy of patient personal health information, except where required or permitted to report the information by law;
- communicate effectively and openly by informing patients of the member's reporting obligations when appropriate and when required by legislation.

I. MANDATORY REPORTING UNDER THE *RHPA*

A. Mandatory Reporting of Sexual Abuse

Under section 85.1 of the *Health Professions Procedural Code,* Schedule 2 of the *Regulated Health Professions Act, 1991* (*the Code),* when a member has reasonable grounds, obtained in the course of practising the profession, to believe that a regulated health professional has sexually abused a patient, in accordance with s. 1(3) of the *Code*, the member must file a report in writing to the Registrar of the college to which the alleged abuser belongs.

A member is not required to file a report if the member does not know the name of the regulated health professional who would be the subject of the action.

Where information regarding sexual abuse is obtained from a patient, a member must exercise their best effort to advise the patient of the requirement to file the report before doing so.

B. Mandatory Reporting by Facilities of Incompetence, Incapacity and Sexual Abuse

Under section 85.2 of the *Code*, a member who operates a facility where one or more regulated health professionals' practise have specific reporting obligations. When a member has reasonable grounds to believe that a regulated health professional who practises at the facility is incompetent, incapacitated or has sexually abused a patient, the member shall file a report in writing to the Registrar of the college to which the alleged member belongs.

A member is not required to file a report if the member does not know the name of the regulated health professional who would be the subject of the action.

C. Mandatory Reporting by Employers

Under section 85.5 of the *Code*, a member who:

- terminates or intends to terminate the employment of a regulated health professional,
- revoke, suspend or restrict the privileges of a regulated health professional, or
- dissolves a partnership, health profession corporation or association with a regulated health professional

for reasons of professional misconduct, incompetence or incapacity must report the events and reasons of the event or intended event to the Registrar of the appropriate college within 30 days.

D. Content and Timing of Report

A mandatory report must be filed within 30 days after the obligation to report arises, consistent with section 85 of the *Code*. If the member has reasonable grounds to believe that the regulated health professional subject of the report will continue to sexually abuse the patient or other patients, or that the incompetence or incapacity will likely expose a patient to harm or injury, the report must be filed forthwith.

No action or other proceeding shall be instituted against a member for filing a report in good faith under section 85.1, 85.2 or 85.5 of the *RHPA*.

The report must contain:

- The name of the member who is filing the report
- The name of the regulated health professional who is the subject of the report
- An explanation of the alleged sexual abuse, incompetence, incapacity and/or act of professional misconduct
- The name of the patient, if the grounds of the member filing the report are related to a patient of the regulated health professional who is the subject of the report, unless the matter is sexual abuse. The name of the patient who may have been sexually abused must

not be included in a report unless the patient, or if the patient is incapable, the patient's representative, consents in writing to the inclusion of the patient's name.

Please see section 85 of *the Code* https://www.ontario.ca/laws/statute/91r18 for further information regarding this reporting obligation.

II. MANDATORY REPORTING UNDER THE CHILD YOUTH AND FAMILY SERVICES ACT, 2017 (CYFSA)

Under section 74 and 125 of the *CYFSA*, a member who has reasonable grounds to suspect a child is or may be in need of protection must immediately report the suspicion, and the information upon which it is based, directly to a Children's Aid Society (CAS)[1]. A "child in need of protection" includes a child who has suffered, or is at risk of suffering, physical abuse, sexual abuse, emotional abuse or neglect.

Section 125 of the *CYFSA* includes circumstances where a member must make a report directly to a CAS. Members who have reasonable grounds to suspect a child is in need of protection must not rely on any other person to report on their behalf. Since the duty to report is ongoing, members must make a further report to a CAS if there are additional reasonable grounds to suspect that the child is or may be in need of protection.

This reporting requirement applies although information reported may be confidential or privileged, and no action for making the report shall be instituted against a member who acts in accordance with this section unless the member acts maliciously or without reasonable grounds for suspicion. However, a member who fails to report a suspicion of child abuse in the course of their professional duties may be punishable by fine.

Please see sections 74 and 125 of the *CYFSA* https://www.ontario.ca/laws/statute/17c14 for further details on these requirements.

III. MANDATORY REPORTING UNDER THE LONG-TERM CARE HOMES ACT, 2007

Under section 24 the *Long-Term Care Homes Act, 2007* where a member has reasonable grounds to suspect that a resident of a nursing home or retirement home has suffered harm, is at risk of harm due to:

- improper or incompetent treatment or care,
- unlawful conduct, abuse or neglect, or
- misuse or misappropriation of a resident's money or funding,

the member must immediately report their suspicion and the information upon which it is based to the Registrar of the Retirement Homes Regulatory Authority, or long-term care home direction.

[1] See section 34 – 39 of the *CYFSA* for details on requirements of a CAS, which may include an Indigenous Child and Family Well-Being Agency that provides services to First Nations, Inuit or Metis children and families. See the following link for a list of CAS's in Ontario.

A member who provides health care services to a resident of a long-term care home is guilty of an offence if they fail to make a report or makes a report that the member knows to be false. No action or other proceeding shall be commenced against a member for filing a report in good faith unless the member acted maliciously or in bad faith.

Please see section 24 of the *Long-Term Care Homes Act, 2007* https://www.ontario.ca/laws/statute/07l08 for further information regarding this reporting obligation.

IV. Mandatory Reporting of Designated Diseases under the Health Protection and Promotion Act, 1990

Please see Standard of Practice S-004: Reporting of Diseases for information on reporting of designated diseases.

V. Mandatory Reporting under the Occupational Health and Safety Act, 1990

The *Occupational Health and Safety Act, 1990* and its regulations specify a number of reporting obligations for members who conduct examinations on individuals in relation to employment conditions or hazards. A member who conducts such examinations should consult the legislation and its regulations. Please see: https://www.ontario.ca/laws/statute/90o01.

VI. Mandatory Reporting of Privacy Breaches

In this section "health information custodian" means a person or organization who has custody or control of personal health information as a result of or in connection with performing the person's or organization's power or duties.

"Privacy breach" is used to refer to any unauthorized collection, use, disclosure, retention or disposal of personal health information. The *Personal Health Information Protection Act, 2004 (PHIPA)* requires reporting of privacy breaches in a number of instances, as outlined below:

A. Reporting to Affected Individuals

A member acting as a health information custodian is required to notify individuals where their personal health information is stolen, lost or used or disclosed without authority. Notification must be made at the first reasonable opportunity and must include both the fact of the privacy breach and a statement that the individual is entitled to make a complaint to the Information and Privacy Commissioner (IPC).

The IPC's Privacy Breach Protocol advised that the following information be disclosed to affected individuals:

- details of the breach, including the extent of the breach and what personal health information was involved;

- the steps the member has taken to address the breach, including if the breach has been reported to the IPC; and

- contact information for someone within the organization who can provide additional information, assistance and answer questions.

The IPC advises that when determining the most appropriate form of notification (i.e., by telephone, in writing, or in person at the next appointment), a member considers factors such as the sensitivity of the personal health information.

For more information about reporting obligations in the event of a privacy breach, please contact the IPC directly and/or refer to the IPC's guideline Responding to a Health Privacy Breach.

B. Reporting to Regulatory Colleges

A member acting as a health information custodian, who employs or is otherwise affiliated with other regulated health professionals, is required to notify to the relevant regulatory body, if any of the following events occur, in accordance with section 17 of *PHIPA*:

- The regulated professional's employment is terminated or suspended, or the regulated professional is subject to disciplinary action, as a result of a privacy breach by the regulated professional;

- The regulated professional resigns, and the member has reasonable grounds to believe that the resignation is related to an investigation or other action by the member with respect to an alleged privacy breach by the regulated professional;

- The regulated professional's affiliation with the member is revoked, suspended or restricted as a result of a privacy breach by the regulated professional;

- The regulated professional relinquishes or voluntarily restricts their privileges or affiliation with the member, and the member has reasonable grounds to believe that the relinquishment or restriction is related to an investigation or other action by the member with respect to an alleged privacy breach by the regulated professional.

Members acting as health information custodians must give written notice of any of the events described above to the appropriate college within 30 days of the event occurring.

C. Reporting to Information and Privacy Commissioner

A member is required to notify the IPC in certain circumstances if an individual personal health information is stolen, lost or used or disclosed without authority. Please see section 6.3 under Regulation 329/04 of *PHIPA* for the situations involving this reporting obligation.

VII. Permissive Reporting of Disclosure to Prevent Harm Under the *RHPA*

Under section 40 of the *Personal Health Information Protection Act, 2004* (*PHIPA*), a member may disclose personal health information to prevent harm where the following criteria are present:

- there is a clear risk to an identifiable person or a group of persons;
- there is a risk of serious bodily harm or death; and
- the danger is imminent

A member is permitted to disclose personal health information in the above circumstances where disclosure is necessary to eliminate or reduce significant risk of serious bodily harm to a person or group of persons.

No action or other proceeding for damages may be instituted against a member for:

- anything done, reported or said, both in good faith and reasonably in the circumstances, in the exercise or intended exercise of any of their powers or duties under *PHIPA*; or
- any alleged neglect or default that was reasonable in the circumstances in the exercise in good faith of any of their powers or duties under *PHIPA*.

Please see section 40 of *PHIPA* https://www.ontario.ca/laws/statute/04p03 for further information.

Legislative Context

Please see the indicated legislation and regulations for further information about specific reporting obligations.

Note to Members

Guideline G-010: Mandatory and Permissive Reporting should be read in conjunction with:

- The sexual abuse provisions of the *RHPA*
- Standard of Practice S-002: Record Keeping
- Standard of Practice S-014: Prevention of Sexual Abuse of Patients
- Policy P-003: Principle of Zero Tolerance
- Guideline G-001: Communication with Patients
- Relevant legislation and regulations

ACCOMMODATION OF HUMAN RIGHTS AND DISABILITIES

Guideline G-011
Patient Relations Committee
Approved by Council: September 15, 2016

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

INTENT

To articulate members' professional, legal, ethical obligations to accommodate patients who may face barriers to accessing care.

OBJECTIVES

- To encourage members to foster an environment in which the rights, autonomy, dignity, and diversity of all patients are respected;

- To outline members' obligations under the *Ontario Human Rights Code, 1990, (the Code)* and *Accessibility for Ontarians with Disabilities Act, 2005 (AODA)* to:
    - provide health care services without discrimination; and
    - accommodate patients who may face barriers to accessing care.

DESCRIPTION OF GUIDELINE

Introduction

Members are expected to act with personal integrity, compassion and trustworthiness in providing care to those who seek it. To this end, members are expected to render care without discrimination on the basis of the *Code* and *AODA*, and accommodate patients with disabilities up to the point of undue hardship.

The following guideline outlines the professional, legal and ethical obligations in providing care without discrimination and accommodating patients who may face barriers to accessing care.

Human Rights, Discrimination and Access to Care

The *Code* articulates the right of every Ontarian to receive equal treatment with respect to services, goods and facilities, without discrimination on the grounds of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.[1] All those who provide services in Ontario, including health care services, shall do so free of discrimination.

[1] *Human Rights Code, 1990, section 1*

Discrimination may be a direct or indirect act, decision or communication that results in the unfair treatment of a person or group by either imposing a burden on them, or denying them services received by others. Discrimination may be entirely unintentional, where practices or procedures appear neutral, but may have the effect of disadvantaging certain groups of people protected under the *Code*.

Members are expected to comply with the *Code, AODA* and CCO's code of ethics, when making decisions relating to the provision of health care services to the public. Members may not discriminate, either directly or indirectly, based on a protected ground under the *Code*, when:

- accepting or refusing an individual as a patient;
- providing an existing patient with health care services;
- providing referrals to patients; and/or
- ending the doctor/patient relationship

The Duty to Accommodate

The professional, legal and ethical obligation to provide services free from discrimination includes a duty to accommodate. This duty reflects the fact that each patient may have different needs and require different solutions to gain equal access to care.

The *Code* requires a member to take reasonable steps to accommodate the needs of a patient or a potential patient, where a disability or other personal circumstance may impede or limit that patient or potential patient's access to care.

"Disability" is defined in section 1 of the *Code* as follows:

> (a) any degree of physical disability, infirmity, malformation or disfigurement that is caused by bodily injury, birth defect or illness and, without limiting the generality of the foregoing, includes diabetes mellitus, epilepsy, a brain injury, any degree of paralysis, amputation, lack of physical co-ordination, blindness or visual impediment, deafness or hearing impediment, muteness or speech impediment, or physical reliance on a guide dog or other animal or on a wheelchair or other remedial appliance or device,
>
> (b) a condition of mental impairment or a developmental disability,
>
> (c) a learning disability, or a dysfunction in one or more of the processes involved in understanding or using symbols or spoken language,
>
> (d) a mental disorder, or
>
> (e) an injury or disability for which benefits were claimed or received under the insurance plan established under the *Workplace Safety and Insurance Act, 1997*; ("handicap")

A member is required to make accommodations in a manner that is respectful of the dignity, autonomy and privacy of the patient. Examples of accommodation include:

- enabling access to health care services to those with mobility limitations;
- permitting a service or therapy animal to accompany a patient;
- ensuring a patient with a hearing or visual impairment can be accommodated; and
- ensuring signage, forms, communications and practices accommodate diversity and do not discriminate on any of the protected grounds under *the Code*.

Limitations on the Duty to Accommodate

A member is not required to accommodate beyond the point of undue hardship, where excessive cost, health or safety concerns would result or where it significantly interferes with the legal rights of others. The *Code* prescribes three conditions in assessing whether an accommodation would cause undue hardship, which are:

- cost;
- outside sources of funding, if any;
- health and safety requirements

The Human Rights Commission and Supreme Court of Canada have set a high standard for undue hardship being a limitation on the duty to accommodate. For more information and examples of undue hardship, please see the Ontario Human Rights Commission's *Policy and Guidelines on Disability and the Duty to Accommodate* www.ohrc.on.ca/sites/default/files/attachments/Policy_and_guidelines_on_disability_and_the_duty_to_accommodate.pdf.

Reconciling Competing Duties to Accommodate

There may be instances where a duty to accommodate a patient with a disability may interfere with a legal right of another patient. For example, accommodating a visually impaired patient with a service or therapy animal may trigger the allergies or illness of another patient, and interfere with his/her ability to receive chiropractic care. In such circumstances, both the patients' visual impairment and allergies would require accommodation under the *Code* and *AODA*.

Although there is not always one solution to balancing the accommodation of patients with different disabilities, the following guiding principles apply:

- Accommodation policies and practices should be flexible and creative and should apply effective problem solving based on the facts of the situation;

- It is useful to consult with each affected patient, individually to gather each patient's feedback on a possible solution that would be satisfactory to them;

- Accommodation practices should not be rigid, nor be based on impressionistic views, stereotypes or assumption, nor rate one right over another

Applying these principles to the scenario above, the member could:

- immediately separate both patients, so the patient's allergic symptoms do not worsen. For example, one patient could be moved to a treatment room or another area of the office;
- consult with both affected patients to obtain their feedback on a possible solution. This could involve rescheduling future appointments, or keeping the patients separated in the office setting;
- note in the patient health record any specific accommodations;
- ensure the waiting area is properly cleaned and maintained so as to avoid any allergic reactions to patients;
- ensure signage, forms, communications and practices accommodate diversity and do not discriminate on any of the protected grounds under *the Code*.

Limiting Chiropractic Services for Legitimate Reasons

There may be reasons that a member refuses or limits the care provided to a patient for reasons that do not discriminate.

If a member feels that he/she cannot appropriately meet the health-care needs, or lacks the competency or focus of practice to provide care to an existing or new patient, the member is under no obligation to provide care to that patient.

A member should only refuse to provide care for such patients in good faith, and communicate to the patient in a timely, direct, clear and straightforward manner, to avoid any misunderstanding. If refusing to provide care, the member is required to provide the patient with referrals to another appropriate health care provider and arrange for the patient to access copies of their record of personal health information.

Legislative Context

This guideline should be read in conjunction with:

- *The Ontario Human Rights Code, 1990*
- The Ontario Human Rights Commission Policy and Guidelines on Disability and the Duty to Accommodate
- *The Accessibility for Ontarians with Disabilities Act, 2005*
- Guideline G-009: Code of Ethics

CHIROPRACTIC ASSESSMENTS

Guideline G-013
Quality Assurance Committee
Approved by Council: April 24, 2018

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

INTENT

The purpose of this document is to clarify the role and importance of assessments that are an essential part of any chiropractic care/plan of care of a patient. Evidence of these assessments in the patient health record helps to demonstrate the chiropractor's critical clinical thought processes.

OBJECTIVES

- To outline the various assessments a member should be conducting on initial and subsequent visits as well as on a periodic basis during the care of patients. Acknowledging previous precedent-setting decisions of discipline panels, it is prudent to keep in mind that, at the bare minimum, a comprehensive re-evaluation must be conducted on or before each 24th visit.

- To emphasize that assessments are critical components of patient care.

- To ensure members understand their responsibilities to both communicate the importance of assessments, as well as the various fees associated with those assessments, and to conduct and record evidence of these assessments in the patient health record at the appropriate times in the care/plan of care of the patient.

DESCRIPTION OF GUIDELINE

Patient assessments are a mandatory component of patient care and performed for reasons including but not limited to the following:

- To determine the appropriate course of care/plan of care based on current consultation and examination findings;
- To set appropriate goals and expectations for patient care/plan of care;
- To outline, as much as possible, potential costs of the expected care/plan of care;
- To periodically plan, during the course of care/plan of care, and evaluate the patient's current condition in relation to any previous assessments;
- To assess the effectiveness of the member's chiropractic care/plan of care;
- To discuss the patient's goals and expectations for his/her ongoing care/plan of care;
- To affirm and/or revise the member's recommendations for the patient's care/plan of care; and

- To provide necessary clinical referral information when appropriate.

Patient assessments should be dedicated to furthering the clinical decision-making processes and formed in conjunction with the best available evidence, patient values and needs and always in accordance with CCO regulations, standards of practice, policies and guidelines.

Types of assessments, conducted by the member, in the typical course of patient care:

1. Initial Assessment

- Done on the first patient visit;
- Before any care/plan of care has been provided; and
- Including appropriate consultation and examinations.

2. Subsequent Visits

- Frequency and goals of these visits are based on previous assessments, either initial, comparative or updated;
- Involves the implementation of the most recent care plan recommendation;
- Done on a visit-to-visit basis, prior to the delivery of care, an evaluation is conducted to determine the next step for that visit (e.g. subjective patient comments, spinal motion or static palpation); and
- Entries are made in the patient health record in a SOAP note or similar format sufficient to document legible, accurate, individualized and personalized notes capturing the unique aspects of that particular patient encounter.

3. Comparative assessment

- Assessment related to progress of ***initial, new or updated conditions/goal assessment***;
- Be sufficiently comprehensive for the member to:
  - evaluate the patient's current condition in relation to any previous assessments;
  - assess the effectiveness of the member's chiropractic care/plan of care;
  - discuss with the patient, the patient's goals and expectations for his/her ongoing care/plan of care;
  - affirm or revise the member's care/plan of care for the patient; and
  - include documented evidence on the performance of three or more of the clinically indicated analytical/assessment procedures listed in section 4(4)(b) (not an exhaustive list) of Standard of Practice S-002: Record Keeping in order to demonstrate the need for ongoing care. Members may use additional procedures not listed.

4. New Conditions/Goal Assessment

- Assessment of any new condition/goal unrelated to any previous ***initial, new or updated conditions/goal assessment***;
- Conducted before any care has been provided to address this condition/goal; and
- Including appropriate consultation and examinations.

5. Updated Condition/Goal Assessment

- Updating status after an interruption in the expected care/plan of care of the most recently evaluated ***initial, new or updated conditions/goal assessment***;
- Be sufficiently comprehensive for the member to:
  - evaluate the patient's current condition in relation to any previous assessments;
  - assess the effectiveness of the member's chiropractic care/plan of care;
  - discuss with the patient, the patient's goals and expectations for his/her ongoing care/plan of care; and
  - affirm or revise the member's care/plan of care for the patient.

6. Discharge assessment (where applicable)

- Would be appropriate to conduct at termination of care/plan of care for a particular ***initial, new or updated conditions/goal assessment*** or meeting a particular goal of care/plan of care even if other aspects of care are ongoing;
- Be sufficiently comprehensive for the member to:
  - evaluate the patient's current condition in relation to any previous assessments;
  - assess the effectiveness of the member's chiropractic care/plan of care; and
  - provide referral reports where applicable.

It is acknowledged that a patient may discharge themselves or terminate care without completing the recommended care/plan of care. This should be noted in the patient health record, in lieu of any record of a discharge assessment.

Please note: There may be different fees associated with each type of assessment outlined. This must be clearly communicated to the patient prior to conducting the assessment. Fees and billing practices must comply with all relevant CCO regulations, standards, policies and guidelines such as Guideline G-008: Business Practices.

Periodic and regular assessments are a mandatory component of any care/plan of care and are based on the same clinical judgement components used in all phases of patient care. Implementation of any evaluation, assessment or treatment is always a clinical judgement call made by the member and based on clinical necessity, best evidence, best practices, experience, patient presentation and many other factors.

Additionally, assessments are valuable opportunities to revisit informed consent with the patient. It is typical that informed consent is obtained and dealt with at the time of the initial examination and then again after the initial diagnosis and plan of care has been delivered to the patient. It is important to remember that informed consent is not a one-time event and it may be necessary to update informed consent on a periodic basis. Some reasons for updating consent include but are not limited to the following:

- Assessing for a new complaint or goal;
- Changes to material risk; and

- Absence from care or an interruption to a plan of care for a period of time.

Therefore, revisiting informed consent is an important component of some assessments.

The timing and reason for each comparative assessment depends on a number of factors including but not limited to:

- patient progress;
- expectations of progress;
- presentation of new conditions; and
- requests from third-party payors such as WSIB, etc.

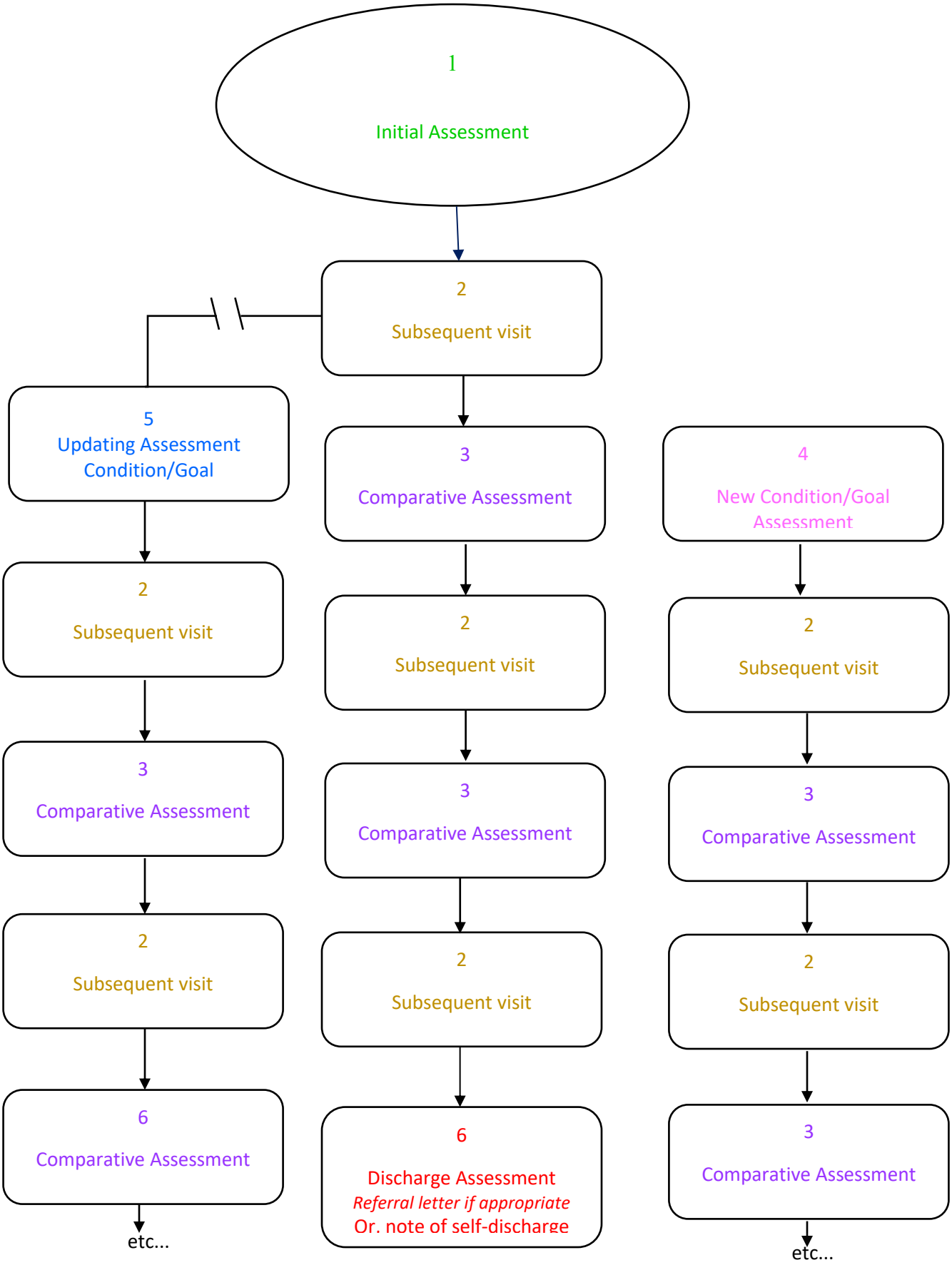
LEGISLATIVE CONTEXT AND REFERENCE DOCUMENTS

Regulation pursuant to the *Chiropractic Act, 1991*. Further, it is an act of professional misconduct under Ontario Regulation 852/93 (Professional Misconduct) to contravene or fail to comply with a standard of practice.

This guideline should be read in conjunction with the following:

- R-852/93: Professional Misconduct
- S-001: Scope of Practice
- S-002: Record Keeping
- S-006: Ordering, Taking and Interpreting Radiographs
- S-008: Communicating a Diagnosis
- S-013 Informed Consent
- S-022: Ownership, Storage, Security and Destruction of Records of Personal Information
- G-008: Business Practices
- Relevant privacy legislation such as the *Personal Health Information Protection Act, 2004*
- *Partnership of Care* Document
- Core Competencies for CCO Members

The following chart is designed to outline the most typical scenarios encountered in a typical chiropractic practice and to demonstrate when the common assessments might fall in the typical course of patient care. It is considered a crucial component of quality patient care to clearly explain, at various stages and prior to the assessment during a patient's care, the reasons for these assessments, when they will occur and the fees associated with each type of evaluation. The importance of communicating this information with the patient cannot be understated.


1
Initial Assessment
2
Subsequent visit
5
Updating Assessment
Condition/Goal
2
Subsequent visit
3
Comparative Assessment
2
Subsequent visit
6
Comparative Assessment
etc...
3
Comparative Assessment
2
Subsequent visit
3
Comparative Assessment
2
Subsequent visit
6
Discharge Assessment
Referral letter if appropriate
Or. note of self-discharge
4
New Condition/Goal
Assessment
2
Subsequent visit
3
Comparative Assessment
2
Subsequent visit
3
Comparative Assessment
etc...

DELEGATION, ASSIGNMENT AND REFERRAL OF CARE

Guideline G-014
Quality Assurance Committee
Amended: November 23, 2023 (came into effect February 23, 2024)

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 guidelines to members on the proper protocols and procedures in assigning any clinical procedures to a staff person or referring of care to another regulated health professional.

OBJECTIVES

- To outline a member's responsibilities with respect to clinical practice, patient communication, record keeping and business practices in assigning any clinical procedures to a staff person or referring of care to another regulated health professional;

- To identify which professional activities may and may not be assigned to a staff person;

DESCRIPTION OF GUIDELINE

Introduction

Members are reminded that they are primarily responsible for the examination and care of patients and adherence to relevant legislation and CCO standards of practice, policies and guidelines. However, in the course of providing care to patients, a member may assign certain aspects of clinical care to appropriately trained, supervised clinical staff, or refer patients to another health care professional.

The following guideline outlines the proper protocols in delegating, assigning or referring any aspect of clinical care of a patient.

Definitions

"Staff person" is a chiropractic office or clinical assistant who is not a member of a regulated health profession.

"Delegation" is the delegation of any controlled act that is authorized to a member under the *Regulated Health Professions Act, 1991 (RHPA), Chiropractic Act, 1991* or *Healing Arts Radiation Protection Act, 1990 (HARP)*.

"Assignment" is the assigning of a diagnostic or therapeutic procedure that is in the public domain (i.e. not a controlled act).

"Referral" is the referring of a patient from the member to another regulated health professional.

Delegation of Care

A member may not delegate the performance of any controlled act to a staff person. Chiropractic students participating in an accredited school's preceptorship program may perform a controlled act for the purposes of "fulfilling the requirements to become a member of a health profession and the act is within the scope of practice of the profession and is done under the supervision or direction of a member of the profession", in accordance with sections 29(1) and 30(5) of the *RHPA* and Policy P-050: Supervision and Direction of Chiropractors in Training http://cco.on.ca/site_documents/P-050.pdf.

Assignment of Care

Introduction

A member is responsible for the ongoing assessment, re-assessment, care and monitoring of a plan of care of a patient.

In the course of providing care to patients, a member may choose to assign certain aspects of clinical care to a staff person. Assignment may include certain aspects of the examination and care, such as:

- facilitating the completion of general intake forms and documents and collecting basic assessment data, such as the patient's height and weight, (other?);
- assisting the member during the examination and care of the patient; and
- performing of adjunctive therapies and modalities that are in the public domain and part of the chiropractic care plan.

A member is responsible for reviewing the totality of information collected on the patient and for any act that is assigned to a staff person.

Requirements for the Assignment of Examination and Care

In assigning any diagnostic or therapeutic procedure, a member shall ensure:

- the assignment of the procedure does not include any controlled acts or other restricted activities or responsibilities that may not be assigned;

- the staff person is competent and has achieved, maintained and can demonstrate the knowledge, skill, judgment and clinical competency to perform any assigned procedure safely and with the same quality of care as the member would provide. Any staff training should be ongoing and properly documented;

- any assignment of care is properly and clearly communicated by the member to the patient, and consented to by the patient before beginning the examination, care or a course of care. This should include a discussion of the roles and responsibilities of the staff person performing the assigned care, the direction and supervision provided by the member, and the right of the patient to communicate with and ask any question of the member at any time during the performance of the assigned care;

- any assignment of care is recorded in the record of personal health information by the member, including:
  - the nature of the care that is to be assigned;
  - who will be performing the assigned care;
  - informed consent to any assigned care, consistent with Standard of Practice S-013: Consent, and
  - what services will be billed as part of the assigned care.

- any assignment of care is based on a chiropractic examination, diagnosis or clinical impression, and plan of care performed by the member;

- the member is available or ensures that another member of CCO is available to provide any direction and supervision of the performance of the assigned procedure, communicate with the patient upon request, and answer any question from the patient at any time during the performance of the assigned care. The member shall ensure that the individual providing the assigned care informs the patient that the patient may communicate with or ask any questions of the member at any time during the performance of the assigned care. The level of availability and supervision required depends on the complexity of the assigned procedure, the abilities of the assistant, the patient's condition, the clinical environment and other determining factors; and

- any assignment of a procedure and performance of an assigned procedure is within the chiropractic scope of practice and complies with all legislation, including privacy legislation, and CCO standards of practice, policies and guidelines.

Procedures that may not be assigned to a staff person include, but are not limited to:

- producing, analysing and communicating the results of radiographic and other diagnostic images;

- interpreting findings and arriving at and communicating a diagnosis or clinical impression;

- obtaining informed consent, consistent with Standard of Practice S-013: Consent, for examination, care, a plan of care, or a referral from the patient or substitute decision-maker;

- initiating, communicating or changing a treatment plan;
- discharging a patient or referring a patient to another regulated health professional;
- ensuring that disclosure of any personal health information of a patient to an outside party is done in accordance with the *Personal Health Information Protection Act* and CCO privacy resources, standards of practice, policies and guidelines; and
- ensuring adherence to legislation and CCO standards of practice, policies and guidelines.

Referral of Care

In the course of providing care to patients, a member may refer a patient for diagnostic or therapeutic procedures. This referral could be to a regulated health professional within the same clinic as the member, or another clinic, or health care facility.

In providing a referral of care, a member shall:

- properly communicate the referral of care to the patient or substitute decision-maker, including the reason for the referral;
- document the referral in the record of personal health information, including:
  - the nature of the referral of care;
  - who will be performing the referred care or where the patient was referred; and
  - what services (if any) will be billed as part of the referred care;

Since any referred care is performed by another regulated health professional, that professional would be responsible for the care of the patient in accordance with the scope of practice and standards of practice of that professional's regulatory college. However, a member should conduct any necessary follow-up if the ongoing care is relevant to the chiropractic care of the patient.

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)*:

6. Contravening a standard of practice of the profession or failing to maintain the standard of practice expected of members of the profession.

16. Failing to reveal the nature of a remedy or treatment used by the member following a patient's request to do so.

17. 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

18. Providing a diagnostic or therapeutic service that is not necessary.

This guideline should be read in conjunction with:

- R-852/93: Professional Misconduct
- S-001: Scope of Practice
- S-002: Record Keeping
- S-008: Communicating a Diagnosis
- S-013: Consent
- G-008: Business Practices

VIRTUAL CARE

Draft Guideline G-015
Quality Assurance Committee
Approved by Council: November 23, 2023 (came into effect February 23, 2024)

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

INTENT

To set the expectations for members providing virtual care to patients based on existing legislation, regulation, standards of practice, policies and guidelines.

DESCRIPTION OF GUIDELINE

Definitions

Virtual care, also known as telecare, is the delivery of chiropractic care and services, using a virtual or telecommunication platform, where the patient is not in-person.

Registration Requirements

Members must be registered as a chiropractor in Ontario in the General (i.e., active) class of registration to provide virtual care to patients in Ontario.

Clinical Competency

Members who provide virtual care must ensure they have achieved, maintain, and can demonstrate clinical competency in all aspects of virtual care.

Limitations of Virtual Care

In providing virtual care services, a member must use their professional judgment to determine:

- whether virtual care is the most appropriate method to deliver services, considering the circumstances;
- whether an in-person examination is required to determine a diagnosis, clinical impression and/or treatment plan, and provide in-person care to the patient;
- where the patient has the physical, sensory, language, cognitive and technological capabilities to be able to participate in virtual care services; and
- whether there are risks, contra-indications or limitations to performing virtual care that outweigh the benefits for the patient.

A member must understand and acknowledge the limitations of virtual care, specifically with respect to: communication with patients, limitations to the performance of examination or assessment, limitations to providing a definitive diagnosis (in which case a clinical impression may be more appropriate), and recognition that no hands-on assessment or care, including a chiropractic adjustment or manipulation, can be provided.

If a member uses their professional judgment to determine that a patient may benefit from in-person examination or care, they shall make that recommendation to the patient and/or provide an appropriate referral. A member shall also accommodate any patient preferences for in-person care.

Standards and Expectations of Virtual Care

All relevant legislation, regulations, standards of practice, policies and guidelines apply to a member's performance of virtual care. This includes, but is not limited to the following:

- The member must ensure a safe, secure and confidential platform is being used for virtual care, and is used with the patient's authorization.

- The member is required to maintain the privacy of personal health information in accordance with the *Personal Health Information Protection Act, 2004* and CCO standards of practice, polices and guidelines, including the use of technological safeguards, cyber security protections, secure transmission and storage systems and mechanisms, password protection for any devices and physical safeguards to prevent unauthorized use. Please see the "Privacy and Security Considerations for Virtual Health Care Visits" document from the Ontario Information and Privacy Commissioner for further guidelines.

- The member must perform patient intake, assessment and examination, document informed consent as obtained in accordance with Standard of Practice S-013: Consent, and perform timely re-assessments.

Professional Liability Protection or Insurance

A member must ensure they have professional liability protection or insurance consistent with CCO by-laws that applies to virtual care.

Record Keeping and Billing Practices

A member must maintain patient health records and billings practices consistent with CCO standards of practice, policies and guidelines, that explicitly indicate that the services provided were virtual care. The financial record and invoices for virtual care must clearly indicate that the care being billed for was virtual care and who provided the care.

A member must discuss with the patient, in advance of examination and care, fees and payments for virtual care, and ensure that the patient has agreed to any fees and payment for virtual care.

A member should advise their patients to confirm with their insurer or third-party payor whether virtual chiropractic care is covered.

Jurisdiction

The regulation of health care is provincially regulated and under Ontario legislation. Therefore, a member should limit the initiation of the provision of virtual care to patients who are living in Ontario or who are present in Ontario.

There may be circumstances where a member may continue to provide virtual care to a patient who is out of Ontario, for the purposes of continuity of care. However, a member must consider that other provinces and countries may require registration in their jurisdiction to deliver any virtual health care services to a patient living or visiting that jurisdiction. It is the responsibility of a member to ensure that they are complying with any legal or regulatory requirements in the jurisdiction where a patient is receiving virtual care. A member should also ensure that their professional liability protection or insurance provides coverage for a patient receiving virtual care while out of Ontario.

If a patient is out of Ontario for a long period of time or has permanently moved out of Ontario, the member should advise the patient to find a chiropractor in the jurisdiction in which they will be residing.

COMMUNICATION TO THE PUBLIC

Guideline G-016
Quality Assurance Committee
Approved by Council: November 28, 2024 (came into effect February 21, 2025)

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

INTENT

Guideline G-016 is designed to detail Standard of Practice S-016 to provide further guidance and explanations of the general communication to the public requirements section of the standard of practice.

GENERAL COMMUNICATION TO THE PUBLIC REQUIREMENTS

Accuracy and Verifiability

Section	Standard of Practice	Explanation
1	A communication to the public must:	
1(a)	be 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.*
1(b)	be readily comprehensible by the target audience; and	*Advertisements should be readily understandable so the general public is not confused by the message.*
1(c)	clearly communicate that the member is a registered chiropractor in Ontario and a member of the College of Chiropractors of Ontario.	*It is important that the public be made aware that the member is a regulated health professional, a member of CCO and of CCO's role in regulating chiropractic in Ontario. This can be achieved by including a reference to the CCO website on a member's professional website and social media page.* *Advertisements must not mislead the public that the member belongs to another regulated health profession, such as the College of Physicians and Surgeons of Ontario or the College of Traditional Chinese Medicine and Acupuncturists of Ontario. Members should use titles such as "chiropractor" "Doctor of Chiropractic" or*

		"DC" and not use titles or representations which include but are not limited to the terms "medicine", "physician", "osteopath" or "neurologist" are misleading to the public. A member may list adjunctive therapies and modalities offered, such as acupuncture and nutritional or exercise counselling; however, it must be clear that they are offering these services as a chiropractor.

Permissible Content

Section	Standard of Practice	Explanation
2	A communication to the public may:	
2(a)	name a specific diagnostic or therapeutic procedure within the chiropractic scope of practice in accordance with Standard of Practice S-001: Chiropractic Scope of Practice, but cannot claim superiority or endorse the exclusive use of such a procedure	*Naming diagnostic or therapeutic procedures may assist the public in finding a particular type of chiropractic care and allow for a n informed choice. However, statements of superiority or exclusive use are unprofessional and inappropriate.* *Members may advertise services (e.g., acupuncture, ultrasound, radiography), adjunctive 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.*
2(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 outlined in Policy P-029:* • *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)* *Use of titles and terms such as "Paediatric Chiropractor", "Obstetric Chiropractor", or "Chiropractic Neurologists" will be perceived as a representation of a speciality. 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.*
2(c)	make reference to the member being affiliated with any professional association, society or body, other than CCO, only on curriculum vitae, a biographical section of a member's website or social media account, 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.*
2(d)	allow an individual or organization to endorse a member, provided, (i) the endorser has sufficient expertise relevant to the subject matter being endorsed; (ii) the member has been appropriately assessed as providing the subject matter being endorsed; and (iii) the member has disclosed any financial or other benefit given or received for the endorsement, if such a benefit has been exchanged.	*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. The public has a right to know if there was any exchange in benefit for an endorsement.*
2(e)	(e) include testimonials, that refer only to the benefits of chiropractic and not to a particular member or office, or testimonials that refer to a particular member or office only in a member's website, provided the testimonials: (i) are accurate, verifiable, and recorded in the patient health record;	*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.*

	(ii) are used only in accordance with the written consent of the patient; (iii) are not obtained using any undue pressure, duress, coercion or incentives; (iv) include a disclaimer stating that the results of the testimonial may not be typical of all patients or that results of patients may vary, (v) do not include any information, testimonial or narrative about the member providing care to the member's own family, and (vi) are otherwise compliant and consistent with the chiropractic scope of practice, privacy legislation, and CCO standards of practice, policies and guidelines.	*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.* *Testimonials may not be indicative of results for all patients and often describe a particularly favourable individual patient outcome. A disclaimer communicates to the public that they should not necessarily expect such an outcome in their case.* *Testimonials and narratives about providing care to family members may be unreliable and present a conflict of interest.* *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.*

Prohibited Content

Section	Standard of Practice	Explanation
3	Any communication to the public with respect to a member's practice must not contain:	
3(a)	anything false or misleading	*False or misleading statements, which include lying, leading one to wrong conclusions, creating a false impression, leaving out and/or making false or inaccurate claims, and undermine public trust in the profession.*
3(b)	an express or implied 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."*

3(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 messaging.* *Members should be cautious about using comparatives (e.g., more or better) in their advertising because they imply a comparison to other professionals and practices. Members may use words such as "safe" and "effective" to describe the chiropractic profession in general.*
3(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.*
3(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.*

Communication of Fees

Section	***Standard of Practice***	***Explanation***
4	A member may communicate to the public their fee(s) for chiropractic services, including any services provided for donations to a charity, provided:	
4(a)	the communication is accurate, complete, clear and not misleading (e.g., no hidden fees);	*The public is entitled to full disclosure of what is and what is not included in the advertised fee. This includes any promotions that are offered by gyms, health clubs and other businesses where members are employed.*

4(b)	(b) the communication of a promotional fee: (i) expressly states the timeframe of the promotion, (ii) does not limit the promotional fee to a specific number of participants, and (iii) does not place an obligation on the patient for any follow-up appointments as a result of the promotional fee; and	*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.* *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.* *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.*
4(c)	the communication of fees is presented in a professional manner; and	*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.*

Communication of Exchange of Products/Services for Charitable Donations/Proceeds

Section	Standard of Practice	Explanation
5	A member may communicate to the public the exchange of products/services for charitable donations, provided:	*An advertisement that encourages philanthropy, if done professionally and ethically, serves the public's interest.*
5(a)	the donations/proceeds are being collected for a registered charity, school or other organization that services the public interest ("charity");	*The charity or organization must serve the public interest.*
5(b)	the charity is disclosed in the communication; and	*The public is entitled to full disclosure regarding the charity or organization for which proceeds are being collected.*
5(c)	the amount/percentage donated to the charity is disclosed in the communication.	*The public is entitled to full disclosure regarding how the proceeds will be divided.*

Solicitation of Business

Section	Standard of Practice	Explanation
6	A communication to a patient or prospective patient for the purposes of soliciting business must be appropriate to the standards of the profession, must be respectful of patient choice, and must not involve undue pressure, including pressuring a patient to bring a family member or guest to a subsequent treatment or appointment, 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. Requiring a patient to bring another individual to any future appointment is a breach of privacy and is inappropriate.*

USE OF ARTIFICIAL INTELLIGENCE BY CCO MEMBERS

Draft Guideline G-017
Quality Assurance Committee
Approved by Council: February 20, 2026 (came into effect April 23, 2026)

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

INTENT

To ensure that use of Artificial Intelligence (AI) by members in practice is safe, ethical, effective, transparent, respects patient rights and privacy, and enhances quality of care while maintaining professional responsibilities.

DESCRIPTION OF GUIDELINE

Introduction

The emergence of AI is rapidly integrating into the delivery of health care. While AI has the potential to enhance and streamline the delivery of chiropractic care, there are important legal, regulatory and ethical considerations to ensure patient trust and professional responsibilities are met.

A member is responsible and accountable for compliance with CCO standards of practice, policies and guidelines and the overseeing of all clinical information in the application of AI in practice. This includes, but is not limited to: patient consultation and assessment, informed consent, reaching and communicating a diagnosis or clinical impression, developing and communicating a plan of care, delivering chiropractic care and any adjunctive therapies, referring a patient to another health professional, performing timely re-assessments, business practices, record keeping, and communication to the public through advertising, websites and social media.

The following guideline identifies key principles for members using AI in practice that maintain professional responsibilities and patient trust. This guideline does not set out new professional obligations but rather applies existing professional obligations and principles from CCO standards of practice, policies and guidelines to the use of AI in practice.

Guiding Principles

Clinical Competency (Standard of Practice S-001: Chiropractic Scope of Practice, Standard of Practice S-008: Communicating a Diagnosis)

- A member must have achieved, maintain and be able to demonstrate clinical competency in the use of AI if using it in practice, consistent with Standard of Practice S-001: Chiropractic Scope of Practice. This includes understanding the AI system and its application to the delivery of chiropractic care, the benefits, risks, biases and limitations of the use of AI, and how to adjust the AI system to different patient populations and circumstances.

- A member must understand the limitations of the use of AI. While AI may be able to analyze vast amounts of data or complex datasets, the outputs generated and the process by which those outputs are generated may not be immediately apparent or understandable to individuals. This creates challenges for validating the accuracy of the information.

  Additionally, some research shows that AI may not always be correct in its decision-making and may provide false or inaccurate information (often referred to as hallucination in AI research). This creates further uncertainty as it relates to the output created by AI.

- A member must always review and oversee the results of any AI output and ensure that the use of AI does not replace sound clinical judgment. Overreliance on AI without applying sound clinical judgment can pose safety risks to patients as AI may replace the judgment of healthcare professionals rather than enhance their approach to patient care.

  Additionally, the responses generated by AI are dependent on the nature and quality of the prompts provided by the human user. A poor prompt may lead to poor results, necessitating some skill on the part of the user. An AI tool must be tested for validity and reliability in the specific context of the application to the delivery of chiropractic care.

- A member must regularly review their AI system to ensure performance, safety and accuracy over time, as well as feedback to detecting errors and unintended consequences.

Consent (Standard of Practice S-013: Consent)

- A member must only use AI when there is a clear benefit to the delivery of chiropractic care to the patient that outweighs the risks.

- A member must obtain documented informed consent from patients prior to using AI in practice. Discussion must include transparency in what type of AI is used, how it is applied to patient care, if it involves any audio recording or transcription of record keeping, benefits and risks, and any other principles consistent with Standard of Practice S-013: Consent.

- Patients rely on regulated health professionals to be educated and qualified practitioners that have the competence, skill and expertise to deliver health care services. It may be challenging for patients to understand or trust the application of AI in the delivery of health care. It is essential that patients have a full understanding and appreciation of the application of AI in the delivery of chiropractic care to ensure trust is maintained.

- A member should be ready to use alternative options if a patient is uncomfortable with the use of AI.

Privacy, Confidentiality and Security (Standard of Practice S-002: Record Keeping)

- A member must comply with all relevant privacy legislation (e.g., the *Personal Health Information Protection Act, 2004*) and CCO Standard of Practice S-002: Record Keeping when using AI for patient personal health information. A member must understand the differences of a closed AI system vs. an open AI system ensure that the use of their AI system protects the confidentiality and privacy of patient personal health information.

- It is advisable for a member to work with their AI vendor to understand and apply security protocols and compliance tools.

Equity, Non-Discrimination and Accommodation (Guideline G-011: Accommodation of Human Rights and Disabilities)

- A member must ensure that the use of AI does not discriminate on the basis of human rights, including disabilities, or apply barriers to chiropractic care.

- A member must provide reasonable accommodations for patients who are uncomfortable, unwilling or unable to use AI, and alternatives to the use of AI.

LEGISLATIVE CONTEXT

This guideline should be read in conjunction with relevant legislation and CCO standards of practice, policies and guidelines, including but not limited:

- *Regulated Health Professions Act, 1991*
- *Chiropractic Act, 1991*
- *Personal Health Information Protection Act, 2004*
- S-001: Chiropractic Scope of Practice
- S-002: Record Keeping
- S-008: Communicating a Diagnosis
- S-013: Consent
- S-016: Communication to the Public
- G-008: Business Practices
- G-011: Accommodation of Human Rights and Disabilities
- G-016: Communication to the Public